UNIVERSITY OF WISCONSIN-LA CROSSE

Graduate Studies

THE BURDEN OF MENTAL ILLNESS: A RERORT ON LA CROSSE AND THE SURROUNDING REGION

A Graduate Project Report Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Science in Community Health Education

Tara De Long

College of Science and Health
Community Health Education

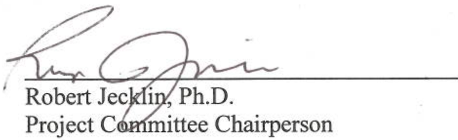
December, 2012

THE BURDEN OF MENTAL ILLNESS: A RERORT ON LA CROSSE AND THE SURROUNDING REGION

By Tara De Long

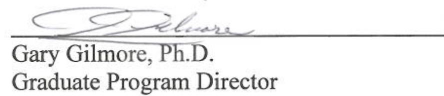
We recommend acceptance of this project report in partial fulfillment of the candidate's requirements for the degree of Masters of Science in Community Health Education.

The candidate has met all of the project completion requirements.



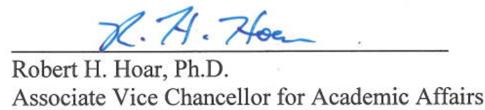
Robert Jecklin, Ph.D.
Project Committee Chairperson

April 3 2012
Date



Gary Gilmore, Ph.D.
Graduate Program Director

March 29, 2012
Date



Robert H. Hoar, Ph.D.
Associate Vice Chancellor for Academic Affairs

April 15, 2012
Date

ABSTRACT

De Long, T.L. The burden of mental illness a report on La Crosse and the surrounding region. MS in Community Health Education, August 2012, 52 pp. (R. Jecklin)

The Burden of Mental Illness a Report on La Crosse and the Surrounding Region is a graduate project in partnership with the La Crosse Medical Health Science Consortium's *Healthiest County 2015: La Crosse* mental health sub-committee, and The Mental Health Coalition of the Greater La Crosse Area. The goal of the burden report is to identify challenges, costs, and other impacts that the pursuit for mental health has on the community. The report will support organizations and agencies to identifying objectives based on public health approaches. The report provides a framework for considering the burden of illness attributed to mental illness in the La Crosse region. The first section presents data on youth and adult mental health risk factors, costs in the workplace, prevalence of health risks and chronic diseases, identified cost by illness, and years of potential life lost. The second section addresses data on prevention and stigma reduction, organizational efforts, healthcare costs and service utilization, identified level of community concern for mental health, and partnering groups and organizations in the community. Additionally, the conclusion highlights a response from key community leaders.

TABLE OF CONTENTS

PAGE

SECTION I: INTRODUCTION AND OVERVIEW…..…………………………..….1

Review of Literature…………………………..………………………..……. 2

SECTION II: METHODS……………………………………………………….…….6

SECTION III: FINDINGS…………………………………………..…………...10

SECTION IV: DISCUSSION, CONCLUSION, RECOMMENDATIONS…………12

REFERENCES ……………………………………………………………………..…15

APPENDICES……………………………………………………………………...17

Appendix A: Burden Report……………………………………………….17

SECTION I

INTRODUCTION AND OVERVIEW

Mental illnesses are common in the United States and throughout the world. The National Institute of Mental Health estimates 26.2 percent of Americans ages 18 and older suffer from a diagnosable mental illness in a given year. Although mental disorders are widespread in the population, the main burden of illness is typically reported to be concentrated in a much smaller proportion (the approximate 6 percent of the population who suffer from a serious mental illness). Additionally, mental disorders are the leading cause of disability in the U.S. and Canada for individuals ages 15-44. (NAMI, 2011)

For the purposes of this research, the focus on mental illness expands beyond what is documented as the concentrated burden of suffering from serious and chronic illness; the disease burden of mental illness is not simply measured by cost, morbidity and mortality. Dissimilar to other disease burdens, measuring mental illness present with multiple diagnoses with varied pathology and symptoms, co-occurring disorders, chronic and acute management of the disorder, and varied and unknown etiology, it spans the lifetime and often involves multiple systems of care. Additionally, each illness presents with its own symptomatology.

As a professional committed to working toward a more mentally healthy community in which I live and work, I envisioned writing a report that brings to light the burden of mental illness in the community. This report identifies various impacts and societal costs of mental illnesses. The purpose of this burden report is to provide

community organizations, the healthcare community, and public health specific information about mental health, specifically mental illness in their community, and for community leaders and partners to focus efforts where there are known problems.

Review of Literature

In preparation for writing the burden report, multiple sources of information are accessed and reviewed. In 1999, The Department of Health and Human Services released a report of the Surgeon General entitled *Mental Health*. The overreaching themes of the report take a broad view of health and illness specific to mental health. In the ten years since its release, the level of concern for the health of a population including mental health, has been gaining momentum. The report goes on to address mental health and mental illness across the age spectrum, advances in research and treatment, recognition of stigma, parity, as well as legal and ethical issues. This report provided a context, as it is the most far-reaching report available in this literature review, which specifies the burden of mental illness.

While the global burden of illness is identified by the World Health Organization, and Centers for Disease Control and Prevention, the resulting health surveillance is similarly reported across the nation. It is estimated that 2.4 million adults age 18-26 had serious mental illness in 2006 (United States Government Accountability Office, 2008); approximately 26.2 percent of adults 18 and older suffer from a diagnosable mental disorder in any given year (National Institute of Health, 2008).

The National Alliance on Mental Illness defines mental illnesses as "medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illnesses are medical conditions that often result in

a diminished capacity for coping with the ordinary demands of life." (NAMI, 2011) The recognition of mental illnesses as medical conditions that are not only diagnosable but also, treatable are important distinctions for moving forward in promoting mentally healthy communities. A number of reasons may contribute to a reluctance to seek and maintain treatment; however, the research indicates that the most influential of them is continued stigmatization of mental illness. (Corrigan & Watson, 2007). It is estimated that two-thirds of all people with a diagnosable mental illness do not seek treatment, furthering the load on communities. Undeniably, mental illnesses go untreated and undiagnosed; however, stigma poses an additional barrier in both measuring and defining the depth of the issue. Therefore, while mental health may be identifiable, it is not easily defined. Perhaps one of the biggest barriers in defining mental health relates to defining it as an absence of illness. Conceptualizing mental health as a state of well-being, or a foundation for well-being and functioning for both individual and community challenges our beliefs about mental illness. Mental health is more than the absence of a mental illness. This is in direct conflict at times with the medical model; indeed, the mental health continuum represents all that embraces health, not just the treatment of symptoms. While not outlined specifically, it should be assumed that both individuals and families suffer greatly at the hands of mental illness. Such personal costs to individual's quality of life directly influence the immediate community and family systems.

Perhaps the most accessible data associated with mental illness is suicide. One of the driving interests behind this project relates to the limitations of using suicide rates to measure progress toward improved community mental health. The Wisconsin Department of Health Services released a comprehensive report entitled *The Burden of*

Suicide in Wisconsin in 2008. It focused on outlining the burden of suicide, to include key findings such as suicide rates that have remaining constant, cost of hospitalizations, disparities among people of color, and high correlation to alcohol use. While the report is comprehensive, the data was limited to suicide. While suicide and suicidal behavior contribute to costly interventions for life saving measures in the medical community, and utilize significant resources in the community, community mental health is inaccurately represented by these statistics.

An effort to pinpoint regional and local information yielded a handful of burden reports not related to mental health. The following two reports *Alcohol Related Injury and Death in La Crosse County – A Report on the Burden of At Risk Alcohol Use* and *Abuse and Burden of Obesity and Inactivity A Report on Obesity and Related Morbidity and Mortality and Physical Inactivity in La Crosse County*, both addressed local and state data when available. The reports represented a collaborative effort in the community to concentrate on significant health problems and health risk behaviors. Additionally health consequences to the community as well as the toll of injury are reported.

The Report *Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey* presents information about the relationship between mental health and physical health among Wisconsin adults for the years 2006-2007. Until more recent years state level data showing the relationship between mental health and physical health has been scarce. The report looks at serious psychological distress (SPD), depression, and their association with chronic physical disease as a source of health-related burden and diminished quality of life. Wisconsin adults with SPD are associated with elevation of chronic disease risk factors such as smoking, obesity, and

higher prevalence of diagnosed cardiovascular disease. (Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services., 2009) The report notes the diminished capacity of individuals with mental illness to engage in their own health promotion, or contribute fully in treatment and tertiary prevention

While defining the burden of mental illness may pose more challenges than other chronic health conditions such as obesity or cardiovascular disease, the growing awareness, understanding, and links to the health of communities presents a need to explore this further.

SECTION II

METHODS

In 2003, the President's Commission on Mental Health identified as its number one goal for a transformed mental health system, Understand that Mental Health is Essential to Overall Health. Nearly a decade later the La Crosse community has embraced this goal as part of the *Healthiest County 2015* project.

During a preceptor experience with The Mental Health Coalition of the Greater La Crosse Area, I became more thoroughly aware of The La Crosse Medical Health Science Consortium (LMHSC) and the Population Health Committee's project called the *Healthiest County 2015: La Crosse* project. *Healthiest County 2015* addresses health needs of the La Crosse County using the County Health Rankings distributed by the Wisconsin Population Health Institute. The purpose of the project is to bring similar organizations working on health initiatives and projects together, focusing efforts on becoming the healthiest county in Wisconsin by 2015. The Mental Health Coalition participated in one of the four focus areas, mental health. It became clear that this sub-group was struggling to identify goals and tactics toward a more mentally healthy community, in part due to a lack of data specific to the status of mental health and illness in the community. Upon seeing the main goal, which was related to suicide rates, it became even clearer that the community needed specific information and data to support this effort in mental health. The first steps in proceeding with the burden report were to address both assets and needs of the population. After eliciting the support of key

community advisors, and Dr. Brenda Rooney, a member of the Population Health Committee and Medical Director of Community and Preventive Care Services at Gundersen Lutheran, the project was ready to move forward.

The purpose of this project is to assist community organizations and institutions in identifying the needs and goals related to mental health in the community, information specific to La Crosse County and the surrounding area. It is believed the report will provide needed understanding of the specific impacts to the community and guide short and long-term objectives for collaborating organizations, in the mental health continuum, community wide.

Measuring the burden of mental illness poses numerous challenges. Data and information from numerous source offers minimal assist in defining the true impact unless a process for sorting and analyzing exist. Determining relative data and information to include in the report is confounded by the complexities in how we measure, or more accurately do not measure mental health. Public health surveillance historically has separated mental health from physical health impacts. It is difficult to isolate data specifically related to mental health given the numerous influences mental health and illness has on the health of individuals and the community. People with mental illnesses are an underrepresented group with significant health disparities. This level of discrimination, exemplified by stigma, has limited the support of such research.

At the start of this project, it appears there are more questions than answers, which speaks to the breadth of this issue. The report, a small representation of a much bigger issue, typifies a certain maneuvering through the maze of information to uncover

meaningful data and represents a launch toward better understanding of the burden on this region.

Multiple systems and organizations complied with requests for data and information, some with greater effort than others did. The timeline for the project involved contacting organizations, agencies, and health care systems to request data. This required multiple attempts depending on the organization. A working outline of possible data sources is created and revisited throughout the process, as continued evaluation is needed. Although health information and data is available, it required additional analysis to include in the report. For example, the Youth Risk Behavior Survey 2010 did not include the additional risk factors based on risk for depression (see appendix A). Data from the following required additional analysis: Youth Risk Behavior Survey, Mental Health Coalition, Compass Now 2012, and medical costs from Gundersen Lutheran Medical Center and Mayo Clinic Health System-Franciscan Healthcare in La Crosse. I worked with Dr. Rooney to understand the process; we collaborated on the specific questions and data that supported the burden report. I entered numerous data sets and sorted through medical center data prior to Dr. Rooney running the analysis. In June of 2011, I presented a sneak peak of the report outline to the Mental Health Coalition board members and the mental health sub-group for the *Healthiest County 2015.* At this time, the report began to take shape and the opportunity to prioritize information for the report ensued. Over the course of the summer, additional data is gathered and sifted through. One of the biggest limitations for me was delimiting information and data. Everything seemed relevant and interesting in the process. I was also reminded that the report, when presented needed to be objective and

straightforward. Throughout the course of the project, I routinely scanned the literature for new and additional reports or data germane to the project. I maintained a connection with the mental health focus group and The Mental Health Coalition of the Greater La Crosse Area, attended meetings and participated in collaborative work outside of the burden report. This allowed me greater understanding of the work already underway. I took great pride in staying visible and accessible; this allowed others a better understanding of the report, generated interest and provided these organizations time to generate ideas for how the report could be helpful. The anticipated release of the report was early fall 2011. Due to unforeseen circumstances with the hospital data, the release was delayed until December 2011.

