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NAMI-Schenectady E-NEWS

National Alliance on Mental Illness

November 1, 2014

Nat'l Alliance on Mental Illness

A sudden loss— a mother's anguish

By Virginia Weston

Our son, Christopher, was 39 years old when he passed away from suicide. He had been diagnosed with Schizophrenia when he was 19 years old. This was his first ever attempt and it shocked us all. You see, we were a hands-on family and very involved in his care. He said that he was attempting to get rid of his "bad blood". We assume that he meant his mental illness.

Chris Weston

He made two visits to Ellis Hospital. The first visit was on a Saturday night. He was experiencing a racing heart and very anxious. After doing an EKG, he was transferred to the Crisis Unit. They released him after 3 ½ hours after giving him a shot of something to calm him down. He asked for something that could be used on an as-needed basis, but was told that his physician (Dr. Metta) wanted to see him on Monday at the Schenectady Franklin Street Clinic.

The following morning (Sunday) he said that he was still feeling very anxious. I fixed his breakfast and he went upstairs to take a shower. He asked his father if he could borrow his portable razor to shave his beard. His dad thought nothing of it because there was no previous mention or attempt of suicide in the 20 years since his diagnosis. He then called me from the bathroom to apologize for getting blood on one of the towels. That was when I discovered his first attempt to end his life.

After much convincing, my daughter and i talked him into going back to Ellis Hospital at approximately 11:00 am. The Emergency Room doctor was ready to give him another shot and send him home. We insisted that he be admitted because we felt that this was a real "cry for help". They agreed to keep him in the Crisis Unit until a bed opened up at a nearby hospital because Ellis Hospital's Mental Health Unit did not have a bed available. We left him at approximately 5:30 pm. The following afternoon they finally found an opening in Samaritan Hospital and I met him at Samaritan that evening and he was hopeful that a "fresh look" by another doctor would prove successful.

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Marc Brandt, about to retire, has headed NYSARC in Delmar for 32 years, worries that with sheltered workshops closing, many disabled persons will be thrown out of work

Should all the sheltered workshops be closed?

Like the shifts we're experiencing in mental health with Medicaid Redesign, the Affordable Care Act and the switch to Medicaid managed care in New York, the state is uprooting its heavyweight system of development centers and sheltered workshops for the developmentally disabled. Those are people once called mentally retarded and others with profound intellectual and developmental deficits and they're under the gun as the state run and state subsidized programs close down around them.

Marc Brandt is the number one advocate for people with these disorders. He's been exec director 32 years for NYSARC, the umbrella agency for the 115 sheltered workshops that dot the landscape. Almost 8,000 people work there and Marc, who works in a wheelchair, is worried they will be thrown out of work in the next few years. The state Office for People with Developmental Disabilities (OPWDD) has told operators of the workshops their funding is being phased out, a product of federal funding reductions, legal challenges against such workshops In other states, and pressure from Washington, DC.

A story in the Albany Times-Union by Rick Karlin in July 2013 reported that operators were told to stop accepting new participants back then. It noted that sheltered workshops have come under fire in recent years from disabilities rights groups who believe they end up keeping the disabled out of the mainstream workforce. Marc Brandt has a different take.

Federal and state officials have come to think that "when you take any group of people and you put them all together, you are segregating them," Brandt said. But people who operate workshops say they don't know what their clientele will do once the doors are closed. No one can guarantee that the workers will find new jobs—especially in regions like the North Country, where work of any kind can be scarce, according to the T-U story.

There are programs where private employers use job coaches and make other accommodations for disabled workers. But those are

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Meetings and events

We're coming up on our next lunch meeting for NAMI Schenectady at the Van Dyck Restaurant at noon on Friday, Nov. 21. The Van Dyck is at 237 Union St in the Stockade neighborhood. There is parking in the lot at the corner of Union St and Erie Blvd., or on street. The dining room is to the right as you enter the restaurant.

As is our custom, we pre-order lunches for the group beforehand, consisting of panini sandwiches and wraps brought out on trays, with a salad, tea and coffee. The lunch is $15 payable to our treasurer Cindy Seacord at the meeting and includes tax and tip. We arrive at about 11:45 and the lunch is served at noon. Kindly call me (Roy Neville, 377-2619) to let me know by early pm Thursday Nov. 20 or before so I can tell the Van Dyck how many are coming.

