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## **Challenges Specific to Women in Detoxification Settings: Providers' Perspectives**

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Challenges Specific to Women in Detoxification Settings: Providers'  
Perspectives

by

Danielle S. Iano, B.S., B.E.S

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. The project is neither a Master's thesis nor a dissertation.

## **Abstract**

Within detox settings, women with substance use disorders may present with a myriad of risk factors and consequences related to their use. This research explored biopsychosocial issues specific to women using detoxification services and how medical concerns, comorbid mental health issues, trauma history, and pregnancy/children affected subsequent linkages to treatment by interviewing professionals who worked with this population within detoxification settings. Licensed professionals ( $n=8$ ) were interviewed regarding their experiences with women in detox settings. The resulting data from interview transcriptions were analyzed, and themes that developed included admission contexts, vulnerability, comorbidity, barriers to treatment, and integrated care. Findings revealed common themes with vulnerabilities unique to women in detox settings, including significant physical and sexual trauma, medical and mental health comorbidity, and barriers to treatment such as being a custodial parent. The need for integrated care also arose as a common theme amongst participants. Awareness of these needs allows social workers to develop a deep understanding of the complexities that women with substance use disorders present with, especially those that access detox services, and acquire the skills to effectively work with this population to improve recovery outcomes.

## **Acknowledgments**

The saying “it takes a village” must have originally been applied to research projects.

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## **Challenges Specific to Women in Detoxification Settings: Providers' Perspectives**

### **Introduction**

Over the past 60 years, attitudes and knowledge among mental health professionals, program administrators, and policy makers pertaining to substance use among women have dramatically changed. Early research and interventions on substance abuse and addiction focused on characteristics specific to men. The world renowned treatment program, Hazelden, started its program in 1949 and was specific to treating only males until the 1960's (McElrath, 1987). Similarly, before the 1960's scholars did not fully analyze male-female differences in substance abuse treatment data, and in some instances, female research subjects were excluded all together (Brady & Ashley, 2005). Beginning in the early 1990's, gender differences in substance use gained attention, and more recent examinations of gender differences in substance use disorders treatment has suggested that women entering substance abuse programs have greater psychological distress, more medical problems, more family/social difficulties, and greater addiction severity than men (Brady & Ashley, 2005; Callaghan & Cunningham, 2002).

In the last decade, the gap between men and women who are diagnosed with a substance use disorder has significantly narrowed (Brady & Ashley, 2005; Center for Substance Abuse Treatment (CSAT), 2009; Greenfield, Back, Lawson, & Brady, 2010). Proportionately, female to male substance abuse treatment ratios have increased over the past decade to approximately one third of the treatment population (Brady & Ashley, 2005). Marked increases in women with substance use concerns highlight the need to focus greater attention on addressing alcohol and drug use among this population.

As views toward substance abuse changed, so have drug use patterns and subsequent detoxification needs among the general population (CSAT, 2006). Prior to the *1971 Uniform Alcohol and Intoxication Treatment Act*, people arrested for public intoxication were generally not referred for treatment (CSAT, 2006). This act provided more civilized views of individuals who suffered from substance abuse and started to focus on providing treatment and recovery rather than punitive consequences (Uniform Alcoholism and Intoxication Treatment Act, 1971). Today in the United States more than 300,000 people per year obtain inpatient detoxification in general hospitals, with a similar rate receiving detoxification in clinically managed settings, such as detoxification (detox) facilities (Mark, Dilanardo, Chalk & Coffey, 2002). Detoxification services have come a long way since the 1970's and have evolved into a system of compassionate care for the increasing number of women with substance use disorders.

In Minnesota alone, more than 30,000 individuals presented to a non-hospital based detoxification facility in 2012, with women representing roughly 25 percent of patients served (Minnesota Department of Human Services, 2013). *Detoxification services* refer to services that provide immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs (CSAT, 2006). In Minnesota, these services occur in licensed facilities that are managed by licensed professionals, defined as Treatment Directors, and are delivered by staff and medical personnel who provide 24 hour supervision and support for patients whose intoxication and withdrawal signs and symptoms are severe enough to require this level of monitoring.



Risk factors that lead to substance use disorders and the consequences of such disorders differ among women and men (CSAT, 2009). Women enter treatment with a variety of concerns directly related to their substance use including parenting issues, male dependency, low self esteem, sexual and physical trauma, and lack of social support (Callaghan & Cunningham, 2002); whereas men most often enter treatment with employment concerns, criminal justice involvement, and at the requests of their families (Green, 2002). Similar research has shown that females who use substances are more vulnerable than males who use substances to psychological and biological effects of substance use, and that substance use among females is rooted more often in psychosocial problems and trauma (Brady & Ashley, 2005), suggesting the need for specialized treatment programming for women that encompasses a more holistic approach. Although there is an abundant need for integrated services, current Minnesota rules and statutes that govern detoxification services do not mandate a mental health professional as part of staffing requirements.

Historically, social work as a profession has inconsistently addressed chemical abuse issues due to early political and societal views of substance use as a criminalized problem (Amaro, 1999). With an increased shift in humane treatment of a substance use disorders, the social work profession began to recognize the importance that social workers be knowledgeable about the process and dynamics of substance abuse and recovery (National Association of Social Work (NASW), 2008). Due to the extreme prevalence of substance abuse concerns among women, it is critical that today's social workers recognize, understand, and are competent in this area. Because substance use disorders are a growing concern among women, it is vital that social workers understand

the factors that are unique to this population. In addition, since women with substance use disorders are often accompanied by comorbid mental illness or medical conditions, social workers are in a unique position to influence the delivery of services by addressing both acute and chronic needs (NASW, 2008).

With the ability to address mental health disorders and substance use disorders simultaneously, licensed clinical social workers are in the position to assist women who undergo detoxification with services for treatment and recovery interventions due to the shift towards a more holistic approach through integrated treatment (NASW, 2008). Despite the improvements in detoxification services since the 1970s, improvements in linkage to treatment and recovery interventions are still needed (Callaghan & Cunningham, 2002; Mark et al., 2002). To increase effectiveness, substance abuse treatment requires a wide range of services including behavioral counseling, medical care, pharmacology needs, mental health therapy, housing and employment assistance, transportation, and other aspects that are vital to recovery (Mark et al., 2002). Integration of these services from an intensive level of care such as detox, to a less intensive level of care and ongoing support in later stages of recovery, is critical for success among women (McLellan, Weinstein, Shen, Kendig, & Levine, 2005). *Recovery*, as defined by the Substance Abuse and Mental Health Services Administration, is a working definition that embodies a “process of change that permits an individual to make healthy choices and improve the quality of his or her life” (CSAT, 2005, p. 1).

To examine challenges specific to the female population in a detoxification setting, this research discusses the unique factors that women with substance use disorders face, its importance to social work, and the emersion of the substance abuse

field with the mental health field. Past research has primarily focused on issues specific to women in a residential and or outpatient setting, leaving a large gap in literature addressing the unique issues specific to women receiving detoxification services.

## **Literature Review**

Currently, research literature specific to women treated in detoxification settings is limited. Research in the area of gender differences in traditional substance abuse treatment settings helped to inform the current research study. The literature review contains three sections. The first section will address challenges specific to women with substance use disorders, describe prevalence and characteristics, and define the biopsychosocial needs of women through a review of eight empirical studies. Second, the role that detoxification facilities play in treatment and recovery will be explored. Detoxification and other terms relevant to this research will be defined to provide meaning and context. Existing research in this area was also a focus, examining five empirical studies that explore gaps in services in detox settings, as well as the importance of linking women to further treatment interventions. Third, because this research study was interested in understanding how clinical social workers can address co-occurring disorders and assist with linking women with treatment and recovery services after undergoing detoxification, the literature review will also examine movements toward integrating substance abuse and mental health, and how that may apply to detoxification settings.

### **Prevalence of Substance Use Disorders Among Women**

Historical exclusion of women in research has resulted in difficulty understanding definite prevalence rates of substance use disorders based on gender. Gender exclusion notwithstanding, current research indicated a narrowing gap in term of prevalence between women and men with substance use disorders (Brady & Ashley, 2005; CSAT, 2009; Greenfield et al., 2010). The 2006 National Survey on Drug Use and Health

found that rates of substance abuse and dependency among females and males between the ages of 12 and 17 were roughly the same (CSAT, 2009). In one research study, Grucza and colleagues found a significant increase in risk for alcohol abuse and dependence among women born after 1944 (Grucza, Bucholz, Rice, & Bierut, 2008). This same study showed that as women become older, the prevalence of substance use disorders becomes lower. However, it is important to remember that women remain vulnerable to substance misuse regardless of age. In another study, Poole and Dell (2005) found that as women encounter major life transitions, they are at a heightened risk for substance use disorders.

