California State University, Monterey Bay

Digital Commons @ CSUMB

2012

Stamp out stigma : putting a face to mental illness : increasing mental health knowledge for local high school students

Danielle Pacheco
California State University, Monterey Bay

Follow this and additional works at: https://digitalcommons.csumb.edu/caps_thes

Stamp Out Stigma:
Putting a Face to Mental Illness
Increasing Mental Health Knowledge for Local High School Students

Danielle Pacheco
May 18, 2012
Department of Health and Human Services and Public Policy
California State University Monterey Bay

Author note

This capstone report prepared for CHHS 400B

Abstract

Adolescence is a critical time for mental, social, and emotional development. Untreated mental health problems among adolescents often result in negative outcomes. Mental illness can decrease an individual's ability to function in the community, with consequences such as suicide, delinquency, truancy, and substance abuse. Adolescents face these determinate costs when they do not receive treatment; consequently, they may increase as the problem of untreated illnesses expands. The lack of resources, deficiency of mental health education, and fear of stigma discourages individuals and their families from seeking the help they need. The Stamp Out Stigma workshop provides information and education about adolescent mental health through a range of interactive activities in a fun and effective way. The workshop was delivered to North Salinas and Salinas High School Students. The results indicated an increase in knowledge or mental health and resources.

Keywords: Mental health, Education, Adolescence, Awareness, Stigma, Workshop, Resources, Mental development

Mental Illness among Adolescents

Mental illness is an important public health problem in the United States. The Center for Disease and Control (CDC) reported about 25% of all U.S adults have a mental illness and that nearly 50% of U.S adults will develop at least one mental illness during their lifetime (2011). The most common mental illnesses in adults are anxiety and mood disorders. According to CDC (2011) nearly 20 percent [8.9 million] of adults are diagnosed with a mental illness also had a substance abuse disorder. The consequences for individuals, families and communities can be devastating. Untreated mental illnesses can result in disability, substance abuse, suicides, and lost productivity. As explored through the CDC (2011) majority of adult mental illnesses are developed from their adolescence years.

Adolescence is a critical period for mental, social and emotional well-being and development. As stated in the study *Adolescence Mental Health in the United States* (2009), "…the brain undergoes significant developmental changes, establishing neural pathways and behavioral patterns that will last into adulthood" (Para 2). Even though most American children and youth experience normal, health development there is approximately 6 to 9 million who have serious emotional disturbances, as indicated by the CDC (2009).

When the adolescent population aged 15-24 years old is growing into adulthood, it is a period of development that many mental health problems emerge in late childhood and early adolescence. Daily Adjusted Life Years (DALYs), defined as the sum of years of potential life lost due to premature, identified mental health problems; in particular, depression is the largest cause of the burden of disease among young people (WHO, 2012). National Center for Children in Poverty (NCCP) states, "Approximately 20% of adolescents have a diagnosable mental health disorder". Studies exemplify that mental health problems affect 1 in every 5 (20%) of young

people at any given time ("Children's mental health", 2012). The first symptoms of severe,

chronic forms of mental illness, such as schizophrenia, bipolar disorder, depression and anxiety

disorders, generally appear at the start of age 15 (CMHA, 2003). According to Whitaker (2010),

there are about "680,000 in that age group with bipolar disorders and another 800,000 ill with

major depression". Mental illness can have serious effects on the wider health development of

adolescents and is associated with several health and social outcomes such as substance abuse,

truancy and delinquent behaviors.

Mental illness refers collectively to all diagnosable mental disorders. Substance Abuse

and Mental Health Services Administration (SAMSHA) defines a mental illness as a health

condition that changes a person's thinking, feelings, or behavior that causes the person distress

and difficulty in functioning in everyday activities (SAMSHA, 2005). The effects of the illness

include disruptions of daily function; incapacitating personal, social, and occupational

impairment.

Behaviors of young people are influenced at the individual, peer, family, school,

community, and societal levels. School influences adolescents as the environment affects

student's attendance, academic achievement, and behavior. A safe and health school

environment affects student's engagement in risky behaviors or dropping out. Therefore

Pescosolido (2008) states the there is growing consensus that healthy development during

adolescence contributes to good mental health and can prevent mental health problems. The

adolescence years are a critical period where students develop a mental and emotional well-

being. National Survey on Drug Use and Health (2009) reported 1 in 20 (5.1 percent) adolescents

received services in both a specialty mental health setting and an educational or general medical

setting in the past year. Feeling depressed was the most common reason for receiving mental

health services in a specialty mental health setting or an educational setting. It becomes crucial

for students to seek the care they need once they have symptoms of a mental illness such as

depression.

Consequences

Untreated mental illnesses among adolescents often result in negative outcomes. The

negative outcomes decrease an individual's ability to function in society. Consequently,

untreated mental illness such as major depression leads to truancy, delinquency, substance abuse

and suicide. Adolescents face detrimental effects when specific illnesses are not treated, it may

cause the illness to deteriorate. Once a student is diagnosed with a mental illness, the student

may develop fear of being different from their peers. Subsequently, the student then develops a

fear of seeking help. The results of untreated Mental illness leads to poor school performance

and dropouts, delinquency, substance abuse and suicide.

One consequence for untreated mental illness amongst adolescence is truancy. National

Center for School Engagement (2009) defined truancy as any unexcused absence from school.

The majority of school-aged students who have untreated mental illnesses may fall behind,

become unaware of such treatments, become isolated and convert to absenteeism from school

(Pescosolido, 2008). As Pescosolido (2008) stated "depression has been shown to be a leading

cause of school failure amongst youth with learning disabilities". Truancy rates are unpredictable

nationwide, however, the CDC (2011) noted every day hundreds of thousands of youth are

absent from school; many are absent without an excuse and deemed truant. Youth with poor

school engagement or become truant are also more likely to participate in risky behaviors such as

substance abuse or crimes.

Therefore, mentally ill adolescents that are untreated have a high rate of experiencing time in the juvenile justice system. As Hammond (2007) explored, "many of the 2 million adolescents arrested each year in the United States have a mental health illness". As Hammond justified the absence of treatment may contribute to a path of behaviors that include continued delinquency. According to the NCCP (2009), an estimated 67% to 70% of youth in the juvenile system have a diagnosable mental health illness. When delinquent youth have mental health issues, as stated through the NCCP (2009), rates of untreated mental illness increase as more delinquent adolescents enter the justice system.