We expect to have a doctor or pharmacist as our guest speaker to discuss medicine and medical treatment for people with psychiatric illnesses. If you know of someone who might be available, please let me know.

Relatives support groups

Relatives mental health support groups continue to meet with a counselor at two locations. Kevin Moran is the social work counselor leading the family education group at Ellis and Frank Greco meets with family members at the CDPC Franklin St clinic. Kevin's group meets at 6 pm every Wed night in classroom B-3 inside Ellis Hospital. You can call him ahead on 243-4255 if you are new to the group. These are conversational groups providing free counseling to those attending. Each person gets a chance to tell about their situation living with someone or in close proximity to a relative with a serious mental illness.

You don't need to live in Schenectady County or have had a family member hospitalized at Ellis to take part. Frank Greco is counselor for the program at the CDPC clinic at 426 Franklin St. which meets as-needed on Monday nights, 5:30 to 7. Call ahead on 374-3403. Frank also runs a support group in Albany at CDPC on alternate Thursday nights. Call 447-9611 x-4512.

Consumer news--

Consumers can check the website Schenectadypeer.com for latest activities of the PEER group (see info@schenectadypeer.com). The PEER group continues its live YouTube Google-plus hangouts on Sunday evenings at 7 where they discuss things mental health-related and community activities happening "live" on the internet. (this is temporarily halted.) To join them, call Mike Abair on 694-6953. PEER advisory board meets first and third Fridays at 1 pm at Apostrophe Coffee in Proctors Arcade. Ellis mental health crisis line is 243-3300.

Dual Recovery Anonymous support group meets Thursdays 5:30 to 6:30 at Conifer Park Outpatient at 600 Franklin St. Reach Out newsletter for July-August is out. Find a copy on www.reachout.com.or schenectadypeer.com. Mike's looking for writers to put together the next issue coming soon.

Dollar Nights at Boulevard Bowl are held every Monday & Thursday night, 9 pm until midnight.$1 each for games, shoe rental,

NAMI Syracuse presidsnt Karen Winters Swartz and board member Dr. Steven Glatt meet the press at Syracuse NAMI Educational Conference

NAMI-NYS conference awaits; Scholarships may be open

The NAMI NYS annual conference in Albany is Nov. 14-16, an excellent way for parents and other family members to keep ;up with the latest educational developments in the field, and it's right next door. The conference, from Friday morning to Sunday noon at the Desmond near the airport, features top speakers and workshops, meals together plus book signings, group discussions and educational displays. It's the high point of the year for us.

Friday, the 14th includes a plenary session on reforming the criminal and juvenile justice systems plus an update on NIMH's study of recovery after an initial schizophrenic episode. US Rep. Tim Murphy is an invited guest and evening speaker. Murphy is the author of HR 3717, The Helping Families in Mental Health Crisis Act, which NAMI NYS's board subscribes to. You can attend just Friday or Saturday at reduced rates.

Saturday's program includes a morning plenary on practice innovations with Lisa Dixon, MD who heads the RAISE project at Columbia University's Psychiatric Institute. The pm workshops deal with cognitive enhancement therapy, finding SSI benefits, research and clinical updates on specific psychiatric diseases. Others explore issues such as geriatric mental health, housing and clubhouses, recovery and peer services.

The dinner program will honor NAMI NYS founding president Muriel Shepherd. An evening speaker is to discuss transforming stigma. Meanwhile, on Sunday, one plenary session is about navigating mental health with Lloyd Sederer, who spoke at our educational forum last June. The other session is Ask the Doctor.

If you are a member of NAMI Schenectady you can apply for one of the six $90 scholarships as part reimbursement for the educational conference. At least three of our scholarships are still open as of Oct. 21. We announced this last month—you apply to Cindy Seacord, treasurer (cell 847-4961), once you sign up for all or part of the NAMI NYS conference. Find registration info on the NAMI NYS website, naminys.org. The state organization also offers scholarships which may be used up by now.

SSI checks causing shock waves

Thousands of people in NYS aged 65 and older, or people who are blind or disabled regardless of age are finding their Social Security checks are now unbundled and arriving in two pieces. The NYS supplement, about $162 a month for a single person living alone, is broken out from the federal portion, $708 for a single person as mentioned. The totals are the same but many of our relatives with mental illness who depend on the checks coming on time were shocked to find only the smaller federal amount arrived on Oct. 1. They screamed.The SSI checks are essential to these folks to pay rent due on the first. A day or two later the state portion came in the mail. Officials said NYS can save a few million dollars by sending out its own checks.

