



# The Iris

*A Publication of  
NAMI Wisconsin  
— the State's Voice  
on Mental Illness*

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## 2009 Year in Review

*By Lannia Syren*

NAMI Wisconsin is thrilled to share with our readers 2009 affiliate accomplishments as well as some of the successes of the state office. According to a November 2009 survey of NAMI Wisconsin affiliates, approximately 8,655 individuals received local NAMI newsletters and 3,594 individuals received individual advocacy and support this year. 280 of those lives were touched directly by NAMI Wisconsin.

The *In Our Own Voice* program shared unique recovery education presentations with 2,128 community members, spreading awareness and reducing stigma. Wisconsin is #3 in the U.S. for the number of individuals reached by *In Our Own Voice* this year, trailing behind only California and Mississippi.

During 2009, NAMI affiliates in Wisconsin reached 1,586 mental health consumers through support groups and educational trainings. Together, we served 2,438 family members and 1,208 mental health professionals, including Crisis Intervention Training for 208 police officers. 113 military veterans participated in NAMI groups, 514 families were reached in a courtroom setting and 290 prisoners became aware of NAMI services they may access when they return to their home community.

In the final total these numbers are likely much higher than those reported, as not all affiliates were able to respond to the survey prior to this publication.

In addition to the work accomplished by our affiliates, NAMI Wisconsin proudly presented an event featuring the former Norwegian Prime Minister, Kjell Magne Bondevik, and provided educational mini-conferences for affiliates at various sites around the state. Outreach resources were shared state-wide with NAMI affiliates, including radio public service announcements that were developed

by Wisconsin Radio. New program outreach materials were developed to assist affiliates in growing Family-to-Family and other programs.

NAMI Wisconsin's *Iris* publication and the *Recovery Newsletter* have touched more than 5,000 lives this year. In addition to our membership, the *Iris* is shared with 484 community organizations and libraries, including: Aging and Disability Resource Centers, Cooperative Educational Service Agencies, tribe-specific or Hispanic health clinics, Wisconsin Minority Health Program and Black Health Coalition of Wisconsin.

NAMI Wisconsin provided outreach and education at a variety of educational fairs and conferences during 2009, including the Oshkosh Correctional Institution Transition Fair, Jackson County Correctional Institution Transition Fair, Coalition of Wisconsin Aging Groups "The Changing Face of Aging", Mental Health Dialogue, Kettle Moraine Correctional Institution Resource Fair, Prairie Du Chien Correctional Institution Transition Fair, UW Stevens Point Disability Awareness Fair, Wisconsin Alliance of Information & Referral Systems Conference, Wisconsin Library Association Annual Conference, and the Children Come First Conference.

In March 2009, twenty-four NAMI Wisconsin Affiliate leaders representing Waukesha, Southwestern Wisconsin, Portage/Wood, Wisconsin, St. Croix, Walworth, Racine, Iron, Door, South Central, Oshkosh and Brown County participated in grantsmanship training. In July, Consumer Council members also received grantsmanship training.

During 2009, NAMI Wisconsin trained 27 new Family-to-Family educators, including individuals in two affiliates, Dodge County and Green County, that are providing Family-to-Family for the first time. The Family-to-

Family Teacher Leadership Summit served to re-invigorate 32 instructors. Eight new NAMI Basics teachers were trained, doubling the number of teachers providing this program across the state and expanding the program into four new affiliates. State trainers certified eleven new *In Our Own Voice* presenters and re-invigorated eight presenters at the IOOV refresher training. NAMI Wisconsin state trainers certified thirteen new Consumer Support Group facilitators and twelve new Peer-to-Peer mentors. A team of NAMI National trainers certified 26 NAMI Connection recovery support group facilitators. The NAMI Wisconsin Consumer Council conducted two consumer leadership summits and co-sponsored the first annual Consumer Council Health and Wellness Fair for Wisconsin's consumers.

The many accomplishments on both the state and affiliate level are far too numerous to list here. Suffice it to say that 2009 has been a good year for NAMI Wisconsin and we are looking forward to making 2010 even better and brighter. 🌸

### Save the Date: NAMI Wisconsin 2010 Conference

Taking the Journey Together:

The Art of Living with  
Serious Mental Illness

April 30 – May 1, 2010

Radisson Hotel and Conference Center  
Green Bay, Wisconsin

# Executive Director's Corner

by Lannia Syren, NAMI Wisconsin Executive Director



Lannia Syren

As we wrap up 2009 and look forward to 2010, I am excited to share a few announcements from the state office. I am pleased to welcome Kate Bahr to our team. She is taking on the full time role of "Administrative and Outreach Coordinator".

Kate comes to us with a varied non-profit background working with event planning, public relations and program support. I am confident she will be an asset to the NAMI state office. Please join me in welcoming her!

We are rapidly moving forward with the 2010 state-wide conference in Green Bay and we're working hard to ensure top-notch keynote speakers. In 2009 we had 377 conference attendees. I would like for us to see 500 attendees in the coming year. The message we hope to share is that through community support and strong, evidence-based services, individuals with mental illnesses can live long, fulfilling lives. The title of the conference is "Taking the Journey Together: The Art of Living with Serious Mental Illness."

Following the most recent Consumer Council meeting, I am thrilled to share that the conference schedule is taking shape. Some of the issues we plan to address include: mental health support for veterans and understanding PTSD; the impact of dual diagnoses; Peer-to-Peer pro-

grams in tribal organizations; parenting with a mental illness; and a resource share for consumers and family members. I am particularly excited that conference attendees will have the opportunity to see one or more In Our Own Voice presentations. It is my hope that the IOOV program will continue to grow and reach more community members in the coming year. If you have thought about becoming an IOOV presenter but were not sure if it was right for you, I strongly encourage you to attend the conference to learn more about this opportunity.