### **Characteristics of Treatment Admission Among Women**

According to the 2006 National Survey on Drug Use and Health, females were as likely as males to abuse or be dependent on substances; however, differences among characteristics of treatment admissions among women do exist (CSAT, 2009). Women are more likely to receive other health care services prior to identification of substance use disorders (Brady & Ashley, 2005; CSAT, 2009). In fact, referrals from healthcare providers (excluding alcohol and drug specialists) are one of the lowest referral routes to treatment for women, with primary sources of referral for treatment being self-referral, social service agencies and the criminal justice system (Brady & Ashley, 2005; CSAT, 2009; Hecksher & Hesse, 2009). In comparison to men, women are more likely to be identified with a substance use disorder through child protective services (Fiorentine, Anglin, & Gil-Rivas, 1997). In one study, Hecksher and Hesse (2009) found that professionals such as physicians and social services workers are hesitant to ask women about their intake of alcohol and drugs, especially if the woman does not resemble the

“typical alcoholic.” In terms of seeking treatment, professionals’ reluctance to ask women about their use of alcohol and illicit substances, along with the stigma attached to acknowledging such behaviors, creates a substantial barrier for women accessing treatment services.

### **Risk Factors and Consequences of Substance Abuse Among Women**

Women’s biological, physiological, psychological, and social characteristics which differ from men’s have specific implications among substance users and inform what risk factors and consequences are specific to their substance use disorders. Several studies showed that female substance abusers are more likely than their male counterparts to report greater dysfunction in the family of origin (Conway, Swendsen, & Merikangas, 2002; Pastor & Evans, 2002; Smith & Brady, 2005) and lack adequate role models for parenting (Smith & Brady, 2005). Consequently, females are often referred to substance abuse treatment through child protective services (Fiorentine et al., 1997), which presents significant stressors that may exacerbate substance use. The study by Pastor and Evans (2002) found that alcohol abuse symptoms were significantly higher in women with a family history of substance use. This is similar to what Conway and colleagues (2002) concluded; that family history of substance abuse was a significant risk factor for problem drinking for both men and women. Other significant risk factors unique to women who engage in substance use include frequently low economic status, the likelihood that they are custodial parents, the greater incidence of trauma and violence, and the societal stigma of substance abuse (CSAT, 2009). There were also unique biopsychosocial issues specific to women that make them highly susceptible to consequences of substance use.

**Psychological Effects.** Prior research has suggested that women with substance use disorders are more likely to meet diagnostic criteria for comorbid mental health disorders specific to depression and anxiety, post-traumatic stress, and eating disorders (Hudson, Hiripi, Pope, & Kessler, 2007; Piran & Robinson, 2006; Tolin & Foa, 2006). Two studies found that rates of mood and anxiety disorders are significantly higher among women than men, with and without substance use disorders, with major depressive disorder being the most common mood disorder and social phobia being the most common anxiety disorder (Greenfield et al., 2010; Hecksher & Hesse, 2009). Literature suggests that for women, the onset of psychological/psychiatric disorders is apt to precede substance use disorders (Brady & Ashley, 2005; Greenfield et al., 2010). Suicidal ideation, attempts, and nonfatal self injurious behaviors are also more prevalent among women with substance use disorders than men (CSAT, 2009).

Post-traumatic stress disorder (PTSD) is also a common psychological disorder experienced by women with substance use disorders (Greenfield et al., 2010; Hecksher & Hesse, 2009). Among women in substance abuse treatment, it is estimated that between 55 to 99 percent have experienced comorbid trauma issues, most commonly childhood physical or sexual abuse, domestic violence or rape (CSAT, 2009; Greenfield et al., 2010). These numbers are likely even higher given the low rate of females that enter substance abuse treatment.

Eating disorders have been historically more prevalent in women than men. Greenfield and colleagues found that among women with substance use disorders, high rates of eating disorders, particularly with bulimia behaviors (binging and purging), have been noted (Greenfield et al., 2010). Approximately 15 percent of women in substance

abuse treatment have had an eating disorder diagnosis in their lifetime (CSAT, 2009).

Studies have found that disordered eating is likely to appear after a period of abstinence from alcohol and drugs, which enhances the risk of relapse to drugs or alcohol to avoid weight gain (CSAT, 2009; Greenfield et al., 2010).

**Psychosocial Problems.** Women are more likely to encounter obstacles across the continuum of care as a result of gender expectations, economic difficulties, and subsequent vulnerabilities, including interpersonal violence. Substance use is more highly stigmatized among females than males, making social stigma, labeling, guilt, and shame barriers for women to acknowledge and receive treatment (Brady & Ashley, 2005). The expectation that women do not display behaviors such as alcoholism and drug addiction has serious implications for women who struggle with substance use disorders as it supports stigmas attached to addiction and creates further barriers to seeking treatment.

Economic difficulties among women also caused psychosocial problems related to substance misuse. Studies show that women whose social relations exist in a drug using environment face several problems, one of which includes living in a male-dominant environment (Hecksher & Hesse, 2009). In one study, Brady and Ashley (2005) found that women with substance use problems who cannot financially support themselves often cope with their life situations by providing sex in exchange for shelter, substances, and protection, leaving them particularly vulnerable physically and emotionally.

In another study, Hecksher and Hesse (2009) found that women with substance problems were significantly more likely than men to exhibit recent physical, emotional,



or sexual abuse, and females involved in substance abuse treatment reported more problems related to physical and sexual abuse and domestic violence than males. The Substance Abuse and Mental Health Services Administration (SAMHSA) found that poor and homeless women reported higher rates of physical and sexual trauma (CSAT, 2009). Similarly, Vogel and Marshall (2001) focused research on sociocultural factors supporting the belief that socioeconomic status contributes more to women's vulnerability to abuse and stress symptoms than does ethnicity.

**Biological/Physiological Factors.** Women with substance use disorders have greater susceptibility to, as well as earlier onset of, serious medical problems and disorders (CSAT, 2009). This research highlighted that gender is an important variable to consider at all levels of biomedical and health related problems. Several studies showed that compared with male substance abusers, female substance abusers experience more physical problems and appear to be more vulnerable than male substance abusers to the physiological effects of substance use (Brady & Ashley, 2005; CSAT, 2009; Greenfield et al., 2010; Hecksher & Hesse, 2009). Greenfield and colleagues (2010) found that the phenomenon of *telescoping*, or the accelerated progression from the initiation of substance use to the onset of dependence and first admission to treatment, is much greater in women than men. This would imply that as women find their way to treatment, they would present with more severe symptoms of substance dependence. In another study by Brady and Ashley (2005), females who abused or were dependent on alcohol reported poorer physical functioning, poorer mental health, and more overall impairment than their male counterparts, as well as higher death rates among female alcoholics than male alcoholics. In this study, Brady and Ashley (2005) highlighted that

the biological ways in which women “absorb, distribute, eliminate, and metabolize alcohol increases their vulnerability to alcohol related problems” (p.10). The same study demonstrated that the female liver appears to be more sensitive to the effect of alcohol than the male liver, and that estrogen may play a key role in alcohol related liver disease (Brady & Ashley, 2005).

In another study, estrogen and the role of the menstrual cycle was also a prominent difference between men and women substance users. Some studies have found that the menstrual cycle plays a role in substance use; however, the degree to which it influences substance use varies (Epstein, Rhines, Cook, Zdep-Mattocks, & McCrady, 2006; Evans & Levin, 2011; McKay & Schare, 1999). In this study, Evans and Levin (2011) indicate that differences in response to alcohol use across the menstrual cycle were moderate; however, behavioral changes in female substance users were greater during specific phases of their menstrual cycle.

### **The Role of Detoxification Services in Treatment and Recovery**

Detoxification is distinct from substance abuse treatment and plays a specific role in the continuum of care. Detox services are not considered to be a treatment modality for substance use disorders (CSAT, 2006). These services are short term and used to medically withdraw individuals from illicit substances, with a goal of stabilization. To provide context, *withdrawal*, refers to a substance-specific disorder that follows the cessation of use of a psychoactive substance that had been regularly used to induce a state of intoxication (CSAT, 2006, p. 4). *Stabilization* includes the medical and psychosocial processes of assisting a patient through acute intoxication and withdrawal to the attainment of a medically stable, substance free state (CSAT, 2006, p. 5). Detox

programs are designed to treat clients who are in a state of crisis due to severe intoxication, withdrawal, and/or substance induced emotional instability. The main functions of detox programs are to stabilize individuals, assess the severity of their substance use, and provide recommendations for treatment interventions based on individual need (CSAT, 2006). Consequently, detox serves as a stepping stone into the substance abuse treatment system.

With the continued improvements in substance abuse treatment since the *1971 Uniform Alcohol and Intoxication Treatment Act*, detox services function with the goals to both safely withdraw individuals from alcohol and drugs, and to form a therapeutic alliance that will encourage entry into treatment and recovery. There are many factors that influence successful treatment interventions and sobriety. Research indicates that addressing psychosocial issues during detoxification significantly increases the likelihood that individuals will participate in further treatment interventions after being stabilized (CSAT, 2006).

While there are studied short term benefits to detox, including abstinence and reduced criminal activity (CSAT, 2006), the ancillary concerns including psychosocial and health concerns often go untreated or overlooked, and the benefits of detox do not continue because they are not addressing the biopsychosocial issues related to substance use disorders. According to Minnesota's 2012 Drug and Alcohol Abuse Normative Evaluation System (DAANES), of all 2012 detox admissions, only 17 percent of clients were recommended to residential treatment services at discharge. Similarly, only 18 percent were recommended to seek mental health services and 7.5 percent were recommended to seek medical services. Similar patterns are seen nationwide, as

SAMHSA reported that one fifth of people discharged from acute care hospital for detoxification received substance abuse treatment, and only 15 percent of people who were admitted through an emergency room for detoxification received any treatment interventions post discharge (CSAT, 2006). Because detoxification services are used to treat the acute intoxication and withdrawal issues, improved rates of linkage to further treatment interventions is critical to assist with the chronic needs of substance use disorders.