Cindy Seacord makes a point in discussion at NAMI lunch at the Van Dyck on Oct. 24

Less use of force by police in responding to crisis noted by Lt. McCracken

By Bob Corliss

Lt. Mark McCracken, commanding officer of the newly formed Schenectady Police Department Emotionally Disturbed Persons Response Team (EDPRT), addressed the monthly meeting of NAMI-Schenectady and reported that use of force by police involving persons in mental health crises has declined since formation of the unit.

The EDPRT was established in Schenectady in early summer as a result of a collaborate effort between the police department, County Office of Community Services and the State Division of Criminal Justice Services. A 40-hour training program was conducted at the community college in May, attended by 16 Schenectady officers and several more from area law enforcement agencies.

Creation of such a response team had been a priority of NAMI-Schenectady for several years during which time NAMI leaders met with city officials as well as police officials to advocate for such a unit and to offer our assistance.

Lt. McCracken said the unit consists of himself as commanding officer, three sergeants and 12 officers assigned to different shifts to create maximum coverage. All officers involved volunteered for the assignment. Officers carry out routine patrol duties, but are specifically assigned to those calls for service involving mental health crises and those involving persons who appear to suffer from a mental illness.

Lt. McCracken noted that there had already been five mental health-related calls today (Oct.24), highlighting the large volume of calls to which the department must respond. As noted, the number of calls for service which has required officers to employ any use of force has decreased, a finding often reported by departments after they institute an EDPRT Team.

Lt. McCracken reiterated the importance of the training in enabling the department to understand the roles and functions of various mental health agencies in the county, including NAMI, and how the department can better collaborate with such organizations. He gave examples of such collaboration and told of referring several families to NAMI.

He fielded questions from those in attendance and impressed the audience as a street savvy realist but one who has been truly moved by some of his experiences in dealing with mental health issues. The combination would seem to make him a wise choice to lead our EDPRT team.

A mother's anguish *from page one*

During his three-week stay he came to the conclusion that after 20 years, there was going to be no "cure" for his illness. I tried to explain to him that his disease was something that had to be treated, like having diabetes. There was no magic pill. He put his head in his hands and said: "then I just want to die". My husband and I tried to tell him that there were more medicines becoming available and that maybe sometime in the future they would find one that worked for him. I feel that at that moment he had made his mind up to take his own life. From that point on, he was on a campaign to get released from the hospital.

We don't blame the staff at Samaritan Hospital. Chris was a very strong-willed individual and when he set his mind to do something, he made sure it was done. When the team met with us and Chris on Thursday, October 2nd, he snowballed all of us. He said that he was feeling much better and was ready to be released. He promised us that he would not attempt suicide again because he saw what it did to us. We believed him.

That night, after checking back into his residence, he took a walk. He was on a mission. Our son-in-law saw him on the side of the road and tried to convince him to get into his truck; he would give him a ride to our house and I could get him back to the residence. He refused and said that he was heading back to the residence and with a big smile and a wave, said goodbye. After hearing from my son-in-law, I went out in my car to try and locate him. I could not find a sign of him. I drove to the residence and checked to see if he was there. They told me that they had not seen him since he left for a "walk". We agreed to notify each other if he was located. I went back to where he was sighted and still could not find him. Later that evening, we were informed of the incident on the railroad tracks. He was identified by his wristband that he had not removed when he left Samaritan Hospital. We were heartbroken, our first-born was gone. We would not get a chance to say goodbye or I love you ever again.

His battle is over. No amount of love could hold him back. We made sure to always include Chris in all family celebrations and fun-filled vacations. Although they sometimes got noisy, he was able to escape to a quiet place and listen to his music. We respected his need for silence.

Although our lives are changed forever, we do not blame Chris for leaving. It was his time. His struggle with the side-effects of medication and the stigma of mental illness is over. He could not come to grips with the idea that he had to live any longer with his "disease" and chose to leave his way. We know that he is now at peace and we're sure that he is in a better place.

