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Mental Illness and Substance Abuse: Perceived Vulnerability Differences Between Students and Professionals

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Abstract: Research cites the prevalence of mental health disorders with co-occurring substance abuse and that substance use poses even greater threats to the prospect of recovery for psychiatric patients. Research has also examined different types of treatment programs and their effectiveness. Using the Structure versus Agency discourse and interviews, this study builds on existing research to analyze student beliefs about persons who are mentally ill and who abuse substances as compared to views of professionals who care for such groups. First, results show that a disproportionate percentage of respondents from both groups have been intimately connected to people with mental health disorders or substance abuse challenges. These experiences inform their views about vulnerability. However, results reveal that populations previously identified as vulnerable such as children and African Americans are perceived less so, but that professionals generally have broader understandings about what constitutes vulnerability and how to more effectively respond. The findings suggest that direct experience is crucial to understanding vulnerable populations.

Keywords: mental illness, substance abuse, vulnerable groups

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INTRODUCTION

Until recently, mental health disorders and substance abuse[1] problems have been identified and treated as two independent syndromes. In the general population, 22.5 percent of individuals have a lifetime mental health disorder, and these include but are not limited to depression, anxiety disorders, bipolar disorder and schizophrenia (Regier et al., 1990). The prevalence of substance abuse, which includes alcohol and illicit drugs, is 13.5 percent of the population (Regier et al., 1990). Research has repeatedly shown that individuals with mental illnesses, compared to those without, are more than twice as likely to have a co-occurring substance use disorder (Clark, Samnaliev & McGovern, 2007; Dickey & Azeni, 1996; Hartwell, 2004; RachBeisel, Scott & Dixon, 1999; Regier et al., 1990). The intersectionality of multiple factors acting together intensifies the negative effects of having a mental health disorder or a substance abuse problem, increasing one's vulnerability. The majority of research cites the prevalence of co-occurring disorders. Further studies examine the different types and effectiveness of treatment for co-occurring disorders.

This study will add to the existing body of research on co-occurring disorders by answering a central question about what some members of the general population think: To what extent do undergraduate students and healthcare professionals differ in their views of those with mental health disorder and substance abuse problems? I use surveys to examine views of two unique groups, undergraduate students from a private, liberal arts university in the southeast and professionals in the field of substance abuse treatment, through the theoretical framework of the Structure versus Agency discourse. Race, class, and gender will also be considered as factors potentially impacting one's vulnerability to mental illness and substance abuse. Findings from this study will have academic and applied implications for the healthcare arena as well as for our general understanding of forms of vulnerability.

LITERATURE REVIEW

Mental illnesses and substance use disorders have a clearly negative impact on the individual and her/his immediate social circle, but the larger community and nation as a whole are impacted as well. Literature has focused on three main ramifications of dual diagnoses: the costs of care are increased partially due to multiple hospitalizations (Dickey & Azeni, 1996; RachBeisel, Scott & Dixon, 1999); the odds that the individual is detached from his or her family and homeless; and the likelihood of incarceration and consequently the costs of the legal system are amplified. Research consistently illustrates that substance use poses even greater threats to the prospect of recovery for psychiatric patients. It complicates treatment and adversely affects their already poor mental health and psychosocial functioning as well as other health conditions like heart disease (Dickey & Azeni, 1996; Ding et al., 2010; RachBeisel et al., 1999).

According to the U.S. Department of Health and Human Services (SAMHSA) 2010 national survey, only 11.5 percent of people who needed treatment for alcohol or drug abuse received any treatment. Although individuals with multiple disorders are more likely to receive some form of treatment than those with single diagnoses (Regier et al., 1990; RachBeisel et al., 1999), treatment is usually insufficient for the complexity of the comorbidity (Abram & Teplin, 1991; Hartwell, 2004). Once in a facility, such patients are less compliant, often exhibit disruptive behaviors such as hostility and negativity, and require multiple acute services, leading to excessive costs for care (Dickey & Azeni, 1996; RachBeisel et al., 1999). Studies find that patients with co-

occurring disorders are hospitalized more frequently (Clark et al., 2007), have longer periods of hospitalization and are in need of more urgent care (Ding et al., 2010). Despite the movement to deinstitutionalize care and create more community-based facilities, public tolerance and services remain limited (Hartwell, 2004).

