*In this issue: *State leaders to divvy up $8 B in Medicaid waiver money * state hospital stays aren't free *Ellis clinic eliminates waiting for new patients *Murphy bill needs a push * judge says treatment court is success *conference planning*

NAMI-Schenectady E-NEWS

National Alliance on Mental Illness

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Nat'l Alliance on Mental Illness of Schenectady

Patients may owe $ to NYS for state hospital care---No free care, OMH declares

(Rob Puccio of the NY State Office of Mental Health in Albany made substantial revisions to this article to make it more accurate. The editor wants to thank Rob for all the time and assistance he provided.)

Few of us know this, but the care our sons and daughters receive in a state hospital like CDPC is not free, even if there is no bill issued at the time. In fact, adult patients who receive care from a state hospital like CDPC without private insurance or Medicaid to pay the bill may be billed years later for the care they received if they come into financial resources which the State Office of Mental Health can seek to collect.

This is important to understand because most of our children do not have private insurance, and Medicaid is not available to pay for inpatient state psychiatric hospital care for individuals between the ages of 22 and 64. There's no free care there, says Rob Puccio, financial manager at the NYS Office of Mental Health. We don't turn anyone away if they can't pay but we have a right to collect for the taxpayers for a stay in our hospital the same as other hospitals do, Puccio said, in a telephone interview April 9 with hospital executive director William Dickson also on the line.

Whew! For the past 40 years or so our family members have benefited by having the Capital District Psychiatric Center not far away, an extension of care for someone too ill to be released outright from a hospital like Ellis in Schenectady or Samaritan in Troy. In the old days of the 70s and 80s you stayed more than a month, perhaps three months there because the medicines weren't as good and the doctors not as precise; while today, the average stay is much shorter--about 10 days, like an acute care hospital.

And it seemed to be free, on the state cuff, so to speak. They don't send you a bill exactly or collect from Medicaid or Medicare (in most cases, they can't). But they can access the patient's bank account which is made known to them at time of arrival, and they can keep a record for later payment which might be much later when parents die and their estate is probated. The point is, the patient does not get off the hook; he or she incurs a debt for each stay which OMH may or may not ever seek to collect. It may not be big money because

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Gov. Andrew Cuomo (center) with allies at NYC forum

The state money machine—with $8B in federal Medicaid money to spend, who gets what?

Sour pickles--Not all of us agree that all this public money coming to NY from the feds under the state's 1115 waiver amendment can be put into managed care for Medicaid patients smoothly. When you hear how uncertain people are about this you have a right to be skeptical. This is billions of dollars, brontosaurus size money, just handed to New York's politicians to spend by the generosity of fellow Democrats in the US Health and Human Services agency.

All that rhetoric we read about saving millions through Medicaid Redesign ideas and creating a better system of care for the elderly, the sick and disabled, including our mentally ill relatives, has to be put in perspective. After all those hands were laid on by politicians from New York City to Albany plus the governor's personal intervention with the mucky-mucks in Washington, did you really think they wouldn't get this money? Did you think it wouldn't go for the purposes they had in mind—to shore up the failing hospitals and keep the hospital and homecare workers in jobs--not the ones we had in mind? Well, they got what they wanted and the truth is coming out now. Most of the $8 billion is going back into the failing hospitals in Brooklyn and elsewhere, evidently a payoff to those heavy downstate lobbies (see reprint of Capital News article April 16 on How the Medicaid Waiver Deal Got Done, on page 7.) That wasn't what upstaters thought the money was for, but the chickens came home to roost.

Follow the money—With all that money on the table, Governor Cuomo and NYC Mayor DeBlasio will surely find ways to spend it among their new partners in managed health care. These are going to be the big insurance companies, hospital powerhouses and health providers, and the labor unions that hang onto their political allies. The other players will tag along. Bigness begets bigness and these companies will need to use all their resources to cope with the tough new requirements of the government.

Besides, what New York is going through is part of the nationwide transformation in health care symbolized by the Affordable Care Act. People might be confused by that but most will wind up with better health care policies than before. New York's managed care Medicaid, on the other hand, breeds contempt. It's putting public purposes in the hands of private companies to manage our health, and some of them

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Meetings and events

No regular meeting of NAMI Schenectady planned this month. Instead, some of us would like to hold a conference or forum later this spring or early summer, bringing in professionals to speak. It could be held at the library, community college or a banquet hall. There are several options: to have a half-day conference starting at noon with lunch at a restaurant preceding the meeting. Or we have forums on several afternoons at the downtown library. Or we engage the auditorium at the community college for speakers there. We're thinking of medical topics of interest to families, consumers and staff members.We already have a speaker promised on the topic of "first break" psychosis and early intervention, in schizophrenia. We'll have a strategy meeting in early May.