Research has found that one major service gap in the continuum of care for substance use disorders among women is the engagement of patients in treatment or rehabilitation services after an initial detox services (Mark et al., 2002; McLellan et al., 2005). This is costly, both economically and for human life. According to the *National Performance Standards for Addiction Treatment*, clients should initiate further treatment interventions appropriate to their level of need within 14 days of discharge from detox (Garnick, Lee, Horgan, & Acevedo, 2009). This is especially crucial, as studies have found that women are extremely vulnerable to relapse and overdose post detox, due to a decreased tolerance (Strang et al., 2003). Continuity of service between detox and substance abuse treatment also reduces costs by reducing readmission to costly forms of treatment such as detoxification or emergency room visits (Mark et al., 2002; McLellan et al., 2005).

SAMHSA defines a successful detoxification process as one that can be measured by whether an individual who is substance dependent enters, remains in, and is compliant with ongoing abstinence (CSAT, 2006). Current data suggests that multiple admissions to detox are common. The Minnesota DAANES report shows that 41.5 percent of all

individuals who accessed a detox facility in 2012, accessed two or more times, and that almost 25 percent accessed detox five or more times over their lifetime. This is significantly higher than the national average, which found that 11.3 percent of patients who receive detox cycle back to detox two or three times, which indicates the chronic nature of addiction, but also inadequate linkage to further treatment interventions (McLellan et al., 2005). With the Minnesota DAANES report showing examples of low numbers of recommendations to further treatment interventions for substance use, mental health disorders, and medical concerns, the failure to link clients with the necessary resources explains higher than average readmissions to detox services. Consequently, the substance abuse field and the mental health field are beginning to recognize the importance of a holistic, integrated approach to treat substance use and mental health disorders.

### **Integration of Substance Use and Mental Health Disorders**

Increased focus on effective substance abuse treatment has begun to incorporate simultaneous treatment for mental health disorders. The relationship between substance use disorders and mental health disorders also dates back to the shift in the 1970s for more humane treatment of substance abuse. Early research showed a striking relationship between depression and alcoholism (Woody & Blaine, 1979). Research since that time has expanded and found that many mental health disorders are connected with substance use disorders. Despite the early findings, it was not until recently that clinicians and policy makers have begun to emphasize the importance of integrated treatment to treat co-occurring disorders. The term *co-occurring disorders* referred to co-occurring/co-morbid substance use (abuse or dependence) and mental health disorders

(CSAT, 2004). A diagnosis of co-occurring or co-morbid disorders occurs when one of the disorders of each type can be established independent of each other and is not a cluster of symptoms resulting from the one disorder (CSAT, 2004). Integrated treatment refers to treating both disorders in a holistic manner. Today, it's estimated that between 50 and 75 percent of women have some type of co-occurring disorder (CSAT, 2004).

As a frontier in traditional substance abuse treatment, Minnesota has recently begun to emphasize the importance of integrated care. In response to the difficulties set forth by the current health care system, which still sees the treatment for substance abuse and mental illness as two separate entities, therefore creating barrier to access integrated treatment, the Department of Human Services released the following statement:

The department recognizes that the traditional model of care indeed involves “silos” of separate care. The integrated dual diagnosis treatment model of care is designed to break down traditional barriers. Integrated dual diagnosis treatment, as described in research-supported clinical manuals and by the proposed rule requirements, is a model of care that improves the likelihood of illness stabilization and recovery for individuals with co-occurring severe mental and substance use disorders by combining substance abuse services with mental health services. It helps people address both illnesses at the same time, through access to integrated services within one organization, provided by an integrated treatment team. (Minnesota Department of Human Services, 2013, p. 3).

**Implications for Clinical Social Work.** Because substance abuse disorders often encompass multifaceted issues, including mental illness, medical concerns, infectious diseases, unemployment, homelessness or unstable housing, and family disruption, it's without surprise that many studies show the benefits of treating co-occurring disorders through integrate treatment interventions (CSAT, 2004; McLellan et al., 2005; Woody & Blaine, 1979). Consequently, this puts increased pressure on clinicians and providers given the substantial numbers of clients who suffer from co-occurring disorders. Given this shift, employment of social workers is expected to grow by 25 percent from 2010 to

2020 due to an increased demand for health care and social services (Bureau of Labor Statistics, 2012). Specifically, employment of mental health and substance abuse social workers is expected to grow by 31 percent, much faster than the average for all occupations (Bureau of Labor Statistics, 2012). This significant growth in specific clinical social work employment rates is related to the shift in policy towards integrated treatment. Furthermore, the *Affordable Care Act of 2010* and other health care reforms are expanding the variety of substance abuse treatment providers and shifting services away from residential and stand-alone programs toward outpatient programs and more integrated programs or care systems (Buck, 2011).

Today, social work clinicians and researchers bring the unique person-in-environment (PIE) perspective to explore the culturally diverse manifestations of the disease of addiction and the multi-faceted ways it affects both the individual and the different systems of one's life. As substance abuse treatment programs of all types are slowly being mandated to shift towards integrated care, the generalist social worker will be in a unique opportunity to provide such services.

### **Implications for Future Research**

The area of challenges specific to women in detoxification settings is an understudied area; therefore, understanding these differences and how they impact the continuum of care towards recovery needs to be further studied. Existing research has found several unique factors among women with substance use disorders. There has also been a noted increase in the prevalence of substance use in the female population (CSAT, 2009; Gruzca et al., 2008; Poole & Dell, 2005). What was historically a "male problem" has now been realized to transcend both genders. Prior research has also suggested that

women with substance use disorders are more likely to meet diagnostic criteria for comorbid mental health disorders specific to depression and anxiety, posttraumatic stress, and eating disorders (Hudson et al., 2007; Piran & Robinson, 2006; Tolin & Foa, 2006). With this increase of women with co-occurring substance use and mental health disorders, the need to focus greater attention on holistically addressing both substance use and mental health concerns among this population is highlighted.

While current research has demonstrated that there are factors specific to women substance users, the majority of this research has focused on women who enter substance abuse treatment (residential or outpatient treatment), leaving a gap in literature that addresses the unique needs of women who utilize detox services. Because this type of intervention addresses acute medical needs and often works with a highly vulnerable population (homeless, degenerative), it appears that little is known about the needs of women who access detox services.

Detox services are often stepping stones into treatment interventions and therapeutic services. As the literature review revealed, addressing psychosocial issues during detoxification significantly increases the likelihood that individual will participate in further treatment interventions after being stabilized (CSAT, 2006). Research also shows that continuity of service between detox and substance abuse treatment reduces costs by decreasing readmission to costly forms of treatment such as detoxification or emergency room visits (Mark et al., 2002; McLellan et al., 2005). With the increased focus on integrated treatment of co-occurring disorders, clinical social workers are in a distinct position to provide this holistic care. This study seeks to explore biopsychosocial issues specific to women using detoxification services and how these affect linkage to



treatment by addressing the primary research question: what are the challenges specific to women in detoxification settings and how do they affect linkage to treatment interventions?

## **Conceptual Framework**

A conceptual framework provides structure to research and guides data collection and analysis. Grounded social work research is formed by building on previous research, and the conceptual framework provides links to inform further areas of study and new research goals (Padget, 2008). The current study has been influenced and shaped by two distinct theories as well as professional and personal experience of the researcher.

### **Biopsychosocial Model**

The *Biopsychosocial Model* informed the development of this research by exploring the intersection of biological factors, psychological factors, and social factors of addiction and mental illnesses (Kumpfer, Trunnell, & Whiteside, 1989). There are several explanations and concepts surrounding substance abuse and addiction. Common approaches include the *disease model of addiction*, which by meaning suggests that addiction is a disease of the brain. A *biological explanation of addiction* suggests that addiction is hereditary and passed through genetics. A *psychological explanation of addiction* suggests that addiction is a mental illness, and a *behavioral explanation of addiction* suggests that addiction is a learned behavior (Kumpfer et al., 1989). The vast differences in the origin of addiction often compete with each other and result in black and white, either or, thinking (Kumpfer et al., 1989). The biopsychosocial model provides a macro framework to integrate multiple theories and causations, treating all aspects of addiction holistically. Due to the multi-faceted nature of addiction, attempting to understand and treat chemical dependency in a constricted framework leaves problems and issues untreated. This model encompasses a holistic framework to address the

biological, psychological and sociological variables of chemical dependency and mental illness.

It has been presupposed in this research that women who utilize detoxification services will present with a number of concerns upon admission. As the literature review suggests, women entering substance abuse programs have greater psychological distress, more medical problems, more family/social difficulties, and greater addiction severity than men (Brady & Ashley, 2005; Callaghan & Cunningham, 2002). It is necessary that each of the areas be addressed thoroughly, as they are often intertwined. Because substance abuse disorders often encompass multifaceted issues, including mental illness, medical concerns, infectious diseases, unemployment, homelessness or unstable housing, and family disruption, it's without surprise that many studies show the benefits of treating co-occurring disorders through integrate treatment interventions (CSAT, 2004; McLellan et al., 2005; Woody & Blaine, 1979). The biopsychosocial model supposes an understanding that to fully treat an individual, the complex interaction between biological, psychological and sociological factors must be addressed.