There is a strong correlation between mental illness, substance abuse, and homelessness, reflecting the intersectionality experienced by this population (Bassuk et al., 1998; Dickey & Azeni, 1996). One explanation is that individuals with mental illnesses and substance use problems are stigmatized and induced with guilt; this is particularly true for females, who, compared to males, experience higher rates of comorbidity (Clark et al., 2007; Ding et al., 2010; Hartwell, 2004). In treatment, a large proportion of females report traumatic life events during childhood such as abuse by a family member (Ashley, Marsden & Brady, 2003; RachBeisel et al., 1999). This can create what Hays (2003) refers to as a "domino effect", when negative life events repeatedly occur and are compounded by one another. Abuse can lead to psychological problems, substance abuse, family detachment, poor academic outcomes, children out of wedlock, jobless poverty, and homelessness (Ashley et al., 2003; Bassuk et al., 1998; RachBeisel et al., 1999, Wilson, 1999). SAMHSA's national survey (2010) reports that the majority of individuals who abuse substances are unemployed and have earned a high school degree or less. Literature also shows that treatment should be aimed at increasing the cultural capital (Bourdieu, 1984), or improving the education, experiences, and skills, to empower people and create more opportunities for success and improvement.

The elevated incarceration rate for this population furthers the domino effect and intensifies the effects having a dual diagnosis. Hartwell (2004) found that nearly 70 percent of mentally ill offenders were also classified as having a substance abuse problem. This pattern was stable across ethnicities, though incarcerated females had slightly higher rates than males. Comorbidity increases the time spent in jail and the chances the inmate serves his or her full sentence, raises the odds of being homeless after release, magnifies the probably of being rejected by the family, and heightens the prospect of being institutionalized after a period of time in the community (Hartwell, 2004). Upon release, persons with co-occurring disorders are often further stigmatized and ostracized by the community as criminals, mentally ill, and substance abusers, making it exponentially more difficult to successfully reintegrate into society (Abram & Teplin, 1991; Hartwell, 2004). Also, offenders with co-occurring disorders have far more difficulty finding jobs and housing. The criminalization of offenders with co-occurring disorders is a result of changes in the legal system to create more stringent criteria and inadequacies of the healthcare system to provide alternatives (Abram & Teplin, 1991; Hartwell, 2004). Unlike members of the general population who generally understand the implications of the correctional system and its consequences, dually diagnosed individuals usually do not interpret incarceration as retribution for their illegal actions (Hartwell, 2004). Imprisoning people with co-occurring disorders rarely helps such individuals, nor does it benefit society to add to the already over-crowded jails. This suggests that policies need to be amended to help this vulnerable population, which would simultaneously enhance society. But the question remains – do members of society understand how vulnerable such people are?

STRUCTURE VERSUS AGENCY

The Structure versus Agency discourse is a widely used theoretical framework through which one can analyze and view society. A

structural force can be defined as a macro-level institution, organization, or ideology that influences us at a micro-level. In this framework, agency refers to our ability to make choices independently, or our free will. A strong argument can be made that certain structural forces are acting simultaneously against one's agency to prevent some people with co-occurring substance abuse and mental health disorders from rejoining society and living healthy lives. Three significant structural forces that do not function independently include the health care system, the broader culture, and the legal system. I will expand on each of these in more detail.

The healthcare system is the most important structural force that impacts those with co-occurring mental health disorders and substance use disorders. As the literature reveals, deinstitutionalization has had opposite consequences than intended. For example, today there are fewer hospital beds available and the healthcare system remains largely fragmented in terms of treatment services (Abram & Teplin, 1991; Dickey & Azeni, 1996; Hartwell, 2004). The facilities capable of dealing with the complexity of co-occurring disorders are scarce. Most facilities treating either type of disorder will not admit those with dual diagnoses because of the unique and more elaborate treatment interventions required, and the higher levels of behavioral problems (Abram & Teplin, 1991; Dickey & Azeni, 1996). High quality, integrated services at all phases of treatment must be established that are specifically aimed at healing both disorders and increasing cultural capital through life skills training and education to improve the quality of life for these individuals. The financial benefits to society in the form of more active and healthy adults, fewer and shorter hospitalizations, lower rates of homelessness, higher employment rate, and fewer incarcerations would outweigh the increased costs of these psychiatric services (Clark et al., 2007; Dickey & Azeni, 1996; Ding et al., 2010; Steadman et al., 2009).