Adolescent depression is associated with an increase risk of suicidal behaviors due to discrimination and lack of productivity at the school (Children's mental health statistics, 2012). These behavioral risks may increase if it is accompanied by conduct disorder and alcohol or other substance abuse. As stated through the CDC website (2009), suicide is the third leading cause of death for youth ages 15-24 nationwide. Though it is likely underreported due to social stigma, reported suicides account for approximately 4,400 deaths a year among youth in the United States. National Institute of Mental Health (NIMH) explored behaviors among adolescents who develop major depressive disorder as many as 7% who may commit suicide in young adult years. In *Child Trends* article (2011), reported 6.3% of U.S. 9th-12th graders having attempted suicide one or more times in the past year. Youth suicide rates have somewhat decrease recently, however, youth suicide continues to be a prominent national issue.

Contributing Factors

In society there is no indication of what a mentally ill person looks like or how they may act in the community. According to SAMHSA (2004) the meaning of stigma that is directed towards individuals with a mental illness is labeled as severely dangerous, unpredictable, and as

different. Also, through the CDC (2011), stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against adolescents who are living with a mental illness. The lives of people living with a mental illness are often drastically altered by the symptoms of the illness and how societies react to them. Usually, stigma takes the form of stereotyping, distrust, fear, or avoidance that can negatively impact pursuit of treatment and self-worth (Pescosolido, 2008). Therefore, these students who are diagnosed with a mental illness do not seek the care they need because of denial and fear.

Mental health services are available to adolescents in three major settings: a specialty mental health setting (inpatient and outpatient services); a school-based educational setting (services received from school counselors, school psychologists, or special education teachers); and a general medical setting (services received from pediatricians or family practice providers). However, the lack of knowledge about available resources is critical when majority of adolescents who are not receiving the care they need.

Although help typically may focus on settings that are familiar and easily accessible for adolescents, different problems may tend to cluster, depending on the type of problem experienced. The most importance cause of this problem is majority of mental health service providers are not aware of the reasons for which adolescents are not receiving the services they need. Although there are various settings to seek help, adolescents are clueless to find the right direction; due to this barrier there is a lack of mental health care for adolescents.

The lack of mental health education in high schools curriculum is a disadvantage to students, due to the lack of access to reliable information about positive mental health and mental illness it will become a crucial barrier for all students to comprehend the importance of mental health. Mental and emotional problems are common among students that need to be addressed,

similarly to student's physical health problems. Adolescents are unaware of the factors and consequences of what mental health problems may cause an individual.

The lack of resources such as mental health service and programs is a disadvantage for high schools. As explored by Foster, et.al (2005), schools have limited availability of mental health services on site and in the community; significantly increasing mental health needs. Therefore, this prevents students to seek professional medical treatment for their mental illness.

Figure 1: Problem Model demonstrates that lack of education about available resources, lack of knowledge, barrier of seeking services due to social stigma which is directed towards mental health. Therefore, the cause of adolescent's aged 15-24 with mental health issues not receiving the treatment or professional help they need. The consequences of this problem erupt with three major contributing costs such as increase of adolescent suicide, truancy, and delinquency rates.

Figure 1 Problem Model
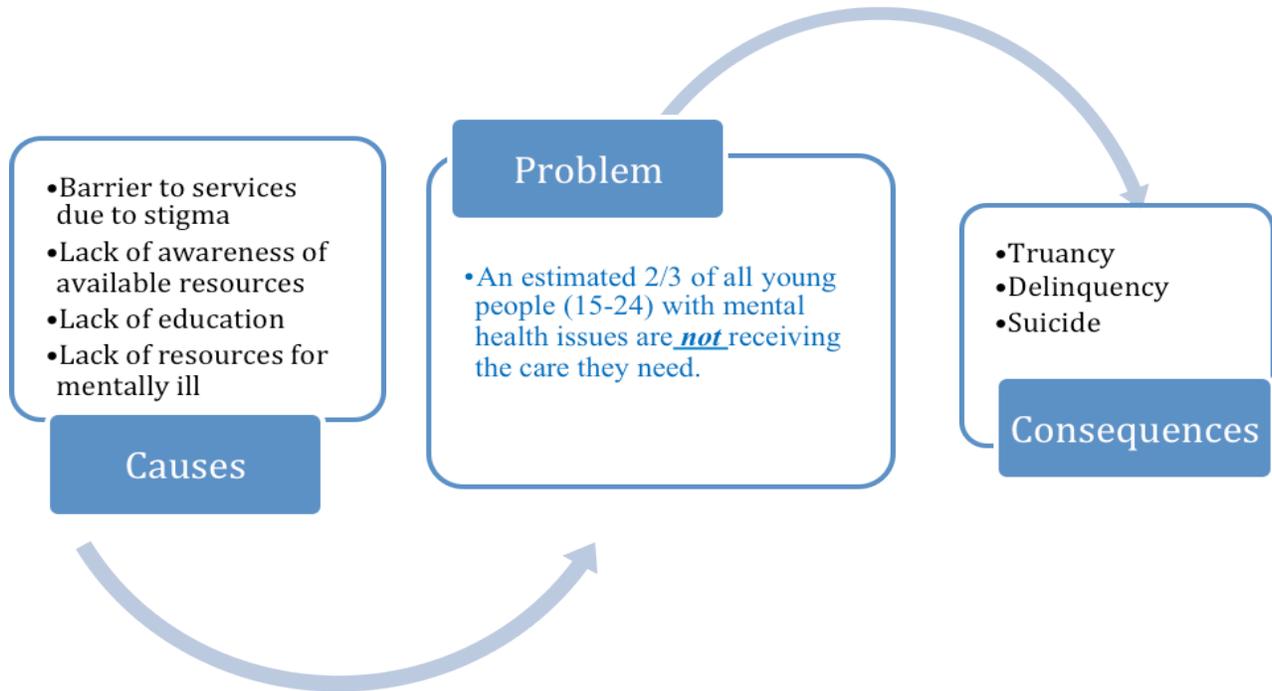
Monterey County Behavioral Health Agency

Monterey County Health Department provides a wide variety of health-related services in the areas of public, environmental, and behavioral health with emphasis through clinical services (MCHD, 2009). As an intern at Monterey County Behavioral Health (MCBH), my duties geared towards the Adult Services Division, Intensive team. The intensive teams mission statement is stated.

