Promoting Mental Health for New Mexico’s Students

Steven Adelsheim, M.D.
Guest Editor

This HealthWise: A Bulletin for School and Community Health explores the issue of mental health among our youth and several exciting initiatives to enhance it in this state. Aspects of mental health include how people think, feel and act in life situations, including how they handle stress, relate to others, evaluate challenges and make decisions. Throughout the nation and New Mexico, the value and importance of linking mental health supports to students are receiving increasing attention. Federal initiatives tied to recommendations of the President’s New Freedom Commission to increase school mental health programs, screening for behavioral health problems, and prevent suicides drive this national focus. In New Mexico, similar efforts, through the state’s behavioral health restructuring, are underway to expand school mental health programs, double the number of school-based health centers, increase support for teen suicide prevention, and increase telemedicine efforts in behavioral health (see “New Mexico’s Redesigned School Behavioral Health Programs: What Does It Mean for Schools?”, page 6.)

Why emphasize school mental health programs? Every day 52 million students attend U.S. schools; children spend most of each weekday in school. At least one in five youth has some type of mental health problem, so it makes sense to link scarce mental health programs and supports to the sites where our children are found. Schools provide services in accessible community settings that are comfortable for families: they can minimize stigma (see “Stigma Associated with Mental Illness,” page 8), and ease transportation issues. School-based providers observe students in various settings—the classroom, lunchroom, and playground—gaining information for designing appropriate clinical interventions. Mental health providers in schools can more clearly identify youth with internalizing disorders, like depression, anxiety, and post-traumatic stress, as well as the more obvious disruptive behaviors most often recognized by school personnel. Finally, schools help frame partnerships among families, school personnel and mental health providers, so they can all come together easily to support the individual student.

Clearly the role of schools is to educate our youth and prepare them to become productive community members. To meet that objective, students must be healthy and ready to learn. For school-based health programs to be effective, an understanding of how these programs support educational objectives is critical. While research shows that school mental health programs improve educational outcomes by decreasing absences, discipline referrals, and course failures, while improving grades, these outcomes only derive from integrated education and health system efforts.

Coordinated education and mental health efforts can only come about when people have a clear understanding of the language both systems must use. For example, the term “behavioral problem,” when used in the educational system, often describes a student who is acting-out or taking aggressive action that can lead to classroom disruption and disciplinary action. In the mental health world, “behavioral problems” can be symptoms or manifestations of emotional or mental disorders, or (continued on page 2)

Inside HealthWise

Mental Health Screening in N.M. ..........3
Preventing Youth Suicide ..................4
School Behavioral Health Programs ......6
Stigma and Mental Illness .................8
substance abuse, with causes that include genetics, environmental events, trauma and/or stress. The term “behavioral health” has come to mean a combination of mental health and substance abuse interventions or programs. The New Mexico Behavioral Health Division of the Department of Health includes both mental health and substance abuse programs.

School staff who notice children with symptoms of behavioral problems are key in identifying students who need help. A child with post-traumatic stress disorder (PTSD), for example, may show a persistent pattern of impulsive behavior, inattention and being easily distracted. A seriously depressed adolescent may use drugs or alcohol, show acting out behavior, or lose interest in once-enjoyed activities. Evaluating, diagnosing and treating mental health problems is a complex task. Like other illnesses, mental illnesses have specific diagnostic criteria and treatments. Recognized mental illnesses and other disorders, such as substance abuse and learning disorders are described in the Diagnostic and Statistical Manual (DSM), which is used by mental health professionals to identify, diagnose and treat a mental health problem.

Language used by the federal government can also generate confusion in this field. Essentially, there are two different kinds of federal definitions, one used for mental health issues, and the other one, which is unrelated to a DSM diagnosis, is used for the education system. For example, the term “serious emotional disturbance” (SED), under federal regulations, means a child has a formal diagnosis of a disorder that severely disrupts family, school, community or other major life activities and places them at risk for out-of-home placement. This is relevant because federal mental health funding to states is often tied to its being used for children with SED. In the world of special education, the exceptionality known as “emotional disturbance” (ED) is tied to a federal definition of a condition with characteristics that, together, can adversely impact a student’s educational performance. This definition does not require a mental health diagnosis to qualify a student for special education services. In addition, many students who have attention deficit/hyperactivity disorder (ADHD), a chronic condition and behavioral disorder, qualify for special education services—not under the ED exceptionality, but under the category of “other health impaired,” which is linked to a specific or chronic health problem. These are just a few examples of the language complexities that must be overcome for education and health professionals to partner effectively in the school setting.