### **Systems Theory**

Ecological systems theory also builds the framework for the current research. In understanding the unique factors that women with substance use disorders face, it is important to examine how different systems in their life interplay in both the development of their substance use and mental health disorders and the treatment support offered to assist in recovery. Bronfenbrenner's (1979) theory of ecological systems identifies five environmental systems with which an individual interacts. This theory

provides the framework to study the relationships with individuals' contexts within groups, communities, and the wider society.

At the *microsystem* level, women are impacted by their immediate surroundings such as relationships and family history. A person's own biology may be considered part of the microsystem as well (Paquette & Ryan, 2001), which for women, has serious implications in regards to the effects of substance use. As the literature revealed, women have an accelerated progression from the initiation of substance use to the onset of physical and psychological dependency (Greenfield et al., 2010). Also at the microsystem level, women with substance use disorders are affected by their relationships and family history. Past research has shown this to have grave implications specific to women with substance use disorders. Several studies showed that female substance abusers are more likely than their male counterparts to report greater dysfunction in the family of origin (Conway et al., 2002; Pastor & Evans, 2002; Smith & Brady, 2005), which supports Bronfenbrenner's theory that an individual is directly impacted by their environmental contexts. Women with substance use disorders are impacted by both their biological make up and by their immediate microsystem of family history and origin.

Women with substance use disorders are also impacted by their own status in society as well by the availability of support resources, including support groups and treatment interventions. As the literature review showed, characteristics specific to women who engage in substance misuse include frequently low economic status, the likelihood that they are custodial parents, the greater incidence of trauma and violence, and the societal stigma of substance abuse (CSAT, 2009). These barriers such as cost of

treatment, lack of child care, vulnerability to trauma and interpersonal violence, and stigmatization all present significant barriers that different systems have on a woman's access to recovery interventions.

On a larger scale, policy shifts, such as the current shift to integrate substance use and mental health, are part of an individual's *macrosystem* and *chronosystem*, as they affect the necessary treatment services toward a path of recovery. In response to the difficulties set forth by the current health care system, which still sees treatment for substance abuse and mental illness as two separate entities, therefore creating barriers to access integrated treatment, Minnesota Department of Human Services has begun to recognize the importance of integrated treatment services. This will have a significant impact on the estimated 50 to 75 percent of women who have co-occurring mental health and substance use disorders (CSAT, 2004). These policy shifts highlight the way in which the larger systems at the macro level influence systems at an individual level. The current research is framed through an understanding of ecological system theory and the impact that systems have on women with substance use disorders who utilize detox services.

### **Personal and Professional Lens**

Development of this research topic originated from a personal and professional interest in improving the quality of care for women who utilize detoxification services. As a Licensed Alcohol and Drug Counselor as well as a Director of Chemical Dependency Services, I considered the lack of resources and the limited attention that is paid to women with chronic substance use disorders. Additionally, through professional experience with this population in traditional substance abuse settings, witness to the

extreme vulnerability that this particular population is subjected to, a desire to learn more about the experience of women who undergo detoxification was amplified. Furthermore, interests in how my role as a dually licensed clinical social worker and alcohol and drug counselor can improve linkage to further treatment and recovery at both a micro and macro level emerged.

I currently function as a Director of Chemical Dependency Services and have witnessed both the devastation that addiction and mental illness can have on someone's life, as well as the transformation that recovery can bring. Although I do not identify as having a substance use disorder, or as an individual in recovery, I do acknowledge the personal investment in the topic and the subsequent potential for bias. With that consideration, it's the same personal investment that motivates me to further study the integration of substance use and mental health within detoxification settings and encourage other social workers to work with and advocate for this highly vulnerable population.

## **Methodology**

### **Research Design**

This research study explored the challenges specific to women in detoxification settings and how those unique issues can affect linkage to treatment interventions using a biopsychosocial framework. Due to the scarceness of research that has focused on the current topic, exploration was an applicable starting point for further research of women with substance use disorders who access detoxification services. The research question for the current study was: “What are the challenges specific to women in detoxification settings and how do they affect linkage to treatment interventions?”

The use of qualitative interviewing was used because it is a method for collecting information in exploratory research. Qualitative research aims to understand the complexity of social experiences, describing what cannot be counted or quantified. Holstein and Gubrium (2002) defined qualitative research as “describing the dynamics and texture of everyday life that quantitative research methods typically overlook in their formal operationalizations and numerical representation” (p.1). In each story there were unique perspectives and intricacies of everyday interactions that cannot be captured in a simple or straightforward manner. Qualitative research has a tolerance for complexity and unanticipated findings. Using this method of research gave voice to the experience of research participants and showed common themes in participants’ experiences. Whereas the majority of previous research studies related to this topic have utilized quantitative methods, this research aimed to obtain the experience and story of those who have worked with this population to better understand the complexities associated with improving outcomes for women with substance use disorders.

## Recruitment

Participants were recruited for this study through Minnesota detox settings that were listed on SAMHSA's Treatment locator website found at <http://findtreatment.samhsa.gov>. These detox settings have been registered with SAMHSA as settings that provide onsite, acute medical treatment for individuals in need of detox services and are licensed by the State of Minnesota under Rule 32, the MN governing statute for detox facilities. There were no additional IRBs specific to Minnesota detoxification settings that need consideration for recruitment.

Due to the limited number of detoxification settings in Minnesota, the researcher used purposive sampling to find participants for the study. *Purposive sampling* was used because it is a form of non-probability sampling in which decisions concerning the sample are taken by the researcher, based upon a variety of criteria including specialist knowledge of the research issue (Monette, Sullivan, & DeJon, 2008). This method of sampling is commonly used when there are a limited number of subjects available. The researcher's prior knowledge of chemical dependency programming was also used to determine detox programs and subject participants that are relevant to the study (Monette et al., 2008). The researcher was also informed of relevant detox programs from others involved in the study and professionals in the field. These referrals offered a form of snowball sampling (Monette et al., 2008).

After determining potential participants, the researcher sent a recruitment letter explaining the study (see Appendix A) via email to program directors and licensed staff at Minnesota detox settings that were listed on the SAMHSA treatment locator website. Interested parties contacted the researcher to express their interest in participation, and



were sent informed consent forms (see Appendix B) for their review. Interview times were then arranged.

### **Protection of Human Subjects**

Prior to any contact with participants, the research design was reviewed by several parties to ensure protection of the participants. The proposal was first reviewed by a research committee comprised of experts on the subject area who have worked extensively with individuals identified as having a substance use and comorbid mental health disorders. The committee reviewed and approved the goals, design, and methodology of the research. The study was also submitted for approval by the Institutional Review Board at the University of St. Thomas prior to any contact being made with the participants. The Institutional Review Board is put in place to review, approve, and monitor behavioral research to ensure the safety of participants. Because the proposed research study presented no more than minimal risk to human participants, the level of review was expedited.

Special care was taken to ensure that the research subjects were fully aware of what their participation in the study included. To do that, participants were given an informed consent form prior to beginning the interview. The researcher reviewed the content of the informed consent with the participants to ensure that they were aware of their rights, understood that the study was voluntary in nature, and the methods that were used to guarantee confidentiality. Participants were informed that the purpose of the study was to learn about the challenges specific to women in detoxification programs and how those challenges affect linkage to further treatment interventions. They were informed of the procedures, including the interview itself, audio recording and

transcription, the presentation of findings in both an oral presentation and written report, and the possibility of using the data in future writing or publications. They were also informed that their name and program name were removed from the transcript to protect privacy and ensure confidentiality.

Participation in the study was voluntary in nature and respondents were told they could withdraw from the study at any time, up to one week after the interview by contacting the researcher by phone or email and requesting their data not be used. Care was taken to reduce risks, in ways such as, including sampling providers rather than clients. While risks associated with taking part of the study were minimal, respondents were told that participation may cause mild discomfort. To address this risk, participants had the right to stop at any time or skip any questions. A list of free counseling and support resources (see Appendix D) were also provided to each participant.

There were no direct benefits to participating in this study. The participants were provided with an opportunity to lend their voices and stories to inform the research and subsequently may have benefited from this opportunity to share.

### **Data Collection**

Interview data for this study was collected in a private setting that was agreed upon between the researcher and the participant ( $n=2$ ), or by phone interviews that took place in private offices ( $n=6$ ). All interviews were digitally recorded. The researcher reviewed the content of the informed consent with the participants prior to scheduling the interview and again before the interview was conducted. Participants were encouraged to ask the researcher questions before signing the consent form. Once the consent forms were signed, the interviews began. The interviews conducted via phone included the

review of the informed consent and the participants signing the form. The participants returned the signed consent to the researcher via scanned email.

Interviews were digitally recorded and supplemental field notes were taken. To protect confidentiality, the transcriptions and recordings were kept on a password protected computer to which only the researcher had access. Information was de-identified in order to safeguard each participant, and numbers such as IP1, IP2, and so on were assigned. For purposes of the final paper, pseudo names were assigned to each participant.