Changes in the healthcare system should correspond with changes in our overall culture about mental illness and substance abuse. Society's tendency to classify individuals with mental illnesses and substance abuse problems in negative ways often furthers their maladaptive behaviors and creates barriers as they work to receive treatment (Hartwell, 2004). For example, depressive symptoms may be amplified or drinking and drug use may escalate. Individuals may deny or hide part of their disorder during the admission process and once admitted (Alexander, 1996). In communities, employers are less likely to hire someone with a history of mental illness or substance abuse (Hartwell, 2004). The tendency for such bias to exponentially increase with each adverse condition parallels the domino effect; dually diagnosed, homeless offenders have more difficulty finding employment (Hays, 2003).

Families are affected by this stigma to the extent that they often resign to them – despite the reality that families are considered a key socializing agent and individuals are considerably more vulnerable when they are isolated. Studies on the effectiveness of different treatments show that involving family members holds the greatest promise (Ashley, Marsden & Brady, 2003). Cultural stigma often leads persons to blame victims, such as abused women who have mental health disorders and substance use problems. The subtlety of this structural force often means that people are less likely to consider the mentally ill and persons with substance abuse disorders *worthy* of protection, interventions, and other services they so need (Alexander, 1996; Ashley et al., 2003; Hartwell, 2004). Yet systemic change would mean altering our common cultural paradigm such that people see the common humanness and Americanness (West, 1993) of individuals with co-occurring disorders

and support the development of integrative treatment facilities.

Lastly, inmates have a constitutional right to adequate healthcare, including treatment of mental health and substance use problems (Steadman et al., 2009). In this context, the legal system is loosely connected to the healthcare system. This suggests that jails, prisons, and healthcare providers must do a better job at forming relationships to identify and respond to mental illnesses and substance abuse (Abram & Teplin, 1991) to fulfill their constitutional obligation to provide adequate services and not just manage symptoms. Increasing the availability of treatment facilities for those with dual diagnoses could lower the incarceration rate (Abram & Teplin, 1991; Hartwell, 2004). Stigma associated with incarceration, despite the cause for incarceration, can lead to a variety of progressively more adverse situations and outcomes such as joblessness and homelessness. In addition to altering our perceptions about mental and substance use disorders, policies within the legal system can be adjusted for those with mental health or substance use disorders to possibly curtail incarceration until there are more treatment centers available.

Yet structural forces can overpower an individual's sense of agency. Specifically, multiple problems associated with the above types of disorders can mean that agency becomes significantly impaired, if not altogether diminished, by nihilism: a severe lack of love, lack of meaning, and lack of hope that results in a "numbing detachment from others and a self-destructive disposition towards the world" (West, 1993, p. 23). According to this scholar, without hope, individuals have no future goals and nothing to fight for; without meaning, they have no reason to fight; and without love, they have no support or motivation to try. Applying this dynamic here suggests that the poor healthcare system with limited treatment options for dual diagnoses can foster hopelessness as individuals have nowhere to go for help. The overarching cultural stigma often associated with mental health disorders and substance abuse can create a lack of love for oneself. This nihilistic threat has negative implications for individuals and the larger society. For individuals with co-occurring disorders, support groups are the most effective way to become a structural force and overpower nihilism.

As part of a cohesive group, individuals are united due to the similar situations and comparable hardships and may experience feelings of love, which West (1993) states is the most powerful force. The bonds within the group can cultivate strong ties based on the close emotional relationships that are established within these immediate social circles (Granovetter, 1973). And a tight social group may foster increased agency on the part of diagnosed persons as they experience support, love, and hope from such persons. Other examples of agency germane here include challenging the healthcare system to establish more treatment centers for co-occurring disorders and creating local alliances and networks to educate others and show our common humanness. Individuals can use their agency to increase their knowledge about disorders and treatment. Through education, persons with co-occurring disorders as well as their peers can combat the stigma surrounding this subject and lessen some of the vulnerability members of the former group experience.