Those of us who work in schools understand how students struggle to learn effectively while facing multiple challenges on a daily basis. We share responsibility to help others understand the importance of providing greater supports for students and families so our children may become successful learners and resilient, productive adult community members. This HealthWise edition strives to clarify some of these complex issues and inform readers about state efforts to improve students’ mental health. Articles address school-based mental health screening, communication campaigns to combat stigma associated with mental illness, and a media program to prevent teen suicide.

Mental Health Screening in New Mexico Schools
Ernest Coletta, B.S.

In April 2002, the President’s New Freedom Commission on Mental Health began studying the problems and gaps in the mental health system and recommending improvements that the Federal and state governments, local agencies, and public and private health care providers could quickly implement. The Commission’s final report outlined goals to directly improve needed support systems for the early-identification of mental illness through screening, and to provide relevant services based on screening results.

Several of these goals supporting mental health screening have direct significance for schools. These include: Goal 4.1: Promote the mental health of young children; Goal 4.2: Improve and expand school mental health programs; Goal 4.3: Screen for co-occurring mental and substance use disorders and link people with integrated treatment strategies; Goal 4.4: Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and support. The Commission’s report also highlighted several model programs, such as the Columbia University TeenScreen® Program. This program, as well as the Dominic Interactive and Behavior Assessment System for Children (BASC) have been shared statewide by the NM Department of Health and have been utilized in several New Mexico schools and communities.

The TeenScreen screening tool, an abbreviated version of the Diagnostic Predictive Scales (DPS), has a series of symptom scales that can indicate the likelihood of a mental health disorder. They are based upon DSM-IV, the most widely used standard for diagnoses. The DPS-8 used by TeenScreen assesses symptoms for 8 disorders that are associated with an increased risk of suicide, and includes specific questions on suicidal ideation and suicide attempts. These disorders are often undetected even though specific treatments are available. The most commonly used DPS format is a self-administered, computerized one that plays a natural sounding recorded voice while displaying the text of the questions on screen.

The Dominic Interactive is a computerized, interactive cartoon that screens for emotional and behavioral difficulties in children 6 to 11 years old. Taking only 10 to 15 minutes to administer, it is fast, simple, and appeals to children. The Dominic questionnaire evolved from many paper versions to its present computerized format, which is akin to a video game. Color pictures, along with a soundtrack, present Dominic, a child facing various daily life situations at home, school, and with other children. When pictures illustrate examples of displayed emotions and behaviors, the voice-over asks a child if s/he would react like Dominic. Children use the mouse to click “yes” or “no.”

The BASC, a set of rating scales that include Teacher Rating Scales, Parent Rating Scales, Self-Report of Personality, Student Observation System, and Structured Developmental History, aid in understanding behaviors and emotions of children and adolescents. Although administration times vary for each tool, most take no longer than 20 minutes to complete. Schools can use the BASC’s multidimensional approach to a comprehensive assessment to identify behavioral problems as required by the Individuals with Disabilities Education Act (IDEA).

In New Mexico, several schools and communities have been implementing mental health screening programs in recent years. These include school-based health centers in Bernalillo, Santa Fe, Ruidoso, Las Cruces, Acoma-Laguna-To’Hajiilee, and Silver City; as well as schools or communities in Loving, Newcomb, Pojoaque, Santa Fe, and at Vision Quest, an alternative setting in Albuquerque. Screening programs can be adapted to accommodate the specific needs and resources of each school or community. Though most screening takes place in schools, programs can also be implemented in residential treatment facilities, foster care settings, clinics, shelters, drop-in centers, juvenile justice settings and with other agencies that serve youth.