On a client's death:

From Mohawk Opportunities leader Joe Gallagher: "With HIPAA laws we're not able to talk about individual clients–what has happened and the circumstances that led to his death. When there's a death in a community residence we meet with staff and clients and discuss these things and give supports they will need. We let clinicians know. We bring in a grief counselor. And we have an increased presence for the next week or so to talk to the residents.

"Any death in our homes is the same as a death in anybody's home and we supply them with support to get them through the loss."

Sheltered workshops to close *(from page 1)*

relatively rare and hard to sustain, according to people in the disability field.

"If we didn't have this, my guess is they would be sitting home doing nothing," said Martin Nephew, executive director of Mountain Lakes Services, which runs Essex Industries, a workshop center in Mineville. "They might otherwise be in nursing homes," added Hanns Meissner, executive director of the Rensselaer ARC, which operates a small work center where people help package instant coffee and soup mix used in the state prison system.

Karlin wrote that the term "sheltered" denotes the idea that disabled people who work there are protected from the competitive pressures found in the larger labor market. But they are falling out of favor, due to concerns about isolation and the pay, which can be below minimum wage. There have been charges that some workshops exploit the disabled. But some say phasing out all of NY's workshops may be a case of throwing out the baby with the bath water in order to head off criticism.

Workshops here once allured mentally ill clients

Sheltered workshops were set up to serve people with mental illnesses as well, back in the 1970s and early '80s in our area. At least 20 men and women toiled in an old building on Catalyn St. off Chrisler Avenue back then, a branch of the Capital District Psychiatric Center's sheltered workshop. They sat at tables and put earrings on cards for which they were paid pennies a card and they inserted pages in Bender Co. law books, the bread and butter contract. Other work, if I remember correctly, included wrapping record album covers in cellophane, and reassembling some small machine parts. Nobody disapproved of the work which was routine and repetitive. It was easy and people were satisfied to do these jobs at low pay. They found friends there and considered these jobs as something they were proud to hold.

Al Holmes, a likeable guy who later became a manager for the state Office of Mental health, ran the program. The building had poor heating and ventilation, was too hot in summer and too cold in winter, and lacked a loading dock, necessary for everyday deliveries. The workshop's failings led parents to become advocates in Schenectady for the first time, clamoring to state officials for them to find something better. Jesse Nixon, CDPC's executive director, began hunting and picked a site on Maxon Road in the former Big N Plaza. That was in the 1990s. While renovations began, the move fell through, I think because the owners of the property had an unsavory background and the state didn't want to do business with them.

So Nixon cast his eyes not far away, selecting new construction on Van Vranken Avenue, now the home of Marty's Hardware. Some of the same clients in the first program chose to continue there. We didn't think of stigma attached to this work. But state policy makers eventually saw the work as stunting to people with different degrees of mental instability who should not be denied full opportunity for competitive jobs. CDPC closed the workshop 10 or more years ago and moved a small remnant within the framing shop space next to the CDPC mental health clinic on Franklin Street. That segment soon shut down as the state ended the era of subsidized workshops for the mentally ill.

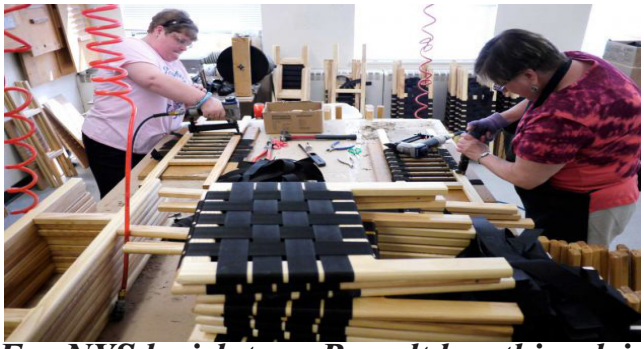
Marc Brandt's messages to the faithful

NYSARC's Marc Brandt put out an advocacy letter on Oct. 1 titled Election Day 2014; Key NYSARC Issues. It's instructive to see how he musters the arguments for his membership. He uses the power of a united front in Congress to go after the administration (HHS and CMS) and its sources of money. He backs the privately operated sheltered workshops and housing providers. He defends policies of the state developmental centers and the revenue they bring in from sky-high billings in the Medicaid program.