> "To assist Monterey County citizens with mental health and addictive disorders to live in the community, to reduce the social, legal, health and economic consequences of mental health and addictive disorders"
>
> (MCBH, 2009).

MCBH belongs to the public sector and provides health care for people who have been diagnosed with a mental illness. Adult mental health services include: psychiatric consultation, medication follow-up, individual, and group treatment as well as case management and home visits. The Adult Division serves population ages 18-65 with chronic end of mental health disorders such as schizophrenia, bi-polar disorder, and personalities disorders. The case managers average about 25 clients who are chronically impaired with a mental illness/disorder. The agency assists clients with housing, medical, psychiatric appointments, medication management, education about hygiene and assessing clients living within community on weekly basis.

When a client becomes a danger to self and others, Adult Services are the first responders, whereas, 5150 is to employ assistance of law enforcement that is mandatory. 5150 is defined in terms of becoming in need of involuntary psychiatric treatment. According to the state of California "it is a legal hold, they believe it is to be a combination of one or more of the following: danger to self, danger to others, and/or gravely disabled" (*5150 and you*, 2010).

Monterey County portrays mental health as a critical problem in society. Their services are meant to provide the assistance of decreasing all mental health clients from hospital visitations. The intensive team is a small component of Adult Services Division, while their mission states "To reduce admission frequency to the hospital, inpatient mental health unit, and other crisis houses"(MCBH, 2009). The Intensive Teams main goal is to transition all their clients who have been in locked-in facilities back into the community with the utmost assertive community treatment.

Mental health services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements

of learning, development, independent living and enhanced self-sufficiency (MCBH 2009). All

services are directed towards achieving the individual's goal and hope to obtain the ability to

reach their desired results or milestones.

As stated in Adult Services policy, the agency should provide and delineate the five

services delivered amongst all Monterey County residents. All Medi-Cal eligible clients should

be granted any service through a "comprehensive evaluation and assessment; individualized

treatment plan; crisis services including residential; inpatient psychiatric services" (MCHD

policies, 2009). The Adult Services provide array of services that is provided for their clients

who are Medi-Cal eligible.

Status Quo-To Do Nothing

Alternative one is leaving the problem at status quo-to do nothing. Therefore, this

potentially remains for more young people (15-24) to develop mental health issues and fail to

receive the care they need. Status quo is sure to increase all consequences such as rates of

suicide, truancy, and delinquency will continue due to the number of adolescents with a mental

health illness.

Mental Health Career Fair

Alternative two is to implement a mental health career pathway fair amongst local high

schools. The Workforce Education and Training Program (WE&T) generated through the

MCBH department developed a mental health career pathway program. I would implement this

program by presenting information to high school students about mental health careers, as I

would develop a short presentation to classes. As this program would provide presentations at

high school career fairs to discuss uprising mental health issues, reducing stigma, and promote

careers in mental health field. This will create a new pathway for the mental health workforce by collaborating with local high schools.

Stamp Out Stigma (SOS)

The Stamp Out Stigma (SOS) workshop provides information and education about adolescent mental health through a range of interactive activities in a fun and effective way. The workshop presents information about mental health to local high schools in the surrounding community. The workshop provides information and education about adolescent mental health. Some activities include exploration of knowledge directed towards mental health, putting a face to mental health, defining mental illness, and providing education about mental health. While facts can give the students an overarching understanding of the impact about stigma the project will incorporate mentally ill clients experience and personal stories when first diagnosed. The clients will share their experience, it will help puts a face to mental illness.

Stamp on Stigma (SOS) as Selected Project

SOS is the best alternative because high school students are not informed about mental health illnesses. Students are able to evaluate and rebut the inaccurate negative stereotypes they may come across in society. Stigma defined, as fear and a lack of information about mental health problems, have been identified as reasons why mental illness has not been adequately addressed in many schools. The activities developed to help overcome some of these barriers. By providing accurate, peer-reviewed information about mental health illnesses also a range of interactive activities, that students understand as crucial information to understand. .

SOS is valuable due to the high rate of adolescents who are not seeking help. Stigma, fear and lack of knowledge about mental health problems are potential barriers for students to not seek help. The SOS presentation is developed to help overcome some of these barriers. Accurate

information was integrated through the client's stories and experiences with stigma. Mental

illnesses were presented through a range of interactive activities, which the students were

capable to interact and learn about mental illness in a fun and effective way.

III. Implementation

SOS Goal

The goal is to have all young people receive the mental health treatment, programs, and services

they need.

Primary SOS Objectives

The objective of this project is to increase mental illness knowledge of 9th and 12th

graders by 15%. The second objective is to increase overall knowledge about local resources.

The third objective is to decrease fear of 9th-12th graders seeking professional help. To achieve

these objectives I collaborated with two high schools, North Salinas High and Salinas High

schools, which are located in Monterey County district. SOS was then scheduled in February and

March. North Salinas High was delivered on February 21,2012 as Salinas High was presented

on March 2, 2012.

Michelle O'Neal who was my mentor through MCBH department worked previously

with various high schools located in Monterey County. Michelle provided informative references

to individuals that were able to help me with my projected workshop. She provided connections

and contact information for I can begin my projects and gain potential recipients. I contacted

health teachers who agreed with my idea of this SOS workshop. Michelle soon connected with

Kontrena McPheter who works for Interim Inc. as a Program Coordinator for *Success Over*

Stigma program located in Monterey County. This program was a huge inspiration for my SOS

presentation. Since Kontrena had prior experience as a program coordinator she was then able to

help coordinate with local schools. She had the ability to assist with implementing a similar

project for my senior capstone. She provided great resources and was able to link with school

counselors and teachers. Soon after, I had a chance to work with her and her program *Success*

Over Stigma. Subsequently, she let me take her project and incorporated my own ideas and

information.