Plans are on schedule for initial training of police officers participating in the EDP Response team (Crisis Intervention Team) training May 12-18 at the community college. The training will be coordinated by OCS Director Darin Samaha, Police Chief Brian Kilcullen and former Rochester Police Department EDP Response Team Commander Eric Weaver. Parents and family members have been recruited in the past few weeks to take part in presentations.

In addition, the Justice/Mental Health Collaboration Program is beginning its one-year planning process to include a review, analysis and assessment of mental health services in the county correctional facility. The aim is to create improvements in clinical services at the jail as well as discharge services.

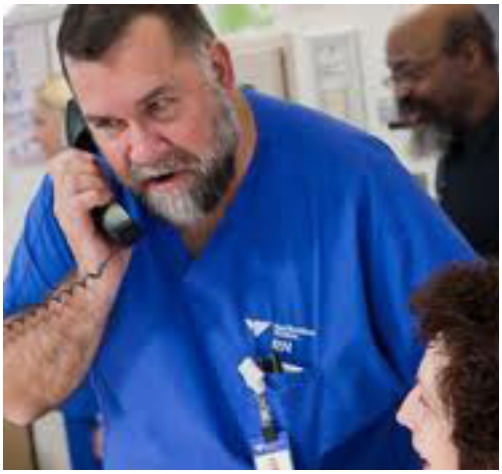
Move-in delayed for men at YMCA—People at the downtown YMCA men's residence say there's a delay in moving the men into the restored Broadway building where 155 men are to be housed in studio apartments. Latest word is that they won't be in until at least June. Delays are said to be the result of the city planning board's hesitancy to allow a pull-off for vehicles in front of the building.and there's an issue over how power is to be brought into the building. The rooms are ready for furniture and appliances but deliveries haven't arrived..

May is Mental Health Month—Roy has booklets to distribute to libraries, mental health clinics, city and county government offices and doctors' offices. If someone is interested, you can pick them up at my house and deliver them to the sites (call Roy, 377-2619). See nami.org and naminys.org websites for activities of other groups.

Relatives support group meetings

The relatives support and education group inside Ellis Hospital meets every Wednesday evening at 6 pm inside classroom B-3 of the hospital (B wing third floor). It's easy to find—park in the hospital garage and proceed through the corridor to the main elevator bank. At third floor, turn left, west, walk down hall to B wing (Psychiatry) and you'll see sign on the wall for the classroom. Counselor Kevin Moran runs these meetings every Wednesday. You can call Kevin ahead on 243-4255. A second family support group meets on an as-needed basis at the CDPC Franklin Street clinic, 440 Franklin St., corner of Jay, on Monday nights, 5:30 to 7. Counselor Frank Greco runs these meetings. Call ahead on 374-3403. Frank also runs a group in Albany at CDPC on alternate Thursday nights. Call 447-9611 x-4512.

Consumer news—the PEER group continues its live YouTube Google + hangouts every Sunday evening at 7 pm where peers discuss things mental health-related and community activities happening in the city and county "live" on the internet. (see info@schenectadypeer.com). Celeste Trotz reports: We just did our 52nd video. Sunday was our one year anniversary. It was longer than our usual episode and focused totally on mental health whereas our usual ones are an hour and include discussions about community events,hobbies, anything else. All our broadcasts are on the website and can-be found on YouTube. Everyone is welcome to participate.



Patient scheduling gets a boost from computer at Ellis MH Clinic (photo not taken at Ellis)

Ellis mental health clinic erases waits for new patients

Shazam! Faster than a speeding bullet! Ellis Hospital's mental health clinic has practically eliminated its waiting list for new patients. That's right! This wonder of the technical age, assisted computerized patient scheduling, eliminates waiting time for all but a few new patients, says Claire Wieman, director of Clinical Services. She and Tracy Jones, intake coordinator, are there to prove it at the Lafayette Street clinic where dozens of patients come for treatment daily. Nobody will have to wait more than one to five days with the new program.

When someone drops in or calls in, Claire says, we look at blank spots on the screen for clinicians who don't have someone and we schedule them in. Patients will have shorter waits, they'll have choice of more than one clinician and we can schedule clinician and doctor time more efficiently so they work a full day. The only waits will be our waits, when we've sent a fax and we're waiting on them to respond. Every doctor, nurse and social worker's time at the clinic is tied in with the intake coordinator who picks the next appropriate opening for the patient.

Wow! The speeded up system is just what the doctor ordered. Families calling the clinic for an appointment for a son or daughter, husband or wife, have had to wait over the years. And the waits stretched to 30 days or more, aggravated by abrupt staff shortages like those in summer vacation periods, or when a doctor leaves, or pregnancies among staff. If everybody is here there will be more openings and if someone is out on leave there will be fewer, but no matter how you slice it, the new system will be quicker, Claire says.