He fights for more pay for employees. In short, he's a super advocate who has used his intelligence and experience to lead the way for those in the field all these years. As the same time he's looked the other way at the notorious Medicaid billings of the state developmental centers which have brought down the wrath of Congress on NYS. He's willing to fight to keep workshops open at a time when the handwriting is on the wall for them to close. He laments throwing the clients off their jobs in the workshops but feels they can't continue in these jobs unless the state finds a better way to employ them and enrich the experience. We too, want more jobs, more housing and community supports for people with mental illnesses. We've had a lot in common in advocacy with Marc Brandt. He's about to retire Dec.31 and we will all miss him.

Aiming at Congress, Brandt writes: "Fight the disallowances for the center overcharges. The additional federal disallowances against NYS for amounts previously paid for developmental center rates would devastate care to people with developmental disabilities. In response to the huge controversy over the $5,000 per day institutional rate scandal, NYS reduced the rate for developmental centers and lost $1.1 billion annually in revenue in last year's budget. Now the federal government wants additional funds returned for amounts paid in prior years (FY 2010-FY 2013). The maximum amount disallowed could be $4 billion."

On a federal law that would force workshop employers to pay minimum wage, Brandt continues: "Subminimum wage serves a critical purpose--Employers won't pay people maximum wage or better unless they can earn it. The US Congress must not phase out Section 14c of the Fair Labor Standards Act providing for the payment of subminimum wage. 400,000 persons across the nation, including many in NYS, depend on the subminimum wage for employment and any earned income whatsoever. A significant curtailment or elimination of 14c would deny those individuals a paycheck and relegate them to a prolonged life of meaningless activity and deteriorating functional capacity."



For NYS legislators, Brandt has this advice

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When you're shifted from Medicaid to Medicare—what then?

A woman called to say her son was just taken off Medicaid and put on Medicare and she wanted to know what this meant. One wonders why the government chooses to do this to someone with a profound disability. It's been a puzzler in our own family. Medicaid and supplementary security income (SSI) are the essential safety net provisions for survival of these folks. Medicare is not. It covers minimal outpatient mental health benefits--190 days lifetime—and is very limited in other ways. The people ordering these changes don't seem to realize the impact of such a decision on the lives of our family members. So let's look into this.

I called a manager in mental health at Ellis Hospital who asked the woman to call her so she could be referred to a Medicaid specialist. That satisfied things for the moment but I wondered how many others also needed an explanation. The problem is that people in the system can become eligible for both Medicaid and Medicare for different reasons. Since the government can't pay duplicate bills, it has to sort out which program pays which expenses. And the two are really for different purposes. Medicaid provides both hospital care and outpatient medical care primarily for low income people, some with a disability. Medicare pays mostly hospital and doctor bills for older citizens 65 or over without regard to income or disability.

Medicaid spending is shared by state and federal governments and in New York by the counties so it is constantly muscled around politically, while Medicare is fully federally financed. Here's where someone can be shifted from Medicaid to Medicare and become dually eligible: It happens for someone 65 or over whose income dips below the poverty line. It happens when a person with a disability is in a household where the breadwinner reaches age 65 and retires, or becomes disabled or dies. Which parts of the bill are assigned to Medicare? I've read that someone's Medicare Part B (doctor's) charges are actually paid by Medicaid. And Medicaid recipients now have their prescription drug bills paid under Part D Medicare in a big changeover a few years ago that still has clients in a dither when they sign up.

Meanwhile, we're told the dual eligibles in Ellis's clinic or its PROS program upstairs are still being billed under the old fashioned fee-for-service method, while other patients have moved on to managed care fee structures or soon will do so. The feds and NYS are still ironing things out. NY has won a demonstration grant from the feds to show how costs can be reduced and duplications erased. The program is called FIDA—fully integrated dual advantage demonstration program--and it's about to start in NYC and suburbs in January. FIDA is described as a managed care plan for certain dual eligibles. (Find write-up on the webpage NY Health Access.) It says until now, dual eligibles have had both Medicare and Medicaid. For both types of insurance, coverage might be fee-for-service or through a managed care plan.

For their Medicare services, it says they have always had the option of receiving their Medicare services either through voluntarily enrolling in a "Medicare Advantage plan" –a type of HMO or other managed care plan that controls access to and manages all of their Medicare services, usually including Part D prescription drugs. If they choose not to enroll in a Medicare Advantage plan, they would continue to use original Medicare which is Medicare on a fee-for-service basis. And enroll in a separate Medicare Part D plan.