The report was presented to the *Healthiest County 2015* mental health sub-group January 18, 2012. Upon its release, it can be viewed in its entirety on The La Crosse Medical Health Science Consortium under the mental health focus group. Additionally I worked with Catherine Kolkmeier, from The Medical Health Science Consortium to create a press release, and made myself available to the press for interviews. I was interviewed by a few local television stations and the stories ran that evening. The local Wisconsin Public Radio station interviewed me, and Patti Jo Severson the co-chair of the Greater La Crosse Mental Health Coalition, for their Newsmakers program. The story aired that week along with a repeat interview about mental health stigma. The result of a few radio and news stories generated ongoing awareness and discussion in the community. Subsequently, these interviews and stories contributed to the *Healthiest County 2015* goal of achieving media impressions intended to educate the community about collaborations in making healthy choices.

SECTION III

FINDINGS

The Burden of Mental Illness A Report on La Crosse and the Surrounding Region

I. Child, Adolescent and Young Adult Mental Health

a. Youth Risk Behavior Survey

b. National College Health Assessment

II. Adult Mental Health

a. Workplace Mental Health

b. Burden by Disease

c. Link Between Physical and Mental Health

d. Suicide

III. Health and Human Services

a. Community Groups and Organizations

b. La Crosse County Services

c. Emergency Detentions

d. Medical Center Data

IV. Mental Illness and Stigma

a. National Alliance on Mental Illness

b. Mental Health Coalition of the Greater La Crosse Area

c. Compass Now 2012

V. Leaders and Partners

This report identifies various impacts and societal costs of mental illnesses. This report was prepared in conjunction with the La Crosse Medical Health Science Consortium's Healthiest County 2015 effort to be the healthiest county in the state. To review the report, in its entirety, refer to Appendix A.

SECTION IV

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

Given the extensiveness of this issue, so much more could be included in identifying the burden of mental illness. Not identified are specific populations such as children with emotional behavioral disabilities, developmental disabilities, co-occurring disorders, substance abuse disorders, veterans, gay, lesbian, bisexual and transgender individuals, people of color, jail and prison population, and transient population. These conditions and populations considered to be beyond the scope of this report and are deserving of a care system/identification all their own. Future reports can build on the identified populations that are likely more vulnerable to mental health issues. Lack of data and underreporting of mental health conditions creates additional barriers for the researcher. Attempts were made to include data from St. Clare Health Mission; however, they reported no means of providing specific data related to mental illness because they did not provide that service. In my work at the hospital, I know patients are seen and provided with psychotropic medications at this clinic, although they are not certified to provide psychiatric services. Examples such as this are reflective of the very challenges communities and individuals face in accessing quality health care, especially those of lower socio-economic status. In discussions with the Sheriff and Justice Sanctions coordinator of La Crosse County, I was surprised to learn that an integrated system did not exist for screening, tracking and treating individuals with mental health needs.

Although, they were working to remedy this significant gap in tracking data, this was not available to include in the report.

In reflecting on the professional and personal value involved in this project, I am reminded of the breadth of this project at its inception and the resolve required for its completion. Working in the field of mental health over the course of the past 18 years, coupled with a strong desire to have this graduate project benefit the community that I work and live in, drove the effort forward.

As a health educator, I feel confident that this experience will allow me to seek and fulfill other projects that highlight and emphasize mental health as a public health concern. Professionally, I have been challenged by this project. I had a huge learning curve, which allowed me to take risks, push myself in an academic and professional capacity, and utilize my passion to focus efforts on creating a worthwhile project. The opportunity to network with groups and organizations, better understand the system of communication, generate awareness about the project, and promote understanding of its benefit became an important part of my professional growth. I also had not anticipated the many layers of work that would surround the project experience. One of the personal and professional motivators for the project believed that the report would benefit a greater community of people and fill a void. Intrinsic motivation paired with external expectations from collaborating groups and organizations exemplified the need for attentiveness to detail, communication, tenacity and a slow and steady pace.

Finally, the report was presented to the Promoting Mental Health and Well Being focus group from the *Healthy County 2015: La Crosse* project. The group consists of representation from across the community: county board members, clinicians,

administrators, instructional staff in higher education, non-profit leaders, family members, school counselors, and the media. This opportunity to release the information, to the group that has anticipated it most, validates the need for the report. The prospect of this group and others seeing value and practical application of the information is hugely rewarding. I feel this project may also lead to some new energy and investment in the commitment to a mentally healthy community here in La Crosse. My hope for the report would first be a more obvious clarity to the coalition group so a more focused effort to establish both short and long-term objectives ensued. Secondly, I envision a stronger presence in the community with programming to address stigma, specifically with prevention and early intervention in mind. Thirdly, collaboration with public health departments to address chronic disease, physical and mental health risk factors with a concentrated effort to engage individuals with mental illness in reducing these risks. Finally, a committed approach to further health surveillance, such as promoting, keeping and tracking data.

REFERENCES

Corrigan, P., & Watson, A. (2007). The Stigma of Psychiatric Disorders and the Gender, Ethnicity, and Educaton of the Perceiver. Community Mental Health Journal , 439-457.

Kopp, B., Schlotthauer, A., & Gross, S. (2008). The Burden of Suicide in Wisconsin . Madison,WI: WISCONSIN DEPARTMENT OF HEALTH SERVICES.

NAMI. (2011). Mental Illnesses. Retrieved February 15, 2011, from National Alliance on Mental Illness: http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm

National Institute of Mental Health. (n.d.). Retrieved March 4, 2011, from http://www.nimh.nih.gov/statistics/2CDNC.shtml

National Institute of Mental Health. (2010). National Institutes of Health. Retrieved May 10, 2010, from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml

U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

United States Government Accountability Office. (2008). YOUNG ADULTS WITH SERIOUS MENTAL ILLNESS. Washington DC: Government Accountability Office.

US Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Wisconsin Department of Health Services, Division of Public Health and Division of

Mental Health and Substance Abuse Services. (2009). Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey. Bureau of Health Information and Policy, Division of Public Health; and the Bureau of Prevention, Treatment and Recovery, Division of Mental Health and Substance Abuse Services.

APPENDIX A

THE BURDEN OF MENTAL ILLNESS REPORT

THE BURDEN OF MENTAL ILLNESS:

A REPORT ON LA CROSSE AND THE SURROUNDING REGION

Released December 2011

This report was prepared in conjunction with the La Crosse Medical Health Science Consortium's Healthiest County 2015 effort to be the healthiest county in the state.

SPECIAL THANKS
Brenda Rooney MPH, PhD, Medical Director of Community and Preventive Care Services at Gundersen Lutheran Medical Center, for mentoring, coaching, consultation and collaboration.

Robert Jecklin MPH, PhD, Assistant Professor Department of Health Education and Health Promotion at University of Wisconsin-La Crosse for project advising.

Child, Adolescent and Young Adult Mental Health

A national report released in April 2011 indicates that 8.1 percent of America's adolescents aged 12 to 17 (2 million youth) experienced at least one major depressive episode (MDE) in the past year. A major depressive episode, defined as a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure and additional symptoms that reflect a change in functioning, such as sleep, energy and eating.

The report by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that only 34.7 percent of these adolescents suffering from major depressive episodes received treatment during this period. (SAMHSA, April 28 2011)

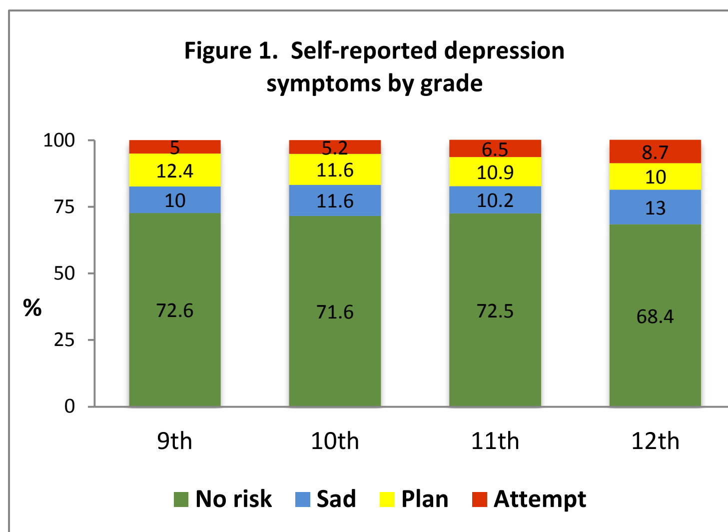
Youth Risk Behavioral Survey –La Crosse County

Students completed a self-administered, anonymous, 99-item questionnaire. In the table below are selected questions and results from 2010 YRBS, High School Students in La Crosse County Public Schools were examined by mental health risk categories.

The risk categories are identified in the following manner in Table 1: no risk of suicide, being sad, both considered and identified a plan, and suicide attempts.

Table 1: Identified Risk Categories

%	Risk category name	Description
71.4%	No Risk	None of the risks below
11.1%	SAD	Stopped doing things for 2 weeks (past year)
5.4%	CONSIDER SUICIDE	Seriously consider suicide (past year)
5.9%	PLAN SUICIDE	Make a plan about how to attempt suicide (past year)
3.9%	ATTEMPTED SUICIDE	Number of times actually attempted suicide (past year)
2.3%	ATTEMPTED NEED TX	Any suicide attempt needing treatment (past year)



Figures 2-7. The analysis showed that students at highest risk for depression were more likely to smoke cigarettes, report binge drinking, use marijuana and other drugs (including over the counter, prescription, steroid, meth, ecstasy and huffing), and use inappropriate methods to lose or control weight.

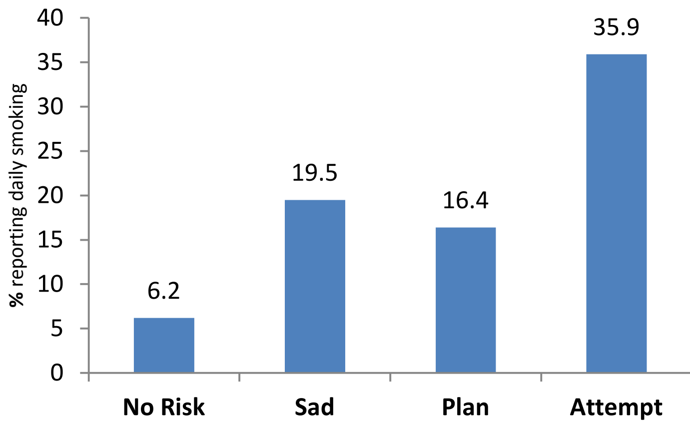


Figure 2. Daily smoking by risk for depression
% reporting daily smoking
40
35
30
25
20
15
10
5
0
6.2
19.5
16.4
35.9
No Risk
Sad
Plan
Attempt

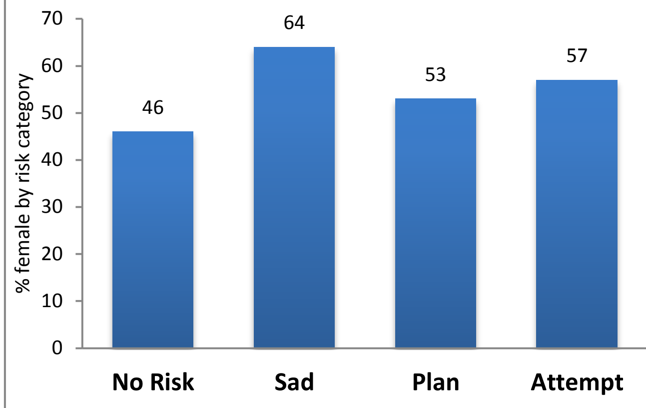


Figure 3. % female by self-reported depression symptoms
% female by risk category
70
60
50
40
30
20
10
0
46
64
53
57
No Risk
Sad
Plan
Attempt

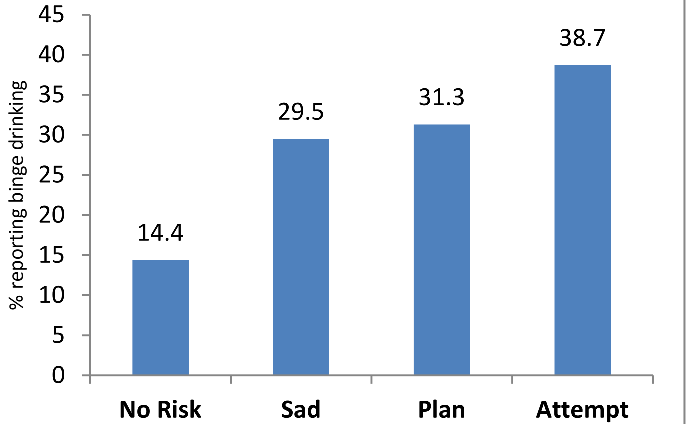


Figure 4. Binge drinking by risk for depression
% reporting binge drinking
45
40
35
30
25
20
15
10
5
0
14.4
29.5
31.3
38.7
No Risk
Sad
Plan
Attempt