The interviews followed a semi-structured format, using a list of predetermined questions (see Appendix C), that allowed for spontaneous conversation and questions was used. The questions were informed by the literature and addressed factors unique to women with substance use disorders, challenges specific to women in a detox facility, factors that affect linkage to further treatment interventions, and attitudes about movements toward integrated care. Thoughtful consideration was given to the content of the interview questions to avoid bias or defensive reactions from participants. The research committee also reviewed the interview questions for objectivity and sensitivity prior to their use in the interview. The complete list of questions can be found in Appendix C.

### **Reliability and Validity**

The questions for the interview were developed from the current literature and the theoretical framework in order to substantiate content validity. The questions were reviewed by student peers and the research committee to determine that they guided responses that addressed the overall research question. Review of the questions by

student peers and the research committee was also to ensure that the questions were similarly interpreted and clearly worded. This process, known as *trustworthiness*, is used in qualitative research to ensure that the study covers what it is intended to measure (Shenton, 2004). The research committee also reviewed the interview questions for objectivity and sensitivity prior to their use in the interview in order to protect the participants.

### **Data Analysis**

The researcher used a data reduction approach to content analysis. *Data reduction* refers to the process of selecting, focusing, and transforming the data that appear in the field notes and transcription (Padget, 2008). This method facilitated the exploration of each participant's lived experience in the coding without limiting the content in the data. The data was then transcribed by the researcher and housed on a password protected computer indefinitely, stored in a locked file on Microsoft Word.

Accordingly, data was drawn from the interviews after review of the transcript by the researcher. This began by examining the specifics of the data and moving toward general themes. Similar and recurring concepts that emerged from the interview transcriptions were identified into themes and subthemes. Differences were also considered, and any data falling outside of the norm was analyzed. The themes were then compared to the previous literature related to this topic.

### **Sample**

The researcher located and interviewed a sample of eight professionals who provide direct service to women in detoxification settings. To obtain a well rounded perspective, participants from various professional disciplines (e.g. social work, licensed

alcohol and drug counselor, and nurses) were recruited to participate in the study. Inclusion criteria included presently working in a detoxification setting for at least one year and providing direct service to women who utilize detox services. Exclusion criteria included unlicensed staff, those who have not had direct service experience for one year or more, and those who are not currently employed in a detox setting. The current sample included all women (n=8, 100%), working as licensed professionals in a detox setting. No demographic information such as age or race/ethnicity was collected. For the purpose of the final paper, pseudo names were given to each participant, detailed in Table 1.

Table 1

*Description of Respondents Who Worked in Detoxification Settings and Their Type of Professional Licensure*

Interview number	Pseudo name	Gender	Professional licensure
IP1	Allison	Female	RN
IP2	Beth	Female	RN, LADC
IP3	Caroline	Female	RN, LADC
IP4	Debra	Female	RN
IP5	Emily	Female	LSW
IP6	Fionna	Female	LADC
IP7	Genevieve	Female	RN, LADC
IP8	Helen	Female	RN

*Note.* Pseudo name = Disguised name for key informant. LADC = Licensed alcohol and drug counselor; RN= Registered Nurse; LSW=Licensed social worker.

**Description of the Respondents**

The participants in the study practiced under different licensures and roles and came from various sized detox settings. Each participant was a licensed professional who had been working in a detox setting for at least one year. Differences among participants included professional licensure, including LADC, RN, and LSW. Several participants

also operated as the program director for the detox at which they were employed. The size of the detox setting in which the participants were employed was also a difference amongst respondents. Table 2 illustrates respondents' professional licensure, and Table 4 illustrates the size of the detox facility in which they worked.

Table 2

*Description of Respondents' Type of Professional Licensure*

	n(%)
Licensure	
LADC	1 (12.5%)
RN	3 (37.5%)
LSW	1 (12.5%)
Dual Licensure (LADC/RN)	3 (37.5%)
Respondents who were acting program directors	4 (50%)

*Note.* LADC = Licensed alcohol and drug counselor; RN= Registered Nurse; LSW=Licensed social worker. This table reflects respondents' professional licensure at the time of the interview.

Table 3

*Description of Respondents' Detox Size per Setting Population*

	n(%)
Size per setting population	
Rural	2 (25%)
Suburban	3 (37.5%)
Urban	3 (37.5%)

*Note.* This table reflects respondents' detox size per setting population according to the 2012 Census Bureau. Rural = less than 20,000 people; Suburban = more than 20,000 people but less than 80,000 people; Urban= more than 80,000 people.

## **Findings**

The interviews resulted in the development of five main themes. These themes unveiled by questions addressed in the interview included five themes: admission contexts, vulnerability, comorbidity, barriers to treatment interventions, and integrated care.

Within each of the five overarching themes there were subthemes that stemmed from prevalent responses among the participants. Within the theme of admissions contexts there were three subthemes: demographics, referrals to detox, and emotionality. Within the theme of vulnerability there were three subthemes: abuse history, sexual trauma, and pregnancy. Within the theme of comorbidity there were two subthemes: medical issues and mental health concerns. Within the theme barriers to treatment interventions, there were three subthemes: children, time constraints, and limited resources. The last theme, integrated care, had two subthemes: bridging the gap and willingness and acceptance. These themes are outlined in Table 4.

Table 4

*Themes/Subthemes and Sample Responses Among Respondents Working with Women in Detoxification Settings.*

Category	Thematic category	Sample response
<i>Theme 1: Admission contexts</i>		
A1	Demographics	The women I worked with were from a variety of socioeconomic backgrounds, many different ethnicities and ages. The most common being White Caucasian then Native American, age 40 to 60.
A2	Referrals to detox	I've noticed our voluntary admissions dropped but our emergency room admissions have increased and law enforcement admissions too.
A3	Emotionality	Subjectively, we find them [women being admitted] more demanding and needy, emotionally.
<i>Theme 2: Vulnerability</i>		
V1	Abuse history	Most of it is the trauma piece. That is where I see a lot of women drinking because of some sort of trauma or domestic violence.
V2	Sexual trauma	There is a lot of issues with rape. ...they talk about consensual sex, but it is for safety or [in exchange] for alcohol.
V3	Pregnancy	Pregnancy [among women in detox] is a huge issue.
<i>Theme 3: Comorbidity</i>		
C1	Medical issues	I feel that women's health deteriorates faster than a man's when dealing with alcohol disorders.



C2	Mental health	We tend to see a lot more women suffering from anxiety and depression, but also many with borderline personality disorder.
<i>Theme 4: Barriers to treatment</i>		
B1	Children	Women are often the sole parent for their children so it's difficult to go to treatment due to having no other alternative for child care.
B2	Time constraints	That just doesn't give them any time to really think about what they want to do or give them any time for that information and education to really process it.
B3	Limited resources	Unfortunately the mental health and substance abuse referrals are often full meaning a long wait time, which is not ideal because then the woman does not, or is at least less likely to follow through.
<i>Theme 5: Integrated care</i>		
IC1	Bridging the gap	Integrated care proves the most effective approach for caring for individuals with multiple health care needs, like our women.
IC2	Willingness and acceptance	They [women] are more willing and accepting of help.

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*Note.* A= admissions, three subthemes, V= vulnerabilities, four subthemes, C= comorbidity, two subthemes, B= barriers, IC= integrative care; five subthemes.

## Admission Contexts

**Demographics.** All respondents interviewed identified similar demographics, including percentage served, age range, and cultural/ethnic backgrounds among the women they serve at detox settings despite coming from different areas of the state. Regarding percentage of women served, each of these participants identified falling “within the state statistics”, serving between 20 and 26 percent female clients.

There were also similarities among respondents in regards to the average ages of women they served. The majority of respondents reported that they served women between the ages of 18 and older; however, two identified serving females younger than age 18. These respondents were from rural and suburban detox settings. Of those that served children and adolescents, Fionna, a respondent from a suburban detox facility stated,

*We do take adolescents here with our youngest female being 12, and I would estimate the oldest at 80 years old. It was very sad and disheartening to see a 12 year old female being admitted. It broke our hearts.*

The majority of respondents reported the largest age group among women being admitted to detox was between 35 and 50. Emily, a respondent from a suburban detox setting near a University stated, “*years ago our detox statistics showed that women between the ages of 18 and 21 were often serviced; however, over the last few years the ages of admittance have increased significantly.*” Emily believed that changes in public policy are to account for stating,

*...since then, law enforcement, court systems, and [place of employment] have made some changes in alcohol intoxication policies and procedures in the last four or so years. In the last few years, many of our intoxicated females have been 40 to 60 years of age.*

No respondents could recollect serving any women over the age of 80.

All respondents in the study, ( $n=8$ ), identified that the largest ethnic background among women served was Caucasian, with Native American and African American coming in at second and third largest groups served. Caroline and Helen, both respondents from urban detox settings also mentioned serving women of Somali decent.

