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Meeting health and psychological needs of women in drug treatment court

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ABSTRACT

We explored healthcare-related experiences of women drug court participants through combining context from the socio-ecological model with motivation needs for health behavior as indicated by self-determination theory. Five focus groups with 8 women drug court participants, 8 court staff, and 9 community service providers were examined using qualitative framework analysis. Themes emerged across the socio-ecological model and were cross-mapped with self-determination theory-defined motivation needs for autonomy, relatedness, and competence. Socio-ecological levels contained experiences either supporting or eroding women's motivation needs: 1) intrapersonal challenges participants termed an "evil cycle" of relapse, recidivism, trauma, and life challenges; 2) interpersonal context of parenting and stigma involving features of this "evil cycle"; 3) institutions with logistical barriers to legal and medical assistance; 4) community resources inadequate to support living and employment needs. Self-determination theory helps explain motivation required to address the women's healthcare needs and multiple demands at all levels of the socio-ecological model.

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1. Introduction

1.1. Drug Treatment Court

Drug treatment court (DTC) offers community court-mandated treatment programs in lieu of incarceration, significantly reducing relapse and recidivism rates (Fielding, Tye, Ogawa, Imam, & Long, 2002). DTC incorporates intensive judicial supervision and community-based treatment, facilitating use of substance abuse resources (Taxman & Bouffard, 2006). These successes provide a foundation to examine, develop, and improve DTC programs to address participants' remaining unmet health needs (Rossman et al., 2011). Given DTC participants' co-morbid physical and mental health needs, and the unique issues female drug users face, this paper explores barriers and motivation regarding meeting the health needs of women DTC attendees (Engstrom, El-Bassel, & Gilbert, 2012).

1.2. Women DTC participants

Depression, posttraumatic stress disorder (PTSD) and trauma histories are paramount among women DTC participants. Women are twice as likely to be depressed or anxious compared to men in DTC (Gray & Saum, 2005). Women with a current major depression episode were almost 6 times likelier to relapse with cocaine use compared to those depressed within the past 1 month to 1 year (Johnson et al., 2011). Among women DTC participants, 20% met PTSD criteria, compared to 12% in the general population and 20–45% among female offenders (Goff, Rose, Rose, & Purves, 2007; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Among these women with PTSD, 91% reported trauma histories with sex work and homelessness 6 times more prevalent than for those without a trauma history (Sartor et al., 2012). These studies highlight the mental health needs of women DTC participants.

Less is known about women DTC participants than women inmates. However, given the preponderance of substance abuse disorders among incarcerated women, they are likely similar (Fielding et al., 2002). The Centers for Disease Control and Prevention (2012) reports that most incarcerated women are arrested for drug-related and sex work crimes that put them at increased risk for HIV and other sexually transmitted infections, trauma, and complicated pregnancies. Women DTC participants are at least as much at risk of infection as are other women inmates, with women of color at particular risk (El-Bassel et al., 2012). Women of color are imprisoned disproportionately at between 2 to 3 times the rates of white women (Carson & Sabol, 2012). DTCs have not systematically assessed proportions of women or people of color in the population they serve (Brewer &

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Heitzeg, 2008). Also, women involved in the justice system report more health problems than other women (Staton, Leukefeld, & Webster, 2003). A qualitative study described female DTC participants' unmet needs for comprehensive services including childcare, parenting training, and medical treatment, yet did not detail unmet healthcare needs (Fischer, Geiger, & Hughes, 2007), leaving a knowledge gap.

1.3. Meeting health needs of DTC participants

Should DTC address health needs when current programmatic goals are to decrease substance abuse and recidivism? We argue yes, given research that documents chronic disease management doubles odds of improving drug and alcohol addiction outcomes (Kim et al., 2012). Conversely, drug and alcohol abuse increase risks of numerous conditions, including cirrhosis and infectious diseases such as HIV/AIDS and viral hepatitis (Rehm et al., 2009). Public health also argues for improved infectious diseases treatment. Substance abuse may precede or spring from mental health disorders, yet the chaotic lifestyle interferes with mental and physical health treatment (Drake, Mueser, Clark, & Wallach, 1996). However, efforts to incorporate health services into DTC programs are in exploratory stages. Comprehensive assessments of DTC participants' service needs and delivery do not include healthcare (Guastaferro, 2011). A few large DTC descriptive studies have explored barriers to "a bridge" between providers and DTC staff with the aim of addressing participant needs and improving outcomes (Wenzel, Longshore, Turner, & Ridgely, 2001; Wenzel, Turner, & Ridgely, 2004). They found formal links primarily with substance abuse treatment providers and lacking with healthcare providers. None of these studies comprehensively assessed needs or barriers regarding healthcare treatment among DTC participants and among women in particular.