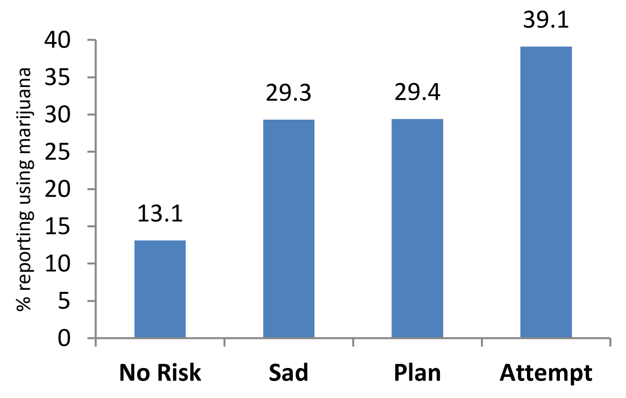


Figure 5. 30-day marijuana use by risk for depression
% reporting using marijuana
40
35
30
25
20
15
10
5
0
13.1
29.3
29.4
39.1
No Risk
Sad
Plan
Attempt

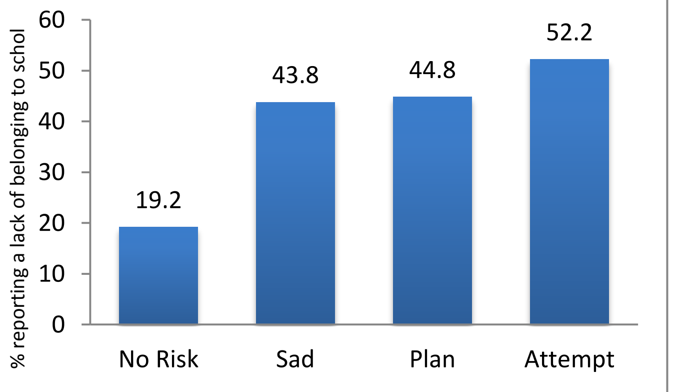


Figure 6. Perceived lack of belonging to school by risk for depression
% reporting a lack of belonging to schol
60
50
40
30
20
10
0
19.2
43.8
44.8
52.2
No Risk
Sad
Plan
Attempt

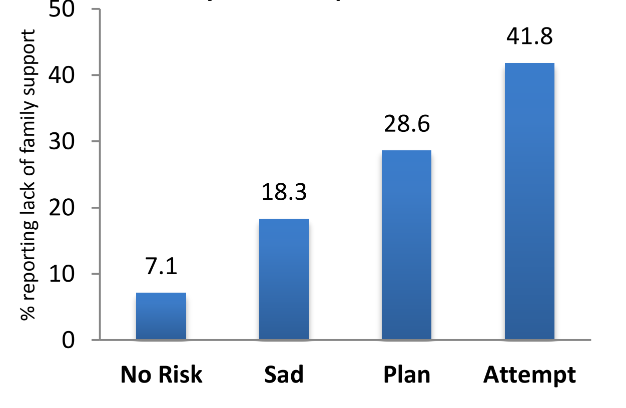
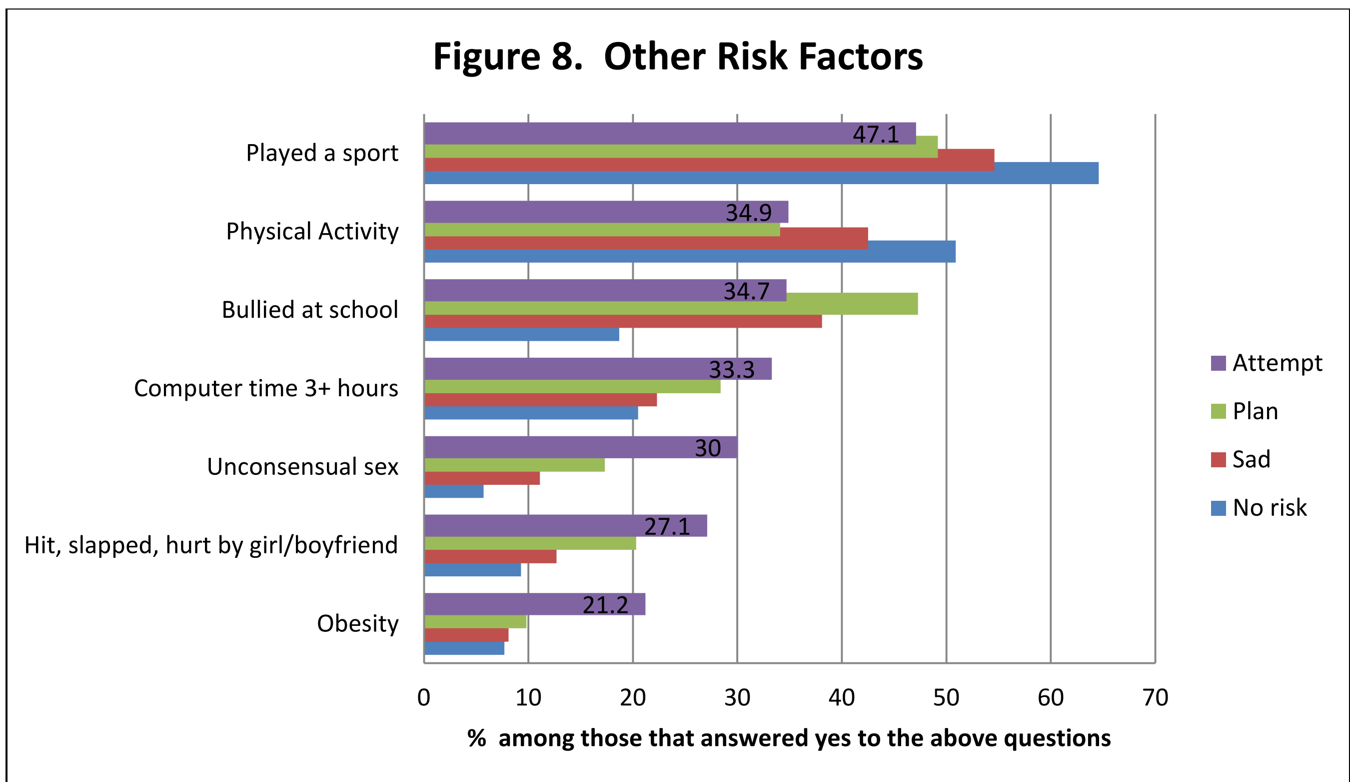


Figure 7. Perceived lack of support of family by risk for depression
% reporting lack of family support
50
40
30
20
10
0
7.1
18.3
28.6
41.8
No Risk
Sad
Plan
Attempt

Figure 8. As the risk of depression increased,

- There was a decrease in the likelihood of being in a school sport.
- There was a decrease in the rate of students meeting physical activity goals.
- There was an increase in the rate of being bullied in school.
- There was an increase in the percent of spending 3+ hours of computer per day.
- There was an increase in the percentage of reported sexual violence.
- There was an increase in the percentage of reported physical violence in a relationship.
- There was an increase in the rate of self-reported obesity.

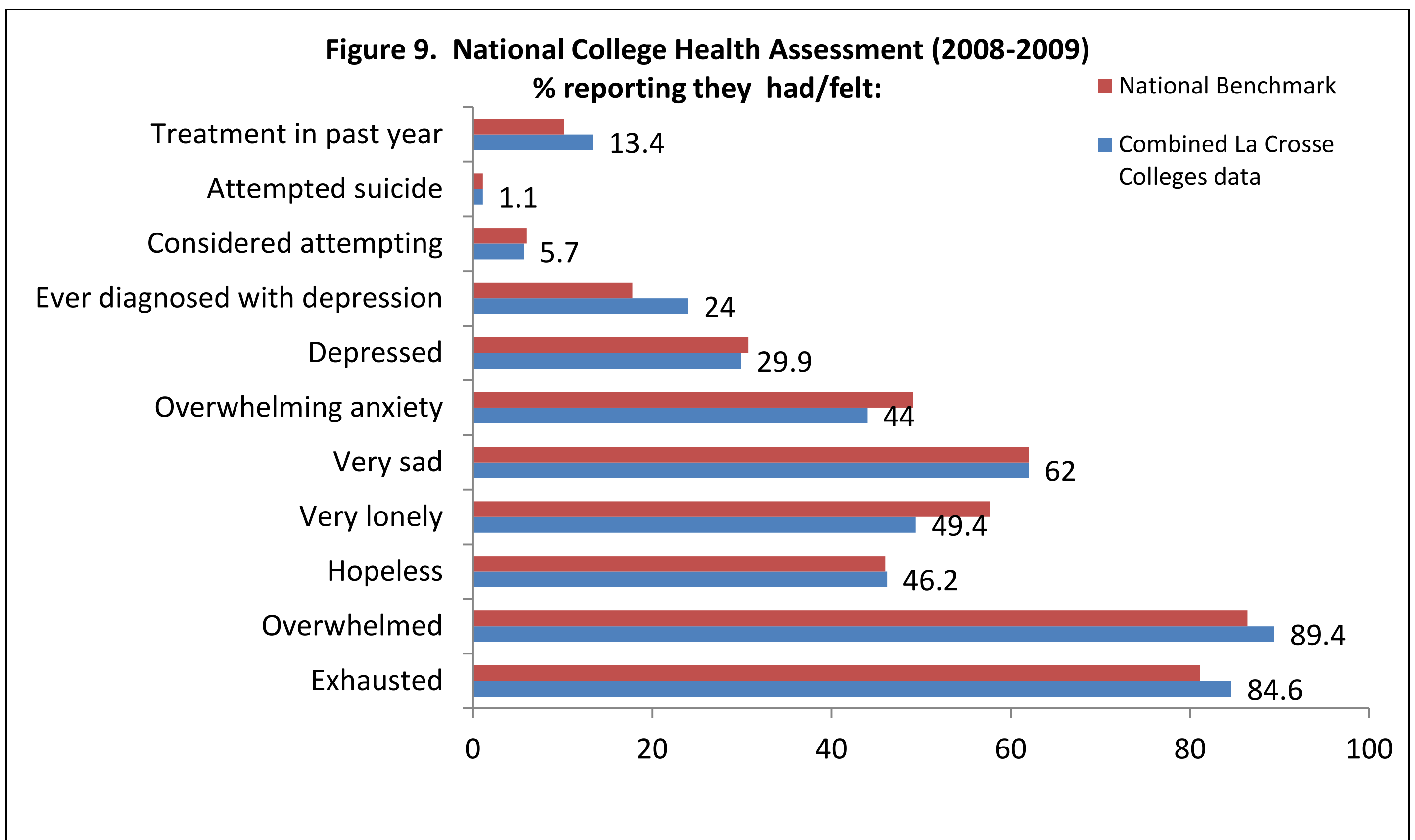


National College Health Assessment Summary

In 2008 and 2009 college students from Viterbo University, Western Technical College and University of Wisconsin La Crosse, participated in the National College Health Assessment. 1682 Students were surveyed and compared to national benchmarks.

As shown in Figure 9,

- Over 80% of college students, in this survey, identify feeling exhausted and overwhelmed.
- Nearly 30% of students report feeling depressed.
- More students reported being diagnosed and treated for depression, within the past year, than the national average.



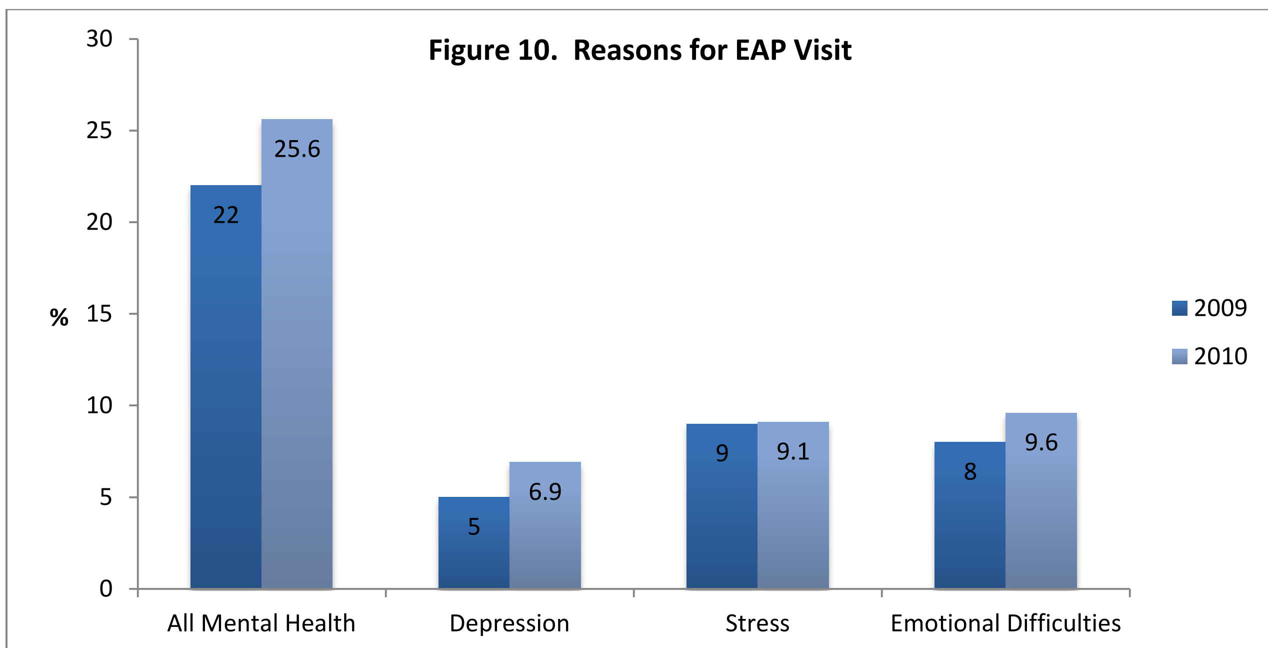
Adults and Mental Health

Workplace Mental Health

Mental illness has a significant impact on the workplace that often goes unrecognized. Mental illness causes more days of work loss and work impairment than chronic health conditions such as asthma, diabetes and heart disease. (NAMI, 2010) Individuals who experience mental illness are a significant portion of the workforce and failure to invest in their mental health is costly to a company's productivity and bottom line. Absence, disability and lost productivity related to mental illness cost employers more than four times the cost of employee medical treatment. (Partnership for Workplace Mental Health, 2006)