Although very few respondents spoke to the socioeconomic demographics among the women they serve, the two that did, mentioned working with a diverse population from a variety of socioeconomic backgrounds. Helen noted the difficulty determining socioeconomic class, but mentioned that there is often a correlation between number of times accessing detox and poverty, stating,

*I would say that if females have only accessed detox one time, we would probably see more distinct socioeconomic trends. You know, substance abuse is not limited to a specific class; however, continued use will significantly impact financial status. If the females have accessed detox at least two times or more, you would find that most are at, or fall below the poverty level.*

**Referrals to Detox.** There are several ways that women enter detox services, which are commonly known as referrals. Referrals among women entering detox settings were similar among all respondents ( $n=8$ ); however, trends varied from external referrals to self admissions. *External referrals* refer to outside agencies bringing clients in for admission. Self admissions include voluntary self admits who present on their own for detox services.

Common referrals for admissions to detox noted by respondents included emergency room referrals, law enforcement, social service agencies, commitment holds, and self admissions. Six respondents identified that law enforcement was the largest route of admission among the women they serve. In fact, Emily recalled, “*There were many months that 97% of the intoxicated females brought to [detox setting] were brought*

*by law enforcement.*” The other two respondents believed that emergency room referrals were the primary routes of admission among the women they serve, with law enforcement being a close second. Fiona stated, “*We’ve seen more and more women on health holds, due to medical problems due to their drinking.*” Of the six respondents that identified law enforcement as the primary route of admission, all cited emergency room referrals as the second. Beth expressed an increase in emergency room or medical hold admissions.

*... I think more females are coming in through the ER. I suspect because so many women will go to their doctor appointments or they will go to the ER and they have either run out of pills or are showing up intoxicated and the doctors may be addressing the health concern that they showed up with but then they end up in detox with us.*

Referrals involving questionable safety to one’s self or others often occur at the county level. Common referrals in this context often stem from social services or court commitments. Social service referrals were mentioned by three respondents, specifically in regards to referrals for pregnant women. Helen described “*Our detox will admit female clients who are pregnant. Many placements occur through social service agencies.*” One respondent from a rural detox setting mentioned tribal court commitments as a common route of admission they see among women. *Commitment holds* refer to involuntary, court ordered episodes. Beth stated, “*I think probably we are seeing tribal court commitments, I think reservation [commitment holds] are more female than male.*”

*Self admits*, or a client voluntarily presenting to detox services on their own accord are also a common referral for admission to detox. This type of voluntary admissions was noted by seven of the eight respondents, citing between 20 and 35

percent of women were voluntary admissions. Helen considered the women who presented at her detox, she stated, *“I would say older women self admit more”*.

**Emotionality.** The views regarding characteristics specific to women’s admissions to detox settings were fairly homogeneous, as six of the eight respondents made mention to a heightened emotional state. Reflecting on the differences unique to women entering detox Genenieve explained, *“They are much more emotional coming in and tend to need a lot of staff time due to being highly emotional.”* Similarly, Allison stated, *“Subjectively we find them [women entering detox] more demanding and needy when they come in. It seems like we do a lot of one to one, especially when they are first admitted, because they don’t have any restraints.”* Also noting a heightened emotional state, Helen mentioned,

*Women are more emotional I have noticed. I would say a high majority of them are crying all the way through admissions, so we have more empathy with them and they are more emotional. Men, I think, are more angry when they come in.*

Three respondents made mention to the circumstances of admission often determining the level of emotional reactivity. Making reference to this Fionna stated, *“Most women coming in being escorted by law enforcement are combative and very emotional.”* In the same way Emily reported her experience as, *“It [high emotionality at admission] was usually precipitated by a 911 call due to the women either becoming unresponsive, public displays of erratic behaviors, being suicidal, and/or in an altercation with a domestic partner.”* Strengthening this point Helen described that the events prior to admissions often trigger highly emotional responses.

*They are usually pretty emotional, like for example, they have either gotten into a verbal fight with a boyfriend, friend, or someone in their apartment, things like that, or they are out in the community and the police have come across them and they are not cooperative verbally with the police. So when they come in they are*

*more emotionally charged and the men are more physically or behaviorally charged.*

## **Vulnerabilities**

**Abuse History.** Vulnerabilities among women in detox settings were a prevalent theme, ranging from abuse history, to sexual trauma, and pregnancy. Abuse history was a predominant sub theme, as it was heavily noted throughout the interview by six of the eight respondents. Participants' views of how abuse history affects women accessing detox varied. For all respondents that discussed this theme, they believed that the abuse suffered impacted the way services were delivered. Reflecting on her own work with women in detox Allison recalled,

*It is getting at their vulnerabilities and what brought them in. The impact that has on them and the abuse that may or may not come in at times having been beaten up or sexually. We just had two of them [women], one was kidnapped and beat repeatedly.*

Three respondents indicated that their detox setting has separate areas for women due to the extreme prevalence of trauma. They believed that due to their previous experiences, often with men, it was beneficial to have segregated areas. Debra described,

*Well we do have a separate area for them. Also, I think that we probably keep a closer observation on them because of their vulnerability; because we worry they have more abuse issues, domestic abuse and possible sexual abuse issues. We need to make sure they are safe.*

Due to the frequency of past abuse concerns, assessing for such abuse is critical among women clients. Caroline reported a different protocol with assessing women due to the prevalence of abuse, stating, "*Well the first obvious thing we look at is the vulnerability a lot differently.*" Fiona also recalls a difference in assessing abuse in women; "*Abuse history is a common thread shared by many women who come to detox. We need to assess that immediately.*" Emily, a respondent from a larger suburban detox

setting discussed that due to the high rate of abuse among women accessing detox services, specialized programming was set up, although described difficulties with the system, *“It is sometimes hard to have staff from the domestic violence program see the patient after a domestic dispute due to the female’s intoxicated state.”*

**Sexual Trauma.** In addition to high rates of abuse concerns among women in detox settings, another prevalent subtheme that emerged from the interviews was sexual trauma. Seven of eight respondents made mention to a high prevalence of sexual trauma among the women they serve. While a few respondents simply mentioned the need for assessing sexual assault among women, some went into greater detail about the experiences they have witnessed. Considering her own experience of working with women who have endured sexual trauma Emily recalled,

*I remember one specific case where a young lady was at one of our universities and some of her classmates came upon her with her skirt up, laying in a parking lot with a blood alcohol of .14. I mean that really says a lot about vulnerability. Another female, in particular, her significant other used to sell her [sexually] in order to get his drugs or her shelter for the night.*

Another respondent, Fionna, spoke to similar situations, *“Most times, their housing depends on an exchange for sex.”* This respondent elaborated with,

*Often times the chronic alcohol abusing women live with men and will exchange sex for shelter and alcohol. Males usually live with other abusing men, they share money or alcohol or drugs. Women have to sell themselves for their drug or their shelter.*

Supporting this theme, Caroline noted,

*There is a lot of issues with rape and then in talking with some of the women, they talk about that they’re consensual with sex, but it is for safety or [in exchange for] alcohol to drink, or just because they are too exhausted. I kinda put that in with rape.*

One respondent even recalled, “...*she had been raped repeatedly and she would scream out, just reliving it all.*”

**Pregnancy.** Pregnancy was a subtheme mentioned by all respondents ( $n=8$ ), with a varied degree of disclosure. Six of the respondents mentioned pregnancy as an obvious difference between the care of men and the care of women in a detox setting. Two of the respondents elaborated on their protocol of serving pregnant females. Fiona discussed, “*Pregnancy is another issue we face when working with women. Detox is an appropriate placement for a female patient to protect the fetus in the short term while looking for a long-term solution. We coordinate with social services agency.*” Beth also noted, “*The biggest thing would be when we have our pregnant women in and then we do an additional screening before we accept them.*”

High rates of sexual trauma often bring ancillary consequences. Speaking to this, six of the respondents made mention to screening for pregnancy on the majority of females accessing detox due to the high prevalence of sexual activity, consensual and non-consensual, as Allison shared, “*There are some things that come up and one is their need to want to be examined for STD and they are worried about being pregnant.*”

### **Comorbidity**

**Medical Issues.** Medical issues unique to women in detox settings were discussed among all eight respondents from the study. Six of the eight respondents made mention to specific medical issues common among women in detox settings, including high blood pressure, diabetes, and hypertension. Three respondents went into further detail, highlighting how women’s substance use intensifies their medical conditions.



Fionna, a licensed alcohol and drug counselor shared her experience around assessing and witnessing the consequences of continued substance use on women's health.