Many of us make resolutions for the coming year. Often we focus on personal changes such as weight loss or saving money. This year, I hope you will join me in resolving to help build NAMI throughout the state by reaching out to new communities and members as well as raising awareness of the amazing work that is already being done in cities and small towns throughout Wisconsin. Invite a friend or co-worker to attend the conference with you. Write a letter to the editor for your local paper. Become an In Our Own Voice presenter and tell your story to reduce stigma. Write an article for the Iris. Join me in making 2010 a remarkable year for NAMI.

As always, I welcome your calls, e-mails and visits. If you would like to share your story, pass along the latest news, discuss a potential conference topic or talk about the impact NAMI could have in 2010, please contact me. I look forward to hearing from you! ✿

## NAMI Wisconsin County Affiliates

Barron .....	(715) 736-0089
Brown .....	(920) 430-7460
Chequamegon Bay.....	(715) 274-8403 (Ashland, Bayfield)
Dane .....	(608) 249-7188
Dodge .....	(920) 887-7211
Door.....	(920) 493-2912
Douglas.....	(715) 378-2772
Fond du Lac.....	(920) 922-0566
Fox Valley .....	(920) 954-1550 (Outagamie, Calumet, Waupaca, Winnebago)
Green.....	(608) 328-9376
Iron .....	(715) 476-2172
Jefferson .....	(920) 262-7887
Kenosha.....	(262) 605-9038
La Crosse .....	(608) 784-7532
Manitowoc .....	(920) 683-3363
Marinette (WI) and Menominee (MI) .....	(906) 864-1933
Mid Central .....	(608) 408-0177 (Adams, Green Lake, Juneau, Marquette, Waushara)
Milwaukee .....	(414) 344-0447
Northwoods .....	(715) 298-2553 (Marathon, Lincoln, Langlade)
Oshkosh.....	(920) 651-1148 (Winnebago)
Ozaukee.....	(262) 241-3929
Portage/Wood .....	(715) 592-4522
Racine .....	(262) 637-0582
Richland .....	(608) 604-4535
Rock.....	(608) 758-8144
Sheboygan .....	(920) 803-6193
South Central .....	(608) 254-7092 (Sauk, Columbia)
Southwest Wisconsin.....	(608) 348-6136 (Grant, Iowa, Crawford)
St. Croix Valley .....	(715) 307-1921 (St. Croix, Pierce)
UW Madison .....	(608) 268-6000
Walworth .....	(262) 495-2439
Washington .....	(262) 338-2393
Waukesha .....	(262) 524-8886
Wishigan.....	(715) 336-2744 (Florence, WI, Dickinson, MI)

**The mission of NAMI Wisconsin is to improve the quality of life of people affected by mental illnesses and to promote recovery.**

**NAMI of Wisconsin will accomplish its mission through the following:**

- Establishing local Affiliates in keeping with NAMI National's principles and guidelines.
- Supporting Affiliates by providing follow-up advice and counsel; educational and training programs and materials; access to financial resources as appropriate; and by offering conferences, seminars, and presentations.
- Advocating at all levels of government and throughout the public sector.
- Promoting public education and understanding of mental illnesses.

# Cues from the past key to future

By Geoff Greiveldinger, Co-President, NAMI Wisconsin Board of Directors

A major anniversary, like NAMI's 30th, is a good time to look both backward and forward. Recognizing that the future is largely unknowable, and the past is subject to differing recollections and interpretations, here are one person's observations on NAMI's past and future.

Think about world events of late 1979. In Iran, our embassy was overrun, and embassy staff members were held hostage for well over a year. In Afghanistan, a long and bitter conflict was getting underway. In late 2009, we still worry about both countries. Although history seldom precisely repeats itself, there are recurring themes.

So it is with advocacy movements that, like NAMI, seek to improve life for individuals affected by factors beyond their control. In NAMI's 30 years, its members have witnessed—and have often contributed to—significant improvements in the lives of persons affected by mental illness. But science does not progress on a predictable trajectory and there is even less certainty on the social, political, and economic contexts in which improvements must be sustained.

Consider, for example, medications. Few would argue that the medications available in 2009 do not offer a better range of choices than those available in 1979. And yet, some of the newer medications present side effects at least as worrisome as those of the older drugs. NAMI has led the call for medications that are safe and efficacious. NAMI's voice is needed still.

Or look at treatments. NAMI champions evidence-based practices, of which the Program for Assertive Community Treatment (PACT) is a prime example. But how many states really employ PACT? Folks more knowledgeable than I will tell you that even Wisconsin, where PACT was born, does not.

Consider mental health coverage in private insurance. Years ago, Wisconsin required such coverage in group plans, but at rates that were low then and are laughable now. There's been success at the federal level, but more must be done. On these issues, NAMI's voice must yet be heard.

NAMI's signature education programs have multiplied exponentially, to better meet the

needs of all segments of the community. NAMI programs are thorough, pertinent, and effective, because they're taught by people who've lived the experience. But these strengths can also be weaknesses. The courses rely almost entirely on volunteers; they financially burden local affiliates; and they lack adaptability. The content of our signature courses is first rate; we must find equally good delivery methods.

As an organization, NAMI is at a crossroads. No longer an aggregation of family members advocating "for the mentally ill," it's now an alliance "on mental illness" in which mental health consumers are full partners. Indeed, some affiliates are so consumer-focused that they are now "learning" to address family members' concerns. Sometimes there are growing pains, but this is quite an achievement.

Without losing our "grassroots" strength, NAMI National wants us to become uniformly accessible and recognizable across the country, much like the American Cancer Society and other national health advocacy groups. For many reasons, that's a worthy goal. But mental illness is not like cancer. Nobody stigmatizes cancer, and cancer treatments don't vary with the preferences and budgetary imperatives of state or local governments. We're still a grassroots organization. We must be able to work in harmony with our local communities. There are limits to uniformity and branding.