With the old system we only scheduled intake Tuesday and Thursday for clinicians. Now with electronic scheduling we look at blank spots for clinicians who don't have someone throughout the day, Claire points out. The patient will have shorter waits and get an appointment faster. Prior to this, doctors had books that the front desk maintained and every clinician had their schedule maintained that way. But the receptionist and support staff didn't know about all of them.

Most folks we've spoken to say that it's working good. The new patients get a sheet of paper that tells them who they can see on staff. The system doesn't affect our regular patients who are scheduled in every two weeks or so, she added.

Consumer News continued: Our goal is to put mental health out on the table for all to see. Reduce stigma. The best way is to stop hiding it. It has worked for many communities that have faced discrimination and stigma and is extremely effective. To those not familiar with our organization, see About Us on the website.

Letters—
Family Courts need more resources

(letter to the Daily Gazette April 23 by Helga Asquith Schroeter, who is on the committee for Modern Courts, a member of NAMI and the League of Women Voters.)

Gazette reporter Steven Cook is to be commended for his thoroughly researched April 13 article on the Family Court. It is very important to create more public awareness of the desperate needs of the Family Courts throughout the 4th Judicial District and the entire state of New York. Other courts have also suffered from a lack of resources, which causes delays in the decisions of the cases they handle. But it's particularly egregious in Family Court, where children and families await permanent solutions and where a judge with previous knowledge of the case—who does not have to be brought up to speed on the background—is very crucial to formulate the best possible solution.

It is true that other resources, including public defenders and other support staff, are in need of more funding, as Jonathan Gradess of the New York State Defenders Association points out. But adding 20 more judges, as adopted in the state budget, is certainly a step in the right direction. Hopefully it will eventually lead to more resources given to the Family Courts. Faster, well-thought-out solutions for the children and families involved in the courts should be an important policy priority in New York State.

Cult of the gun has created outlaws *(Letter to the editor of the Albany Times-Union that ran Saturday, April 19 by Roy Neville)*

With the arrival this past week of the deadline for registering military style weapons in New York, our gun-carrying comrades appear to be more tightly bound to the code of the gun than to the laws that bind the rest of us in a civilized society.

How startling to find that the cult of the firearm should monopolize the passions of this group over their responsibility to uphold and follow the law, the same as all others in society do — their wives and children, neighbors and friends and community leaders.

How discouraging to hear various police chiefs and sheriffs declare they will not enforce the law to arrest those who fail to register their firearms. And how odd it is, as Christian churches prepare for Easter week celebrations with messages of mercy and forgiveness, that the gun lobbies grow more rowdy, preaching defiance and aggression instead.

How sad to read that police officers, city councilmen and county and state legislators are willing to stand opposed to the law, contrary to the oaths they swore when they took office. New York's SAFE Act was designed as the strongest measure in the country to keep illegal guns off the street, make us all feel safer, and keep guns out of the hands of violence-prone individuals. How wrong for the head of the NY Pistol and Rifle Association to turn this into a political campaign when members of both parties in the state Legislature voted for passage of the SAFE Act in January 2013.

How unforgiveable that all those opposed seem to have forgotten

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Rep. Tim Murphy (R-Pa.), right, welcomes Noble Energy Company workers who support his bill for treatment of mental illness.

Advocacy—
Murphy bill in Congress needs a push

Advocates, including NAMI National and those who support legislation to improve treatment for serious mental illness, are battling for a bill in Congress known as the Murphy bill (HR 3717). Rep. Tim Murphy (R-Pa.) has a bill that will expand access to sparse mental health care resources. "The Helping Families in Mental Health Crisis Act would reorganize the billions the federal government pours into mental health services, prioritizing initiatives backed by solid evidence and tracking their success," a Washington Post editorial claims. "It would change the way Medicaid pays, or in this case underpays, for certain mental health treatments, it would fund mental health clinics that meet certain medical standards, and it would push states to adopt policies that allow judges to order some severely mentally ill people to undergo treatment."

Not everyone is satisfied, the Post agrees. "Some patients' advocates have condemned Mr. Murphy's approach as coercive and harmful to those who need help." But as the newspaper states (and we agree), "We do not see those aims as mutually exclusive and neither do the bill's backers. It makes obvious sense for the government to back community-based clinics that promise to prevent individuals' mental illnesses from spiraling out of control, when possible. But some people with very severe disorders do not know or do not admit that they are sick. For a small class who will not accept treatment between hospital visits or repeat arrests, states have good reason to require them to accept care, under judicial supervision."