*I feel women's health deteriorates faster than a man's when dealing with alcohol disorders. Those females have a marked difficulty in tolerating alcohol and also have a much more difficult withdrawal. If the female goes into alcohol or substance withdrawal, it exacerbates any of their medical issues.*

Another respondent, Helen, a registered nurse, declared, *"Their nutrition is really bad. Using alcohol and drugs at length really impacts these health conditions, like diabetes or hypertension."* She went on to discuss the ramifications, *"There are so many complications for women due to poor health and the toll that alcohol and drug use has taken on their body."* Genevieve, also a registered nurse, noted, *"I see a lot of women deteriorate very quickly, you know, health wise."*

The interaction between substance use and women's unique physiological composition was also discussed. Two respondents mentioned that they believed women's physiological make up, including hormonal changes impact their substance use. Reflecting on her own experiences treating women in detox Fionna explained, *"I think that hormone fluctuations play a large role in how alcohol is metabolized."* In addition, three respondents shared seeing an increase in gastric bypass surgeries among women and believe it has implications on the absorption of alcohol. Genevieve shared, *"We are seeing a lot more women that relapse that have a history of gastric bypass."*

Other factors that exacerbate women's health and medical concerns were explored. Three respondents discussed seeing an increase in prescribed medications among women entering detox settings, further complicating their substance use. Beth shared, *"We have seen women coming in that are on an increased amount of medications, sometimes multiple doctors."* Despite the increased prescription

medication, one respondent noted, *“Our female clients tend to be more medication compliant than the males. Much more aware of their medication name, dosage, and actions of the medications than our male clients.”*

**Mental Health.** Mental health concerns among those with substance use disorders occur at a high rate. An increase in comorbid mental health issues among women was another subtheme that was dominant throughout the study. Several respondents believed that depression, anxiety, and post traumatic stress disorder (PTSD) were among the most prominent mental health diagnoses among women in detox settings, noting both diagnosed and undiagnosed symptoms. Specifically, six respondents identified that depression and anxiety were the most common mental health diagnoses among women who access detox services. Three respondents also spoke to high rates of Borderline Personality Disorder amongst women in detox. Allison expressed, *“I mean we have all that, you just see so much mental illness now. In every direction; there is a histrionic and borderline personalities, and they are emotionally mentally ill with the alcohol and drugs.”*

Likely correlating to the high rates of trauma among women in detox, PTSD was a common mental health diagnosis respondents reported. Five of eight respondents spoke specifically to their experience with women presenting with PTSD symptoms, likely as a result of trauma. Recalling such experiences Emily shared,

*Any of the women that I dealt with had several mental health diagnoses from Major Depression, Anxiety, and PTSD. Many of them did not seek any mental health treatment but would use alcohol as their coping tool. One woman I can think of had PTSD due to childhood trauma and she told me she drank to relieve the pain of nightmares.*

Emotional responses regarding their substance use and mental health concerns among women in detox were also seen as unique among participants. Three respondents noted that women tend to exhibit more guilt and shame than their male counterparts. Beth reported, *“I think women coming into detox centers are full of more guilt, shame, and remorse than men.”*

### **Barriers to Treatment**

**Children.** Respondents in the study noted several current barriers to women accessing services after detoxification. Children were a prevalent subtheme among these barriers. Five respondents spoke to their experience of a women’s concern for her children being a significant obstacle to further treatment interventions. Recalling times when women’s children prevented follow through to further treatment interventions Beth stated,

*So often they are single parents so children are issues and that is a big concern about what is going to happen while they are here, what is going to happen if they go to treatment, and that stands in the way sometimes of them going to inpatient treatment programs.*

Another participant shared a similar experience of the difficulties of assisting women who have children with continued care services after detox, *“Women, often being the sole parent for children, find it difficult to go to treatment due to having no other alternative child care. Programs that take women and children together are scarce.”*

Yet another provider discussed this concern, but more within the context of women’s hesitation for treatment involvement due to fear of social services involvement; *“They don’t want to lose their children and they’re scared to move forward because of that, they lose the rights a lot when human services takes over with their care.”*

**Time Constraints.** Another barrier to treatment for women that surfaced throughout the interviews included the time constraints that providers have in detox settings. Currently, Minnesota legislative policy states that detox facilities are allowed a maximum of three days to hold an individual for intoxication. Seven of the eight respondents mentioned the limited amount of time that they spend with women accessing detox. Six of eight respondents saw this as a significant barrier to recovery. Caroline discussed how this affects service delivery.

*Longer detox stays would be real helpful. Currently it is two and a half days and my gosh, the first day they are intoxicated, the second day they are sick, and the third day they leave. That just doesn't give them any time to really think about what they want to do or give them any time for the information and education to really process it.*

Overwhelmingly, respondents did not believe that comprehensive care was possible without longer stays. Debra shared her reason why she did not believe that the current stay of three days (maximum) was enough to begin the recovery process, *"They have trust issues to begin with and also what complicates the referral process is that they are not here long enough to develop a trusting relationship."* Sharing similar concerns regarding the limited time detox providers have with the women they serve, Fionna stated, *"You can have all the greatest staff in the world, but these people can't use that to the full extent unless detox stays are longer."*

**Limited Resources.** Limited resources were a common subtheme that arose from conversations regarding barriers to treatment interventions among women in detox settings. All eight respondents spoke to limited resources for women, with differences in perspective regarding why scarce resources caused barriers to further treatment and care. Four of the eight respondents mentioned the long wait lists at residential settings, which

can significantly impact the rate of follow through. Fiona shared her experience with making referrals to residential settings following a woman's stay in detox.

*Well we do the best we can; we always assist the women in making the call to a referral. I like to make sure they know the contact information for the referral and where it is located. It is best to try and get care close to where the patient lives due to possible limited transportation or childcare. Unfortunately the mental health and substance abuse referrals are often full meaning a long wait time which is not ideal because then the women does not, or is...at least less likely to follow through.*

Two respondents mentioned the lack of specialized services for women or for comprehensive services. Sharing her experience with the difficulties of properly referring women to a comprehensive care setting rather than a program solely focused on chemical dependency, Debra illustrated,

*You know, looking at the whole person is the recovery of care system and trying to deal with primary care and not just looking at that person as a substance abuse issue or just looking at that person as a mental health concern but looking at addiction and looking at mental health symptoms on a continuum of care as an acute issue. Just as women have relapses with their diabetes, they have remission with cancer, all of those kinds of things and that they will look at mental health concerns and substance abuse disorders in the same way in the future.*

Two respondents believed that the limited resources for women with substance use disorders in conjunction with the formality of the "system" were barriers to treatment. Caroline described her difficulties in finding proper placement and providing comprehensive care in a "silo-ed system", "...[treatment within detox] is very limited and includes no testing. A lot of them aren't diagnosed with mental health issues, but obviously have them. If they don't sign release forms to talk to their workers, we can't contact anyone and are stuck." Experiencing similar struggles with the fragmented system between mental health and substance use Beth stated, "We really struggle with all

*of the gatekeepers that are out there or the few mental health beds that are available in the state of Minnesota, but we can't get to them."*

## **Integrated Care**

**Bridging the Gap.** Bridging the gap between the mental health system and the substance use system would involve a holistic treatment approach, treating all concerns simultaneously. All respondents believed the integrated care would significantly improve recovery outcomes for women for several reasons. The most prevalent subtheme that arose from interviews was the belief that integrated care would bridge the gap between detoxification and continued therapeutic services. Each interview subject ( $n=8$ ) spoke to increased benefits that having an onsite mental health professional, although difficulties with treating the population were still noted. Allison believed this would increase the linkage to further treatment stating, "*...We recognize that it is a rocky road ahead for them, so to start them on their journey. Better mental health services and how it affects their addiction. It's wonderful to think we could give them that added road.*" Similarly, Fiona shared her belief that integrated care would vastly improve women's rates of recovery.

*Having a mental health professional on site would ensure that women would have immediate access to address their mental health needs, which directly affect their substance abuse problems thus integrating care. Yeah, I do think that if we could get something going to look at women's specific health issues, because they have so many strikes against them out there compared to men. The homeless female is so vulnerable, many have reported gang reports, sexual assault, etc. And these often lead to health complications. Something to assist them with prevention and coping mechanisms to deal with emotionality and personal health issues.*

Beth believed that having an onsite professional would assist women due to the reluctance that agencies have treating the population. She shared her experience,

*I am seeing more and more dual diagnosed women come in, and in human care and this is something that I have really been focusing on, probably with three or*

*four different agencies that have been talking to me kind of about this, is that this is a concern that we have and I don't know what the answer is. We do need help with getting mental health follow up, there is no doubt about that. We are sometimes running into mental health centers. We admitted from [number of] counties last year and we are sometimes running into mental health centers who will say "gosh, I don't want to make an appointment for her because most people never show up," and I am thinking that if there was maybe some more mental health involvement and acknowledgement that [substance use] is a problem among women and that we are services so needed and we need to be part of that care that maybe we wouldn't be hearing those things about our people.*

Respondents also believed that integrated care would enhance the continuum of care for women, as Emily reported,

*This is a much needed service to assist women in making educational decisions about their mental health and the use of chemicals to mask their mental health symptoms. I think it would also greatly assist the women to get into long term medical and mental health services.*

**Willingness and Acceptance.** Willingness and acceptance was another subtheme that emerged from the interviews. Five respondents made mention to women being more willing to address psychosocial problems than men, under the context that it was their belief that women would be more likely to benefit from integrated care due to their social nature. This was illustrated in Helen's interview as she spoke to the openness she sees in women and how she believed they would benefit from meeting with a mental health professional to address concerns beyond substance abuse at length.

*I think that would help, for women especially, because I have noticed that women are more social and want to talk about their problems. They are more willing and accepting of help. So yeah, I think it would help them to have a professional to talk with. Right now they have their counselor [licensed alcohol and drug counselor] but it's not very in depth and it really only address their alcohol and drug use.*

Allison shared similar experiences of women's willingness to accept help, "*They are reaching out for as much help as they can get. They want to sit down with you right away, where men are a little bit less needy. There is just so much mental illness to*

*address.” Lastly, Genevieve described, “We have a much harder time getting mental health help, but women are much more willing to get that help.”*

### **Summary**

Participants in the study explored their experiences working with women in detox settings. Through this exploration themes and subthemes emerged. In each theme, most participants reports similar experiences, though some differences were noted. Each theme included a myriad of responses that reflect the unique perspectives and experiences of the respondents working with women in detox settings across different licensures and settings.