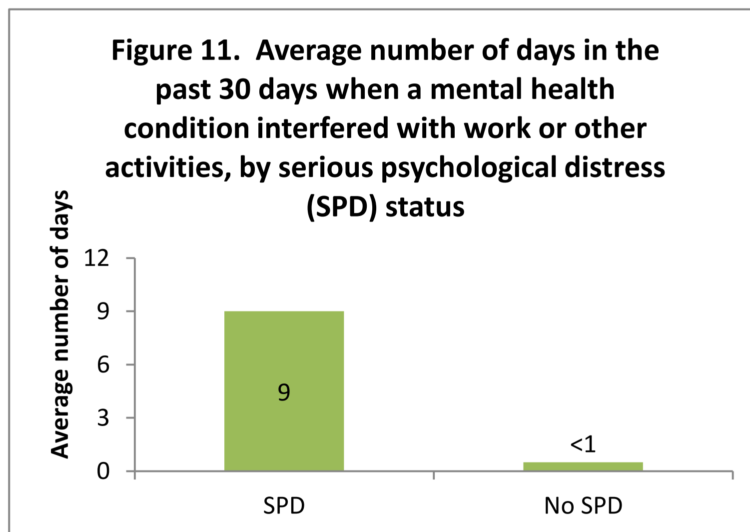
In 2002, serious mental illness in the United States was associated with more than $190 billion in lost personal earning, mostly due to lost productivity in the workplace. (Ronald C. Kessler, 2008) Significant loss of productive human capital defined by impaired functioning associated with mental health related illnesses bears a huge societal burden.

Gundersen Lutheran Employee Assistance Program (EAP) reports that emotional difficulties, depression and stress make up a combined 26% of visits for all EAP appointments in 2010 (multiple companies and businesses), second only to relationship issues. See figure 10.



Source: Gundersen Lutheran Medical Center Employee Assistance Program

Those individuals with serious psychological distress reported interference with work or other activities, nearly 30% of the past 30 days. As reported by the Behavioral Risk Factor Survey (BRFS), see figure 11, Wisconsin adults with serious psychological distress (SPD) appear to experience impaired functioning. Compared to adults without SPD, those with SPD are more likely to have a disability and to be unable to work. Adults with SPD are also more likely to be dissatisfied with life, to have little or no social support, and to have fair or poor health, suggesting poor overall quality of life. (Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services., 2009)

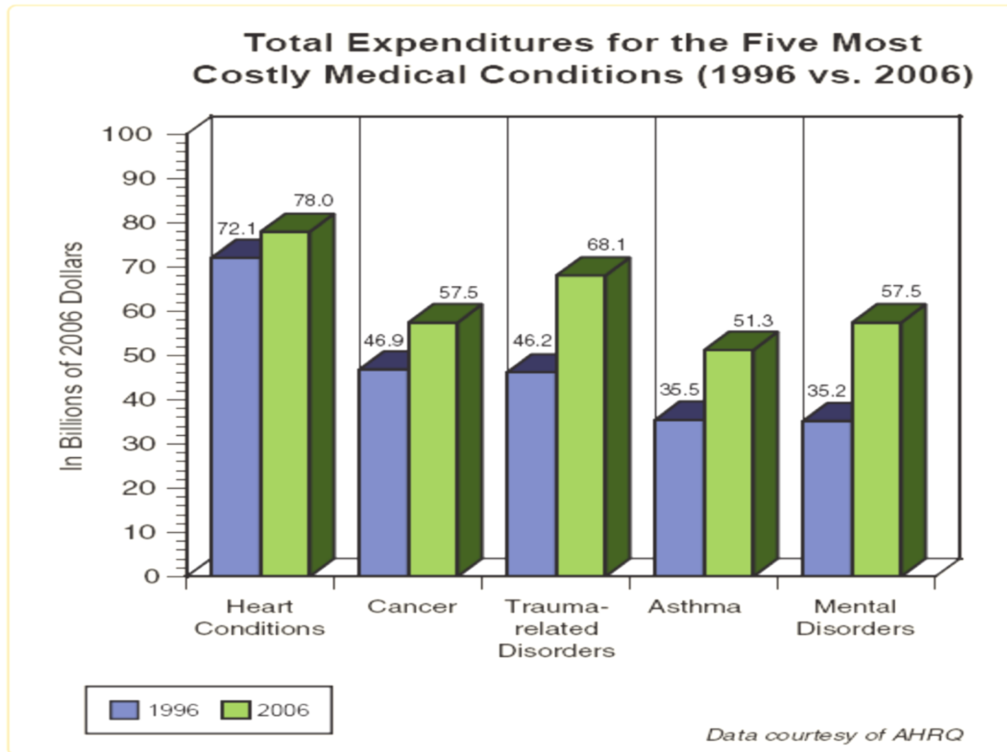


Source: Wisconsin Behavioral Risk Factor Survey, 2007

Burden by Disease

National data is used here to illustrate disease expenditures, as local data is not available. As shown in figure 12, mental illnesses account for the greatest increase in medical cost expenditures, compared to other conditions, while heart conditions and cancer saw minimal increases comparatively. It is estimated that by 2020 mental illness will be second to cardiovascular disease in the global burden of disease. (National Institute of Mental Health)

Figure 12.



Source: US Department of Health and Human Services; Agency for Healthcare Research and Quality

A more recent study in 2010 generated a list of the top diseases responsible for the greatest financial expense in the United States. (Kockaya & Wertheimer, 2010) Mental Disorders account for the third highest costly diseases in the U.S., an indication that the financial burden of mental health is rising as predicted.

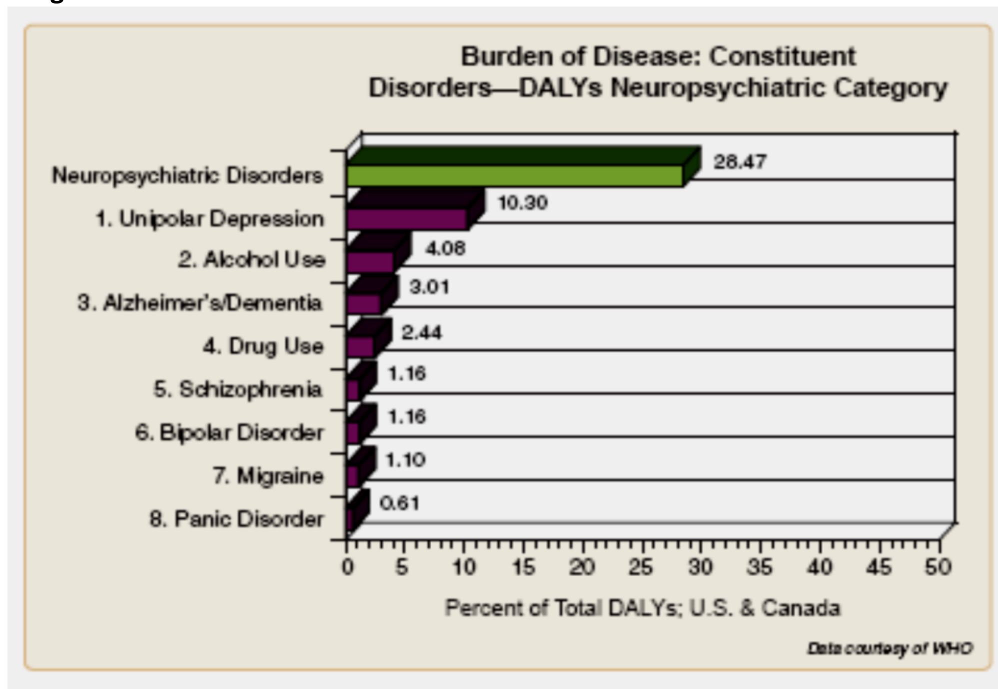
Table 2: Top Five Most Direct Costly Diseases in the United States

Diseases	Direct Cost (in billion US dollars)
Heart & CVD	313.8
Digestive Diseases	220.8
Mental Disease	175.7
Disease of the Nervous System	153.3
Diabetes	128.3

Source: (Kockaya & Wertheimer, 2010)

The World Health Organization (WHO) estimates show the total percentage of disability-adjusted life years (DALY) contributed by the neuropsychiatric disorders category (top bar figure 13) within the United States and Canada, as well as the top individual disorders that contribute to this category (1-8). Depression makes up more than one third of the DALY in this category, and on its own represents 10 percent of all DALY in the U.S. and Canada.

Figure 13.



Source: National Institute of Mental Health, nimh.nih.gov/statistics/pdf/DALY-ConstituentDisorders.pdf

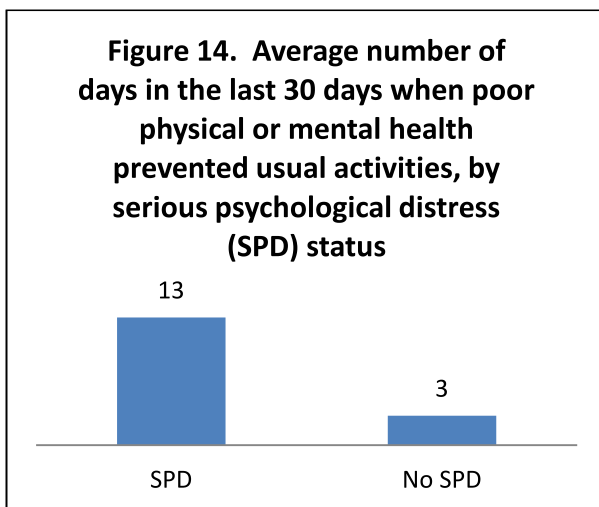
Link between Physical and Mental Health

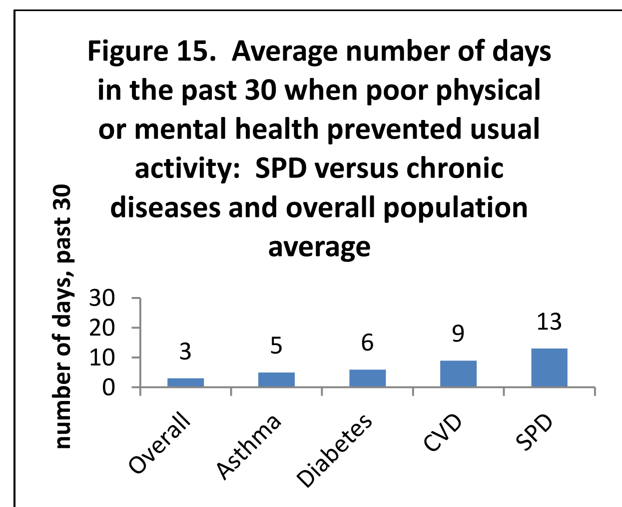
Mental health and physical health are closely connected. Mental health plays a major role in a person's ability to maintain good physical health. Mental illnesses influence people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

Individuals with a major mental illness diagnosis die at a younger age than those who do not have a major mental illness. The majority of these individuals are dying from natural causes, similar to the population at large, such as heart disease, cancer, stroke, respiratory, and lung diseases. (Colton & Manderscheid, 2006)

Attention to the interconnection between mental health and physical health is gaining attention. A growing body of research indicates that mental health problems contribute to premature death. Using information from the Wisconsin Behavioral Risk Factor Survey (BRFS) a report was generated to examine links between mental health conditions and chronic disease risk, functioning, and quality of life among Wisconsin adults. Some of the key findings note that such a strong link exists between mental health conditions and chronic physical diseases, functional impairment, and overall quality of life warrant the need for attention to mental health as a primary health issue. Mental health is significant in its own right; greater evidence is showing the influence on physical health. In 2006 and 2007, BRFS included questions on mental health in the survey. Wisconsin adults with SPD report the highest number of days, in the past 30, of poor physical or mental health preventing usual activities.

As noted in Figure 15, adults with SPD also experience as much or more activity limitation as those with chronic physical conditions such as asthma, diabetes and cardiovascular disease.