And we know that a few people with these serious disorders badly need services that will keep them from harming themselves or others. We urge you to write or call your Congressman now to support the Murphy bill (HR 3717). For us in the 20th Congressional District (Schenectady, Albany and parts of Schoharie, Montgomery and Fulton counties), our representative is Paul Tonko, (202) 224 6542 in Washington, or 374-4547 locally. You can reach Paul by emailing cora.schroeter@mail.house.gov.

As DJ Jaffe writes on behalf of his Mental Illness Policy Organization: "You are all key people who have worked hard to improve treatment for seriously mentally ill people. Everyone else has moved on to 'mental health.' Tell the government what federal policies do you believe would reduce incarceration and arrest of people with serious mental illness. Here are some ideas: Fund AOT—Kendra's Law in NY State; preserve and increase hospitals by reforming the provision in federal law that keeps hospitals from billing Medicaid for patients' services (the IMD exclusion); let families have access to medical records of their seriously mentally ill loved ones (reform HIPAA and FERPA laws); and end the funding of anti-psychiatry" by the federal agency known as SAMHSA in Washington. Find more on Jaffe's website, djjaffe@mentalillnesspolicy.org, including a list of provisions that most directly improve care for the seriously ill and reduce the chance of violence, homelessness and suicide.

Patients may owe NYS for care *from page one*

Puccio says they try to be reasonable about it, but with the hospital costing about $1,000 a day and our children in there possibly multiple times in their lifetime, it's real money. This could substantially eat into an inheritance if you allow your money to pass directly to your child rather than into a supplemental needs trust as permitted by the social services law and Estate Powers and Trust Law 7-1-12.

A special or supplemental needs trust is one that allows the person or heirs to hang on to much of the money when there are claims placed against the person named in the trust. Many of our NAMI families have drawn up a will for ourselves and a special needs trust for our disabled child to see that our assets intended for his or her support cannot be taken at probate to pay for their hospital bills or other debts. But if we don't make these arrangements and OMH learns that a former or current patient may be coming into an inheritance, what happens to that money?

A relatively recent change in the law over the past few years provides two situations in which OMH is REQUIRED to seek to establish a Medicaid qualifying trust or similar device for the benefit of a patient. Under Mental Hygiene Law Section 29.23, if a State facility director receives a windfall on behalf of a patient which will make the patient ineligible for government benefits (e.g., an inheritance or lottery winnings), the director must seek to set up a trust for the patient's benefit. Under MHL Section 33.07, if the State facility director acting as representative payee receives a lump sum retroactive benefit for a patient which will make the patient ineligible for government benefits, again the director must seek to set up a trust for the patient's benefit.

If the money has not been paid to the director on behalf of the patient, the rules are different. If, for example, OMH learns that the executor of an estate is holding money to pay to a current or former patient as an inheritance or that some other fiduciary is holding the proceeds of the sale of a patient's property, OMH has the right to enforce its claim for payment against the executor or fiduciary, even if OMH never previously billed the patient. BUT Puccio says that when OMH does this, it tries to work it out so that the patient will have the benefit of most of the funds during his or her lifetime. First, OMH seeks to make sure that the patient is represented in these cases, either by MHLS or by a guardian ad litem. Second, OMH generally negotiates a settlement which involves using the fact that the patient owes OMH money to enable OMH to use a substantial percentage of the money (typically 50-90%) to set up a supplemental needs trust which can be used to benefit the patient during his or her lifetime, with the remainder going to OMH only upon the patient's death.

Nobody stops you at the door

Perhaps we've missed this because nobody stops you at the door like the admissions folks when you enter a general hospital like Ellis, or when you enter a nursing home like Kingsway as a Medicaid patient. For example, we read that nursing homes have a right to collect a portion of their costs each month from Medicaid patients (many of them are on Medicaid and Medicare). The state hospital doesn't get any state-federal Medicaid payment for patients aged 22-64, which includes most of them. Yet under NYS mental hygiene law, no one will be refused care even if he or she is indigent or ineligible for Medicaid or any other federal benefits such as Veteran's benefits, Puccio remarks.

What happens is more complicated. "When a patient comes in the hospital the patient is referred to our Patient Resource Office. We try to figure out what he or she is eligible for—we put the patient on Medicaid if he or she qualifies. But if the patient is an adult between 22 and 64, the government has a provision called the IMD (Institution for Mental Disease) exclusion. It prevents a hospital from billing Medicaid for his or her care."

"The Patient Resource office will look at all sources of income and assets of the patient to determine if the patient has the ability to pay something toward the cost of care being provided, which is no different from what any other hospital in the community would do. In the instance above, where the patient is aged 22-64, the patient is allowed to keep the maximum assets (such as bank accounts) allowed by Medicaid, which is $14,550. A patient's home is never considered towards this asset limit. The patient is also allowed the standard Medicaid income exemptions, which are $809 a month income plus a $20 income disregard. This allows the patient to keep a total of $829 a month, which helps him or her when they return to the community. The monthly charge or bill to the patient would be the only amount he or she is held responsible for, if any, above $829 per month."