After linking with two high schools North Salinas and Salinas high, I confirmed set dates,

times and locations. The teachers provided their availability within in the upcoming months.

Both schools had flexible dates, which then helped my team of collaborators confirm set dates.

North Salinas high was set for February 21st from 8am-10am. Then I had Salinas high was set for

March 2nd from 10am to 2:30pm. After the dates were confirmed I started to plan out how many

students were attending, also, the thought of interactive activities. I had to create a time

scheduled of an agenda that provided enough information for a large amount of students versus a

small amount. North Salinas offered 2 hours of their time with 55 students; on the other hand,

Salinas offered 4 classes, with a 55 minutes with an allotted of 30 students.

SOS is developed to be an interactive presentation amongst the students and

collaborators. The workshop provided activities to demonstrate ways to reduce stigma, defining

stigma, exploring attitudes, personal stories shared from people who have mental health

illnesses, and information about local resources. The time period varied between the two high

schools. Thus, the North Salinas presentation was two hours for a class of 55 unlike Salinas High

that allotted 4 classes with 55 students. Their was a set agenda for both high schools, however,

the class with less time did not have the full experience as the students who were allotted 2

hours. This is an overview of the activities expected in the workshop (See appendix A for agenda

in detail). The presentation was developed through surveys, activities such as definitions, exploring attitudes, knowledge, education about stigma, and stories from client's stories.

Project Obstacles

I developed a passion for spreading awareness, knowledge, and education about mental illness to those who are unfamiliar with the subject. My project started in the month of December 2011 and finished my research in the month of April 2012. This was an extensive project but felt that I needed more results and evidence that I could have gained. This project had a lot of major challenges that I jumped through to be where I am today. Majority of my obstacles included barriers to meet certain deadlines such as completing assignments in a timely manner due to such limited time to understand my SOS project. I had no guidance with what I wanted to accomplish, however, with such limited time I was then pressured into implementation of an idea that has been done by other collaborators before.

It was not until mid January that I started to take initiative and confirming dates for potential schools. Soon I had two different high schools that agree to let us come and present to their students. Next, I then had to figure out the gist of what I wanted to do, however, it was a challenge to work individually to make this implementation work. On the contrary, I could say this was my *own* project that I designed. I designed the majority of the project they way I perceived it happening. Consequently, the outcomes could have been improved; conversely, it's shown that I made connections to collaborators who were "on board" with working with me. Soon, my project was then designed to be goal-oriented that did face some obstacles along the way.

During the implementation period I did face a problem that occurred during this workshop; since I dealt with students aged 14-18 I had to work along the lines of catching their

attention. High school students have the tendency to show no interest in school-related projects. However, I did gain enthusiasm and encouragement from collaborators that helped gain focus from students throughout the presentations. Another aspect that I battled with was the use of time. The time scheduled and amount allotted for each activity overlapped. I had troubles with wrapping up an activity then moving onto the next, it was challenging to maintain the use of time in an effective way. Some activities lasted longer, such as the client's stories that did overlap into students completing the surveys. It was difficult to keep track of time due to the time I spent for each activity.

IV. Evaluation

Evaluation Design

The sole purpose of SOS is to create a sustainable and informative mental health curriculum amongst school-aged students. The goal is to have all young people receive the mental health treatment, programs, and services they need. The SOS objective is focused if the presentation increased students' knowledge, moreover, if students increased knowledge of resources and decrease the fear of getting help if mentally ill. This goal and objective helped determine my evaluation design. I evaluated the SOS project by measuring student's knowledge about mental illness.

My evaluation design was developed through various steps to measure the success of increased knowledge. Firstly, North Salinas and Salinas High were evaluated differently due to a change of results and outcomes I wanted to analyze. North Salinas High was evaluated through a pre and post-tests. While Salinas High was approached differently, I had a sample of students who participated in one control group and a different sample of students who participated in one intervention group.

The surveys had the same 15 questionnaires that were directed towards definitions about different mental illnesses that were formulated into a true or false test. All surveys provided quantitative information about mental illness knowledge and competency. In addition, I provided two qualitative questions that were directed towards student's attitudes and thoughts about what comes to mind when they think of mental illness and what available resources are available if mentally ill (See Appendix B).

North Salinas High provided a 2-hour time slot dedicated to our presentation. It was enough time for all presenters to share their personal stories, present all information, complete all the activities and still have times for questions and answers. I administered pre and post surveys at North Salinas High School to 30 9th-12th-grade students. The surveys were administered the day of the workshop since it was a one-day presentation. Students were allotted 10 minutes to complete the pre and post surveys. The time adjustment created a barrier to finish, since they were given 10 minutes, majority of students had a challenge with completing in a timely manner.

Salinas High School had a different approach; I administered surveys to 53 students at Salinas High as my intervention group. I also had a control group at Salinas High by administering surveys to 51 students. These students were volunteers who took the survey willingly. The purpose of the control group is to develop a standard comparison between the two groups, since a set of students received the intervention and the other group did not. The end results will determine an increase or decrease of knowledge about mental health. In regards to the findings, it will be based upon who had higher percentages between the two groups (intervention and control).

Results

   The evaluation of results consisted of a total number of questions regarding topics such as depression, bi-polar disorders, and development of such illnesses. The results of these findings illustrated some interesting outcomes.

   North Salinas High demonstrated an increase of knowledge. North Salinas High's evaluation had a sample of 55 students that participated in the pre and post survey. The students answered the pre test with a total average of 68 out of 100 (68%), which indicates a low percentage score. On the contrary, sample of students who answered the post-test had an total average of 79 out of 100(79%), which indicates the SOS had a slight increase of improving mental health knowledge, as shown in the figure 1 below. The difference was 11%, which shows that it had a slight increase, even though; the result barely surpassed the objective of increase of knowledge of 10%. This increase shows that the SOS project made an impact to student knowledge about mental illnesses such as depression.