Financially, we face real challenges—quite apart from the nation's current economic woes. NAMI National has been trying to reduce the amount of pharmaceutical funding, and recent congressional attention will only encourage that effort. But unless alternative funding sources are found, NAMI National must cut back on what it can do—including offering assistance to state organizations and local affiliates.

NAMI Wisconsin can no longer simply expect that it will receive a major grant from the state of Wisconsin, nor that a state grant will come without major strings. Without other funding sources, NAMI Wisconsin can offer local affiliates little direct financial support. It's conceivable that NAMI Wisconsin might have to reduce services.

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# The Facts About Seasonal Affective Disorder

If you notice periods of depression that seem to accompany seasonal changes during the year, you may suffer from seasonal affective disorder (SAD). This condition is characterized by recurrent episodes of depression—usually in late fall and winter—alternating with periods of normal or high mood the rest of the year.

Most people with SAD are women whose illness typically begins in their twenties, although men also report SAD of similar severity and have increasingly sought treatment. SAD can also occur in children and adolescents, in which case the syndrome is first suspected by parents and teachers. Many people with SAD report at least one close relative with a psychiatric condition, most frequently a severe depressive disorder (55 percent) or alcohol abuse (34 percent).

## What are the patterns of SAD?

Symptoms of winter SAD usually begin in October or November and subside in March or April. Some patients begin to slump as early as August, while others remain well until January. Regardless of the time of onset, most patients don't feel fully back to normal until early May. Depressions are usually mild to moderate, but they can be severe. Very few patients with SAD have required hospitalization, and even fewer have been treated with electroconvulsive therapy.

The usual characteristics of recurrent winter depression include oversleeping, daytime fatigue, carbohydrate craving and weight gain, although a patient does not necessarily show these symptoms. Additionally, there are the usual features of depression, especially decreased sexual interest, lethargy, hopelessness, suicidal thoughts, lack of interest in normal activities, and social withdrawal.

Light therapy, described below, is now considered the first-line treatment intervention, and if properly dosed can produce relief within days. Antidepressants may also help, and if necessary can be used in conjunction with light.

In about 1/10th of cases, annual relapse occurs in the summer rather than winter, possibly in response to high heat and humidity. During that period, the depression is more likely to be characterized by insomnia, decreased appetite, weight loss, and agitation or anxiety.

Patients with such “reverse SAD” often find relief with summer trips to cooler climates in the north. Generally, normal air conditioning is not sufficient to relieve this depression, and an antidepressant may be needed.

In still fewer cases, a patient may experience both winter and summer depressions, while feeling fine each fall and spring, around the equinoxes.

The most common characteristic of people with winter SAD is their reaction to changes in environmental light. Patients living at different latitudes note that their winter depressions are longer and more profound the farther north they live. Patients with SAD also report that their depression worsens or reappears whenever the weather is overcast at any time of the year, or if their indoor lighting is decreased.

SAD is often misdiagnosed as hypothyroidism, hypoglycemia, infectious mononucleosis, and other viral infections.

## How is winter SAD treated with light?

Bright white fluorescent light has been shown to reverse the winter depressive symptoms of SAD. Early studies used expensive “full-spectrum” bulbs, but these are not especially advantageous. Bulbs with color temperatures between 3000 and 6500 degrees Kelvin all have been shown to be effective. The lower color temperatures produce “softer” white light with less visual glare, while the higher color temperatures produce a “colder” sky-light hue. The lamps are encased in a box with a diffusing lens, which also filters out ultraviolet radiation. The box sits on a tabletop, preferably on a stand that raises it to eye level and above. Such an arrangement further reduces glare sensations at high intensity, and preferentially illuminates the lower half of the retina, which is rich in photoreceptors that are thought to mediate the antidepressant response. Studies show between 50% and 80% of users showing essentially complete remission of symptoms, although the treatment needs to continue throughout the difficult season in order to maintain this benefit.

There are three major dosing dimensions of light therapy, and optimum effect requires that the dose be individualized, just as for medications.

- **Light intensity.** The treatment uses an artificial equivalent of early morning full daylight (2500 to 10,000 lux), higher than projected by normal home light fixtures (50 to 300 lux). A light box should be capable of delivering 10,000 lux at eye level, which allows downward adjustments if necessary.
- **Light duration.** Daily sessions of 20 to 60 minutes may be needed. Since light intensity and duration interact, longer sessions will be needed at lower intensities. At 10,000 lux—the current standard—30-minute sessions are most typical.
- **Time of Day of exposure.** The antidepressant effect, many investigators think, is mediated by light's action on the internal circadian rhythm clock. Most patients with winter depression benefit by resetting this clock earlier, which is achieved specifically with morning light exposure. Since different people have different clock phases (early types, neutral types, late types), the optimum time of light exposure can differ greatly. The Center for Environmental Therapeutics, a professional nonprofit agency, offers an on-line questionnaire on its website, [www.cet.org](http://www.cet.org), which can be used to calculate a recommended treatment time individually, which is then adjusted depending on response. Long sleepers may need to wake up earlier for best effect, while short sleepers can maintain their habitual sleep-wake schedule.


Side effects of light therapy are uncommon. Some patients complain of irritability, eye-strain, headaches, or nausea. Those who have histories of hypomania in spring or summer are at risk for switching states under light therapy, in which case light dose needs

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## Cues

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And so, 10, 20, or 30 years from now, NAMI will be doing what it's always done: struggling at the national, state, and—above all—the local level to improve life for all whose lives are affected by mental illness. 

## SAD

*continued from page 4*

to be reduced. There is no evidence for long-term adverse effects, however, and disturbances experienced during the first few exposures often disappear spontaneously. As an important precaution, patients with Bipolar I disorder—who are at risk for switching into full-blown manic episodes—need to be on a mood-stabilizing drug while using light therapy.