New Mexico screening programs are key to appropriate utilization and coordination of limited adolescent mental health resources. Parents provide active consent for children to complete brief, self-administered mental health evaluations. Mental health professionals review results, and hold face-to-face interviews with students whose screenings indicate mental illness or suicide risk. When indicated, families are referred to local mental health professionals for further evaluation and/or treatment. Other key components of the state’s effort to link students to appropriate, local mental health services include on-going follow-up of referrals, and child and family education about mental health concerns.
We have all heard too many similar stories in our state. A high school junior shoots himself with his father’s gun. A young girl takes an overdose of anti-depressants. A top athlete and grade A student hangs himself. But New Mexico is taking a strong, positive step forward to help young people such as these, and to overcome the fact that suicide is the third leading cause of death among its youth. The state has made youth suicide prevention a priority in the New Mexico Comprehensive Strategic Health Plan and has created a Task Force to advise the Governor on how to address this issue.

This initiative will increase communication, coordination and collaboration among state agencies, universities, advocacy groups, community coalitions and others to integrate funding and project activities to better serve at-risk youth. Promising recommendations currently under consideration by the Governor’s Task Force include:

- the expansion of a statewide coalition to prevent youth suicide made up of behavioral health professionals, primary care providers, substance abuse education programs, concerned citizens, suicide attempt survivors, and other community members;
- the development of a statewide youth suicide prevention plan that will expand prevention and early intervention services, public education programs to reduce stigma associated with mental illness, training and education programs for community and educational systems, and implement comprehensive evaluation of the overall effort;
- the consideration of pilot youth suicide prevention programs that include prevention, screening and early intervention activities that will be tested and evaluated over three years each.

Current funding pays for school and community awareness education and training activities; limited identification, referral and counseling services in Santa Fe County; anti-bullying programs in several northern New Mexico communities; and the development of a statewide youth suicide awareness and education mass media/TV production that aired in December 2004 (see Stigma Associated with Mental Illness article in this edition). New Mexico’s initiative is supported by other recent findings and events in the mental and behavioral health field. In 1999, the U.S. Surgeon General issued a “Call to Action” to address youth suicide at a national level; the development of the National Strategy for Suicide Prevention in 2001 answered this call. The President’s New Freedom Commission on Mental Health has studied the problems and gaps in the nation’s mental health system and has recommended such actions as advancing a national campaign to reduce the stigma of seeking mental health care, promoting the mental health of young children, expanding school-based mental health programs, screening for mental and substance use disorders and linking people to integrated treatment strategies.

A 2002 NM Department of Health, Office of School Health (NMDOH-OSH) survey of the state’s public schools to determine how mental health and substance abuse evaluation and treatment was being provided to students indicated that up to 93% of the school respondents would request an increase in mental health service hours if they were available. A study of 10,700 New Mexico students compared those with a history of suicide attempts and those with no such background, and found that those least at-risk had positive relationships with parents and other adults—they felt they mattered, and that adults considered them important and listened to them.1 Screening and early identification has been shown to be an important means of helping children before problems become acute; these are strategies that

(continued on page 7)
Preventing Youth Suicide in New Mexico Schools: Television to “Touch the Heart”

Christopher Schuler, M.A.

“So just watch your kids closely…they mean the world”

So says a mother of a child who committed suicide. She was one of several parents who were interviewed for an extraordinary documentary on youth suicide called “Coming Back: A Death and Life Story about Sons, Daughters, and Friends” that was broadcast during prime time on December 15, 2004 on the PBS television affiliates throughout the state. ABC-affiliate KOAT also broadcast the show on December 16 and 18, 2004 and January 9, 2005. The documentary was followed by a half hour live broadcast that included a unique opportunity for members of the public to call in and discuss issues of mental health care and suicide prevention strategies with a phone bank of mental and behavioral health experts. Governor Richardson’s taped introduction to the documentary project also helped other key policy makers in the state understand the importance of the issue of youth suicide and consider collaborative ways to address it.

My company, Christopher Productions, began this project two years ago when I was approached by the CEO of a major company who had lost his son to suicide and who had seen one of our earlier projects on underage drinking. He wanted to do for youth suicide what we had done to address drinking. The challenge was to take a stigmatized topic—one that television journalists tend to avoid—and create a television special that would both grab an audience’s attention while also informing parents, educators, and teens about the signs and symptoms of serious depression, and how to get help for a young person considering suicide.