Figure 2 North Salinas High School Students

Average Knowledge Scores for North Salinas High School (2012)
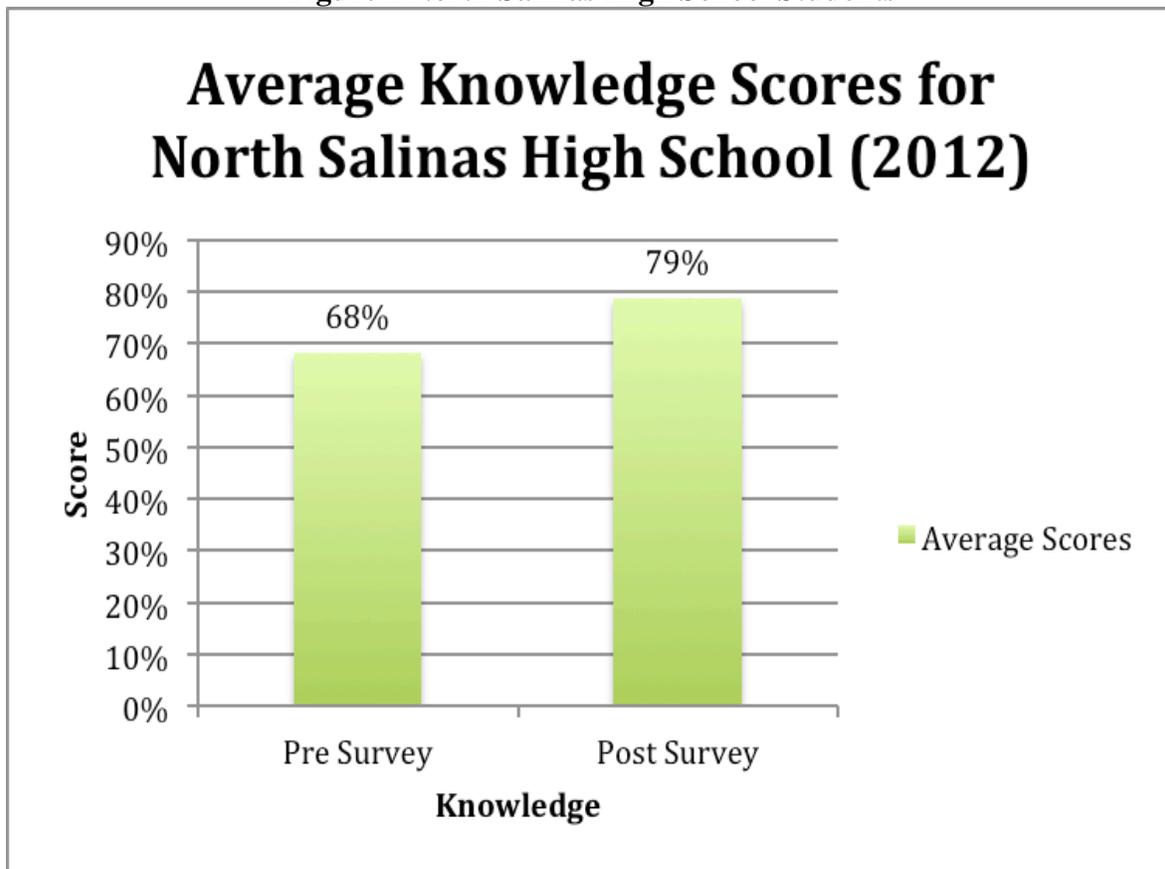
On the contrary, Salinas High School was evaluated between a control group and the intervention group. There was a total average score between the control and intervention group that presented to be an 18% increase of knowledge. The results demonstrated that the sample of students in the control group had a total average score of 49 out of 100(49%), which indicates that it is below average when it is ranked out of 100. Besides the control group, the sample students who were part of the intervention group, also known as the students who received the SOS presentation, had the chance to receive a higher percentage. As shown in Figure 2 below, the intervention group exemplified a positive increase of knowledge. The intervention group had a total average of 67 out of 100(67%), which indicates it had an 18% difference from the control to intervention groups.

Since the North Salinas High control group averaged 49 out of 100(49%), this shows that

the intervention group had the ability to gain more knowledge about mental illness when

receiving the SOS presentation. The results show that the students without the presentation were

not aware of mental illnesses such as depression, schizophrenia, or bi-polar disorders. The

intervention group scored a total average score of 67 out of 100 (67%). In table 2, it shows that

the sample of Salinas High intervention group benefited from the SOS presentation by meeting

the objective of SOS, which is to increase knowledge of 10%. This shows as an example that this

SOS presentation is beneficial and is need to be sustained.

Figure 3 Salinas High School Average Scores For Knowledge
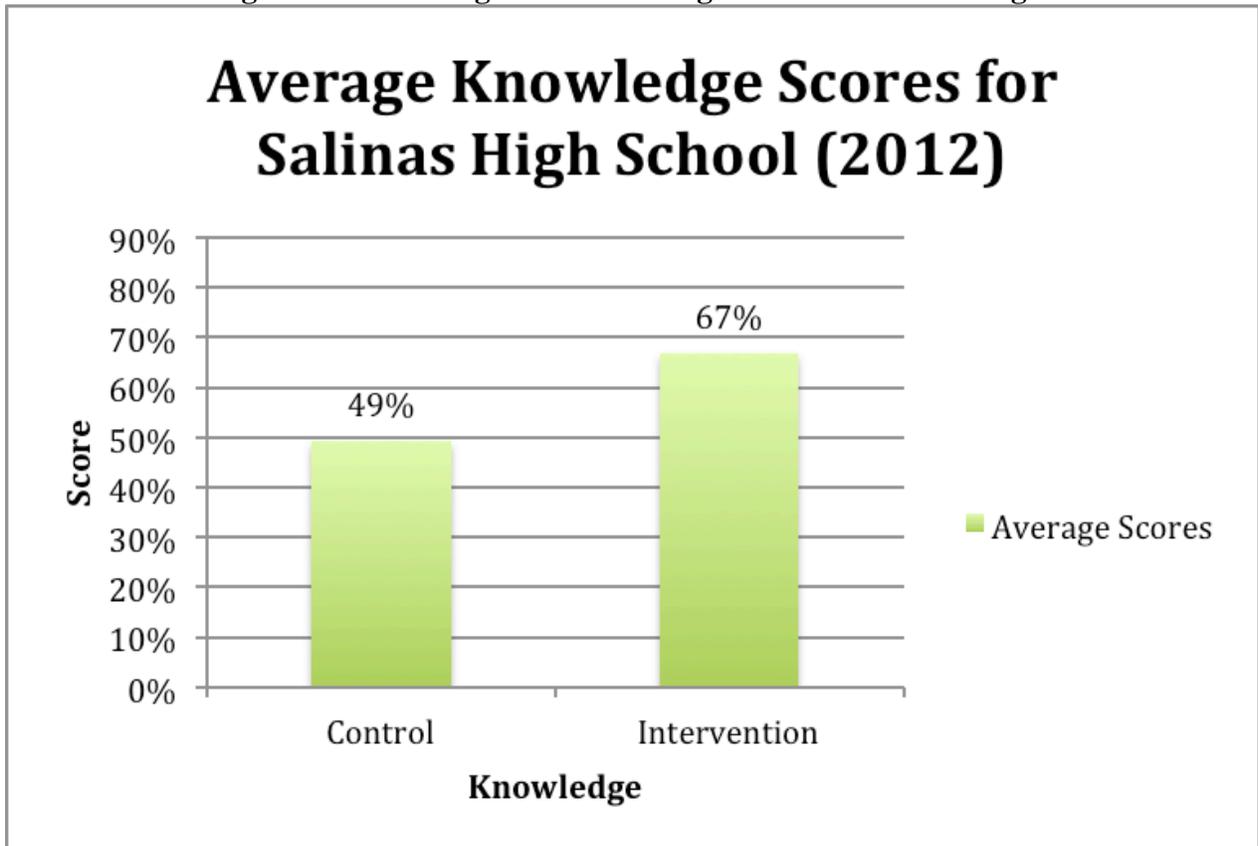
Discussion

