

Co-occurring disorders are a huge problem in our society. A co-occurring disorder is a label that refers to a person with, “one or more mental disorders co-occurring with one or more disorders relating to the use of alcohol or other drugs” (Sacks and Pearson, 2003:32). “Society often places stigmas and blame on the mentally ill and this can often lead to self medication through the use of [alcohol and other drugs]” (Gertz and Sharp 1998:1758). This fits nicely into my theory of how negatively labeling a person can cause them to become, “immersed in their illness [and] this can foster addictive behaviors” (Gertz and Sharp 1998: 1759). I have a personal interest in this subject matter because my sister was diagnosed with a co-occurring disorder five years ago. Through her experiences I have noticed that society regularly dismisses people with co-occurring disorders labeling them as alcoholics and or drug addicts totally overlooking their mental instability. Because of all the stigmas involved with substance abuse and mental illness, I wanted create a preliminary tool that could help people understand the disorder.

According to the Substance Abuse and Mental Health Services Administration, “seven to ten million individuals in the United States have a co-occurring disorder” (ED. Enos 2002:4). The high percentage of persons with co-occurring disorders implies that the disorder should be the expectation not the exception in substance abuse treatment programs and mental health services. The research on this subject is very preliminary and results from the studies tend to be inconclusive. There has been more research on individuals than groups; however there are many studies that show persons with co-occurring disorders that have access to integrated treatment programs fare better. This concept became the solution I wanted to present at the culmination of my video.

The process of creating my educational video began with research on the subject matter. After reviewing more than a dozen articles, I began to synthesize information into a script format. Certain facts such as “treatment programs for patients with co-occurring mental health and substance abuse disorders are often inadequate or inaccessible” (Bender, 2003:65) and that “addiction programs are reluctant to admit people with serious psychiatric disorders and psychiatric services usually lack the resources to help alcoholics and addicts” (Harvard Mental Health letter, 2003:3) began to build the foundation for our societal need. Other information that I uncovered through my research recurrently points to the importance of integrated treatments. “Dual diagnosis individuals traditionally have been and continue to be treated sequentially- one problem first and then the other- or in a parallel fashion, using two separate programs at once” (Devine 2000:1). “Patients with substance abuse disorders in conjunction with mental illness need to have a different course of treatment than those with mental illness alone” (Barnaby et.al 2003:785). Integrating the treatment philosophies of mental health and substance abuse holds “the potential for the development of better understanding regarding the beliefs and assumptions of each along with the possibility of shared visions and goals” (Brown et.al. 2002:706). “Integrative treatments work well with this population” (O’Hare 2002:45). A co-occurring disorder is created out of a societal problem. Social factors contribute to co-occurring disorders. A social problem demands societal intervention. The current lack of approved solutions keeps those afflicted from becoming integrated as functional members of society.

According to figures from a recent National Co-Morbidity Survey Replication, “only about twenty percent of people that are afflicted with co-occurring disorders are

treated for both” (Harvard Mental Health Letter, 2003:2). “A long term treatment model appears essential for individuals with co-occurring disorders to prevent relapse maintain sobriety and promote psychiatric stability” (Finnell, 2003:14). This model serves to address all of the problems in the individual. It is important to provide services that address the whole problem, mental and physical, and not just one piece of the puzzle.

Much of the information I gathered from the research phase went into the script for the video. After receiving feedback from my instructor on the project, I contacted Professor Jerry Krause to find data on local programs that service co-occurring disorders. My instructor suggested that my video would benefit from a local perspective on the problem. Professor Krause sent me the CASAE evaluation report of the New Horizons program. New Horizons is a community program, that works with incarcerated and “at risk” youth. The program evaluation cites that an estimated “40%-90% of the children in the juvenile justice system have one or more mental disorders [and] most of the youth in the New Horizons program have a dual-diagnosis for substance abuse issues, which further complicates treatment” (CASAE, 2003:15). He also sent me information regarding the AK ONES program which is Yurok for “to hold close”. This program utilizes a wraparound approach for youths, many of which suffer from co-occurring disorders. The premise for wraparound is an empowerment oriented approach that starts with strengths and proceeds to needs only after strengths have been identified. Another program was, The Mentally Ill Crime Reduction Program (MICRP). This program was set up for adult offenders with a major mental health diagnosis and co-occurring substance abuse disorder. This program lasted for four years, but ended a few months

ago. Information on all of these programs was scripted and recorded but truncated in the editing room in the interests of pacing.