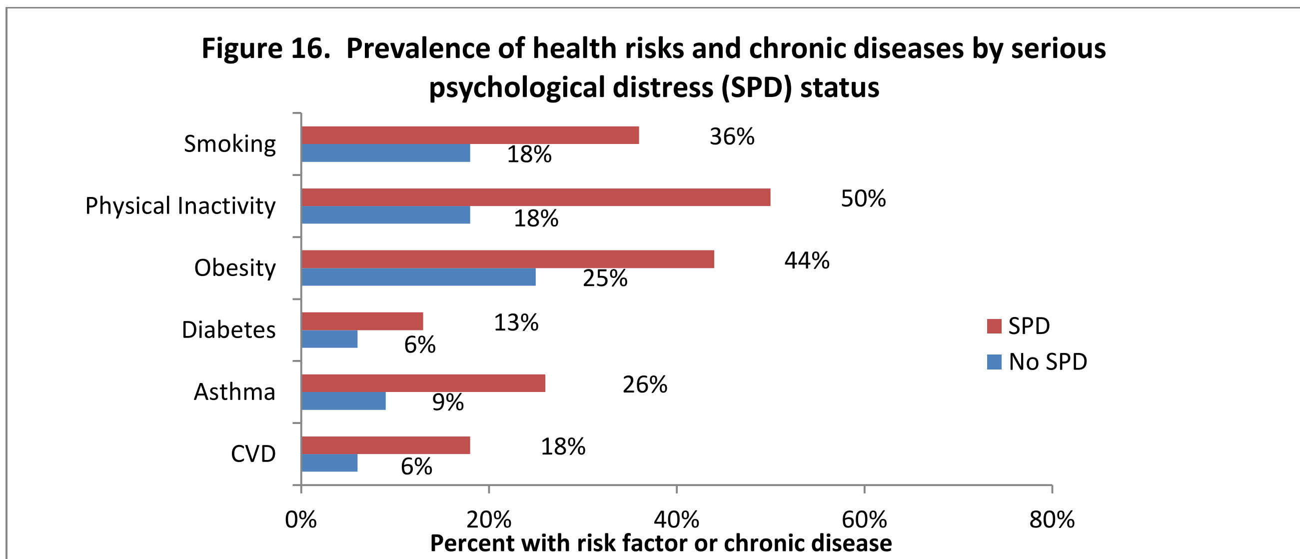




Source: Wisconsin Behavioral Risk Factor Survey. 2007
Note: CVD is cardiovascular disease, defined as ever having had a heart attack or stroke or a diagnosis of coronary heart disease.

As shown in figure 16, Wisconsin adults with SPD, as compared to those with no SPD are,

- Associated with elevation of chronic disease risk factors such as smoking, obesity and lack of exercise, and a higher prevalence of diagnosed asthma, and cardiovascular disease.
- Twice as likely to smoke or have asthma.
- Twice as likely to have cardiovascular disease.
- Over two times as likely to be physically inactive.



Source: Wisconsin Behavioral Risk Factor Survey. 2007
Note: The estimate of diabetes prevalence for SPD group has a large standard error and may be unreliable. CVD is cardiovascular disease, defined as ever having had a heart attack or stroke or a diagnosis of coronary heart disease.

Suicide

In 2008, a supplemental report to "The Burden of Injury in Wisconsin" entitled "The Burden of Suicide in Wisconsin" was published. The report details the significant impact of suicide on public health. Summarizing the burden of suicide utilizing data from the Violent Injury Reporting System (VIRS) and the Wisconsin Violent Death Reporting System (WVDRS) from the years 2001- 2006.
The report presents data on trends of suicide by age, sex, education, race, ethnicity, marital status and veteran status as well as circumstance information surrounding the suicides. Additional data provided includes the number of suicide attempts and economic factors such as years per life lost (YPLL), hospitalization and emergency department visit costs. The report offers a comprehensive approach to understanding the burden of suicide on the state of Wisconsin. The report can be viewed in its entirety at http://www.mhawisconsin.org/content/burdenofsuicidereport.asp.

Table 3: Deaths by Suicide, Suicide Rate for 2007-2009

County	Deaths by Suicide (2007-2009) Age 0+ #	Rate per 100,000	Years of Potential Life Lost (YPLL)
Houston	9	15.5	240
Jackson	8	13.2	324
La Crosse	41	12.1	1279
Monroe	23	17.4	757
Trempealeau	17	20.1	509
Vernon	11	12.4	271

Source: WISH, Wisconsin Department of Health Services, Division of Public Health, and Office of Health Informatics. Minnesota Department of Health, Center for Health Statistics

In this region, Trempealeau, Monroe and Houston Counties have the highest rate of suicide.

Suicidal behavior places a large burden on individuals, families, and communities throughout the state of Wisconsin. Suicidal behavior is a major contributor to hospitalizations and treatment, it also goes largely underreported, self-inflicted wounds may go unreported as intentional, or treatment is not sought at all. The burden of suicide frequents the literature of mental health, required reporting by state and local health departments allows for easy access to data when individuals die by suicide. Historically there is evidence that suicides are underreported. Suicide rates and attempts are only one piece of the mental health predicament for public health.

The Burden of Suicide in Wisconsin indicates a higher rate of suicide (in Wisconsin) than neighboring states. (Kopp, Schlotthauer, & Gross, 2008) The National Institute of Mental Health reports ninety percent of individuals who die of suicide have a diagnosable mental illness. (U.S. Department of Health and Human Services, 2010) In 2007, suicide was the third leading cause of death for 11-24 year olds, the fourth leading cause of death for 25-44 year olds, in the United States. (Centers For Disease Control and Prevention)

Health and Human Services

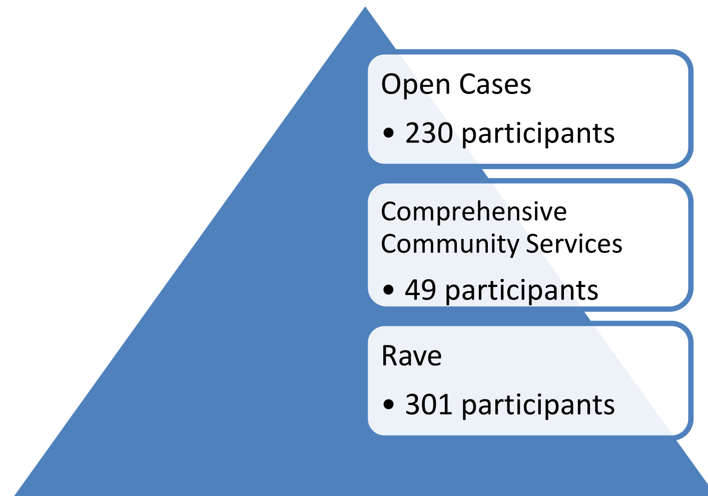
Management of mental illnesses and their consequences in the community can strain local Health and Human Service Agencies. Agencies such as Independent Living Resources, 211, local law enforcement, care facilities and county mental health recovery services are all faced with the challenges of adequate provision of services.

Community Groups and Organizations

Independent living Resources (ILR): 2010 Services for individuals with Mental Illness

- ILR services the regions five Wisconsin counties identified in this report.
- ILR provides individualized services supporting recovery needs with a variety of services. Comprehensive Community Services (CCS) is a mental health recovery and empowerment based program, the goal is to assist persons with mental illness to live independently in the community with services that align to improve their quality of life and meet their needs.
- Recovery Avenue (RAVE) is a drop in center for individuals with mental illness; it is staffed by peer specialists and provides peer facilitated programming.

Figure 18. ILR Services



Great Rivers 2-1-1

Great Rivers 211 provides information, referral and crisis call management. The following list details calls to Great Rivers 211 in 2010.

Table 4: 211 Crisis Calls

Source: Great Rivers 211 Annual Report (Great Rivers 211, 2010)

Life Threatening Crisis		Other Crisis	
Child Abuse	50	Basic Needs Crisis	883
Domestic Violence	84	Developmental Crisis	18
Drug/Alcohol Crisis	162	Life Transitions Crisis	100
Runaway	26	Mental Health Emergency	699
Self-Mutilation	56	Other Traumatic Stress	258
Sexual Assault	18	**Total**	**1,958**
Suicide	311		
Vulnerable Adult	9		
Total	**716**		

- In 2010, suicide accounted for 43% of life-threatening crisis calls.
- Mental health accounted for nearly 50% of all crises related calls, not including alcohol and other drug emergency.
- La Crosse County accounts for the biggest volume of calls to Great Rivers 211.

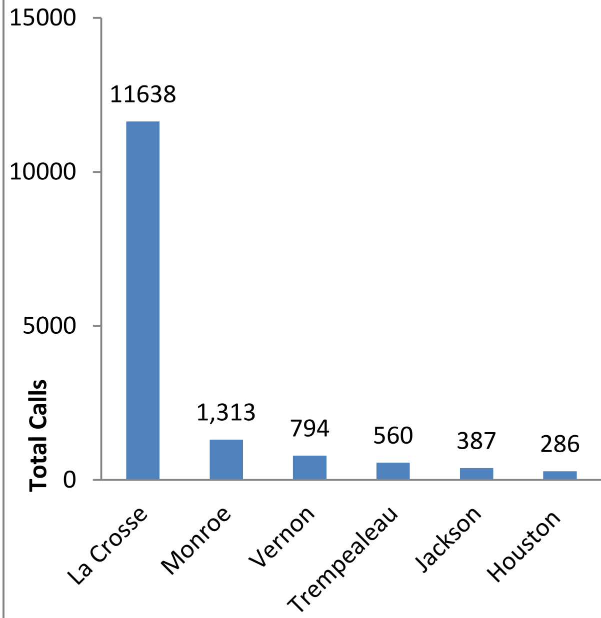


Figure 19. Great Rivers 211 calls by county
15000
10000
5000
0
Total Calls
11638
1,313
794
560
387
286
La Crosse
Monroe
Vernon
Trempealeau
Jackson
Houston

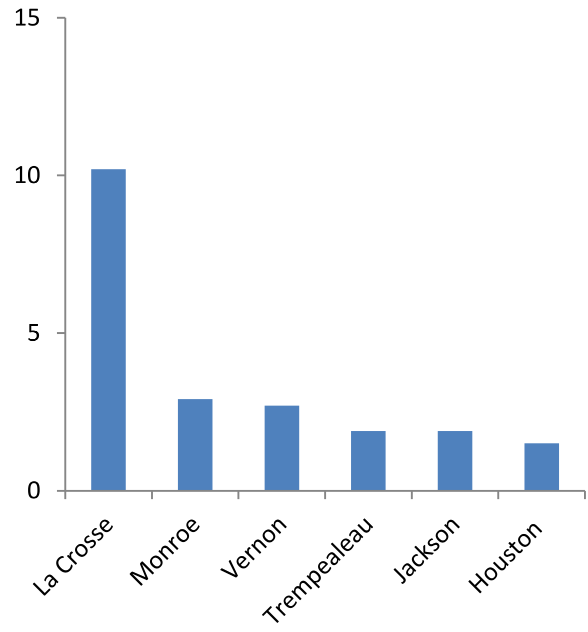


Figure 20. Great Rivers 211 calls per 1000 population
15
10
5
0
La Crosse
Monroe
Vernon
Trempealeau
Jackson
Houston

La Crosse County Facilities

In the La Crosse region, Community Based Residential Facilities (CBRF) and long-term care facilities, specifically for individuals with mental illness, accommodate a limited capacity. Data that is available:

- CARE (Crisis Assessment Recovery Empowerment) Center
  Mental health crisis center for La Crosse County; Bed Capacity 8
  - 271 admissions from May-December 2010.

- Lakeview Healthcare Center La Crosse County (2005); Bed capacity is 156 with average daily census 137.
  - 31% of residents are under age 65.
  - 44.5% of residents were staying longer than 4 years.
  - 39% resided for 1-4 years; 16% for less than a year.
  - 84% have a diagnosed mental illness; 16% other.

- CBRF/Halfway House (La Crosse County)
  - In 2010, there are 56 identified mental health beds.

Involuntary Admissions to Inpatient Facilities by County

An emergency detention occurs when a law enforcement officer takes a child or adult into custody because their recent actions pose a significant risk of harm to self or others. Individuals may remain under an emergency detention for up to 72 hours, during which they are assessed at a mental health facility.

The volume of emergency detentions inaccurately represents the number of individuals committed to court ordered treatment. The numbers reflect individuals escalating to a level of crisis that law enforcement or crisis response teams become involved. Many emergency detentions are not pursued to a final hearing, patients may be willing to receive treatment on a voluntary basis or agree to a stipulation of treatment. Many of the counties utilize crisis response teams to evaluate individuals in crisis, possibly diverting hospitalization and/or triaging for appropriate levels of treatment. For example in 2010, only 25 of the 64 individuals detained in Vernon County where pursued through the Chapter 51:15 process.

Mental health crisis and detentions represent a significant burden to law enforcement, crisis response teams and trauma emergency centers. Mental health crisis often involve multiple levels of services.