The total average score from North Salinas and Salinas High proves to be critical to integrate mental health education in the schools curriculum. After the pre and post surveys were noted, there was a gradual increase after the presentation was given.

Students exemplified an open-mind about asking questions after the presentation. This was based off of qualitative questions deepening their thought process after the presentation was given. It showed that these adolescents wanted to seek help. These students who sought help to these mentally ill clients is demonstrated a gradual change and one step closer to accomplishing my SOS overall goal. The goal is to have all young people receive the mental health treatment, programs, and services they need. With 2 or 3 students who confront these clients promotes that this workshop made a impact in one way or another. This generally appears that SOS is crucial and is able to make a difference

V. Conclusion and Recommendations

Conclusion

The SOS project introduced adolescents to mental health. This project slightly increased student's knowledge towards mentally ill individuals who may be affected with stigma on a daily basis. As students achieved a greater understanding of mental illness, the increase of mental health knowledge may help reduce the fear of adolescents seeking mental health treatment.

SOS presentation provided a panel of clients who were willing to share their experience when they were first diagnosed with a mental illness. It was more of a reverse psychology, since the students were not aware of the challenges and barriers that these individuals face everyday it

provided an unexpected outcome. It was a good experience to see both sides of the spectrum interact and collaborate to destroy the stigma on mental health.

From the project, I have made some realizations about the education in high schools. A well-development health course that is delivered in high schools rarely focuses on what mental health is defined as. It takes time understand the core concepts and ideas when someone is diagnosed with a mental illness.

CHHS Major Learning Outcomes

The major learning outcomes that will apply to my capstone project are Information management, Statistical and Research Methods, and Conflict Resolution, Negotiation and Mediation.

Information Management

Information management was crucial in completion of this project. Throughout my capstone project I acquired skills through managing information using Internet and electronic software such as Microsoft Excel, reliable website and electronic research sources. I have demonstrated my skills through gaining access to information through electronic and published media and presenting information in electric formats such as excel and PowerPoint. My capstone helped me acquire the quality of information via technology. I developed knowledge through accessing electronic media and differentiating between "good" and reliable data that is suspect of credible sources.

Statistical and Research Methods

Statistical and Research methods is another major learning outcome I acquired from my capstone process. I am capable of demonstrating an understanding the importance of program design and service delivery. For example, I acknowledged the details amongst the research and

background information. I developed a basic survey to evaluate the increase or decrease of high school student's knowledge and attitudes.

Conflict Resolution, Negotiation and Mediation

Conflict Resolution, Negotiation and Mediation are another major learning outcome I acquire from my capstone process. I was able to demonstrate an understanding of the characteristics of conflict and how it manifests in inter-professional and organizational contexts. For example, I had knowledge directed towards the level of understanding about conflict resolution. Since I collaborated with people on a regular basis, I experienced conflicts that escaladed due to different standpoints. I have gained the ability to integrate core concepts from the classroom into the field placement. I improved my conflict resolution skills by learning mediation between clients, family members, and case managers.

University Vision

When reflecting on CSUMB's vision statement, I think about the focus on serving diverse populations, especially the working class and uneducated. My SOS workshop objective was to increase knowledge directed toward mental illness and readily resources for students. Furthermore, SOS assists everyone with education and knowledge about what mental illness is and who can and will be affected by it.   The workshop empowered students who were not readily accessible to resources become more aware and knowledgeable about symptoms, diagnosis, and most of all where to find help, the evaluation demonstrates that many of them increase their familiarity and understanding about mental illness.

Final thoughts

This capstone project helped me develop a level of understanding about mental health education. I developed a sense of importance of research, statistical information, professional communication, and research methods. Overall, this project has expanded my knowledge into deeper concepts than I would have imagined.

I have been struggling to meet certain deadlines with projects and papers. Throughout my process I was worried a lot with my academic life parallel to my personal life. Stress is obviously a major factor in my life; I am trying to balance my academics, work, my internship, and my personal life. It is manageable but is very stressful. Being a busy bee in my last year does have a fine line between happiness and overworked. When it comes down to meeting deadlines I tend to become worked up on stress because I don't have enough time to write papers, work and try to be healthy at the same time. Sometimes I lack sleep because I have to work late then rush home to write a paper. I know I am not the only one struggling to meet my academic standards, however, I just try to succeed to the best I can.