Mental health conditions and services can impact DTC completion. One study found that participants who had received mental health prescriptions in the 30 days prior to entering DTC were 700% more likely to complete the program than those who did not (Gray & Saum, 2005). Conversely, those who reported depressive symptoms were 55% less likely to complete the program than those who did not have depressive symptoms. The authors suggested that more DTC programs should address unmet mental healthcare needs among DTC participants.

A recent comprehensive assessment of DTC participant outcomes showed little evidence of improved mental or physical health and confirmed that depression upon entry predicted depression at follow-up (Rossman et al., 2011). Improving healthcare delivery to women DTC participants remains an unmet goal while needs and barriers are inadequately described. DTC could benefit from a broader perspective incorporating both intrapersonal and systemic analyses.

1.4. The socio-ecological model, self-determination theory, health, and study aims

The socio-ecological model (SEM) is a multi-level systems approach to understanding individual behaviors as embedded in different, interacting social contexts (Stokols, Allen, & Bellingham, 1996). The SEM is congruent with research and interventions addressing the individual and their behaviors, within the multiple settings and social contexts where behavior originates, including the context of the justice system (McLaren & Hawe, 2005). Use of the SEM allows an exploration of women's health behaviors as embedded in multiple levels of influence: intrapersonal, interpersonal, institutional, and community contexts (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009). This approach is consistent with community-based participatory research (CBPR) strategies to obtain stakeholder input for a planned intervention (Israel et al., 2010; Sormanti, Pereira, El-Bassel, Witte, & Gilbert, 2001). Because SEM does not explain health related motivation, health behaviors, or how they change, self-determination theory is complementary.

Self-determination theory (SDT) is a general theory of human motivation that has been applied in many life domains including health (Deci & Ryan, 2000; Ng et al., 2012; Ryan, Patrick, Deci, & Williams, 2008). Motivation is defined as psychological energy directed at a particular goal. SDT assumes that humans are innately motivated toward growth and well-being (i.e., psychological and physical health), and that humans have basic motivational needs (also called psychological needs) for autonomy, relatedness, and competence. Autonomy is defined as the degree to which people feel volitional and responsible for initiating their behavior. Relatedness is defined as the extent to which they feel positively, authentically connected to caring others. Competence is defined as the degree to which people feel able to achieve desired goals. Autonomously regulated behavior is done willingly, because of personal importance. Controlled motivation, in contrast, involves feeling pressured by an outside or internal force (Deci & Ryan, 2000). If the social surround supports these needs, humans become naturally more motivated by internalizing autonomous self-regulation of their behaviors and by developing a better sense of competence (Deci & Ryan, 2000). Furthermore, the degree to which the various social structures in the SEM support or undermine people's motivation needs is expected to enhance or lower patient motivation for initiating and maintaining healthy behaviors, including stopping smoking (Williams et al., 2006) or taking a medication regularly (Kennedy, Goggin, & Nollen, 2004). When a patient trusts and feels respected by the healthcare provider, it satisfies needs for autonomy, relatedness, and competence, which is associated with positive mental health, and healthy behaviors according to a meta-analysis of over 184 data sets (Ng et al., 2012).

The SEM and SDT models overlap in examining the context in which autonomy is supported or thwarted. In particular, it is important to consider the role of culture among women of color, as they are over-represented in justice settings (Brewer & Heitzeg, 2008). Basic SDT-defined motivation needs are held to be universal across cultures and gender (Chirkov, Ryan, & Sheldon, 2010; Deci & Ryan, 2011; Ryan & Deci, 2011). Furthermore, influences on individual health behaviors, and support for the motivation needs of autonomy, relatedness, and competence can be identified in the SEM at intrapersonal, interpersonal, institutional, and community levels (Ryan & Deci, 2011; Stokols, 1996). Lastly, SDT indicates that individuals become more motivated with optimal challenges– not too difficult or too easy– and only when patients feel fully autonomous with respect to the behavior while the SEM helps contextualize individual challenges in the social context (Ryan & Deci, 2000). Understanding the broader context for healthcare discrepancies could help in addressing these discrepancies.

The SEM and SDT models differ in that the SEM does not address the internal process of change while SDT does. SDT demonstrates that the energy required to overcome SEM described barriers is maximized by supporting needs for autonomy, relatedness, and competence. For example, when people are required at an institutional level to have substance abuse treatment, they are likely to experience feeling controlled when starting the treatment. However as treatment progresses and if autonomy is supported, they shift their locus of causality through internalization. After internalization, treatment motivation is autonomous as they seek health on the intrapersonal level (Ryan & Deci, 2000). Hence the combined models are complementary.

This paper explores healthcare-related needs and motivations of women participants in DTC within the wider social context of their lives. We combined levels of the SEM with SDT to get a robust picture of how social context may support or undermine women's motivation needs. The information will inform an intervention for women DTC participants. This exploratory research phase is not hypothesis-driven. Our approach is based upon the stage model for the

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