DATA AND METHODS

During the fall of 2011, I administered a survey to fourteen individuals: seven undergraduate students at a private, liberal arts university in the southeast, and seven professionals in the field of substance abuse treatment in that same city. The latter group was employed at the recovery facility, Helping Hands[2] that treats women who would otherwise be homeless due to

substance use and who consistently have co-occurring mental health disorders. All staff persons are females and about two thirds of them have undergone recovery themselves. The sample was selected in two ways. A purposive sample of students was surveyed in a Cognitive Psychology course. The sample of students included five females and two males; all the females were White and the males were Asian. The age range was from 19 to 23 years old. Helping Hands workers were surveyed via email. Respondents from Helping Hands were all White females with ages from 22 to 62 years old.[3] Persons participated without receipt of payment or gift. Although purposive, the sample was selected to provide a cross-section of responses based on factors such as age, education level, work experience, potential exposure to co-occurring disorders, and race. Participants were told that the study was on vulnerable populations and, specifically, people with addictions and mental illnesses. The definition given of a vulnerable population was, "people who are more susceptible to negative experiences in society. They have a high likelihood of having problems in their lives due to various challenges" (survey provided in the appendix).

Participants were first asked to rate the vulnerability of six different populations: children, people addicted to alcohol, African Americans, people with mental illnesses, poor people, and people addicted to drugs. The additional three populations have been consistently found to be vulnerable and were included for comparison purposes (Hays, 2003; West, 1993; Wilson, 1999). The rating scale was: "0" means "not vulnerable"; "1" means "somewhat vulnerable"; "2" means "vulnerable"; and, "3" means "very vulnerable". They were then asked to explain their reasoning for the groups they rated as "very vulnerable". The intent was to assess views about different types of possible vulnerability and some reasons for their views. Participants were also asked about any personal experiences and what they think could be done to improve the lives of people with mental illnesses and addictions.

FINDINGS

Personal Experiences with Mental Illnesses or Substance Abuse

Undergraduates report mixed experiences with individuals with mental illnesses or substance abuse. Although three of the seven students had no personal experience with either population, particularly the two Asian respondents, the majority of students had familial or personal exposure to these issues, particularly mental illnesses such as depression and bipolar disease. However, none report personally struggling with such disorders. For example, a White female 21 year-old student comments, "Yes, depression runs in my family. [and] My brother was addicted to pot last year." Other student responses include;

> Yes, my father was an alcoholic, mother had depression, and a close friend has PTSD/depression. (White female, 23 years old)
>
> Yes, I had a cousin with a heroin addiction and an uncle with bipolar disorder. (White female, 22 years old)
>
> I have multiple friends who have suffered from severe depression and drug abuse. I have also worked with mental health while interning in a behavioral health clinic. (White female, 19 years old)

It is unclear whether this pattern is a result of the presence in the selected course (i.e., Cognitive Psychology) or reflects a broader societal pattern. Next, Helping Hands staff all report having personal experience with addictions. Six of the seven persons have a family member with a substance abuse problem and three of the seven women are in recovery themselves. Recordings of mental illness are less common; three women report both family and personal struggles with mental illness and two of these three women

report having friends with mental illnesses as well. Their comments often parallel those of the student respondents, yet are usually more personal. For example, a 62 year old clinical director notes; "Personally, I was married for many years to a practicing alcohol/drug addict who never received treatment. Professionally I have worked in the field of mental health and addictions for the last 25 years." Another staff person notes; "Yes, I have worked as a counselor in the addictions field since May 1997. I am a recovering addict since Feb. 1993" (57 year old therapist). Next, a 43 year old case worker provides additional detail;

> Yes, my father was an alcoholic, and it's suspected that my grandfather was as well. I became an addict as well (most of my friends in college and beyond were at the very least substance abusers if not addicts) and am in recovery myself from substance abuse, ED, PTSD and depression. Through recovery I have come to know and be friends with several addicts who are also diagnosed as bi-polar, and thru my work I have met many addicts diagnosed with various other mental illnesses.

It is more common for staff persons to initially identify substance abuse more than mental illness in their pasts. Yet they often associate their addictions to mental illnesses such as depression and anxiety disorders. Common addictions are to drugs, alcohol, and cigarettes. Although over-representation by staff persons with ties to such disorders is expected to be tied to their occupational choices, the pattern of exposure to such challenges is important as I consider the issue of vulnerability further in the analysis.