The idea of an obstacle is referred to difficulties I faced through my project. My project started off as a problem because of the lack of support from my agency I was placed at. The lack of support starts off with the lack of communication. It is the most important means to achieve success; it is a crucial need for communication in all aspects of completing a successful project. Of course, there are other barriers to project success. But communication between collaborators was difficult to manage throughout the whole process. Although my mentor wanted to assist with my capstone project, it was difficult for her to set time aside of her busy schedule to figure out what the critical need was needed for the population of the chronic mentally ill.

As an undergrad, this capstone project was difficult to understand and manage. However, I do not want to express the hardships, because this is life. Life will hit you with major hardships, but something I figured out was that life will throw things your way but it will never throw things that you can't handle. This project may not be my best work, however, I personally know this capstone process made something of myself, definitely a process I can say I "SURVIVED". Through the tears, stress, fights, doubts and even more hardships; there was an end to it all, which means that I accomplished something that most people cannot do. I can officially say I graduated with a major in Collaborative Health and Human Services wit help from professors, colleagues, family and friends.

References

Centers for Disease Control and Prevention (CDC). (n.d.). *1991-2009 High School Youth Risk Behavior Survey data.* Retrieved October 31, 2011 from http://apps.nccd.cdc.gov/youthonline

Centers for Disease Control and Prevention (CDC). (2009). *Suicide prevention.* Retrieved October 31, 2011 fromhttp://www.cdc.gov/ViolencePrevention/pub/youth_suicide.html

Children's Mental Health, Mental Health America. (2012).*Children's mental health statistics.* Retrieved from Mental Health America website: http://www.nmha.org/go/information/get-

Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School mental health services in the United States 2002-2003.* DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved January 20, 2006 from http://www.samhsa.gov/publications/allpubs/sma05-4068

Hammond , S. (2007). National Conference of State Legislatures: Mental Health Needs of Juvenile Offenders. Denver, CO. Retrieved from: http://www.ncsl.org/(p.2-11)

Kataoka S, Zhang L, Wells K.(2002). Unmet need for mental health care among U.S. children: *Variation by ethnicity and insurance status.* American Journal of Psychiatry, 159, 1548-1555, 2002

Lebrun, M. (2007). Student Depression: A silent crisis in our schools and communities. (p. 25). Maryland: A Division of Rowman &Littlefield Publishers, Inc.

McIntosh, J. L. (2011). *U.S.A. suicide 2008:* Official final data. Washington, DC: American Association of Suicidology, dated 24 October 2011, from http://www.suicidology.org.

Monterey County Health Department. (2010). *Our Mission.* Retrieved from http://www.mtyhd.org/index.php?option=com_content&view=article&id=1560%3Aour-mission&catid=242%3Adirector-of-health&Itemid=500&lang=en

NIMH (2006). *What is borderline personality disorder*?. Retrieved from NIMH · Home website: http://www.nimh.nih.gov/health/publications/borderline-personality-disorder/what-is-borderline-personality-disorder.shtml

National Institute of Mental Health, U.S. Department of Health and Human Services. (2007). *1999—2007 trends in suicide rate.* Retrieved from website: http://www.nimh.nih.gov/statistics/4SR99.shtml

National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. (2009). Healthy youth! Mental health. Centers for Disease Control and Prevention: Atlanta, GA.

National Institute for Health Care Management. (2009). Strategies to support the integration of mental health into pediatric primary care. Retrieved February 16, 2011, from http://nihcm.org/pdf/PediatricMH-FINAL.pdf

Pescosolido, B (2008). *Cross-Cultural Aspects of the Stigma of Mental Illness.* In Julio Arboleda-Florez and Norman Sartorius (eds) *Understanding the stigma of Mental Illness: Theory and Interventions.* London: John Wiley& Sons, Ltd.

Scheffer, R. (2003). Addressing Stigma: *Increasing public understanding of mental illness*. Centre for Addiction and Mental Health

School Health Policies and Program Studies (2006). Suicide Prevention *Journal of School Health.* Centers for Disease Control and Prevention: Volume 77, Number 8, October 2007

Substance Abuse and Mental Health Services Administration (2004). *Statistical Methods and Measurement* mental health. DHHS Publication No. SMA-05-4060. Rockville, MD: U.S. Department of Health & Human Services. Retrieved from http://oas.samhsa.gov/nsduh/2k8nsduh/AppB.htm

Substance Abuse and Mental Health Services Administration (2005). Transforming mental health care in America: *The Federal action agenda—First steps*. DHHS Publication No. SMA-05-4060. Rockville, MD: U.S. Department of Health & Human Services. Retrieved from http://samhsa.gov/Federalactionagenda/NFC/TOC.aspx

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (February 19, 2009). The NSDUH Report: Adolescent Mental Health: Service Settings and Reasons for Receiving Care. Rockville, MD.

The Science of Mental Illness. (2005). *Mental illness in children and adolescents: 2.2*. Information about Mental Illness and the Brain ren, Retrieved from BSCS website:http://science.education.nih.gov/supplements/nih5/mental/other/copyright.htm

U.S. Government Accountability Office. (2008). "*Young adults with serious mental illness*". GAO: June.

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

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

Whitaker, R. (2010). Anatomy of an Epidemic: *Magic Bullets, Psychiatric Drugs, and the astonishing rise of mental illness.* A division of Random House, Inc.: New York

World Health Organization (2004a). <u>Prevention of mental disorders</u>: *Effective interventions and policy options,* Summary Report. A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva, World Health Organization (http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf)

Appendix A

Stamp on Stigma towards Mental Health **Agenda**

This presentation will provide a closer look at mental illness and some of the challenges facing our youth.

Outcomes: Students will be able to:

- Identify stigma on mental health and the challenges people face when battling with an mental illness

- Identify the definition of specific mental illness such as Schizophrenia, Bipolar, Depression, and ADHD

- Become familiar with schools mental health resources

- Become educated and aware of the causes and consequences of mental health illnesses

Pre-surveys (North Salinas and Salinas Control Groups)

Lists of 13 questions about the mental health

Agenda

1. Welcome/Introductions: 5 minutes

    a. Who are we? Why are we here?

    b. The importance of Mental health and adolescents

2. What is mental Illness: 15 minutes

    a. Game activity: Bingo/ popcorn

    b. Prevalent public misperceptions of people with mental illness

    c. How misperceptions impact stigma and discrimination, and affects help seeking behaviors.

    d. How people who live with mental illness or serious emotional disturbance CAN recover and live independently.