For their care covered by Medicaid, if they need Medicaid home care or other community based long term care services and if they live on Long Island, Westchester or one of the other counties with mandatory managed long term care, they have been required to enroll in a plan.

Up to now, dual eligibles have had an option of enrolling in a single plan that combines all of their Medicare and Medicaid services in one managed care plan. These are the Medicaid Advantage plans.

How is this changing? The new FIDA plans will cover not only Medicaid long-term care services, as MLTC plans do, but also cover all other medical care covered by Medicare and Medicaid. In other words, a FIDA member will essentially trade in all of his or her insurance cards—Medicare original or Medicare Advantage; Medicaid, MLTC, Medigap, and Medicare Part D—and only have one health plan—their FIDA plan.

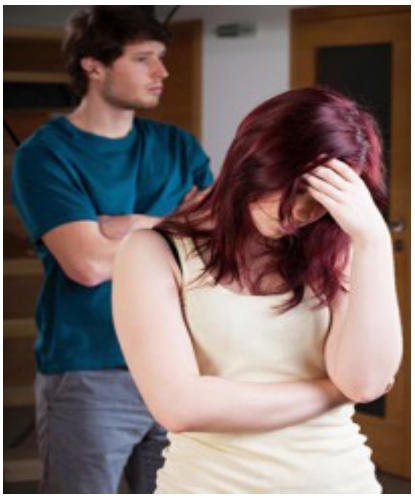
Sounds like a real breakthrough and it affects thousands of people in mainstream mental health care. The web site has information on appeals, complaints, consumer problems and advocacy concerns.

Doing the right thing—why leave out Schenectady?

The NYS Office of Mental Health is crowing about $2.25 million it has awarded in new funds for supported housing and community based mental health services in the Lower Hudson Valley region and another $3.3 million for Long Island. The money is in the 2014-15 state budget and meets needs specific to these counties and localities.

Rockland, Sullivan and Ulster counties get mobile crisis teams, Westchester gets adult outreach programs and a children's crisis intervention team, while Putnam gets advocacy and support services and a self-help program to protect and promote consumer rights. Orange County gets supported housing and Dutchess gets a crisis self-help program. It's all to the good. On Long Island, Nassau County gets over $1 million to install two assertive community treatment teams and Suffolk gets over $2 million to create 72 non-Medicaid care coordination slots for children with emotional disturbance and their families.

While state OMH is slow on the trigger (the budget passed last April), it's an example of NYS doing things right. But why not Schenectady County? Our housing directors and county community services director have petitioned the OMH for more supported apartments here and we're justified to get them. We need them, too. Why won't they listen?



Schenectady YWCA program coordinator says cause of domestic violence is not mental illness of the victim.

Domestic violence and mental illness—are they related?

Recently TV media has had a field day with revelations about family violence involving big name pro and college football players. One big name was Ray Rice, star running back for the National Football League Baltimore Ravens, who was caught on TV dragging his wife by the hair out of an elevator after flooring her with a punch. Rice has been sacked for the time being. His and the other cases aren't so unusual, the news media tells us.

Domestic violence takes place in thousands of households across the country. It's drawn the attention of state and county governments like Schenectady's to set up hotlines and protection services for the victims. The Schenectady YWCA is designated as the county coordinating agency here for counseling, advocacy and crisis services for abused women. It has a 25 bed shelter for these women and their children. The hotline is 374-3386.

Violence and mental illness are sometimes linked. We asked Kim Siciliano, domestic violence and abuse coordinator for the Schenectady YWCA, if the abuse she sees and the presence of mental illness in the victim or the partner are interrelated. She says as far as the women go, she sees all kinds of people come in the door and mental illness is not the cause of the violence between the two.

"We work with the victim. Many present with anxiety but the cause of domestic violence has nothing to do with mental illness of the victim. It's due to one person exerting power and control over the other.

"Many people we treat present with anxiety and depression. Now they might be showing signs of mental illness because of the abuse they've received. We don't work with the perpetrators. Domestic violence doesn't have to do with mental illness. Time and time again it happens--it's not a one-time event. Over time there's a need of one party to control your time and money and it escalates to someone putting his hands on a person.

"It's really the person's choice," Kim said. "They'd be violent with any person they know—the person can come across politely to anyone else but it's what they're doing to the victim. It's not impulse control. It's not ADHD (attention deficit hyperactivity disorder) or other disease. The person has identified this person and is controlling—telling the person to stay home or not go to work, for example. Domestic violence is power and control between two people in an intimate relationship.