How much do we owe?

How much does the patient owe? Every person's case is different depending on his financial situation, Puccio continues. "Let's say the patient is a male between 22 and 64 and has a Social Security income of $1,200 a month, owns his own home, and has $1,000 in the bank. The value of the patient's house does not count toward his assets for this purpose. So we would determine that the patient's total assets were $1,000, which is below the permissible Medicaid resource limit, and we would not charge against that account. We would then look at whether the patient's total monthly income is over the permissible Medicaid income ceiling of $829 a month--that is, the amount of income a person is permitted to have while living in the community and still qualify for Medicaid. Because this patient has income of $1,200 per month, we would bill him for $371 a month ($1200 less $829). When you consider that our cost of giving care is $1,000 per day, or $30,000 per month, the amount we bill is not very much."

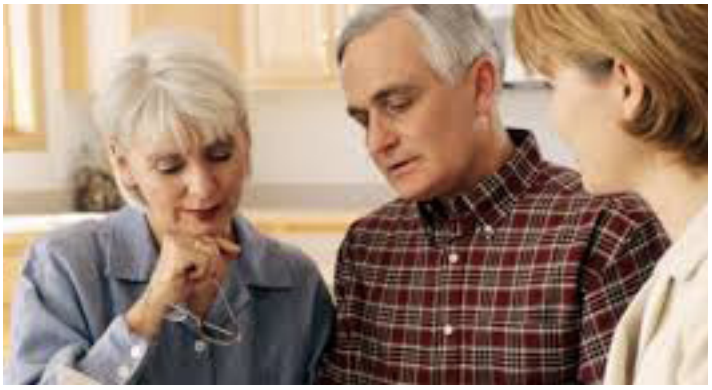
"Or let's take the case of a 50 year old person whose parents leave him a direct inheritance. The hospital may have spent thousands of dollars for the person's care, but rather than seek to collect all the inheritance to pay our claim, we will usually work out a settlement that includes putting most of the money in trust for the patient. By placing the money in trust for the patient, the patient is assured of receiving a real benefit from a substantial portion of the money as opposed to what would most often be the case -- that is, that the money would render the patient ineligible for government benefits so that almost all of it would have to be used to pay for the basics of care until it had been spent down sufficiently to render the person eligible for benefits again."

When there is no one in the family to take charge of the patient's Social Security or other federal benefits, the facility director can be assigned as "representative payee" for that patient. Other agencies, like the YMCA in Schenectady, have this role for clients or residents, too, and there are rules for how much patient income goes to the payee.

It's based on ability to pay

"What we're going to charge you is based on your ability to pay," Puccio added. "When our hospitals can bill Medicaid there is no debt. But we have the IMD and so can't bill Medicaid and must pursue payment from the patient if they have the ability to pay. Our Patient Resource Office is expert at getting someone on Medicaid. Very little of our hospital's income comes from billing patients. Medicaid and Medicare are the important sources of money to us," he concluded.

We didn't discuss in the interview what happens to the money received by the hospital. Does it go into the state's general fund and therefore doesn't benefit the state OMH hospital system? And what if the law were changed to put the money recouped into funds for the OMH's new centers for excellence where resources are to be transferred from institutions to outpatient care in the community? That's what the advocates would most like to see.



Here's the line on special-needs trusts, from an expert

(taken from Jane Bryant Quinn, personal finance expert writing in the AARP Bulletin July-Aug 2013, titled "Protecting a Relative with a Disability," much shortened and with slight editing.)

A huge concern is how to pay for care if you die before your child does. Typically, the best plan is to create a special-needs trust. You might fund the trust with money you're leaving in your will, current savings for a life insurance policy. It's critical that the trust be drawn by a lawyer who knows the disability rules. To qualify for, and keep, their Medicaid and SSI, children and adults with disabilities have to have virtually no money in their own name.

Parents, relatives or friends can contribute to a third-party special-needs trust. Because the money never belonged to the child, it won't interfere with his or her government benefits. The trust can cover "extra" quality-of-life needs, such as personal care, gifts and travel.

If the child personally comes into money, from an inheritance or an insurance settlement, that can go into a "self-funded" special-needs trust. The child continues on Medicaid or SSl, but when he or she dies, the government reaches into the self-funded trust to recover its money. That's why no one should leave money directly to the child. It should all go to the third-party trust.