### **What should I do if I think I have SAD?**

If your symptoms are mild—that is, if they don't interfere too much with your daily living, you may want to try light therapy as described above or experiment with adjusting the light in your surroundings with bright lamps and scheduling more time outdoors in winter.

If your depressive symptoms are severe enough to significantly affect your daily living, consult a mental health professional qualified to treat SAD. He or she can help you find the most appropriate treatment for you. To help you decide whether a clinical consultation is necessary, you can use the feedback on the Personalized Inventory for Depression and SAD at [www.cet.org](http://www.cet.org).

*Article contributed by the National Alliance on Mental Illness. (800) 950-NAMI; [info@nami.org](mailto:info@nami.org) Reviewed by Michael Terman, Ph.D., Director, Winter Depression Program, New York State Psychiatric Institute at Columbia University Medical Center. New York City. 🌿*

## Survey Reveals Big Gap in Understanding of Depression

Americans do not believe they know much about depression, but are highly aware of the risks of not receiving care, according to a survey released in November 2009 by the National Alliance on Mental Illness. See full survey results at <http://www.nami.org/depression>.

The survey provides a “three dimensional” measurement of responses from members of the general public who do not know anyone with depression, caregivers of adults diagnosed with depression and adults actually living with the illness.

- Seventy-one percent of the public sample said they are not familiar with depression, but 68 percent or more know specific consequences that can come from not receiving treatment—including suicide (84 percent).
- Sixty-two percent believe they know some symptoms of depression, but 39 percent said they do not know many or any at all.
- One major finding: almost 50 percent of caregivers who responded had been diagnosed with depression themselves, but only about 25 percent said they were engaged in treatment.
- Almost 60 percent of people living with depression reported that they rely on their primary care physicians rather than mental health professionals for treatment. Medication and “talk therapy” are primary treatments—if a person can get them—but other options are helpful.
- Fifteen percent of people living with depression use animal therapy with 54 percent finding it to be “extremely” or “quite a bit” helpful. Those using prayer and physical exercise also ranked them high in helpfulness

(47 percent and 40 percent respectively).

- When people living with depression discontinue medication or talk therapy, cost is a common reason, but other significant factors include a desire “to make it on my own,” whether they believe the treatment is actually working and in the case of medication, side effects.

“The survey reveals gaps and guideposts on roads to recovery,” said NAMI Executive Director Michael J. Fitzpatrick. “It tells what has been found helpful in treating depression. It can help caregivers better anticipate stress that will confront them. It reflects issues that need to be part of ongoing health care reform.”

“There are many treatment strategies,” said NAMI Medical Director Ken Duckworth. “What often works is a combination of treatments that fit a person and their lifestyle. Research indicates that the combination of medication and psychotherapy are most effective. The good news is that 80 percent or more of the public recognize that depression is a medical illness, affecting people of all ages, races and socioeconomic groups, which can be treated.”

Harris Interactive conducted the survey for NAMI on-line between September 29 and October 7, 2009. Participants included 1,015 persons who did not know anyone diagnosed with depression, 513 persons living with depression and 263 caregivers of a family member or significant other diagnosed with depression.

*Article contributed by the National Alliance on Mental Illness. (800) 950-NAMI; [info@nami.org](mailto:info@nami.org) 🌿*

## Autumn NAMIWalks garner essential funds

Three successful NAMIWalks helped fill the coffers of NAMI Brown County, NAMI Dane County and NAMI Fox Valley, assuring essential education, support and advocacy will continue in those counties. NAMI Brown County held their NAMIWalk on September 29th at Green Isle Park in Green Bay. According to NAMI Brown County Affiliate President Donajane Brasch, “Over 300 people came out for NAMI Brown County and made our second annual

walk a success. Preliminary accounting shows that we received over \$22,000.” NAMI Fox Valley was next with a NAMIWalk on October 3rd at Appleton Memorial Park in Appleton. The NAMI Fox Valley is a long running and highly successful event and once again members of the Fox Valley community came through raising almost \$90,000 at last count. NAMI Dane County held their 4th annual NAMIWalk on October 4th at Olin-Turville Park in Madison.

Nearly 1,000 people joined in the Dane County NAMIWalk raising over \$95,000 to date.

The combined efforts of NAMI Wisconsin's affiliates and the members of their respective communities are to be commended for the supreme effort expended to make these events possible, and for the selfless donation of time and funds. Through their hard work the work of the NAMI Wisconsin mission continues. 🌿

# New Publication Maps Approach to Successful Re-Entry for Jail/Prison Inmates with Mental Illnesses

October 30, 2009—A new publication from the Bazelon Center for Mental Health Law offers state and local officials and corrections administrators a blueprint for linking inmates of jails and prisons who have psychiatric disabilities to federal benefits promptly upon their release back into the community.

In its new analysis, *Lifelines: Linking to Federal Benefits for People Exiting Corrections*, the Bazelon Center walks users through steps for aligning the complex rules of federal benefit programs to state and local policies in order to create a system of services and support for released inmates. A plan for action at the facility level lists steps that administrators can take within existing rules to address re-entry issues for inmates with psychiatric disabilities.

Entitlements such as Medicaid, Veterans benefits and Social Security disability payments are critical to enable eligible ex-offenders to


access mental health care, housing and other services they need for successful re-entry. Yet without assistance, released inmates face months of delay before receiving these benefits, resulting in a rate of re-arrest more than twice that of ex-inmates generally.

*Lifelines* is published in three sections for user convenience:

- Volume 1: The Case for Benefit Assistance as Part of Re-Entry Programming (14 pages) includes data on need and cost-benefit analyses from existing initiatives.
- Volume 2: What State and Local Governments and Correctional Facilities Can Do, the heart of the blueprint (48 pages), lists policy changes and implementation steps to ensure access to benefits.
- Volume 3: Appendix (34 pages), explains the federal rules on benefit programs, discusses ways for corrections and mental

health systems to collaborate in sharing health information and offers an extensive list of links to model policies and other resources.