Table 5: Emergency Detentions by County

Emergency Detentions by County	2009	2010
Houston	NA	NA
Jackson	NA	NA
La Crosse	610	534
Monroe	226	197
Trempealeau	90	93
Vernon	60	64

Source: Clinical/Human Services Departments in the respective counties submitted the above information. Complete review of state statue 51:15 is available at i*legis.**wisconsin**.gov/statutes/Stat0051.pdf*

Medical Center Data (Outpatient, Inpatient and Emergency Department)

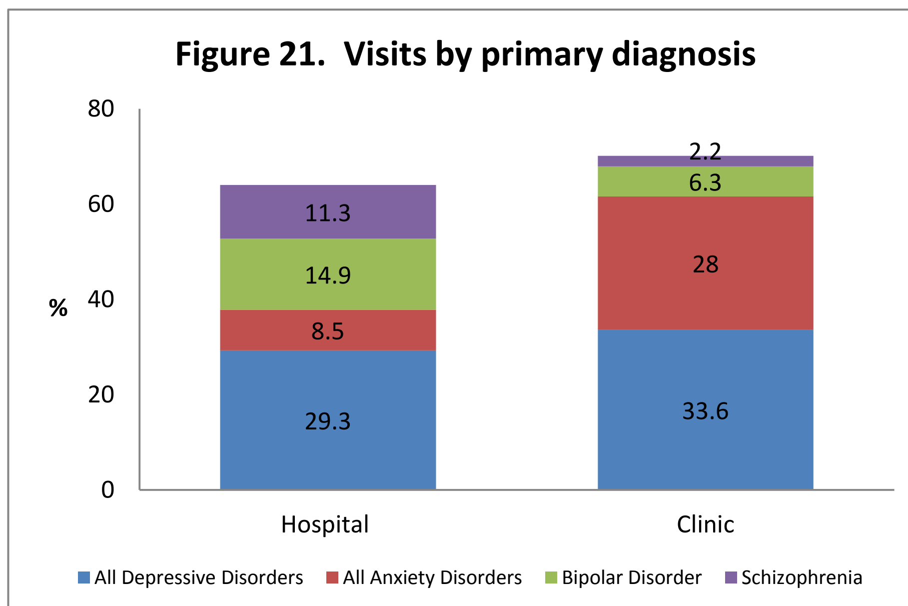
Data reported in this section came from both Gundersen Lutheran Medical Center and Mayo Clinic Health System-Franciscan Healthcare in La Crosse for the years 2009 and 2010. Data was obtained from Trauma Emergency Center (TEC), inpatient hospitalizations and clinic appointments with primary mental health diagnosis.

Charges for clinic and emergency room visits along with hospital stays due to mental illnesses, account for over $52 million dollars in medical expenses for the region. The region included residents from the named surrounding counties. This dollar amount does not account for multiple other services. Charges not accounted for include: visits to private practice clinics, counseling centers, community health centers, tribal health services (Ho-Chunk health care center), free-clinics and regional VA centers and clinics, and admissions to other hospitals within the region who triage, treat, and refer to Psychiatric facilities (in and outside of the region) or hospitals outside the region who treat residents of the multi-county area. The financial cost reaches far beyond the $52 million dollar amount.

Table 6: Healthcare Charges

	2009	2010	2009-2010
TEC charges	$1,116,958.01	$1,273,272.83	$2,390,230.84
Hospital admission charges	$19,303,275.23	$20,894,452.63	$40,197,727.86
Clinic charges	$4,468,384.80	$5,415,670.28	$9,884,055.08
Total cost	$24,888,618.04	$27,583,395.74	$52,472,013.78

- Although total hospital admissions decreased from 2009 to 2010, treatment costs have continued to increase.
- The average length of stay for hospital admissions is 5.2 days.
- Children and adolescents (<18 years of age) account for 10.6% of hospital admissions and 21.5% of clinic visits.
- 53.7% of TEC visits do not result in hospital admissions, placing huge burdens on TEC systems.
- Depressive disorders account for the highest percentage of clinic visits and hospital stays.
- Average charge per hospital admission is $13,236.
- Dementia/Alzheimer has the costliest average hospital charge.
- Primary care clinics are increasingly becoming critical sites for tertiary prevention.



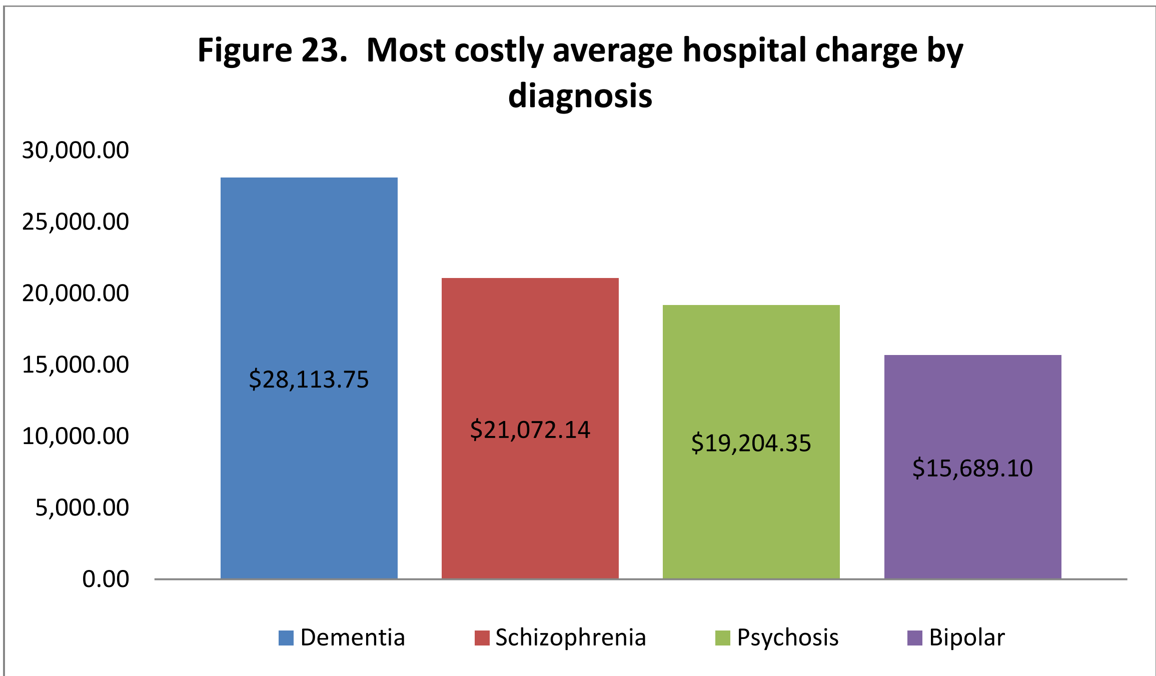


Figure 23. Most costly average hospital charge by diagnosis
30,000.00
25,000.00
20,000.00
15,000.00
10,000.00
5,000.00
0.00
$28,113.75
$21,072.14
$19,204.35
$15,689.10
Dementia
Schizophrenia
Psychosis
Bipolar

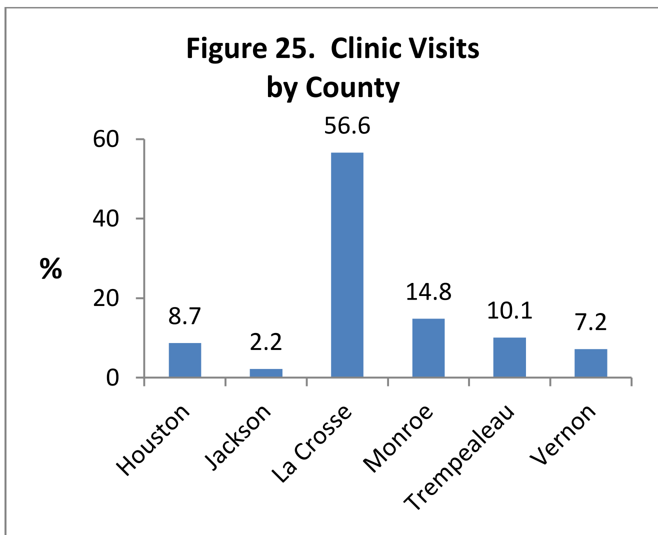


Figure 25. Clinic Visits by County
%
60
40
20
0
8.7
2.2
56.6
14.8
10.1
7.2
Houston
Jackson
La Crosse
Monroe
Trempealeau
Vernon

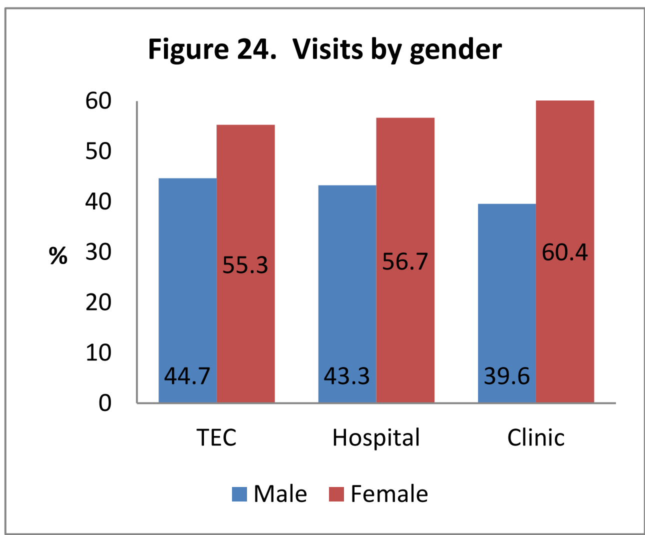


Figure 24. Visits by gender
%
60
50
40
30
20
10
0
44.7
55.3
43.3
56.7
39.6
60.4
TEC
Hospital
Clinic
Male
Female

Mental illness and Stigma

Stigma refers to a cluster of negative attitudes and beliefs that motivate the public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads others to avoid living, socializing, working with, renting to, or employing people with mental illness—especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness in those individuals living with a mental illness. It deters the public from seeking and wanting to pay for care, therefore people with mental health problems internalize public attitudes, and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment. (Health, 2003)

In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity, and interferes with their full participation in society.

The stigmatization of individuals with mental illness represents a primary deterrent to prevention and treatment efforts. A literature review reveals multiple studies focused on the impact of stigma related to specific illnesses, the perception of dangerousness, mental health treatment, racial and ethnic disparities, and paradoxical responses. Historically, the most common approach to stigma research has involved surveying groups of individuals about their attitudes toward people with mental illness. There are a number of limitations to this, such as the public prejudice and response to mental illnesses. Participants in surveys tended to see mental illnesses in their most severe diagnostic groups, those that are more negatively portrayed in media etc, therefore conjure up fear and inaccurate beliefs about the dangers of mental illness.

A 2004 study indicated the tendency for the public to see depression less like a mental illness than other illnesses such as schizophrenia (a more negatively represented illness). This being said stigmatizing attitudes about severe illness might remain higher than attitudes about illnesses such as depression or anxiety. Those participants in the study, who had more positive attitudes about treatment, demonstrated significantly less stigmatizing attitudes toward people with mental illness. (Mann & Himelein, 2004) The later, perceived as more treatable. More impressively, targeted programming to reduce stigma has had some successes, however little impact is made on attitude about the controllability of illness. Individuals may avoid seeking medical treatment for illnesses that they perceive to be untreatable.

National Alliance of Mental Illness (NAMI) La Crosse County

NAMI is a national grassroots mental health organization dedicated to advocacy for access to services, treatment, supports and research. The La Crosse County NAMI Chapter provides the following programs. Participation levels in these programs are not an accurate reflection of need.

- **Family to Family** is a twelve-week education program facilitated by trained family members for family caregivers of individuals with severe mental illnesses. It is the only family specific education program offered in the region. It has seen low and declining participation levels in 2010.
- **NAMI Basics** is a six-week education program specifically for parents of children with mental illness. It is new to the region in 2010.
- **NAMI Parents and Teachers as Allies,** general education program for parents and school professionals. It targets a pre-assembled audience, and can accommodate large numbers of attendee's.