As for insurance, caregivers need a "permanent" policy that covers them for life. Whole-life coverage is a good choice—its premiums and benefits are guaranteed. Universal-life policies permit a variety of payment schedules that might or might not be enough to fund the policy in later years. Please, don't let a special-needs planner or adviser at a financial services company talk you into buying more insurance than you need. (You might be shown a "financial plan" that is nothing more than a sales document.) Your policy should fund only the "extras" that you want the trust to pay.

If you're leaving a modest amount of money, consider trusts offered by non-profit organizations for people with disabilities, such as NYSARC (Delmar, NY) or the National plan Alliance. The organizations manage the trust and work with the family on a general plan of care. For larger sums, check the Special Needs Alliance for a lawyer who has experience with these trusts.

For a spouse with a disabling disease, you also need a care plan, including insurance in case you die first. Check the National Academy of Elder Law Attorneys. Ask for a lawyer who can tell you if your spouse qualifies for Medicaid's nursing home coverage. Pay special attention to your spouse's health care proxy and living will. The care you want early in the disease might differ from what you want later. Your spouse should control personal medical and financial decisions as long as possible. Sign forms while your spouse still can.

$8 Billion to spend *from page one*

have little reputation for doing so.

Believers to the core--The people who believe in a future for managed care Medicaid speak of the opportunities for service providers. NYAPRS, for example, the Albany based association of providers and consumers, writes of "opportunities within this waiver to promote behavioral health through innovative, rehabilitation-oriented techniques." Brianna Gilmore in a NYAPRS memo, April 18 writes, "The Delivery System Reform Incentive Payment (DSRIP) model is a performance-based reinvestment system. DSRIP will distribute $6.42 billion of the $8 billion to integrated networks of safety net providers called 'performing provider systems' (PPS). The money will be used to invest in new collaborative project models with the ultimate goal of reducing avoidable hospitalizations by 25% over five years. PPSs will achieve this goal by working together to improve care coordination and delivery, disease management, behavioral health interventions, and population health."

There are others less sanguine. One reviewer sees the big insurance companies coming in and hiring away the best workers from the non-profit companies by paying them more. They're much bigger and can pay whatever they wish. This in turn will weaken smaller providers who may close their doors, putting people out of work. Already several smaller hospitals have closed, like St. Francis in Poughkeepsie, or lost psychiatric beds, like Bassett in Cooperstown. It works a hardship for patients and their families who may have to travel long distances to the nearest hospital with psychiatric beds.

Doubters persist--In fact, few leaders have much assurance about how it's going to come out. A program director says he's spoken to a manager of an insurance company intent on running Medicaid managed care in this area and he said he had no idea how they would proceed. A Schenectady county leader tells me she is worried about the whole changeover—what is going to happen to the people in these programs, to the staffs and the programs. Will they survive? The record of big insurance companies running public health care, like the long term care program in Tennessee, is bad. An article in The NY Times tells us (March 6) that in some cases as needs of the elderly grew costlier the care was denied. That could happen here, too.

You're in or you're out--With NY's ambitious plan under the waiver to create networks of collaborative hospitals and agencies to bring down costs, can bigness be bad here? Yes, said one industry spokesperson: These big systems will make demands on the providers and if the providers can't come through, they won't survive. They'll be bought up by the larger ones, he said. This is a competitive model. The hospitals around here are buying up doctors' practices like crazy. If a doctor has a few hundred patients they'll come in with him and that hospital is part of an insurance plan, like the HMOs today—Blue Cross or Mohawk Valley Physicians Plan, for instance. You're either in or you're out. Those outside the network won't be able to afford to pay for health care as an outsider and they won't find services anywhere else. There won't be anything else.

Where will they go? There aren't going to be any other service entities outside the big managed plans. How does someone with severe mental illness figure out which plan is best to join? The man said, Our employees can't decide. And if he doesn't join the right one, he's out.

An unhappy future--This person sees an unhappy future for people in the public mental health system. You get from people at the top that they don't really care what happens to people in the mental health system, he says. They haven't done anything to open up this system and spend more in the past. They want to cut out all the spending they

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City Judge Matt Sypniewski (at right) addresses NAMI lunch group April 11 at Van Dyck Restaurant

Judge praises city's mental health court for restoring lives

Schenectady's City Court Judge Matthew Sypniewski told our NAMI lunch group that he felt the alternative treatment court he heads has been a success in restoring lives and in upholding our values by giving people with disabilities a new lease on life. The court is also saving the city money by taking people out of jail and letting them continue to live and work in the community so long as they obey the rules.

Judge Sypniewski, who has headed the alternative (mental health) court for two and a half years, was our guest speaker at the Van Dyck Restaurant April 11. He said "It's an important program. It saves money. We have good results." He told how the process worked and what he thought the results were. Among them, the judge said he thought the special court "says a lot about Schenectady's values—the same as for the drug court. It's giving them a chance for a better quality of life and it's voluntary, for those who want to do it. "

The judge arrived at our lunch meeting after having finished a busy morning agenda at police court where he is one of two city criminal court judges. There were about 100 cases to dispose of that morning, he said.