Vulnerability Ratings

What are respondents' views when asked to rate groups of people along a *vulnerability* scale? Certain results are unexpected and inform our understanding about the nature and scope of personal experiences and cultural influences. As presented in Table 1, mean scores for both groups show that people with mental illnesses and people addicted to drugs are considered most vulnerable (mean = 2.79 based on a range from 0.00 - 3.00). This figure is followed by people addicted to alcohol (mean = 2.71). Research has found that these groups are extremely vulnerable to negative life events, often evident in a *domino effect* that occurs for those with addictions or mental health disorders in terms of such compounded factors as lower education, homelessness, and poverty (Clark et al., 2007; Ding et al., 2010; Hartwell, 2004). Although children, African Americans, and poor people have been widely identified as vulnerable populations in numerous studies (Hays, 2003; West, 1993; Wilson, 1996), respondents tend to rate these three groups the lowest in terms of perceived vulnerability.

The lowest rating is African Americans (mean = 1.64). Respondents rate children the second lowest, followed by poor people. With one exception, the groups rated most vulnerable also tend to have smaller response differences in these ratings (i.e., standard deviations get increasingly smaller as the rating of vulnerability increases). This suggests that groups considered most vulnerable are more highly agreed upon by respondents in general than groups considered less vulnerable. The exception occurs when children are rated. Although they are considered relatively less vulnerable as compared to the five other groups, standard deviations for their ratings (and for those of African Americans to a lesser degree) reflect more disagreement about children's perceived vulnerability.

Table 1. Mean Scores of Vulnerability Ratings for the Total Sample

Vulnerable Group	Mean Rating and SD (Highest to Lowest)
People addicted to drugs	***2.79 (SD = 0.43)***
People with mental illness	***2.79 (SD = 0.58)***
People addicted to alcohol	***2.71 (SD =0.61)***
Poor people	2.14 (SD = 0.86)
Children	2.07 (SD = 1.07)
African Americans	1.64 (SD = 0.93)

Note: SD = standard deviation, N=14, highest three ratings in bold italics

Table 2. Comparison of Mean Scores of Vulnerability Ratings Between Students and Helping Hands Professionals

Vulnerable Group	Mean Ratings and SD (Highest to Lowest)	
	Students (n=7)	Helping Hands (n=7)
Children	1.71 (SD = 1.25)	2.43 (SD = 0.79)
People addicted to alcohol	***2.57 (SD = 0.79)***	***2.86 (SD = 0.38)***
African Americans	1.29 (SD = 1.11)	2.00 (SD = 0.58)
People with mental illness	***2.57 (SD = 0.79)***	***3.00 (SD = 0.00)***
Poor people	2.00 (SD = 1.15)	2.29 (SD = 0.49)
People addicted to drugs	***2.71 (SD = 0.49)***	***2.86 (SD = 0.38)***

Note: SD = standard deviation, highest three ratings for each group in bold italics

As documented in Table 2, findings for the subject groups provide more detail about perceptions about vulnerability in general and for persons with mental illnesses or substance abuse challenges in particular. First, both students and Helping Hands staff consider African Americans to be least vulnerable (means of 1.29 and 2.00, respectively). Students ratings are, in order of *increasing* vulnerability: African Americans; children; poor people; people addicted to alcohol and the mentally ill (equally vulnerable); and people addicted to drugs. The latter group has an average vulnerability rating of 2.71 (st. dev. = 0.49). In contrast, the ratings of Helping Hands staff are, in order of increasing vulnerability; African Americans, poor people, and children. Furthermore, Helping Hands staff rate the mentally ill the highest (rating of 3.00 and st. dev. = 0.00). The latter result reflects complete agreement that mentally ill persons are the most vulnerable and probably reflects the realities staff experience as they work with such groups daily. Overall, Helping Hands staff has higher mean ratings and lower standard deviations for each of the six populations. This means that they tend to consider each of the six groups more vulnerable than not *and* there is less variability in their beliefs as compared to students in the study.