Overwhelmingly the articles stressed the fact that co-occurring disorders are a social problem. People with co-occurring disorders face many challenges in daily life. There are “higher rates of homelessness, unemployment, suicide, contact with the criminal justice system, hospitalization and HIV infection compared to those with mental illness alone” (Hoyt 2002:558). This implies that people with co-occurring disorders have different needs than persons with either mental illness or substance abuse addiction alone. One article dealt with the need for specific treatment programs for persons with co-occurring disorders. The findings were that, “individuals with co-occurring disorders are different from other populations in whom this model has been tested” (Finnell, 2003:10).

Overall I felt that the articles supported my theories and had the same goals and ideals as I do in regards to co-occurring disorders. More often than not people do not recognize that mental illness and substance abuse addictions are diseases. Society commonly reacts to the mentally ill and substance abusers with negativity. These stigmas and negative labels exasperate symptoms and complicate treatment. While these disorders are often psychological in nature, there is a large social aspect as well. My theory is that society in a sense creates co-occurring disorders because people with mental illness are so stigmatized they may self medicate causing a downward spiral of addiction in conjunction with their mental illness. Strain theory works well here. With all the stressors society creates, people are often depressed and turn to alcohol or other drugs to relieve symptoms. These coping mechanisms are common reactions to a stressful

existence. Integrative community support has been found to address some of the needs of persons with co-occurring disorders. In one study, “the group which received integrative community treatment fared better overall than the group that did not” (Finnell, 2003:16). This further explains how important social factors are and how they play into mental illness or substance abuse disorders. While there are biological aspects to mental illness, social factors contribute greatly to overall symptoms and recovery. The article goes on to explain that integrating the mental health system and the substance abuse treatment systems are important to treat this population.

I found in most of my research that integrative treatments fare better than parallel systems of care. The parallel systems may inadvertently work against each other causing a counterproductive effect. “In 1998 Drake and colleagues reviewed research emanating from studies conducted within mental health centers concluding that comprehensive integrated treatment, especially when done for eighteen months or longer resulted in significant reduction of substance abuse and in some cases substantial rates of remission (Sacks and Pearson 2003:35). While this article focused mainly on incarcerated adults, the recommendations can be applied and or modified to encompass the general population. The authors expressed that there is an overrepresentation of people with co-occurring disorders in the criminal justice system. The National Institute of Mental Health surveyed a Chicago prison and found 28% of their inmates have co-occurring disorders. Co-occurring disorders tend to be chronic so in theory acceptance of treatment and care combined with community support lowers recidivism rates in offenders. This also reduces the likelihood of non-offenders becoming involved in the criminal justice system. “Prevalence of co-occurring disorders in the offender population

is high and shows indicators of being on the rise” (Sacks and Pierson, 2003:38). The education of what co-occurring disorders are, and how to meet the needs of this population, leads towards integrated treatments and community support

One might wonder what proper treatments look like. The ideal for persons with co-occurring disorders is to have a treatment program that integrates all their needs. This is somewhat an all encompassing umbrella of care. Baker Places Inc., a San Francisco non-profit organization that has residential dual diagnosis treatment programs, is cited as an example in several cases as what treatment facilities should look like. While this may be the ideal, agency collaboration and community support on even the smallest levels, such as positive relationships with loved ones, builds tools for recovery from substance abuse addictions and helps to manage mental health symptoms. “The [co-occurring] population has been considered one of the poorest treated populations in the behavioral health sector” (ED. Enos 2002:4). Treatments that have been termed successful are “motivational intervention, dual recovery programs, modified therapeutic communities, assertive community treatment (ACT) and cognitive behavior therapy” (ED. Enos 2002:4). Agency collaboration and accessible treatment options allow for recovery.

Education also needs to be done at the level of health care providers. One article explores this problem in depth. They found that “Health and Social care professionals attitudes towards substance abusers have a direct effect on the care they provide” (Richmond and Foster 2003:394). Moralistic and stereotyping attitudes among mental health and social care professionals cause inappropriate treatment. The stigmas and negative labels are not only found in the general population but among health care providers who work with persons with co-occurring disorders. “As a result potential

service users with co-occurring disorders are rejected from mental health services and fall through the net of care” (Richmond and Foster 2003:394). They recommended “the implementation of training strategies designed to enable staff to develop a range of skills, attitudes and expertise for working with people with co-occurring disorders” (Richmond and Foster 2003:395).

There need to be more programs available nation wide. Currently only sixteen U.S. states have programs that specifically address the needs of people with co-occurring disorders. Locally, I was surprised to find that the only adult based program that dealt specifically with co-occurring disorders was for inmates and it ended. Even if budgets are cut, people with co-occurring disorders need to have access to treatment. Simply going to a substance abuse program or a mental health program is not enough.