The city's mental health court is a misdemeanor court set up about six years ago to create a better surrounding for hearing the cases of defendants who have a diagnosed mental illness. The court meets on Monday afternoons every two weeks, separate from the regular courts so that those coming before the judge don't have to stand up in a crowded courtroom. He has the assistance of social workers and probation officers and occasionally others are in court who come from a hospital, the Franklin Street clinic and the downtown alcohol and substance abuse agency.

The idea of the court is to allow someone with a diagnosis of mental illness to stay in the community under supervision while meeting the standards set for him and to keep him out of jail, Judge Sypniewski said. Persons who have been recently arrested are chosen as candidates and evaluated by the Ellis social worker. If accepted in the program, the individual has to plead guilty, usually to a lesser charge, and agrees to sign a contract. It calls for him to come to court regularly, plus go to treatment, keep appointments and stay out of trouble. From that point he is released from jail with approval of the district attorney's office. He must attend court every two weeks for sometimes up to a year to prove to the judge he is abiding by the rules such as taking his medicine and staying off drugs.

Nearly always, the deal is going to be successful, the judge says. "Treatment court works. I've rarely had to send someone back to jail. There has only been one or two in a year. But that doesn't mean there aren't setbacks. Some of the people don't live up to the terms slack. He has put some of them in jail for a weekend. But with the threat of returning to jail hanging over his head, the individual is not likely to repeat the same criminal conduct that got him there, the judge points out. He gets to know these people pretty well--he meets personally with each of the 15 people in the program every two weeks. And some of the families attend, he said.

When these people finish the program, they are released from the charges placed against them. "We hope we have established connections, they're law abiding, and they've connected with their families," the judge noted. "We've graduated many of them."

Judge Sypniewski, 38, was appointed city court judge by former Mayor Brian Stratton after serving seven years in District Attorney Bob Carney's office where he prosecuted major crimes. The judge read to us from his speech county court the previous Sunday on the courthouse steps. He wrote that he was committed to treating all people fairly and equally. And that is good news for those coming before him in the treatment courts.`

Impressions from Cindy

(Cindy Seacord, our NAMI treasurer and membership coordinator, writes about her activities and interests and about bringing the NAMI Signature Program Family to Family to Schenectady County.)

When I linked up with NAMI years ago, in order to gain support with respect to and insight into my loved one's mental illness, I welcomed the meetings, first the Wednesday evening support group at Ellis with Kevin Moran, and then the monthly meeting of NAMI-Schenectady which at the time was held in the early evening in a building on Wendell Avenue in Schenectady. I learned a lot from the meetings and from reading NAMI brochures and when I joined, I got a great deal out of newsletters that came from NAMI-Schenectady, as well as the great periodicals sent to me from NAMI-NYS and the national NAMI organization. Since then, I've found the various NAMI websites to be very helpful, as is the annual education conference held each November.

Recently NAMI-Schenectady started a video and book lending library. The items in the library are generally available on loan at the Wednesday night meetings, and will be added to over time. A great read that I found for myself at the education conference is Dr. Lloyd I. Sederer, MD's The Family Guide to Mental Health Care, which is loaded with advice on helping your loved ones who have mental illness. Sederer is the medical director of the country's largest state mental health system right here in New York State (OMH) and the mental health editor of The Huffington Post. His book is loaded with information for any person who either fears their loved one is mentally ill, or knows it and may be just beginning the trip through the "maze" that the current mental health system presents. Sederer has anticipated nearly every question a lay person might have, while also providing his reader with hope. Well-written and empathetic, I personally found the book added to my knowledge base, if nothing else, as I zipped through the 250 pages (the book also has several helpful appendices.) I have my own copy because it will probably serve me well in the future as a great reference!

What is also proving to be extremely helpful because of being supportive and educational is the NAMI Signature Program Family to Family class that I am attending under NAMI-Rensselaer. A 12-week program, Family to Family classes run 2 1/2 hours each, with a break, and lead you through a great deal of material in a very structured and easy to follow way. The class is taught by two teachers who have personal knowledge of the issues because they have a loved one with mental illness, and are willing to give up their time in order to help others facing the challenges they have faced. The program helps us by providing knowledge of what to do, how to do it, who can help, and a detailed understanding of the major mental illnesses and how one is diagnosed, including treatments, medications, even how to find a good psychiatrist or psychiatric social worker.