In the two years it took to develop this 27-minute “tell-a-vision” program, complete with images that will spark and touch the heart, I came to understand how utterly hopeless the feelings are that ultimately lead to a decision to take one’s life. The reasons for youth suicide are multiple and difficult to assess; these problems can be accentuated by the loss of strong friend and family connections, pressures to participate in many activities while excelling in school, and isolation from others. If something then goes wrong in the life of such a young person, she or he may not be aware that there is actually a light at the end of the tunnel. Molly Brock, Executive Director of the Agora Crisis Center and participant in the video, notes that “Depression disables people. It paralyzes them. You can’t decide to cheer up; you can’t take action to make yourself better.”

On the other hand, while my staff and I were doing the research to create an educational yet entertaining show to serve as a catalyst for action and change, we learned of the incredible dedication of volunteers, non-profits, state agencies and others who are trying to make a dent in this health crisis that’s killing our kids. To assist these people, as well as teachers, parents and community members working with youth, Christopher Productions is distributing copies of the video, “Coming Back: A Death and Life Story about Sons, Daughters and Friends,” to all New Mexico school districts, along with ancillary tools, such as parent and educator training videos. The intent is to focus on empowering family and friends with tools and abilities—such as recognizing warning signs of suicide—to help prevent suicide. This is a unique opportunity for teachers, school health professionals and others to discuss this health issue with students and promote greater understanding. For more information, or access to the video, go to www.christopherproductions.org.
New Mexico’s Redesigned School Behavioral Health Programs: What Does it Mean for Schools?
Steven Adelsheim, M.D.

New Mexico is redesigning its Behavioral Health Care System, and School Behavioral Health Programs and Services (SBHP) are critical components of this effort. School behavioral health programs are a continuum of supports offered on-site in schools to promote student mental and emotional health, prevent the onset of mental health and/or substance abuse problems, and screen for, identify early, and treat mental health and substance abuse disorders. A range of modalities, including mental health and/or substance abuse prevention efforts, screening, early intervention, counseling/psychotherapy, case management, and/or crisis intervention and medication management may be provided in or through schools. When appropriate, students can be referred to a range of community treatment services.

The redesign of the state’s behavioral health care system will ensure that community behavioral health providers link with the state’s schools to support programs and services. Local community partnerships will need to include school district representation and involvement. Linking behavioral health supports to schools follows recent goals developed by the President’s New Freedom Commission on Mental Health. Goal 4 of the Commission’s report recommends: (a) promoting the mental health of young children, (b) improving and expanding school mental health programs, and (c) screening for co-occurring mental and substance use disorders and linking students with integrated treatment strategies. Taking a major step forward, the state agencies that previously provided independent school health and behavioral health services have come together in the Interagency Council for School Health (ICSH). The ICSH encourages a seamless system of care that is accessible, and it promotes prevention and early intervention, resiliency, recovery and rehabilitation efforts. In addition, the ICSH supports provision of community-based services that stress the individual’s capacity to recover in a culturally-responsive and respectful manner. At the same time, services must be coordinated, accountable, of high quality, and include behavioral health promotion, early intervention, treatment, community support, and activities that further recovery.

Why School-based Services?
Children spend much of their time in schools, so it makes sense to link scarce resources, like behavioral health programs, to these community sites. Schools are accessible, comfortable community settings for families. When families partner with school personnel and mental health providers, approaches for helping students are enhanced. School-based health providers can observe students in a variety of social settings, like the classroom, cafeteria and playground, which helps in identifying youth with certain “internalizing” disorders such as depression, anxiety, and post-traumatic stress, as well as students with more obvious disruptive behaviors. These observations provide valuable information for better determining both appropriate diagnoses and interventions.

In addition, there is growing evidence to indicate that SBHPs provided in partnership with community agencies help elementary and secondary students succeed academically in school, as they help address behavioral and emotional barriers to learning. Students receiving mental health services through the Dallas Public Schools, for example, had a 31% decrease in course failures, a 32% decrease in absences, and a 95% reduction in disciplinary referrals. Baltimore elementary school students seen four or more times through their SBHPs improved their grade point averages (from 1.8 to 2.11).