Table 3. Age-Group Comparison of Mean Scores of Vulnerability Ratings

	18-20 Years (n=4)	21-30 Years (n=6)	31 + Years (n=4)
Children	1.25 (SD =1.50)	2.67 (SD = 0.52)	2.00 (SD = 0.82)
People addicted to alcohol	2.25 (SD = 0.96)	***2.83 (SD =0.41)***	***3.00 (SD =0.00)***
African Americans	1.25 (SD =1.50)	1.67 (SD = 0.82)	2.00 (SD=0.00)
People with mental illness	***3.00 (SD =0.00)***	2.50 (SD = 0.84)	***3.00 (SD =0.00)***
Poor people	1.75 (SD = 1.26)	2.33 (SD = 0.82)	2.50 (SD = 0.58)
People addicted to drugs	2.5 (SD = 0.58)	***2.83 (SD = 0.41)***	***3.00 (SD =0.00)***

Note: SD = standard deviation, highest ratings for each group in bold italics

Lastly, I examine ratings for the entire group based on age groupings (Table 3). The first group consists solely of students (ages 18 to 20 years). They have the greatest variation in average scores (mean range of 1.25 - 3.00 and st. dev. range from 0.00 - 1.50). The second age group (21 to 30 years) consists of half the students and half the professionals. Ratings are much more mixed (1.67 - 2.83), but with the smallest standard deviation range (0.41 - 0.84). The oldest group (ages 31 years or more) are Helping Hands personnel. They have ratings from 2.00 to 3.00 and similar patterns of agreement. These findings suggest that increased experience with and exposure to various forms of vulnerability (and one's age) can lead to heightened empathy and generally more response agreement. Findings based on age group parallel those presented in Tables 1 and 2. Lowest ratings are given to children, African Americans, and poor people. The lowest mean score is given to African Americans in all three groups, although ratings tend to increase with each age group.

Next, the group consisting of 18 to 20 year-olds believe that people with mental illness are very vulnerable (mean = 3.00), followed by people addicted to drugs and alcohol. The group consisting of 21 to 30 year-olds show different results. They rate groups with addictions similarly (mean = 2.83) and their next highest rated group is the children. Interestingly, the oldest population does not differentiate between mental illness and alcohol and drug usage – all reflect means of 3.00 (st. dev. 0.00). I contend that their occupations, exposure to the co-occurring nature of disorders, and personal challenges with addictions inform their understanding of vulnerability and result in more consistent responses. In contrast, the youngest group feels those addicted to drugs are more vulnerable than persons addicted to alcohol, quite possibly due to the illegal nature of the former drugs and use and/or acceptance of the latter drug on college campuses.

Reasons and Vulnerability

In addition to ascertaining ratings about vulnerable groups, I am interested in getting respondents' opinions about why groups they consider most vulnerable are such. Student views vary and reflect rationales informed by the Structure versus Agency discourse. For example, a 20 year-old Asian male provides the following abbreviated list of reasons; "children - easily influenced; alcohol – they're addicted already, high likelihood to be influenced; mental illness – they're not in a stable mental state; drugs – same as alcohol." Despite his brief comments, this respondent's views suggest that vulnerability is largely a result of one's

inability to make sound choices and productive decisions. A White female 21 year-old thinks similarly, "Children and people with addictions have poor judgment, kids because they are still learning. People with addictions will do anything for drugs and alcohol."

Interestingly and contrary to existing literature, although children are considered vulnerable by student respondents, the *reasons* for this susceptibility is usually attributed to the children themselves, rather than to adults who fail to provide care or take advantage of children (Hays, 2003; West, 1993; Wilson, 1999). Another less often noted perspective provided by a White 20 year-old female student reflects existing research on continued challenges associated with race as well as mental illness; "African Americans still experience a great deal of racism and do not have equal opportunities. Mental illness – I think they are more stigmatized rather than some other addictions although it may be considered a mental illness."

On average, Helping Hands professionals give more detailed reasons for their vulnerability rankings and explicitly state that there are multiple problems that can be emotional, physical, or social (RachBeisel et al., 1999). Similar to students, the largest overarching theme present in five of the staff rationale for vulnerability is a higher susceptibility to be taken advantage of. However, their representative responses provided below illustrate the complexities when vulnerability is considered. For example, according to a 62 year old clinical director;

> Poor people do not have the resources available such as good health care, legal representation, adequate housing, etc., which can lead to many negative experiences. Persons with a mental illness are more susceptible to be taken advantage of as well as not having the capabilities at times to care for issues that arise. Persons addicted to alcohol and/or drugs (because of the very nature of the disease) display behaviors and flawed cognitions that can lead to many negative consequences.