*Lifelines* can be downloaded free as a PDF file or purchased (\$6 plus shipping and handling) at [www.bazelon.org/issues/criminalization/publications/Lifelines/Lifelines.htm](http://www.bazelon.org/issues/criminalization/publications/Lifelines/Lifelines.htm).

The Bazelon Center has produced various publications on access to benefits for inmates exiting correction facilities, from a model law, to a plain-language booklet, to a PowerPoint and training manual for corrections staff. For a list and details of how to obtain them, visit <http://www.bazelon.org/publications/criminal/index.html>. 


## Bondevik: "It is about human dignity."

On September 25, 2009 an appreciative audience of NAMI Wisconsin members, board members, staff, legislators, and persons interested in mental health parity and stigma gathered at the Inn on the Park in downtown Madison to hear former Prime Minister of Norway Kjell Magne Bondevik discuss mental

health care as a "basic human right." Citing Article 12 of the International Covenant on Economic, Social and Cultural Rights adopted by the General Assembly of the United Nations that states, "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," Bondevik added, "It is about human dignity."

In August of 1998, Bondevik found himself dealing with a major depressive episode. Overwork, stress, lack of sleep, and his failure to deal with the grief of the loss of three close friends to cancer, all

contributed to his illness. His Minister of Foreign Affairs, his psychiatrist, and another friend in his administration helped Bondevik decide to take a leave of absence. In the decision on what to announce about his health Bondevik stated, "Why don't we say it as it is?" Thus Kjell Magne Bondevik became the first sitting head of state to take a leave of absence for an announced mental illness. Following three and one half weeks of treatment and rest, Bondevik returned to his office.

In closing, Bondevik said, "Through this experience I have become a stronger person, a more complete human being. I live a more rich life. Stigma is still the main problem. Government leaders must be willing to work with health care providers to make sure mental illness is an important part of health care. I want to thank you all, especially NAMI, for doing this important work. I know you are making a difference." 



NAMI Wisconsin Board members and staff pose with Kjell Magne Bondevik following his speech. Front row, left to right: Sandy Hall, Gail Auerbach, Jennie Lowenberg, Bondevik, Patti Jo Severson, Lannia Syren, Carmen Valdez. Back row: Vaunceil Kruse, Don Pirozzoli, Bruce Rboades, Pat Rutkowski

# Incidence of mental illness in elders calls for wider use of evidence-based practices

By Catherine Swanson-Hayes

Mental health is essential to overall health and well-being and must be recognized and treated in all Americans, including older adults, with the same urgency as physical health. For this reason, mental health is becoming an increasingly important part of the public health mission. In fact, the mental health of older Americans has been identified as a priority by the Healthy People 2010 objectives, the 2005 White House Conference on Aging, and the 1999 Surgeon General's report on mental health (CDC Issue Brief #1).

Eye-opening data on the incidence of behavioral health disorders in older adults in the U.S. indicates that 1 in 4 have a significant mental disorder (26%, including 16% with a primary psychiatric illness) (Bartels, 2005), and that neuropsychiatric symptoms occur in the majority of persons with dementia over the course of the disease (Lyketsos, 2002). Substance abuse among those 60 years and older (including misuse of prescription drugs) currently affects about 17% of this population (Hazelden), and the combined difficulties with alcohol and medication misuse may affect up to 19% of older Americans (Bartels, 2005). The projected growth of the older population has significant public mental health implications with respect to the provision of appropriate substance abuse and mental health services. By the year 2030 the number of persons with psychiatric disorders, including substance abuse disorders, in this older group will equal or exceed the number with mental illness in younger age groups (Bartels, 2005). Equally concerning are the projections of the rapidly increasing numbers of older adults in the U.S. and in Wisconsin.


Prevention and early intervention programs, including those focused on risk and protective factors associated with this age group, are some of the most promising and appropriate ways to maximize health outcomes and minimize health care costs among older adults. These programs represent the future of age-appropriate care for the growing number of older Americans (Lyketsos, 2002). An emerging evidence base supports the efficacy

of a variety of pharmacological and psychotherapeutic interventions for substance abuse problems and major psychiatric disorders in older persons. Current prevention services for this population are extremely limited from both a substance abuse and mental health perspectives. While the last two decades have provided the foundation for effective treatment and prevention strategies aimed at these issues, the developing knowledge base has received minimal dissemination and implementation within routine health-care settings. Despite the substantial prevalence and adverse consequences of substance abuse and mental health problems in older persons and the considerable knowledge related to preventing these problems, evidence-based prevention and early intervention services are not widely available nor promoted for this at risk population. Implementing EBP usually happens by training clinicians and providers to provide the EBP; training is necessary but is not enough. Each stakeholder group has a role for EBPs to be successfully implemented and a partnership needs to exist so that groups are mutually reinforced.

SAMHSA has established the NREPP, National Registry of Evidence-Based Programs and Practices. Evidence-based practices generally refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence. Evidence is often defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, or belief or anecdotal evidence. SAMHSA also recognizes that there is a wide spectrum of possible definitions of "evidence." With this in mind, the agency aimed to make the NREPP rating criteria and processes as transparent as possible, so that all definitions are clear to NREPP users.