Table 7: NAMI Education Programs

	2008	2009	2010
Family to Family Participants	23	20	7
NAMI Basics	NA	NA	6
Parents and teachers as allies	NA	100	507

Mental Health Coalition of the Greater La Crosse Area

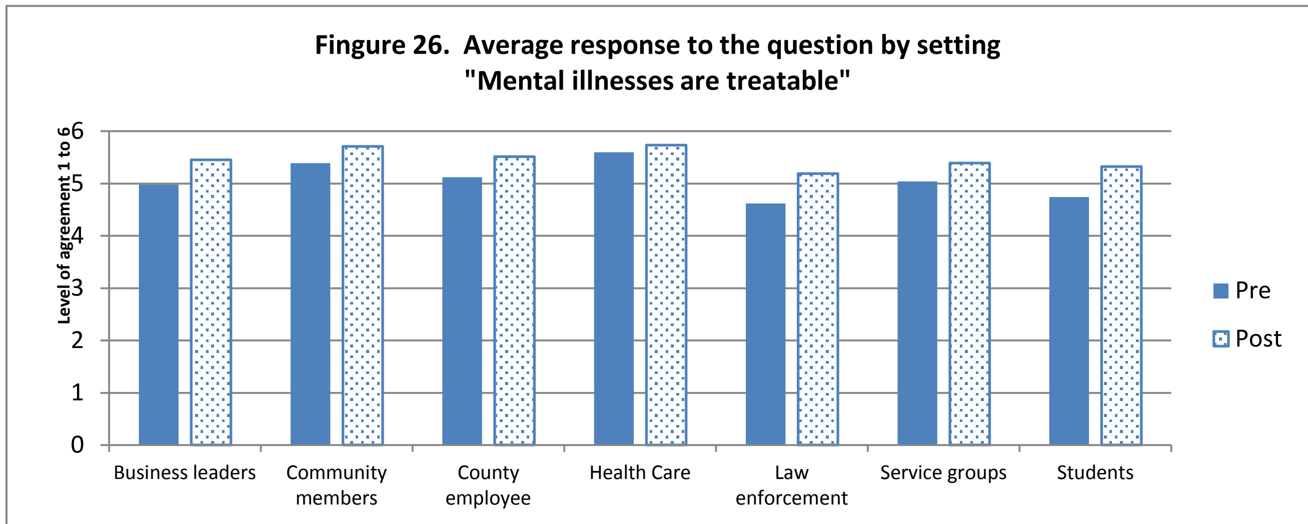
Starting in 2005-2007 the Mental Health Coalition of the Greater La Crosse Area conducted stigma reduction presentations community wide. The data was collected through a pre and post presentation survey of 725 participants.

The mean scores are ranked from highest to lowest based on change in mean score. Overall, scores increased in level of agreement from pre to post-survey (ranging on a scale from 1 to 6, 1 indicated strongly disagree and 6 strongly agree), the difference was statistically significant, indicating a level of improvement from pre to post-survey evaluation.

Table 8: Mean Scores of Stigma Survey

Question	Pre mean	Post mean
People can recover from mental illnesses	4.53	5.13
If I or family member needed help, I know who to contact	4.67	5.26
People with mental illnesses are dangerous	3.14	2.59
I am comfortable talking about living with a mental illness	4.35	4.74
Mental illnesses are treatable	5.06	5.47
I would be comfortable working with someone who has a mental illness	4.74	5.13
Discrimination is a major factor that keeps people from seeking help for a mental illness	4.79	5.15
Mental health services are as important as other health services	5.44	5.63
It is important to reduce discrimination against people who have a mental illness	5.31	5.44
I know someone with a mental illness	5.18	5.40

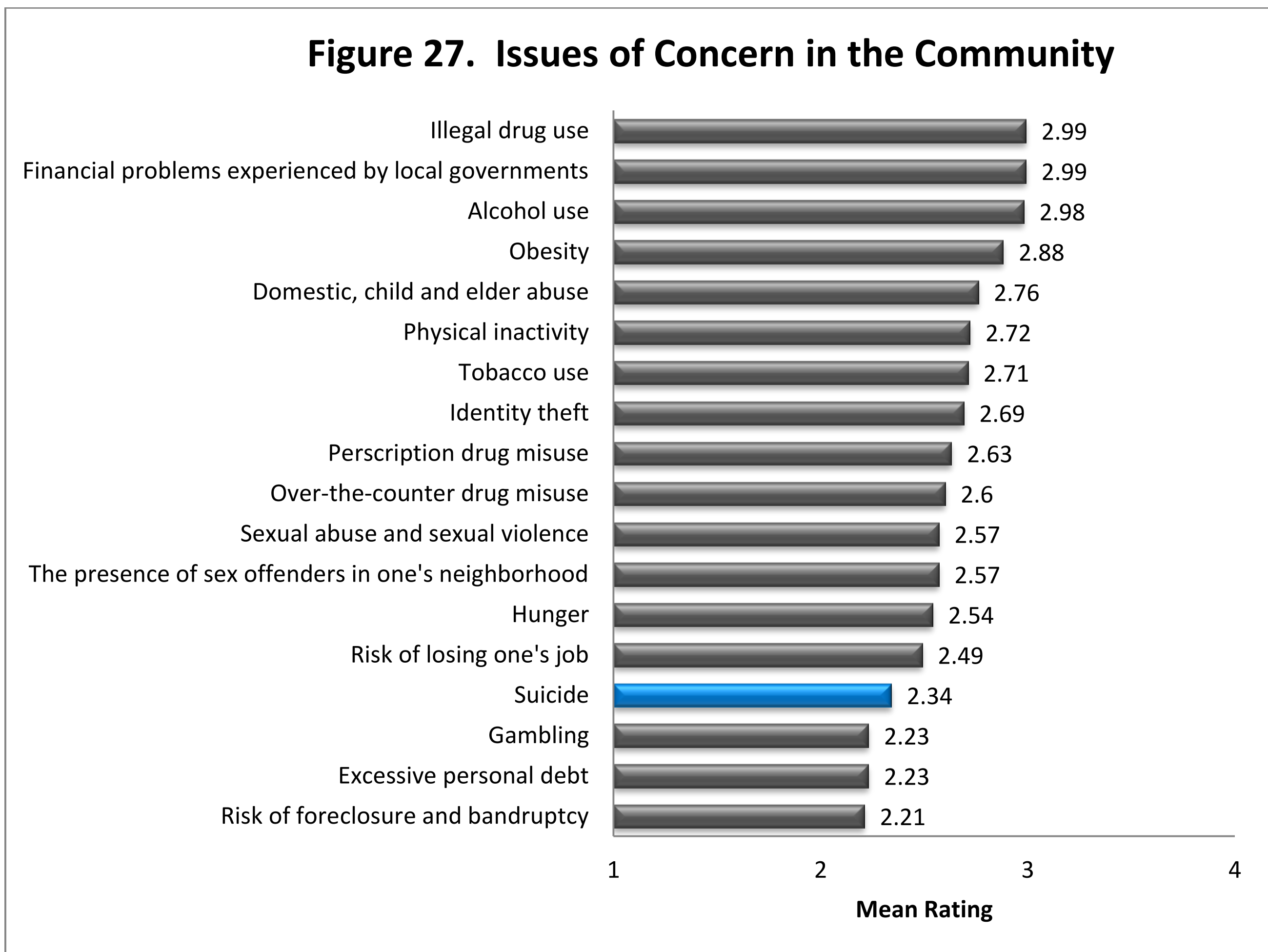
The question “mental illnesses are treatable?” showed an overall mean score increasing from 5.06 to 5.47. Increases in scores among presentation settings reflected consistent increases between groups with the exception of health care, whose initial level of agreement was highest and increased slightly at post-survey and law enforcement, who demonstrated a lower mean score to start with. Surprisingly law enforcement showed the lowest pre and post survey responses, compared to all other settings. Scores increased for all levels of education; however, those holding advanced degrees exhibit a higher starting score than other groups, with only slight increases. 18-25 year olds saw the biggest increase between mean scores, while 26-44 year olds the lowest starting and ending mean score.



Reducing the stigmatization of mental illness remains an important goal. Eliminating prejudices of mental illness supports prevention and treatment efforts.

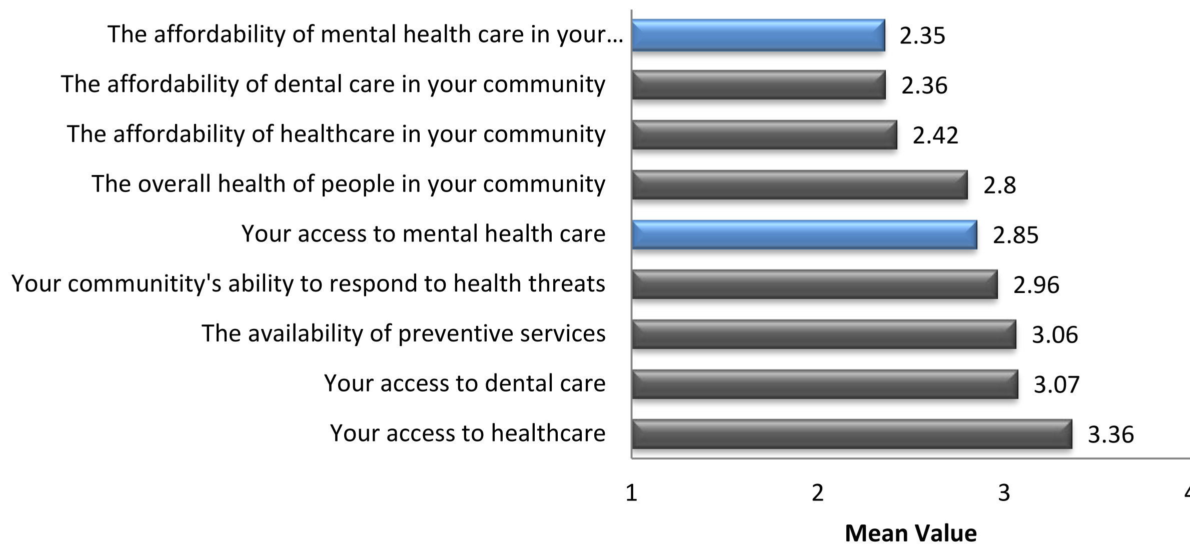
Compass Now 2012

Compass Now 2012 is a community needs assessment that was conducted in La Crosse, Monroe, Trempealeau, Vernon and Houston Counties in 2011. This joint effort between the United Way, the county health departments in each of the 5 counties, and all the hospitals in the 5 county area, included a random household survey, for which 1100 adults responded. Of 18 key issues of concern in the community, suicide ranked among the lowest issues of concern



Source: COMPASS NOW 2012: Community Needs Assessment. http://www.compassnow.org/

Stigma may be a contributing factor in the lack of concern suicide yields in the above results, as noted in figure 27, in the Compass Now community assessment. For example, substance use is ranked at the top of the issues of concern, a known contributor to both dying by suicide and suicidal behavior. In all five counties, suicide was consistently ranked lower among concerns.



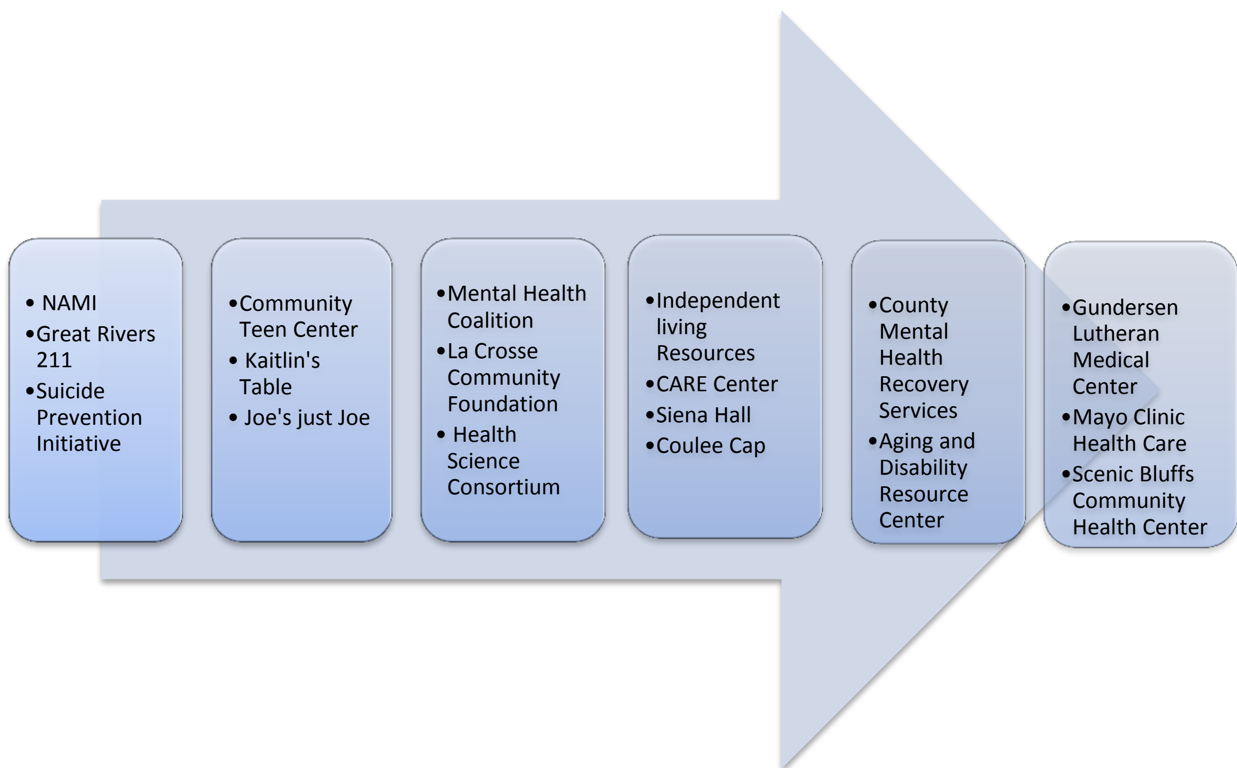
Source: COMPASS NOW 2012: Community Needs Assessment. http://www.compassnow.org/

In figure 28, Affordability of healthcare, dental and mental health is relatively similar, mental health has the lowest mean value of the three. Access to both healthcare and dental care are cited with the highest mean value. While the majority of participants reported access to mental health care as good, less than 20% reported it to be excellent as compared to access to health care, which 48% reported to be excellent. Individuals who do not access the mental health systems may have a more favorable attitude about access than those currently utilizing services.