To be successful, SBHPs must include: (a) integration into the school culture; (b) collaboration among school behavioral health and community health care systems; (c) a full continuum of services that include training, prevention, screening, direct and case management services, and other interventions; and (d) sustainability through diversified funding sources and community partnerships. Sustainability factors may include: increasing the capacity of SBHPs to access public and private payer sources and other reimbursement mechanisms, collaborating on finances and in-kind contributions with Local Education Agencies (LEAs) and community partners, and integrating behavioral health services with primary physical health services.

What Requirements Must Programs Meet?
SBHPs can be provided as stand-alone services or as part of a comprehensive School-Based Health Center (SBHC). Often students come to SBHCs initially with a physical health problem that, as the health provider works with the student over time, becomes recognized as a manifestation (continued on page 7)
of a mental health issue. SBHCs are unique models for meeting the health needs of children and adolescents in an appropriate and accessible manner, and are important sites for the integration of physical and behavioral health services.

Another option is to provide SBHPs through LEA-employed school health professional staff or by arranging with community behavioral health providers to provide services in the school. In either case, all state requirements for community-based child and adolescent behavioral health providers and agencies, as well as the existing standards of the New Mexico Department of Health’s Office of School Health (NMDOH-OSH) for school behavioral health programs and SBHCs must be followed. These requirements cover issues related to patient confidentiality, medical records, HIPAA* and Medicaid criteria, and credentials of clinical providers. LEAs that cannot meet all these requirements should partner with community-based behavioral health providers to set up appropriate SBHP partnerships through contracts or other relationships.

In 2002, the New Mexico Behavioral Health Gaps Analysis recommended setting standards for school-based mental and behavioral health. As SBHPs expand statewide, it is time to clarify roles and functions of school behavioral health providers, whether they are school employees or community providers. Representatives from state and community agencies, school districts, professional and advocacy organizations, and youth will be asked to give input into the development of school behavioral health standards, including clinical competencies and interventions, and the minimum required service capacity (assessment, referral, prevention and intervention) that should be available at each grade level. The ICSH, a recently formed partnership of multiple state agencies that provide and support school health services will lead this effort.

So What Does This Mean for Your School?
As the state behavioral health system provides increased support for community-based programs, more services should be available in each community to assist families and schools to help our children live at home and be successful in school. In addition, as schools engage in community collaborative efforts, programs and services will be more efficiently linked to schools. As SMHPs gain support throughout the state, critical mental health and substance abuse services will be more directly accessible to schools. As New Mexico develops school mental health standards, opportunities should increase to identify and implement truly optimal mental health systems that serve the needs of and support not only school health professionals and community providers, but also educators and administrators in schools statewide.

* The Health Insurance Portability and Accountability Act of 1996 mandates protections for working Americans and their families who have preexisting medical conditions or might suffer discrimination in health coverage based on factors related to an individual’s health.


Preventing Suicide Among New Mexico’s Youth

schools, school-based health centers and primary care offices can implement. Since primary care providers prescribe most of the psychotropic medications in the U.S. but have little behavioral health training, the NMDOH-OSH recently held the “Managing Child/Adolescent Behavioral Health Problems: Practical Solutions for the Busy Primary Care Provider,” attended by primary care providers from 25 different New Mexico communities to improve their knowledge in this area.

These positive actions, and this forward-looking initiative have major hurdles to overcome. In 2003, according to the state’s Youth Risk and Resiliency Survey (YRRS), 14.5% (about one in 7) of adolescents said they had attempted suicide in the previous 12 months, and 21% (almost one in four) had seriously considered killing themselves in the previous year. In 1997, of the 63 New Mexico youth 15-24 years old that died by suicide, almost half tested positive for drugs and alcohol. Nationally, attempted suicide rates are highest for Native American youth, and higher for Hispanic youth than for White and African-American youth. Unfortunately, although more than 60% of youth who commit suicide have a mental health problem, only about one-third (36%) of youth at risk for suicide receive appropriate treatment. It has been shown that access to relevant treatment decreases suicide rates. This is the overall goal of the state’s youth suicide prevention initiative.