In the next issue: Specific EBPs outlined and stakeholder's roles

## Resources

- (1) Bartels Stephen J, Blow Frederic C., Brockmann Laurie M., Citters Aricca D., (2005). Substance Abuse and Mental Health Among Older Americans: The State of the Knowledge and Future Directions. Older American Substance Abuse and Mental Health Technical Assistance Center Substance Abuse and Mental Health Services Administration. Rockville, MD. Available at: <http://www.samhsa.gov/OlderAdultsTAC/index.aspx>
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# NAMI National trainer certifies 11 NAMI Basics teachers

By Donajane Brasch

Green Bay was the site of the 2009 NAMI Basics Teacher training. National trainer Alicia Stevenson certified eight new Basics teachers from Wisconsin and three friends from NAMI Ohio. Teams of teachers from NAMI La Crosse, NAMI Michigan, and NAMI Racine were certified. Trish Laurent-Behnke and Donajane Brasch of NAMI Brown County were also certified.

NAMI Basics is a peer education program for parents and caregivers of children and adolescents with mental illness. Having a child with a mental illness is like riding a roller coaster and never knowing if it will come to the stop position. The focus of the course is on the family member, not the child. All of the information taught in this course gives the parents back a sense of control. We are not alone and do not have to fight through the school years of our child alone.

There was a lot of information given in the training session. I wish it would have been

available when two of my children, who were diagnosed with a mental illness, were still in school. It would have saved me a lot of heartache and second guessing of myself and my family members.


First we need to know and understand to the best of our knowledge, the various diagnoses that can impact our children. We are not to blame and neither are they. It can take a lot of education to get past the guilt that society has often placed on us as parents. We need to realize what our child is and is not responsible for and recognize the impact that miscommunications in the brain can have on them. With this knowledge we will know what to expect of them and learn to love them for who they are.

We need to understand the importance of record keeping, whether it is for an IEP, teacher's conference, social services or behavior modifications. We might have to deal with the mental health system, juvenile justice sys-

tem and transitional services into adulthood. We should keep our records close at hand so we have the data to back up what ever services we are advocating for our child.

During the training we worked on communication within the family, general communication skills, problem solving skills, tips for handling challenging behavior, crisis preparation and response as well as developing a relapse plan.

Our children need our help; they cannot do it by themselves. We also need the support of others who have already walked or are currently walking in our shoes.

Anyone who is the parent or caregiver of a child or adolescent with mental illness should take the NAMI Basics class that meets for two and a half hours one night or day a week, for six weeks. It will make you a much better person and improve the relationship with your child with a mental illness. 

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## Family-to-Family Holds First Teacher Leadership Summit

By Gail Louise Auerbach

NAMI Wisconsin's Family-to-Family Education Program (FtF) held its first Teacher Leadership Summit Saturday, November 7, 2009, at the Mead Hotel in Wisconsin Rapids. The Summit reunited 32 Family-to-Family teachers, who revisited a portion of the FtF curriculum, and learned new material.

The event kicked off with a welcome by Marvin Lutz, NAMI Portage/Woods President and FtF teacher, followed by recognition of Nancy Abraham, NAMI Wisconsin's first FtF Program Director, who brought FtF to Wisconsin.


First item on the Summit agenda was Gail Louise Auerbach presenting NAMI WI's first statewide FtF Marketing Plan, intended to guide all FtF affiliates' outreach plans. The *FtF Outreach Manual* includes ten outreach strategies that are the backbone of the plan and are presented in a worksheet, interactive format along with supplementary materials and readings.

Jana Hockerman, long time FtF teacher and trainer, delivered a forceful and explanatory talk on Joyce Burland's philosophy and the trauma-based learning model that supports the FtF curriculum, "Trauma's Effect on People's Learning Capacity." The curriculum has always been built on the trauma-based model but this is the first time that it has been introduced to the FtF teachers.

Gail's presentation on "FtF—An Evidence-Based Practice?" gave a review of what Evidence-Based Practice is and why it is important, followed by a review of FtF researcher Lisa Dixon's, MD, MPH, talk on the topic presented previously via teleconference to mental health professionals in Wisconsin. It was resolved that FtF is an emerging Evidenced-Based Practice. (Individuals who are interested in learning more about Dr. Dixon's research are invited to participate in a second informative teleconference on December 10, 2009 from 11:00 AM to 12:00

PM. Please contact Gail Louise Auerbach at 608-268-6000 for more details.)

Barbara Jacobs, another experienced FtF teacher and trainer, helped the teachers with one of the most challenging classes in the curriculum, problem solving. In her talk "Successful Problem Solving," Barbara elicited discussion from the teachers by contrasting problems that could be solved, while recognizing that some problems related to mental illness in the family, cannot be solved by the relative who owned the problem.

The keynote speaker was Nancy Abraham, presenting "FtF, Advocacy, and NAMI Membership." She challenged the attendees to look at the state of mental health services and mental illness needs in Wisconsin and see the lack of progress and the need for advocacy. She also challenged Summit attendees to examine the health and growth of NAMI. 

# Peer-to-Peer Mentor Training certifies twelve PtP mentors

By Don Pirozzoli

The 2009 Peer-to-Peer (PtP) Mentor training was held October 23-25. The training was facilitated by NAMI Wisconsin's PtP State Trainers, Luann Simpson and Andy Barnhill. Twelve participants represented NAMI Greater Milwaukee, NAMI St. Croix Valley, NAMI Waukesha, NAMI Racine, and NAMI Portage/Wood.

The Peer-to-Peer Mentor Training and Education Course, according to NAMI National, "is a unique, experiential learning program for people with any serious mental illness who are interested in establishing and maintaining their wellness and recovery. The course is taught by a team of three trained mentors who are personally experienced at living well with mental illness."

Following certification, mentors are encouraged to take the full nine week course before teaching it. Once they have completed the PtP course, trained mentors will work in teams of three to teach the course to individuals with mental illness in their communities.

By sending individuals to the training, local affiliates commit to conducting the course in their communities, providing a location, materials, and a stipend to each of the three mentors. Certified mentors agree to teach the PtP Education Course at least twice within the next two years.