Now mid-way through the program, I must say that I'm even more determined that we bring the course to Schenectady. NAMI keeps its course materials up to date so that attendees are let in on the latest in research, as well as treatments. It also offers insight into what our loved ones go through; for example, we learned about the impact these illnesses have on one's self-esteem, and how better to provide empathy and support. NAMI offers other programs that can also be offered. The Basics class is six weeks, and is intended more for families whose loved one is 18 or younger. You can learn more about the Signature Programs by checking them out on the NAMI websites and reading about them in NAMI publications.

continued on page 8

How the Medicaid waiver deal got done

(shorter version of article on Capital New York, April 16.)

In January of 2011, Gov. Andrew Cuomo, fresh off a landslide election win and faced with a struggling economy and a bloated state budget, needed to find ways to reform the state's Medicaid program, the most expensive in the nation.

Medicaid had been a growing problem and a source of frustration in Albany for decades, with previous governors foiled in their reforms by both hospital management and the state's powerful health care unions. But Cuomo saw an opportunity to enlist some potential adversaries.

In one of his first major meetings, the new governor sat down with Dennis Rivera, executive director from 1199 SEIU Healthcare Workers East, and Ken Raske, president of the Greater New York Hospital Association, according to multiple sources familiar with the meeting. The two sides struck a broad deal: The unions and the hospitals would have a seat at the table to help plan changes to the program, and together with Cuomo's office they would come up with some of the largest cuts to the Medicaid program the state had seen. There would be no whining, no marches on Albany and no backstabbing. Everyone would agree to billions less in revenue.

Governor Cuomo

In exchange, Cuomo promised to aggressively lobby the Obama administration for a Medicaid waiver that would bring billions in federal dollars back to the state, which could then be used for specific programs that would hopefully make hospitals more financially secure.

On Monday, Cuomo delivered on his end of the bargain, announcing that New York finalized terms and conditions with the federal government for a Medicaid waiver that will allow the state to reinvest $8 billion over five years."In 2011, New York did what people said couldn't be done: we overhauled our Medicaid system to save taxpayers billions while delivering better health care," Cuomo said in a press release.

That 2011 overhaul was orchestrated by the state's Medicaid Redesign Team, which was co-chaired by Rivera and Michael Dowling, CEO of North Shore-LIJ, and also included Raske and George Gresham, president of 1199 SEIU.The team, working with Jason Helgerson, New York's Medicaid director, allowed hospital executives and labor leaders to essentially find ways to cut their own payments, and the state later announced it had saved $17.1 billion by implementing 78 specific reforms.

Some of the decisions could have proved very contentious, like a cap on spending growth and a 2 percent across-the-board cut to providers' reimbursement rates. (If providers couldn't meet the cap, the Medicaid Redesign changes would have given the state's health commissioner the ability to slash funding at will.) But the coalition held together.

The Medicaid savings set Cuomo on a path to reduce New York's budget, which would eventually allow for a tax cut and a surplus, the two main talking points in the governor's re-election campaign. And it did so without prompting the attack ads from labor unionsthat had become an annual rite of the budget process.

Letter to editor (by Roy Neville) *from pg 3*

the impetus for the act—the slaughter of 20 children and six adults at Sandy Hook Elementary School in Newtown, Conn. by a man who had lost his senses. Those shootings should be seared in our memory. They were committed by a man with a Bushmaster assault rifle, the type outlawed now and glorified as a prize possession of many in the pro-gun crowd.

Don't these people read? There has been shooting after shooting by gun-toting individuals who might have been prevented from their acts if a tough anti-gun law was in place. I believe the SAFE Act was constructed as the most comprehensive way to get at these problems. It addresses the seriously mentally ill, domestic violence and suicides as major issues to resolve.

The message this week should be forgiveness and support for one another to make these laws work. Not the call of the gun lobbies to incite us to disobey the law.

$8 billion to spend *from page 5*

can. They just want people to go away. You know what they want? To have families take in their adult child when they've had a shot at public services like the housing programs. And these people are put out of housing because it's decided they're not progressing, not moving ahead. That's a rule now but it's loosely enforced. So are families ready to take back their mentally ill relative, the way it was back in the 50s and 60s? Yep, that's the way we're headed, all the way back, he believes.

Cindy Seacord Impressions *from page 7*

We want to begin to offer Family to Family sometime this year. NAMI-NYS knows of our interest. While I believe I have secured a co-teacher, we can always have more than two trained to teach the course. Let us know if you are interested in becoming a co-teacher. Contact me, Cindy Seacord, at cwseacord@hotmail.com for more information!

Editor's note: you are invited to call the editor, submit an article or letter about anything germane to local mental health services or the situations families and consumers face in our community, to run in the E-News. This is the monthly NAMI Schcnectady newsletter and is primarily issued via e-mail. if you want an e-mail copy send your e-mail address to the editor, rneville@nycap.rr.com. Back issues are on the website, namischenectady.org and can be downloaded in pdf format.

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