3. Clients stories: 25 minutes

      a. Discussion of battle with stigma directed to their personal life

      b. How they feel when people "label" their illness

      c. Experiences

4. Wrapping up: 20 minutes

      a. Statistics about consequences such as Suicide, Discrimination and stereotyping, and Lack of productivity among life activities (truancy and Delinquency)

      b. Post test: after thoughts

            i. Knowledge of students awareness after the workshop has been completed

            ii. Information about local resources such as Interim Inc., Monterey County Behavioral Health and guidance counselors, teachers, and peers

Appendix B

<u>*MENTAL ILLNESSES SURVEY*</u>

Please answer the following questions to the best of your ability. This survey helps me determine statistics for my senior project at CSUMB. This will help determine the awareness of high school students about specific mental illness and if the students increase their level of understanding after this presentation.

Name (Optional):

_____

Age: _____
Gender: Male   Female
Grade: Freshman   Sophomore   Junior   Senior
Ethnicity (Circle all that apply):
- o Caucasian
- o African American/Black
- o Hispanic/Latino
- o Asian
- o Middle eastern
- o Pacific Islander
- o Native American/Alaskan
- o Other

1. Depression is the same thing as being sad.

True   False

2. Mental illness is like other diseases because a person who has it has symptoms that a doctor can diagnose.

True False

3. Individuals who have a family member with a mental illness are more likely to have a mental illness themselves.

True   False

4. The brain of a healthy person works the same as that of a mentally ill person.

True False

5. A person who does not get treatment for depression may feel better after a while, but there may be some long-lasting effects.

True   False

6. How bad a person's mental illness is depends on many things, including his or her genes and family environment.

True   False

7. A person uses his or her brain to learn, but the heart controls a person's feelings.
   True   False

8. Most people with mental illness can do normal things like go to school or work at a job.

True   False

9. Treating mental illness can change the way the brain works.
   True   False

10. People with depression don't need to see a doctor—they just get over it.

True   False

11. Depression is a disease.

True   False

12. There are no treatments that work for most mental illnesses.
    True   False

13. Students and other people who have a mental illness can't learn.
    True   False

14. What available places are you able to find locally if you have a mental illness?

15. What comes to mind when thinking about mental illnesses?

THANK YOU FOR YOU ANSWERS. ☺

FOR MORE INFORMATION PLEASE CONTACT US AT

Kontrena V. McPheter, Program Coordinator

Success Over Stigma Monterey County

KMcPheter@interiminc.org or PachecoDS@co.monterey.ca.us

Or visit your school counselor for more information. ☺

Appendix C

PRE/POST QUESTIONAIRE SURVEY
1. Depression is the same thing as being sad. (F)
2. Mental illness is like other diseases because a person who has it has symptoms that a doctor can diagnose. (T)
3. Individuals who have a family member with a mental illness are more likely to have a mental illness themselves. (T)
4. The brain of a healthy person works the same as that of a mentally ill person. (F)
5. A person who does not get treatment for depression may feel better after a while, but there may be some long-lasting effects. (T)
6. How bad a person's mental illness is depends on many things, including his or her genes and family environment. (T)
7. A person uses his or her brain to learn, but the heart controls a person's feelings. (F)
8. Most people with mental illness can do normal things like go to school or work at a job. (T)
9. Treating mental illness can change the way the brain works. (T)
10. People with depression don't need to see a doctor—they just get over it. (F)
11. Depression is a disease. (T)
12. There are no treatments that work for most mental illnesses. (F)
13. Students and other people who have a mental illness can't learn. (F)

Multiple Choice Bingo Game
Source: http://www.mental-health-today.com/stigma/test.htm

1. **All but one of these are brain disorders:**
   a. Depression
   b. Nervous breakdown
   c. Schizophrenia
   d. Obsessive-compulsive disorder
2. **Which of the diseases below are less common than severe mental illness (name all that apply):**
   a. Cancer
   b. Diabetes
   c. Heart disease
3. **Mental illnesses profoundly disrupt a person's ability to (name all that apply):**
   a. Think
   b. Feel
   c. Relate to others and their environment
   d. Have a high IQ
4. **Schizophrenia is a brain disorder, which affects one percent of the population, beginning most frequently between the ages…**
   a. 0 to 5
   b. 14 to 18

    c. 16 to 25
    d. 35 to 50

5. <u>**Types of Stigma and Discrimination:**</u>
    a. **Self – Internalized**
    b. **Community, Organizational, and Systems**
    c. **And General Public** <u>answer</u>: *All of the above*

6. **Half of all lifetime cases of mental illness begin before the age of fourteen.**
    True or false?

7. Attitudes and beliefs that motivate individuals to fear, reject, and avoid those who are labeled, diagnosed, or perceived to have a serious mental illness-often anyone who is seen as "different".
    Stigma or Discrimination

8. **Actor Jim Carrey suffers from:**
    a. **Depression**
    b. Obsessive Compulsive Disorder
    c. Schizophrenia

9. **Which of these actors suffer from a mental illness? (List all that apply)**
    a. **Harrison Ford**
    b. **Kirsten Dunst**
    c. **Jim Carrey**

10. **Lionel Aldridge had schizophrenia. What professional sport did he play?**
    a. Basketball
    b. Football
    c. Ice Hockey

11. **Mark Twain suffered from depression. He was**
a. An author
b. A football player
c. A poet

12. **Which of these American Presidents suffered from depression?**
    a. Lyndon Johnson
    b. Abraham Lincoln
    c. Franklin Delano Roosevelt

13. **How many people living with severe mental illnesses seek treatment:**
    a. 10%
    b. 30%
    c. 60%
    d. 90%
    e. 100%

14. **All but one of these are brain disorders:**
    a. Depression
    b. Nervous breakdown
    c. Schizophrenia
    d. Obsessive-compulsive disorder

15. **Severe mental illnesses are caused by:**
    a. Bad parenting
    b. A physical problem in the brain

c. Hitting your head against a wall
d. Drug abuse