Imagined that you discover you have a disease that affects one in five children in the U.S. Now imagine that friends blame you for having this disease and start avoiding you, thinking your disease is due to bad character, personal weakness or poor upbringing. You see television programs making fun of people with this disease, portraying them as unstable or violent. You try to conceal your symptoms or avoid situations that could expose you. You might even avoid seeing your doctor for treatment. Your parents may avoid bringing you to social events because you might show symptoms, and they would have to endure judgmental stares or unsolicited advice from other parents. Beyond your actual condition, you would be dealing with stigma.

What Is Stigma?
Any one of the 44 million children and adults (22%-23% of Americans) who experience a mental illness can tell you. Stigma is a cluster of negative attitudes and beliefs that result in the public fearing, labeling, rejecting, and discriminating against people with perceived differences—like a mental illness. It’s much more than name-calling. It is a lack of respect. Stigma can lead people to avoid living, socializing or working with, renting to, or employing persons who have a mental illness. It can lead to violence against those living with mental illness. Misconceptions about those with mental illness abound, largely fueled by negative media images, fear, lack of knowledge and prejudice. Given these circumstances, it’s not hard to understand why people experiencing mental health issues may feel shamed enough to avoid seeking treatment.

What Are the Facts?
Did you know that people who have a mental illness—
- have the same needs as everyone else: these needs include: meaningful work, decent affordable housing, access to health care, a public education, positive relationships, and acceptance by family and peers.
- can and do recover and live productive lives: whether recovery is from medication, traditional therapy or alternative treatments, results include a sense of control over one’s life.
- make valuable contributions to society: Abraham Lincoln and Winston Churchill experienced depression. Actress Patty Duke lives with bipolar disorder. Many other talented and capable people who have mental health problems live among us. Overcoming stigma, seeking and getting treatment enable people living with mental illness to reclaim their lives and dignity and enjoy meaningful careers.

Unfortunately, stigma can keep people with mental illness from seeking help. Fear of disclosure, rejection by friends and outright discrimination are just a few reasons why people with mental illnesses may not go for treatment. Even though discrimination against people who have a mental illness violates their basic human rights, and despite legal protections guaranteed in the Americans with Disabilities Act and other civil rights laws, people continue to discriminate against those who have mental illness by restricting their options in the workplace, at home, and in education.

What Is Being Done?
Breaking down the stigma associated with mental illness can open doors to opportunity—the right to quality treatment, affordable housing, health care, equal opportunity employment and public education. Everyone should use respectful language, emphasize people’s abilities rather than limitations, and call
A Parent’s View: When Children Act Differently
Delfy Peña Roach

Consider the words fear, panic, dread, stigma, shame, disgrace, diagnosis, opinion, labeling, denial, and rejection. These words take on a reality all their own when you are the parent of a child who exhibits “extreme” behavior—behavior different from that of other children. It is hard for a parent of such a child to know what came first—the fear of what others will think about you as a parent, or the worry that your child will be hurt by judgmental people who don’t understand (or try to understand) or don’t care about him/her.

Parents of such children always worry, as I did, that their child may be hurt (physically and/or emotionally) because their behaviors upset others. First, you wonder if something is horribly wrong with your ability to parent your child. Shame quickly follows when you hear comments that are judgmental of your parenting skills or home life. People say you are either too lax or too hard, that your home life is too laid back or too busy. You cannot seem to satisfy anyone. Your confidence in your parenting ability wears down; denial becomes a respite from fear and shame. Sadly, denial is just as bad as fear and shame because the paralysis keeps you from getting the help you need.