As she explains her rankings, a 57 year-old therapist also describes how vulnerability can influence varied dimensions of one's life;

> Addiction increases multiple life problems, physical, emotional, and social. Mental illness creates problems with coping and in a society that promotes taking something or drinking something to feel better anyone with impaired coping skills has an increased risk factor. Drugs create even greater problems in physical, emotional, and social arenas as most drug addicted individuals eventually have to resort to illegal or dishonest means for maintaining their level of addiction.

The above explanation shows how intersections of vulnerability can make persons even more susceptible to poor decisions, abuse by others, and risky behavior. Her comment also alludes to society's complicity in addictive behavior based on a culture that seems to condone use of prescription drugs and other methods of self-medication. The last quote informs the beliefs of a 43 year-old case manager who generally considers all six groups vulnerable;

> I ranked poor people and African Americans with a "2" because they are subject to prejudice and many would benefit from specialized social services. I ranked "3" for children, people with addictions (alcohol and drugs), and people with certain mental illnesses – they have in common potential inabilities to perceive their own situations and/or protest themselves and/or care for themselves.

Overall, five staff persons associate the inability to care for oneself or harming oneself with vulnerability, which is the nature of addictions and mental illnesses. Moreover, four respondents mention macro-level societal dynamics associated with limited education and lack of opportunities and social services, as well as prejudices. Their theme of increased susceptibility

appears to be part of a larger, more complex understanding of the many factors that can result in vulnerability, particularly for the mentally ill and persons coping with drug addictions.

How to Improve the Lives of Mentally Ill or Addicts

Lastly, respondents are asked to specifically provide suggestions about how to improve the lives of people with addictions and/or mental illnesses. As is the case when reasons for vulnerability are cited, student suggestions for improvement are thoughtful, but tend to provide less detail than staff personnel. Furthermore, student responses center on micro-level, individual changes rather than broader societal changes. One male, 20 year old Asian student responds, "I don't know." The remaining six respondents all give broad, traditional responses. Four are about treatment such as: "long-term intervention programs", "therapy", "support groups", and "making resources more available". The remaining two suggestions focus on increasing awareness for the general population and those that need services. Responses are somewhat egocentric because despite no expertise in this field, students' responses are vague and focused on micro-level remedies that are most apparent to them.

In contrast, Helping Hands staff provide multiple solutions as well as details to explain their thoughts more fully. For example, one 22 year old executive assistant acknowledges the complexity of this population's situation, and writes;

> That's a hard question. I think every person's situation is so different and it's difficult to generalize about things that should be done for addicts or the mentally ill. However, a couple of things that can help some alcoholics get better is –getting inspired to hold themselves accountable, pull themselves back, and not slip back into drinking and having a really good support team of family and/or friends to confide in and cheer them up – continuing to increase public knowledge about the causes of the addiction, the symptoms, and what they can do to recover, and what actions are counterproductive. The other thing that's hard about generalizing is that a lot of mental illnesses and addictions can be concurrent in an individual so that makes it more complicated.

Her response also requires individual initiative and involvement by a network of other persons. Professionals precisely identify ways to combat the specific challenges suggested in research such as homelessness, fragmented treatment, ostracism, and hostility of patients and to simultaneously better cultural capital (Bassuk et al., 1998; Dickey & Azeni, 1996; Hartwell, 2004). The majority of them, including each of the older professionals, identify macro-level social policy improvements that enhance cultural capital. For example, the following 57 year old therapist suggests;

> Step down phase of treatment based on ASAM [American Society of Addiction Medicine] assessment of needs would be the most appropriate. There are other assessment tools that may also be helpful. However a good and thorough ASAM assessment is the most global form I have ever used. Most often basic education, like skills training, and job readiness/placement programs are also going to be integral to healing the lives of the dually diagnosed individual.

It is common to name specific types of treatment and programs that should be used such as long-term, inpatient and out patient facilities, case management, life skills training, basic education, and help with housing and job search. Holistic care is central as they mention providing support for the individual; the key socializing agent, the family, is recognized; and changing the culture by educating the population and increasing awareness. Three other Helping Hands respondents (two of whom are at least aged 50 years) emphasize improving quality

of life, evident by phrases like "good quality", "healing the lives", and "assessment of needs". Overall, their comments suggest that in order to be successful, comprehensive, holistic services are needed for persons struggling with addictions in addition to increased knowledge and involvement by persons and groups at varying levels of society.