Becoming a certified Peer-to-Peer mentor requires enthusiasm, commitment, and passion in assisting other individuals in learning about, and coping with, mental illness. Comments from the PtP Course evaluations bear out the quality of the training. One new mentor commented, "It was a very worthwhile and empowering course. It lifted my spirits and got me excited about learning and doing more." Another trainee said, "Peer-to-Peer has given me an education that will be a huge part of my life."

The knowledge and understanding demonstrated by trainers Luann and Andy also received comment. "They are excellent,

really knowledgeable. I admire the fact that they have accomplished so much in their lives," remarked one new mentor.

One participant summed up the feelings of the group, "It was so great to be with a group where I did not feel different." In the end these dedicated new mentors expressed that the overall experience was positive and they are excited about the opportunity to teach the Peer-to-Peer Education Course in their local affiliates. 🌿



Peer-to-Peer trainees Bruce Powers, Janet Robde and Pat Sederholm discuss a training document.

## IOOV refresher training renews presenters' commitment to successful program

by Don Pirozzoli

NAMI Wisconsin held its third annual *In Our Own Voice* (IOOV) refresher training September 12, 2009 at the Ramada Inn, Stevens Point. Eight previously trained IOOV presenters attended the refresher which was facilitated by IOOV State Trainers, Ava Martinez and Mary Balzar. Ava is a NAMI Wisconsin Board member and an employee of the NAMI Dane County affiliate. Mary is a member of the NAMI Washington County affiliate. NAMI Wisconsin staff members, Don Pirozzoli, new IOOV State Coordinator, and previous coordinator, Vaunceil Kruse, also attended.

The IOOV presenters in attendance represented NAMI St. Croix Valley, NAMI Racine, NAMI Waukesha, NAMI Portage/Wood and NAMI Fox Valley. The training offered active presenters the opportunity to network and to gain new marketing strategies for making

presentations in their affiliates' service areas. The refresher also gave presenters the opportunity to become reenergized and recommitted to the IOOV program.

Following opening activities and guidance on the IOOV program led by Ava and Mary, attendees shared personal experiences about their presentations, audience reactions, and other stories helpful to fellow IOOV presenters. One issue of interest to IOOV presenters is how to modify their personal stories for diverse audiences in their communities.

In a brief update on IOOV reporting and record keeping, NAMI Wisconsin staffers shared the Wisconsin IOOV success story with the group. The In Our Own Voice program is active in all fifty states and NAMI Wisconsin's IOOV presenters are currently fourth in the nation in number of presenta-

tions and total audience members hearing their recovery stories. In the twelve months between August 30, 2008 and August 30, 2009 NAMI Wisconsin IOOV presenters gave 115 presentations, reaching 2,269 diverse audience members all over Wisconsin.

Following the training, one participant, who had not conducted a presentation in quite some time, reported to the program coordinator that she did an IOOV presentation at a county mental health facility with their affiliate's Executive Director present. "Our Executive Director had never seen a presentation, and my co-presenter and I felt it went very well. We also have an IOOV scheduled at the local jail. For me, it's great to get IOOV off the ground again and I am looking to do many more!" 🌿

# NAMI of Barron County hosts 4th annual mini-conference, "Overcoming Roadblocks to Recovery"

By Laura Oser

On October 17th NAMI of Barron County hosted a half-day mini-conference, "Overcoming Roadblocks to Recovery." Held at the Wisconsin Indianhead Technical College in Rice Lake, the event, offered free of charge, was the 4th annual conference presented by the group and was well attended by consumers, family members and friends.

The conference featured four speakers. Bradley Foss, a program planner for veterans at the VA Medical Center in Minneapolis, is also CBOC Care Manager for the OEF-OIF program. Foss' topic, "Recognize Obstacles for Reintroduction of Veterans," communicated his mission to ensure that veterans and their families receive the support they need following veterans' return home. He also focused on ways in which communities can support and encourage those individuals who serve our nation and their families. Geoff Greiveldinger, co-president of NAMI Wisconsin, presented information about the development of the NAMI organization and the services available through NAMI Wisconsin.

The other two speakers gave powerful personal presentations on their recoveries. Beverly Norelius, the founder and past president of NAMI of Barron County, gave a moving talk entitled, "Long was the night, how beautiful the sunrise." The audience found her recovery story to be uplifting and enlightening. Nettie Nolan, occupational therapist and co-chair of the NAMI affiliate in the St. Croix Valley, shared her recovery story in detail using symbolism to communicate her emergence from her despair. She is now an active member of her community and her NAMI group.

A question and answer session following the presentations resulted in a lively interchange of ideas. Conference attendees were also supplied with information and resources by a number of local mental health providers, including the Aging and Disability Resource Center, Barron County Health & Human Services, Wisconsin Family Ties and New Directions Support Center.

Participants' written evaluations of the day's program reinforced the value of the conference to attendees. One attendee commented, "It was unique having testimonies. My personal interests were supplied by the resources available." Others agreed that the conference should "continue to have 'my story' speakers."

One participant added, "Important—I thought, not only with how to help change things in our community, but also on a large scale."

In addition to the annual mini-conference, NAMI of Barron County provides support and education at monthly support group meetings and participates in area health fairs and workshops. The group is currently conducting NAMI Wisconsin Family-to-Family Education classes at the local library for eleven participants.

NAMI of Barron County's support, education and advocacy work is made possible primarily through a United Way of Rice Lake grant. 🌸

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## Northeast Wisconsin Affiliates Benefit from NAMI Wisconsin Outreach Mini Conference

By Mike Williams

On Saturday November 21st, NAMI Wisconsin Co-Presidents Pat Rutkowski and Geoff Greiveldinger presented an informational mini-conference at NAMI Fox Valley in Appleton. This mini-conference is part of an affiliate outreach program designed to bring important information to all NAMI Wisconsin Affiliates. NAMI Wisconsin expects to benefit from the feedback the state office needs to better serve this affiliate population in the future.