Indeed, I was actually relieved when a psychologist first said, “Your son has Attention Deficit Hyperactivity Disorder.” My son, four at the time, received this diagnosis after two and a half years of hearing what a “bad, spoiled” little boy he was. I wanted to send out announcements that read, “I told you something wasn’t right! We are the proud parents of a boy who has ADHD,” to family and friends who had been so free with their parenting advice. Little did I know that this was only the beginning; there would be more parental “announcements.” I diligently took my son to speech/language therapy, sensory integration therapy, psychology appointments and attended parenting classes (while working full-time). I did what I had to do. However, three years later, my son was diagnosed with depression. The depression years were even more difficult because my son was often irritable or experienced rage. Not tantrums, rages. I still took him to speech/language and sensory integration therapy, and psychology appointments, but now we added medication and special education. Despite this, his symptoms worsened. As his rages intensified, so did our fear. I again questioned my ability to parent, asking: “What am I doing wrong?” Others undermined my confidence by unhelpfully asking what I did to make my son’s condition worse. Although the psychiatrist we saw was kind he did not really seem to hear my concerns and issues. School staff recognized my concerns because they also faced my son’s rage-filled behaviors, but like many others, their reactions tended to be punishing, rather than supportive of my son and myself. There were times when I picked up my son at school and was directed to a “seclusion room” where he had been left to rage or cry most of the afternoon. I still cannot explain the painful emotions I felt, trying to imagine the daily hurt, fear, and shame he went through from that treatment.

At age nine, my son saw a new psychiatrist. Again, I felt an odd sense of relief when told he had bipolar disorder. Imagine a parent’s feelings when told your son’s rages were symptoms of bipolar disorder—aggravated by medications he took for depression. We held off on another “announcement” to explain all this to others, however, just in case there was more to this diagnosis than we knew. I continued spending as much time as possible going to parenting classes, attending conferences or trainings on children’s mental health, and reading everything I could to find THE answer to gain relief from this illness. Though I finally had to conclude there was no real answer, I did, more importantly, stop caring what others thought about my parenting.

Time passed and we coped. But then my son experienced something more frightening. He heard voices, which meant psychosis. This time, denial truly became my best friend. I remember my panic when I first saw my son hold his ears because he couldn’t take the inner chatter anymore, and I was heartbroken when we realized my son might face life with schizophrenia. I agonized when side effects of the medications prescribed were worse than hearing the voices. But we struggled to accept this development and move forward. We tried acupuncture, acupressure and deep tissue massage in addition to Western medications. Although mental health professionals expressed discomfort with this, we were grateful for the support received from our son’s psychiatrist and school social worker.

I began to fight my way out of the stigma and fear. I stopped attending parenting classes, but continued going to national conferences on children’s mental health. Most (continued on page 11)
Become HealthWiser

1. **New Mexico School Mental Health Initiative** staff support teachers in the classroom and parents at home, and improve access to qualified mental health programs for youth. Go to the website for information on programs, articles, links to further resources, and more: www.nmsmhi.org.

2. **The National Mental Health Information Service** of the Substance Abuse and Mental Health Services Agency (SAMHSA) provides access to educational resources, program descriptions, current data and statistics, and links to other credible sites. Go to: www.mentalhealth.org/

3. **The National Institutes of Mental Health**’s website provides a major health information section for public readers. Much information can be downloaded, and links to other sites can be found. Go to: www.nimh.nih.gov.

4. **The Center for Mental Health in Schools**, located at the University of California at Los Angeles and funded by the U.S. Department of Health and Human Services, is an excellent source of assistance for school staff looking for resources and information on children’s mental health issues, as well as burn-out, stress and other concerns. Go to: http://smhp.psych.ucla.edu.

---

**An Apple a Day: Info Bites**

1. Approximately what percent of all schools contract or make other arrangements with a community-based organization to provide mental health or social services to students?
   - 1%
   - 20%
   - 50%
   - 95%

2. Approximately what percent of America’s 1500 school-based health centers (SBHCs) have mental health professionals on staff?
   - 10%
   - 25%
   - 60%
   - 100%

---

1. Answer: Nearly half (50%) of all schools do this. Source: Brenner et al. (2000). Jrnl of Sch Health, 7 (7).

2. Answer: About 60% of the nation’s SBHCs have mental health professionals. Source: National Assembly on School-Based Health Care: Creating access for children and youth. (June 2000).
people’s attention to their behavior if they express a stigmatizing attitude.