"We don't have any statistics on the perpetrators," she continued. But the difference, Kim suggested, is that "domestic violence is only horrible to the person he's chosen to control." By contrast, someone with a violent nature could be violent with everybody he comes across.

While that may suffice as an explanation for the women, what about the man involved? We've had women come to the family support and education group meetings inside Ellis Hospital who tell of the abuse they receive from their grown sons. The son takes the keys and drives off with her car, orders her to make his meals, do his laundry and give him money. He's surly and angry—and he has a mental illness. Despite this, the Ellis counselor, Kevin Moran, tells her she has the right to be safe and run her own household and should evict him if he behaves like that. That's different, Kim remarked, that's family violence and ours is between two intimate partners. But abuse patterns are much alike.

"When a victim comes in to the YWCA we get her safe," Kim said. "We can go to the police and file a police report. With a mentally ill person you can get help from the police or voluntarily go to the hospital. I noted the difficulty facing families who call police against a violent family member when he has caused damage or threatened others in the family. If the family presses charges, it can lead to the prosecution of their son which can send him away to jail or prison.

Are there other causes producing domestic violence? Some sources suggest poverty breeds more stress for couples and families and this causes the violence. For example, an article on the website Get Domestic Violence Help.com states:

"Poverty and the strains that accompany it can make the people living in a poor household feel frustrated, useless, angry, and inadequate. Unfortunately it is often the other family members who are the outlet for this anger, and through violence a partner prone to aggression and control makes themselves feel better. Often the domestic violence is kept quiet, and the abuser will be full of remorse after every outburst. The wives will blame themselves for the violence, claiming they are not doing enough, or not being supportive of their mate. The environment creates a vicious cycle that many women and men find it difficult to escape from.

"If a woman suffering from domestic violence and poverty does manage to escape, they often face many different problems, and struggles in their future. The physiological effects of the violence may destroy any self-confidence the woman has. This can lead to them not being able to attend a job on a regular basis. Over 70% of women do not ever report their abuse, making it very hard to stop the problem. Without the correct support, and financial network, often women who suffer from domestic violence will drift from one abusive relationship to another."

In sum, domestic violence and family violence with a mentally ill son or daughter differ in the dynamics but they confound us all.

Assault weapons like this are outlawed by NY's SAFE Act, which the governor defended in speeches before election.

Letter to the editor—

NY's SAFE Act keeps guns out of the hands of mentally ill persons

To the editor, Times Union:

A NY Times story Oct. 19 about the NY SAFE Act told of large numbers of people with mental illnesses who have been reported to the state's database to keep them from owning guns. That restriction is used as an argument by advocates who don't want the law to single out this group unfairly. I can understand that and the fear that some people won't come in for treatment if they face loss of their guns. But the importance of having this law on the books is that we must prevent further mass shootings by crazed gunmen like what happened to the school children at the Shady Lane Elementary School in Newtown, Conn. in late 2012. We need to support NY's SAFE Act, the strongest law of its kind in the US, regardless of those imaginary issues mentioned above and the opposition of the gun-toting public.

The SAFE Act is the civilized way to have licensed mental health professionals corral people who are "likely to engage in conduct that would result in serious harm to self or others." Most of those names on the database are people involuntarily admitted to hospital emergency rooms and community hospitals like Ellis or Albany Med. Very few are an imminent danger to society and the rest should not be reported on the lists. *(Roy Neville)*

Cuomo says SAFE Act numbers too low

Gov. Andrew M. Cuomo defended a New York State law that has made it easier to take guns away from people who have been deemed mentally unstable, saying on Oct. 19 that the number of people banned from owning firearms since the law took effect over 18 months ago could be too low.

Speaking after a campaign rally in the Bronx, two weeks before the election, Mr. Cuomo was reacting to a report in The New York Times on Sunday, which disclosed that 34,500 people in New York have been reported to a state database as a danger to themselves or others, and prohibited from owning firearms for five years.

Some supporters for the mentally ill have said the number seemed high, and suggested that the law may have included people who were not truly dangerous, stigmatizing the mentally ill.