After evaluating all this information my script ran approximately twelve minuets. I began the production phase by realizing the restrictions of my equipment. My main piece of equipment was a low-end digital video camera. I learned from my experience with the Humboldt International Film Festival that I needed to have good sound for my video. As a preliminary viewer for the festival, I was exposed to a lot of student work and the work with poorly recorded audio stood out as bad over all. Sound from the camera microphone was very poor and the camera did not allow for other microphones to be used. This was the main factor in my decision not to feature any interviews in my film. My husband was able to check out a digital audio recorder from the film department and that is how my narration was recorded and why it sounded so crisp and clean. This aspect only took one evening of reading and re-reading my script. It was the easiest part of the whole process.

Before this project I had never had any hands on filmmaking experience. Obtaining the imagery in the video proved to be more difficult than anticipated. Originally I had planned to shoot everything hand held but after watching the first day's filming I went out and borrowed a friend's tripod. The aesthetical difference between tripod and no tripod was night and day. The hand held footage was nauseating and amateurish while the steady tripod footage seemed professional. It was also easier to shoot with a tripod because I did not have to worry about dropping the camera or my arm getting tired from holding it.

Shooting happened over the course of two months and I was glad to have this time-span. I feel the weather and foliage changes communicate to the audience a sense of timelessness. I do feel however that the movie is trapped in Humboldt County. I would like to have had scenes shot in San Francisco or Sacramento, but leaving the area was not possible considering my commitments and my family's. I would have preferred to show congested freeways and high-rise structures to communicate the millions of people this disorder affects. Transitioning to the editing process felt like a relief. Trying to come up with imagery that expressed what I wanted to express within Humboldt County was the one of the most difficult things to do in the whole process.

Due to time constraints my video is only seven minutes and thirty seconds in length and a training video should be thirty minutes to one hour. The video could be designed in different ways to meet the needs of various organizations. My first step in the editing process was to place all the best takes of the recorded narration in order. This audio only version was roughly twelve minutes and felt too long with many segments feeling redundant. After fine tuning the audio content I began looking through my video

clips to find what would work to reinforce my narration. For example, in the portion of the film concerning the justice system I showed images of police vehicles. When I was speaking about incarceration I used action occurring behind a fence. To convey a feeling of hope, I ended the film with the image of a tree blossoming. Although I was not the one utilizing the editing software, I was present directing what edits to make and when.

In my original draft of the script I had wanted actors at certain times to portray people dealing with co-occurring disorders. I found these scenes distracting to the audio content and decided to fully rely on visual metaphors. After this edit, the film was just voice over pictures. By using visual metaphors to reinforce my content, I was attempting to engross my audience in my movie without distracting them from my points.

Even after trimming the voice over down, my film remained overwhelmingly dense with verbally expressed content. I became insecure on whether or not the audience would retain the knowledge they were hearing. I felt that the film needed more. This is how I came to incorporate the script into the video as a visual text element. My first text version was just plain text over the imagery. It was very hard to read and not engaging. To fix the legibility aspect, I added a translucent black mask underneath it. By adding this mask in made the text easier to read but a new problem was created. Compositing the tree layers: the text, the translucent mask and the background image took between twenty and fifty minutes to render per statement. Rendering is how the computer creates video effects and turns them into new video files. I was not expecting it to take this long and I was not one-hundred percent satisfied with the image. I did not like how the masking layer shadowed the entire image. As a final touch, I letterboxed the text giving the whole image a more cinematic appeal.

The total rendering and re-rendering time for my text effect was approximately thirty six hours. This figure does not include the time I spent editing and typing. I was not prepared for the editing stage to take this long but I am happy with how the final video looks. After having the picture and voice over locked down, I utilized sound effects CDs to create a more dynamic environment. The decision to use music was a very loaded one. I did not want the music to overpower the voice over so it took many adjustments to create the tenuous balance.

Looking back over the many stages of the project, I feel that I was not able to incorporate as much information as I had intended to. I felt that it is always better to leave the audience wanting more rather than being bored. Perhaps if I was ever to pursue a project like this again, I would create an interactive DVD so the learner could go in segments and at their own pace. This video was intended to open the door to understanding co-occurring disorders. Societal problems require social actions. At the end of the video I conveyed my hope that every county in the United States will become educated and offer proper treatment options to persons with co-occurring disorders. In this, everyone in our society has the option of a better quality of life.

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