The NM Department of Public Health, Office of School Health is sponsoring a Youth Mental Health Anti-Stigma Campaign in the Albuquerque, Farmington, Roswell, Hobbs, Gallup, Las Vegas and Espanola areas. The approach of the campaign is to normalize adolescent mental health issues, inform the public about the most prevalent adolescent mental illness (depression), and give direction to family members who suspect a teen may be depressed and wish to seek help. The campaign is disseminating its anti-stigma messages through print ads (being shown as movie screen slides), 30-second radio spots, a 30-second TV public service announcement, 16” x 22” posters distributed to schools, and print articles for local and school newspapers. For information on the campaign or its materials, contact Kris Carillo at 505-841-5884 or krisc@doh.state.nm.us.

This Issue’s Authors

Steven Adelsheim, M.D., (guest editor) is a child psychiatrist consultant in the New Mexico Department of Health. He is also the Associate Vice Chair for Psychiatric Outreach Partnerships at the University of New Mexico Health Sciences Center. He works one day per week in the Acoma-Laguna-To’Hajiilee School Based Health Centers.

Ernest Coletta, B.S., has worked in school health for eight years, and currently, as part of a collaborative between the University of NM/ Department of Psychiatry and the NM Dept of Health / Office of School Health, provides training and technical assistance to schools and communities implementing early mental health assessment and intervention programs.

Christopher Schuler, M.A., has won 15 Emmy awards and his company, Christopher Productions, seeks to empower organizations and improve lives by creating community organizing projects using electronic media as a primary partner. His company will provide the video, “Coming Back: A Death and Life Story about Sons, Daughters and Friends,” and curriculum guides to school districts throughout the state. It will also provide a special video for educators, another video for families, and coordinate media outreach in radio, television, and newspapers.

Kris Carrillo, M.S.W., L.I.S.W., received her Master of Social Welfare from the University of California-Berkeley in 1982. She has 22 years experience as a clinician, administrator, and program developer, all in the field of children’s mental health. She is now Program Manager for the NMDOH/Office of School Health Mental Health Programs.

Delfy Peña Roach is the Executive Director of Parents for Behaviorally Different Children (PBDC), the New Mexico Statewide Family Network for Children’s Mental Health. PBDC provides information, support and advocacy for families with children and youth (ages 0-21), who have neurobiological (mental illness), emotional, or behavioral differences.

important, I no longer accepted the blame or shame so willingly and unthinkingly offered me by others. My son and I worked together to make our situation “non-disabled.” I focused less on trying to manage his behavior, and more on creating natural or logical approaches to living. We began to celebrate our difference and we boldly went wherever we wanted—granted, sometimes for only short periods of time—but we went anyway. We learned about bipolar disorder so my son would not feel ashamed about having a mental illness. I helped him learn healthy interventions to use if his symptoms became unbearable, and to be his own advocate. Although he and I continue to face stigma and fear, my son now has the tools to fight it. I have come to see his “mental illness” as a difference, and despite pain and frustration, I have also learned to appreciate and celebrate the joy and talent my son brings with him to this world. I continue to hope that brain research, education and awareness-raising will eradicate stigma in my son’s lifetime and that those living with differences will be given every opportunity to be all that they are and can be.
HealthWise is published quarterly by the University of New Mexico Center for Health Promotion and Disease Prevention, New Mexico’s Prevention Research Center, and is funded by the Centers for Disease Control and Prevention, cooperative agreement U48-CCU610818-08.

We encourage readers to share their experiences by submitting articles or reviews related to planning, implementing, or evaluating health promotion and disease prevention programs—or simply send us your suggestions for topics. A copy of our “Guidelines for Submission of Manuscripts” is available on request.

Address all correspondence, including reprint requests, to Christine Hollis, Editor, HealthWise, Prevention Research Center, Department of Pediatrics, 1 University of New Mexico, MSC11 6145, Albuquerque, NM 87131. Email messages to PRCPublications@salud.unm.edu, or phone at (505) 272-4462.

Founding Editor: Sally M. Davis, Ph.D.
Guest Editor: Steven Adelsheim, M.D.
Editor: Christine Hollis, M.P.H., M.P.S.
Graphics and Layout: Andrew Rubey, B.F.A.
Web Master: Elverna Bennett, B.A.
Director of Publications: Linda J. Peñaloza, Ph.D.
Production Assistant: Leslie Trickey