Mr. Cuomo said that compared to the roughly 140,000 people in the state hospitalized for mental illness in a year, 34,500 seemed to be a conservative number. "I've heard concerns that the number is too low, because obviously there are about 110,000 people who are institutionalized, but yet could still get a gun..

With Electronic Records, Doctors Read When They Should Talk

(Shortened version of piece in NY Times by Abigail Zuger, October 13.)

We do not really know whether dysfunctional software contributed to last month's debacle in a Dallas emergency room, when some medical mind failed to connect the dots between an African man and a viral syndrome and sent a patient with deadly Ebola back into the community. Even scarier than that mistake, though, is the certainty that similar ones lie in wait for all of us who cope with medical information stored in digital piles grown so gigantic, unwieldy and unreadable that sometimes we wind up working with no information at all.

We are in the middle of a simmering crisis in medical data management. Like computer servers everywhere, hospital servers store great masses of trivia mixed with valuable information and gross misinformation, all cut and pasted and endlessly reiterated. Even the best software is no match for the accumulation. When we need facts, we swoop over the surface like sea gulls over landfill, peck out what we can, and flap on. There is no time to dig and, even worse, no time to do what we were trained to do — slow down, go to the source, and start from the beginning.

The fact is that even if all the redundant clinical information sitting on hospital servers everywhere were error-free, and even if excellent software made it all reasonably accessible, doctors and nurses still shouldn't be spending their time reading.

The first thing medical students learn is the value of a full history taken directly from the patient. The process takes them hours. Experience whittles that time down by a bit, but it always remains a substantial chunk that some feel is best devoted to more lucrative activities.

It turns out that the pathway into the medical brain, like most brains, is far more reliable when it runs from the hand than from the eye. Force the doctor to take notes, and the doctor will usually remember. Ask the doctor to read, and the doctor will scan, skip, elide, omit and often forget.

Like good police work, good medicine depends on deliberate, inefficient, plodding, expensive repetition. No system of data management will ever replace it.

Hospitals fined for readmissions

Medicare is on a tear—fining 2,610 hospitals nationwide a record $428 million for having too many patients return within a month for additional treatments. The high readmissions cost Medicare $26 billion in the past year, of which $17 billion is said to come from potentially avoidable readmissions. Nearly all hospitals in this area were fined, none at the top penalty allowed under federal law, 3% of each payment. In this area, the hospital and readmission penalties are: Albany Med Center Hospital, 0.29%; Albany Memorial Hospital, 0.9%; Cobleskill Regional Hospital, zero; Columbia Memorial Hospital, 1.39%; Ellis Hospital, 0.07%; Glens Falls Hospital, 0.06%;Nathan Litthauer Hospital, Gloversville, 1.92%; Samaritan Hospital, 0.05%; Saratoga Hospital, 0.61%; St. Mary's Hospital, Troy, 0.19%; St. Mary's Hospital, Amsterdam, 0.15%, St. Peter's Hospital, Albany, 0.03%, and Sunnyview Hospital and Rehab Center, zero.

Sheltered workshops to close (from pg 4)

"Development of out-of-home day and residential care—the number of people with development disabilities in need of day and out-of-home residential services has been growing dramatically, a trend that will continue possibly for years to come. Many of these individuals live with aging parents who may have disabilities more severe than the adult child whose parents care for. However, it appears that the state has responded to the challenge by cutting back on development of critical services and supports, Brandt said.

"The best available information is that some 50,000 New Yorkers with developmental disabilities are living with parents aged 60 and over. As of April 2013, 12,057 of these individuals statewide were waiting for residential services of which 4,204 stated that the need was "asap".

"Legislators must be told that it is imperative for the upcoming state budget to contain substantial new funding for people living at home.

On the workshop closings, Brandt remarked: "The governor issued an executive order underscoring the critical importance of integrated, competitive employment for people with disabilities. Presumably this includes many of the 8,000 people now served in the sheltered workshops which the state has promised the federal government to close in the next six years."

He asks: "Is competitive employment realistic? For a good portion of the 8,000 in sheltered employment it could be if it is backed with significant additional resources and supports. However, for many people in workshops—those individuals with the most significant disabilities—it is imperative that a credible solution be developed by advocates, family members and the state. Some ideas have been advanced including integrating former workshop facilities and utilizing adult day care. But no one knows if those or other solutions will be viable in the context of government policy and, most important, in the context of what really works for these individuals."

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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