By locating the mini-conference in the central part of the state, the conference attracted a group of members who find it difficult to travel to Madison.

Pat and Geoff presented a robust agenda cov-

ering topics of interest to local affiliates along with an opportunity to have a lively discussion on the NAMI National Draft Standards of Excellence. Other Topics included:

- A. Federal and State reporting rules for 501(c)3s;
- B. Public Policy & Advocacy suggestions for having more impact in the local community while nurturing the "grass roots" nature of our organization;
- C. Legislative Hot Topics that included the State Budget, Wisconsin Mental Health Parity, and the current debate about psychologists being able to write prescriptions for psychotropic medications.

The conference included a working lunch with lively discussion of the concerns of our affiliate members. The next mini-conference is scheduled for Saturday December 12th in Oconomowoc.



Dan Poulson and Sherry Williams take a break at the NAMI Wisconsin Affiliate leaders mini conference.

# Economic Downturn Taking Toll on Americans' Mental Health

October 6, 2009

Washington, DC—A new national survey shows the economic downturn is taking a toll on the mental health of Americans. Individuals who are unemployed are four times as likely as those with jobs to report symptoms consistent with severe mental illness.

Americans who experienced involuntary changes in their employment status, such as pay cuts or reduced hours, also are twice as likely to have these symptoms, even though they are employed full time.

The survey was conducted for Mental Health America and the National Alliance on Mental Illness in collaboration with the Depression is Real Coalition. The results come from telephone interviews of 1,002 adults nationwide from September 17–20.

The release of the findings coincides with Mental Illness Awareness Week (from October 4 to 10) and National Depression Screening Day, which takes place this Thursday, October 8.

“This survey clearly shows that economic difficulties are placing the public’s mental health at serious risk and we need affirmative action to address these medical problems,” said David L. Shern, Ph.D., president and CEO of Mental Health America. “Individuals confronting these problems should seek help for their problems—talk to their doctor, trusted friend or advisor or mental health professional.”

“Unemployment today stands at almost 10 percent. Nationwide, we face a mental health crisis as well as an economic crisis,” said Michael J. Fitzpatrick, M.S.W., executive director of the National Alliance on Mental Illness. “There is no shame in seeking help to overcome unemployment or a medical illness. For the sake of all our loved ones, it’s important to learn to recognize symptoms of depression and other mental illnesses. Screening helps. Talk with a doctor about any concerns.”

Other key findings of the survey:

- Thirteen percent of unemployed individuals report that they have thought of harming themselves which is four times more than reported by persons with full time work.
- People who are unemployed are approximately six times as likely to have difficulty meeting household expenses—22 percent

report great difficulty paying their utilities and almost half have significant difficulty in obtaining healthcare further compounding their situation.

- People who are unemployed are also twice as likely to report concern with their mental health or use of alcohol or drugs within the last six months than individuals working full time.
- Of those who have not spoken to a health professional about these concerns, 42 percent cited cost or lack of insurance coverage as the main reason.
- Nearly 20 percent of the sample reported that they had experienced a forced change (e.g. pay cuts, reduced hours) in their employment during the last year.
- Although most of these individuals are employed, individuals with a forced change in employment are twice as likely to report symptoms consistent with severe mental illness than would be expected. They are also five times more likely to report feeling hopeless most or all of the time than individuals who hadn’t experienced a forced change.

Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population in a given year, whether they are unemployed or not. Depression is also very treatable. In fact, treatment such as antidepressants and talk therapy is effective over 80 percent of the time.

But fewer than half of people confronting this medical illness seek treatment, regardless of economic or employment status.

Individuals can go to [www.mentalhealth-screening.org](http://www.mentalhealth-screening.org) to find out about free, confidential screenings behind conducted around the country on Thursday and take an anonymous screening online. An additional free, confidential, online screening test is also available at [www.depression-screening.org](http://www.depression-screening.org). More information about depression is available at [www.DepressionIsReal.org](http://www.DepressionIsReal.org).

## About the Survey

The survey was conducted via telephone among a national probability sample of 1,002 adults, comprising 500 men and 502 women 18 years of age and older, living in private households in the continental United States. Fieldwork for this study was conducted using

Opinion Research Corporation’s CARAVAN® Survey during the period September 17-20, 2009. It has a margin of error of plus or minus 3.1 percentage points for results based on the total sample.

## About the Depression is Real Coalition

The Depression Is Real Coalition ([www. DepressionIsReal.org](http://www.DepressionIsReal.org)) is sponsored by the American Psychiatric Foundation, Depression and Bipolar Support Alliance, Mental Health America, National Alliance on Mental Illness and National Medical Association and is made possible through the support of Wyeth.

*Article contributed by the National Alliance on Mental Illness. (800) 950-NAMI; [info@nami.org](mailto:info@nami.org)*

## Put NAMI WI on your shopping list

As the holidays approach and we turn our thoughts to giving we hope you might consider a donation to NAMI Wisconsin. In addition to the always appreciated cash donations, this year we have compiled a NAMI Wisconsin holiday wish list for your consideration. Donations to NAMI Wisconsin are tax deductible to the fullest extent of the law. Value of donated items will be acknowledged and a receipt provided to the donor.

Reams of paper

Name Badges and refills: Avery 3”X 4” hanging or clip-on preferred

Ink cartridges for printers (call office for numbers)

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I'd like more information about the following:     a local NAMI affiliate in my area     becoming a NAMI member

**Your gift to NAMI Wisconsin will change minds, raise voices, and help many individuals and families affected by mental illness.**

*"Very worthwhile empowering course. It lifted my spirits and got me excited about learning and doing more."*

*—Peer-to-Peer trainee*

*"Important—I thought, not only with how to help change things in our community, but also on a large scale."*

*—Barron County Conference attendee*

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