CONCLUSION

Results from this research inform our understanding of the views of a group of students and professionals about vulnerable groups in general and persons with mental health disorders and substance abuse problems in particular. In response to my research question, both groups tend to associate vulnerability with mental health and addictions more than with the other groups identified – and as expected, personnel who work with such persons more than students. Both groups provide similar strategies that suggest that people should be accountable and actively involved in their treatment process. However, Helping Hands staff tend to include the importance of systemic change in health care, economic, and social arenas. Additionally this same group tends to provide more detailed commentary on the subject in general. Yet most students have been exposed to mental health and addictions among their families and friends. This exposure may have minimized ethnocentric responses and suggest that some students may be better prepared than older persons might imagine to learn about such social problems and participate in societal change.

Several general conclusions are important. Findings reveal that both groups consider children, African Americans, and the poor to be relatively less vulnerable, which is contrary to the last body of literature that details the continued challenges the three groups, particularly children, face (Hays, 2003; West, 1993; Wilson, 1999).[4] These populations' primary features are largely ascriptive in nature (for example, children do not have control over the reality of their age, African Americans cannot alter their race, and persons born into poverty can have difficulty escaping it), yet these traits influence life chances and quality of life. The pattern that emerges in the current study is all the more intriguing because respondents are not precluded from identifying each group as vulnerable if they believe them to be so. Yet relative rankings emerge that help us better understand how awareness and empathy may be increasing for some vulnerable groups, but less so for others. It is also important to note the more consistently high rankings and lower standard deviations for Helping Hands staff (i.e., older respondents), which suggests the possible influence of exposure and experiences that can inform our understanding about the complexities associated with varied types of vulnerability. These findings suggest the need for additional studies based on larger, more diverse samples as well as focus groups and in-depth interviews using more detailed surveys. Although my results cannot be generalized, I contend that they provide important insights for social policy in terms of preventive and intervention programs, increased national education efforts about vulnerability, and heightened advocacy.

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APPENDIX

I am a student in HOD-2690-03: Vulnerable Populations this semester. Vulnerable populations are broadly defined as people who are more susceptible to negative experiences in society. They have a higher likelihood of having problems in their lives due to various challenges. For my class project, I am performing a survey to see what [University's name] students think about the subject of addictions and mental illness compared to health care professionals. This is a confidential survey (do not place your name on it). Please answer honestly, and thank you for your help.

1. Age _____

2. Job (check one):
_____Student
_____Case Manager
_____Therapist
_____Administrator
_____Other (_____)

3. Race (check one):
_____White
_____Black/African American
_____Hispanic/Latino
_____Asian
_____Other (_____)

4. Gender: _____Female _____Male

5. Do you have any personal experiences with and connections with people with addictions and/or mental illnesses? If yes, please explain.

6. Below is a list of different groups of people. Identify those you think are more of less vulnerable by circling the appropriate number.

	0 Not Vulnerable	1 Somewhat Vulnerable	2 Vulnerable	3 Very Vulnerable
a. Children				
b. People addicted to alcohol				
c. African Americans				
d. People with mental illness				
e. Poor people				
f. People addicted to drugs				

For those you identify as "3", very vulnerable, please explain why you believe they are very vulnerable.

7. What do you think should be done to improve the lives of people with addiction and/or mental illnesses?

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[1] Throughout this paper I refer to the concepts "substance/drug abuse" and "substance/drug use". They are not used interchangeably, but rather to reflect the terminology used by the cited authors or to illustrate the subjective nature in often determining when "abuse" rather than "use" occurs.

[2] A pseudonym is used here.

[3] I acknowledge the absence of other racial/ethnic groups such Latinos and African Americans in both groups as well as the lack of White males in general. Despite these limitations, the existing diversity is expected to still provide important results about the research topic.

[4] It will be important to determine whether changes in views about problems for some African Americans is partly due to the election of Barack Obama as U.S. President. Many Whites believe that Obama's election singles that racism is no longer a problem in society (Bonilla-Silva, 2010).