Leaders and Partners

Efforts in the La Crosse community to champion issues of mental health include collaborative work with the Healthiest County 2015: La Crosse, educational campaigns such as the suicide summit, community dialogs such as a conversation with Pete Earley, Crisis Intervention Training for law enforcement, and a community teen center. While mental health and mental illness are growing concerns to population health, there is considerable evidence, at the community level, of investment in the mental health of the region along with opportunities for reducing the burden of mental illness.

Community groups Non-profit Organizations Human Services Healthcare Organization



Goals identified for the community thus far include stigma reduction, suicide prevention, law enforcement training, provider access and overall prevention efforts.

Summary

This report identifies various impacts and societal costs of mental illnesses. While not outlined specifically, it should be assumed that both individuals and families suffer greatly at the hands of mental illness. Such personal costs to individual's quality of life directly influence the immediate community and family systems.

Not identified are specific populations such as developmental disabilities, co-occurring disorders (although occurring with frequency with other mental health disorders), veterans, gay, lesbian, bisexual and transgender individuals, people of color, jail population and transient population. These conditions and populations considered to be beyond the scope of this report and are deserving of a care system/identification all their own. Specific populations documented with increasingly higher risk for mental health issues include: veterans, individuals in communities with large-scale psychological trauma caused by natural disasters and older adults due to an aging population. Future reports can build on this.

One of the biggest limitations to the data is underreported information. We know mental illness is a public health issue, but questions such as what can and will reduce prevalence remain. Evidence exists in the past decade that a movement from a tradition of separate mental health and public health surveillance efforts to an increasingly integrated approach. There is a need to educate clinicians (both primary and specialists) along with the public in the effective treatments that are available for mental illness.

Vision for the future

Strengthening collaborations, to focus on reducing stigma, improved awareness of effective treatment and ensuring supply and delivery of services is critical for promoting and sustaining good mental health for the community.

The challenges for public health as it relates to mental health include identifying risk factors, increasing awareness about mental disorders and the effectiveness of treatment, removing the stigma associated with mental disorders and receiving treatment for them, eliminating health disparities, and improving access to mental health services, particularly among populations that are disproportionately affected. (Centers for Disease Control and Prevention and National Association of Chronic Disease Directors, 2008)

There are no simple formulas to measuring the burden on individuals, institutions and communities; perhaps the complexity itself speaks to the value of mental health. Mental Health is something we value by default; however, in the face of managing an illness, it is everything.

Community Response

"Finally, a report that confirms what advocates have known all along: mental health is fundamentally linked to physical health and quality of life. Mental Health can no longer be viewed as the absence of mental illness, it is not a luxury. It is the foundation of health and a key consideration in changing the health status of a community. "There is no health without mental health." Thank you Ms. Delong."

Patti Jo Severson, Co-chair of the Mental Health Coalition of the Greater La Crosse Area and Co-President of NAMI Wisconsin

To: Tara DeLong

From: Mary Jo Klos RN, BBA, MASL
Vice President – Clinical Operations and
Regional System
Gundersen Lutheran Health System

Re: The Burden of Mental Illness Report

The burden of mental illness is complex and can seem overwhelming. In fact, it is actually quite overwhelming. The data shared in the "Burden of Mental Illness Report" is quite disturbing and yet, it provides some very clear direction on where we need to focus our resources and energies to begin to better manage the mental health situation in our area.

As the administrative leader of Gundersen Lutheran Behavioral Health, I have seen a recent increase in the awareness of the importance of effective mental health care – both in our community and in our own organization. Much of this is because of the efforts of our own Behavioral Health team, and because there is a growing grass roots movement within the greater La Crosse Area to increase awareness and support for need for care of the mentally ill patient population. Toward the end of the report under the category "Leaders and Partners", the agencies involved in the greater La Crosse Area are listed. In recent years, they have greatly increased their membership, visibility and advocacy and this effort is getting some very positive traction.

That being said – we are still far from a perfect world in the care of the mentally ill and chemically dependent patient population. As a community responder responsible for providing care to this important patient group, I find that our demand far exceeds our capacity. We struggle to provide access to services in a timely and effective manner. We have excellent programs in our Behavioral Health department, both on the inpatient side and the ambulatory side. We have comprehensive programming that covers children, adolescents, adults and the elderly – in the areas of both mental health and chemical dependency. We have waiting lists and are often forced to be on diversion in our inpatient psychiatry unit because of either census or acuity or both. We are in the process of building a new psychiatric hospital and redesigning our ambulatory programming to continue to strive to meet the important needs of these patients.

In looking more deeply into the data, it seems very clear that the earlier intervention occurs the better in terms of interrupting the cycle and helping the patient become stable and have a productive and meaningful life. If you review, the information in the section related to the adolescent population there is a high degree of depression related to unhealthy relationships, obesity and inactivity. In addition, as you look at the college aged data, the only increases, very noteworthy in this category are the feelings of being overwhelmed, and exhausted. These areas of risk are treatable and even preventable. If there were solid, reliable and sustainable programs for children, adolescents and young adults that taught life skills, coping mechanisms, and concepts like resilience to young people – including and especially healthy lifestyle approaches from a dietary, physical activity and emotional health standpoint, many of the issues listed would dramatically decrease.

If we consider the major illnesses like heart disease, trauma related injuries, and even cancer, and asthma to a degree – prevention, healthy lifestyles and solid coping skills would all contribute to preventing and minimizing these illnesses in adults. The earlier the better.

The cost to the systems and the community are high. We could and should be spending our dollars much further upstream in the realm of prevention rather than to try to fix what is broken.
While the dollars are very important – as they are necessary for us to provide care – still the most important and the most heart breaking part of this report is the fact that it reveals the human cost in such clear and

unambiguous terms. These data and this information reflect human lives, real people who are struggling every day with devastating illnesses that they must deal with in every aspect of life.
There are tragic outcomes for many, and lives of despair for most – we, as a human community, are morally obligated to provide support and healing for those struggling with mental illness, and chemical dependency – these are non-discriminatory illnesses. We are obligated to help our fellow human beings become whole, healthy, happy and productive people who have the ability to experience life to the fullest.

Mary Jo Klos

The Burden of Mental Illness; A Report on La Crosse and Surrounding Regions is well written, telling and timely. It is a comprehensive assessment of a number of indicators and is a rich source of data that reveals the prevalence of mental illness and the nuances and challenges of effectively meeting the needs of those who face mental illnesses in our community.

As the mother of two teenagers, I was especially startled by the alarming number of youth in La Crosse County Public Schools who self-reported in the 2010 Youth Risk Behavioral Survey that they had considered planned or attempted suicide. The analysis of the survey went on to show that students in these higher risk categories are also more likely to engage in unhealthy behaviors such as smoking cigarettes and binge drinking. When I then put on my Public Health official hat and correlate the potential physical health risks associated with tobacco and alcohol abuse I cringe at the lose-lose of that scenario.

That said, as Chair of the La Crosse County Board of Supervisors I am heartened to see the abundance of agencies and providers cited in the report, which are delivering programs and services to those suffering from mental illness. My conclusion is that we must redouble our efforts to address the needs of a growing number of our neighbors and community members who suffer from mental health challenges as well as their families and friends. The Burden of Mental Illness is a wake-up call for all of us to focus on strengthening collaborations, reducing stigma and increasing awareness of effective treatments so we are all working to promote and sustain good mental health for our community. There is no greater priority for our children and for our future.

Tara Johnson, Chair of La Crosse County Board

Bibliography

Bender, A., & Farvolden, P. (2008). *Depression and the Workplace: A Progress Report.* Torronto: Current Medicine Group LLC.

Benjamin L. Cook, T. M. (2007). Measuring Trends in Mental Health Care Disparities, 2000-2004. *Psychiatric Services* , 1533-1540.

Caroline E. Mann, M. J. (2004 , February). Factors Associated With Stigmatization of Persons With Mental Illness. *Psychiatric Services* , pp. 185-187.

Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. (2008). *The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us.* Atlanta.

Centers For Disease Control and Prevention. *WISQARS Leading Causes of Death Reports, 1999-2007.*

Colton, C., & Manderscheid, R. (2006). Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. *Preventing Chronic Disease* , 1-12.

Corrigan, P., & Wassel, A. (2008). Understanding and Influencing the Stigma of Mental Illness. *Journal of Psychosocial Nursing* , 42-48.

Corrigan, P., & Watson, A. (2007). The Stigma of Psychiatric Disorders and the Gender, Ethnicity, and Educaton of the Perceiver. *Community Mental Health Journal* , 439-457.

Craig W. Colton, P. R. (2006). Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. *Preventing Chronic Disease* , 1-12.

D P Rice, S. K. (1992). The Economic Burden of Mental Illness. *Hospital and Community Psychiatry* , 1227-1232.

Goetzel, R., Hawkins, K., Ozminkowski, R., & Wang, S. (2003, January). The Health and Productivity Cost Burden of the "Top 10" Physical and Mental Health Conditions Affecting Six Large U.S. Employers in 1999. *Journal of Occupational & Environmental Medicine* , pp. 5-14.

Great Rivers 211. (2010). *Information and Referral.*

Health, T. P. (2003). *Achieving the Promise: Transforming Mental Health Care in America, Executive Summary.* Rockville.

Horton, R. (2007, September 4). Launching a new movement for mental health. *The Lancet* , p. 821.

Keyes, C., & Dhingra, S. S. (2010, December). Mental Health Promotion and Protection Vol 100, No. 12. *American Journal of Public Health* , pp. 2366-2371.

Kockaya, G., & Wertheimer, A. (2010). What are the top most costly diseases for USA? The alignment of burden of illness with prevention and screening expenditures. *Health* , 1174-1178.

Kopp, B., Schlotthauer, A., & Gross, S. (2008). *The Burden of Suicide in Wisconsin .* Madison, WI: WISCONSIN DEPARTMENT OF HEALTH SERVICES.

Kopp, B., Schlotthauer, A., & Gross, S. (2008). *The Burden of Suicide In Wisconsin.* Injury Research Center at the Medical College of Wisconsin.

Mann, C. E., & Himelein, M. J. (2004, February). Factors Associated With Stigmatization of Persons With Mental Illness. *PSYCHIATRIC SERVICES* , pp. 185-187.

NAMI. (2011). *Mental Illnesses*. Retrieved February 15, 2011, from National Alliance on Mental Illness: http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm

NAMI. (2010, January). The High Cost of Mental Health: Mental Illness and the Workplace. Arlington, VA, USA.

National Alliance on Mental Illness. (2008). *Schizophrenia: Public Attitudes, Personal Needs.* Arlington: National Alliance on Mental Illness.

National Institute of Health. (2008, February 8). *National Institute of Mental Health*. Retrieved November 16, 2008, from National Institute of Mental Health: http://www.nimh.nih.gov/health/topics/statistics/index.shtml

National Institute of Mental Health. (n.d.). Retrieved March 4, 2011, from http://www.nimh.nih.gov/statistics/2CDNC.shtml

National Institute of Mental Health. (n.d.). *Statistics.* Retrieved March 10, 2011, from National Institute of Mental Health: http://www.nimh.nih.gov/statistics/4TOT_MC9606.shtml

Partnership for Workplace Mental Health. (2006). *A Mentally Healthy Workplace--It's Good For Buisness.* Arlington: American Psychiatric Foundation and The American Psychiatric Association.

Rao, D., Feinglass, J., & Corrigan, P. (2007). Racial and Ethnic Disparities in Mental Illness Stigma. *The Journal of Nervous and Mental Disease* , 1020-1023.

Ronald C. Kessler, P. S. (2008). Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication. *American Journal of Psychiatry* , 703-711.

SAMHSA. (April 28 2011). *The NSDUH Report: Major Depressive Episode and Treatment Among Adolescents: 2009.* Rockville: Center for Behavioral Health Statisitcs and Quality and Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2011). *The NSDUH Report: Major Depressive Epsiode and Treatment Among Adolescents: 2009.* Rockville, MD: Center for Behavioral Health Statistics and Quality and Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Health and Human Services. (2010, 12 3). *The Numbers Count: Mental Disorders in America*. Retrieved 12 3, 2010, from National Institute of Mental Health: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml

United States Government Accountability Office. (2008). *YOUNG ADULTS WITH SERIOUS MENTAL ILLNESS.* Washington DC: Government Accountability Office.

US Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services. (2009). *Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey.* Bureau of Health Information and Policy, Division of Public Health; and the Bureau of Prevention, Treatment and Recovery, Division of Mental Health and Substance Abuse Services.

WISH, Wisconsin Department of Health Services, Division of Public Health. (n.d.). *Wisconsin Interactive Statistics on Health (WISH) data query system*. Retrieved March 9, 2011, from WISH: http://www.dhs.wisconsin.gov/wish/

World Health Organization. (2005). Mental Health Policies and Programs in the Workplace. Geneva, Switzerland.