## **Discussion**

The research examined the experience of providers working with women in detoxification settings through a lens of biopsychosocial factors that considers, physiological/biological, psychological, and social influences that impact women with substance use disorders. While the participants in this study supported some of the literature on women with substance use disorders, respondents also added unique perspectives that were not covered in a review of current literature. This section will examine both the similarities between recent studies and the current findings of this research, as well as highlight the distinctions of emerging themes that surfaced from this research. The themes from the study will be further explored in relation to the literature review.

### **Admissions Contexts**

Respondents' experiences of the different types of admissions contexts in this study had little variation and identified similar demographics among the women they serve, similar referral types and experiences of admitting women to detox, as well as common emotional states of women who are admitted to detox services.

One aspect among admissions contexts that was frequently noted by respondents were the demographics among the women they served. All participants interviewed identified serving women of all ages, with the majority falling between 18 and 80 years of age. The largest ethnic background among women served was Caucasian, with Native American and African American coming in at second and third largest groups served. Two respondents also mentioned serving women of Somali decent. All respondents reported serving between 20 and 26 percent women, annually, a reported increase over

the years. The literature review revealed a narrowing gap between men and women with substance use disorders (Brady & Ashley, 2005; CSAT, 2009; Greenfield et al., 2010), which was consistent with what this study revealed. Each respondent identified an increase in the number of women they served, noting that approximately 20 to 26 percent of clients served were female.

Past research also found a significant increase in risk for alcohol abuse and dependence among women born after 1944, and noted that as women become older, the prevalence of substance use disorders becomes lower (Grucza et al., 2008). This research was consistent with what was found in this study, as the largest age group of women being admitted to detox was between age 35 and 50; however, one respondent noted that the age of admittance among women has increased significantly over the past few years. This would support the idea that it is important to remember that women remain vulnerable to substance abuse disorders regardless of age. Another past study that supports the findings from this study was Poole and Dell (2005) who found that as women encounter major life transitions, they are at a heightened risk for substance use disorders. Although this was not mentioned specifically among any the respondents, it can be argued that major life transitions among women in middle adulthood happen between ages 30 and 50 based upon Erickson's psychosocial stages of development. During this time, defined by Erickson as *generativity versus stagnation* stage, a woman would be considered developmentally on task by contributing to society, creating a sense of productivity and accomplishment; whereas, a woman who is unable to accomplish this task would be left stagnant, or dissatisfied with a relative lack of accomplishment (Slater, 2013). For women this largely consists of motherhood, or other contributions to society

such as entering the workforce or volunteer work. These tasks can be difficult to achieve for women with chronic substance use and mental health concerns.

While this study yielded information about racial/ethnic similarities and differences among the women the respondents served in detox, the literature review did not focus on this variable. Past research had very little focus on the socioeconomic trends among women who access detox services, and what was noted was in reference to accessing detox services multiple times and the correlation of the chronic nature of addiction (Minnesota Department of Human Services, 2013). This study revealed that multiple admissions correlated with low socioeconomic status including poverty and homelessness. Although past research focused on multiple admissions and the chronicity of addiction, this study found there is correlation between chronicity and poverty. Helen discussed her experience with witnessing how continued use of substances significantly impacts financial status. These findings between past research and current research show a strong correlation between the severity of substance use disorders and its affects on financial stability and socioeconomic status. This can further inform knowledge in this area for both providers and policy makers by recognizing the financial strain that chronic substance use has on an individual and the individual's family system, and provide the appropriate education and resources, both at a preventative level, and as an intervention or referral for continuing care.

The ways that women enter detox, or the referrals to detox, both confirmed and contrasted with previous research. Fiorentine and colleagues (1997) found that women are more likely than men to be identified with a substance use disorder through social services (child protective services). This was echoed by three respondents who made

specific mention to admitting pregnant females that were referred through social services. This is likely a reflection on other research which identified that women who engage in substance misuse are more often custodial parents (CSAT, 2009); therefore, women would be more likely to be involved with child protection services. Previous research also cited other prominent routes of admission for women entering detox included self-referral and criminal justice/law enforcement (Brady & Ashley, 2005; CSAT, 2009; Hecksher & Hesse, 2009). Consistent with these findings, this study revealed law enforcement as the most common route of admission among women, and self-referral as the third largest route of referral. A unique finding in this study included a respondent who noted that in her experience, older women self-admitted more than younger women.

While previous research found that health care providers are hesitant to refer women to substance abuse treatment (Hecker & Hesse, 2009), this study departed from the literature, finding referrals from the emergency room/healthcare providers to be second most common referral among women. The literature review revealed that referrals from health care providers as one of the lowest routes to treatment. In one study by Hecker and Hesse (2009) found that professionals such as physicians and social services workers are hesitant to ask women about their intake of alcohol and drugs. To the contrary, this study found emergency room/hospital referrals to be a high referral source for women. This contrast in findings could be based on a few different factors. First, it can be noted that many of the participants came from detox settings that worked very closely with their local emergency rooms and medical providers. Second, while the literature reviewed studies that focused on women with substance use disorders in a traditional treatment modality, this study focused on women who access detox services,

and it can be argued that women with detox needs present with more distinguishable substance dependency concerns. These findings have implications for future understanding of referrals from health care providers.

While current literature made very little mention to the emotional state of women who accessed substance abuse treatment, a highly aroused emotional state upon admission was a prevalent subtheme among the participant's experiences with women in detox. This study found that women are much more emotionally charged and need more one to one assistance from staff than their male counterparts. In fact, several respondents made mention to a certain amount of "neediness" among women entering detox. Past research made little mention to this; however, one study by Evans and Levin (2011) suggested that behavioral changes in female substance users were greater during specific phases of their menstrual cycle. It is possible that there could be a correlation between a woman's menstrual phase and subsequent hormone fluctuations and emotionality, as both are unique to women.

### **Vulnerabilities**

Participants in the study confirmed what other studies have indicated about the different vulnerabilities unique to women in detox (Brady & Ashely, 2005; CSAT, 2009; Hecker & Hesse, 2009). Ranging from abuse history, to sexual trauma and pregnancy, each respondent spoke to their experiences of working with women who were extremely vulnerable with regard to abuse, trauma, and safety concerns. In a previous study, Hecker and Hesse (2009) found that women with substance use problems were significantly more likely than men to exhibit recent physical, emotional, and or sexual abuse, and women in substance abuse treatment reported more problems related to physical and sexual abuse

and domestic violence than males. This was echoed by six of the respondents who spoke to women having a significantly greater history of abuse. For all respondents that discussed abuse history, they believed that the abuse a woman suffered impacted the way that they delivered services with them. Most revealed that they have segregated areas for the men and women due to the prevalence of trauma suffered among women who enter detox.

High rates of sexual trauma among women who access detox services was also a reoccurring subtheme that emerged from the interviews, and supports what current literature suggests about women with substance use disorders (Brady & Ashley, 2005; Hecker & Hesse, 2009; CSAT, 2009). Women who live in poverty or experience homelessness were noted to be particularly vulnerable to physical and sexual abuse. It can be noted that four of the respondents detailed that often times women exchange sex in return for drugs and alcohol or housing. Mirroring these findings, literature highlighted that women with substance use problems who cannot financially support themselves often cope with their life situations by providing sex in exchange for substances, shelter, and protection (Brady & Ashley, 2005). These findings, along with the findings regarding the correlation between chronicity and poverty, echo what Vogel and Marshall (2001) found in their research, which support the belief that socioeconomic status contributes more to women's vulnerability to abuse and stress symptoms than it does ethnicity or other factors.

High rates of sexual trauma bring ancillary consequences, including pregnancy, which was a relevant finding of this study. Contrasting the literature, findings from this study revealed that pregnancy was viewed as a vulnerability among women in detox by

the respondents. Past literature has focused mainly on the involvement of child protection services with pregnant women who abuse substances, or family of origin concerns (Conway et al., 2002; Fiorentine et al., 1997; Pastor & Evans, 2002; Smith & Brady, 2005). Other significant concerns that emerged from this study were the high rate of sexually transmitted infections among women who access detox services due to sexual trauma endured. This was not addressed in the literature; however, these findings have implications for future understanding of holistic care and treatment needs of women with substance use disorders.

### **Comorbidity**

Past research as well as the current study illustrates that chronic use of alcohol and illicit substances takes a toll on the body, both physically and psychologically. Respondents spoke to the varied degrees of health related issues and psychological issues that often accompany substance abuse. In previous studies on women with substance use disorders, it was found that female substance abusers experience more physical problems and appear more susceptible than male substance abusers to the physiological effects of substance use (Brady & Ashley, 2005; CSAT, 2009; Greenfield et al., 2010; Hecker & Hesse, 2009). One participant, a registered nurse, spoke to the rapid deterioration that she has witnessed alcohol use take on a woman's body following chronic use of alcohol and other drugs. Greenfield and colleagues (2010) coined this term *telescoping*, or the accelerated progression from the initiation of substance use to the onset of dependence, and found this to be much higher in women than men, implying that as women find their way to detox or treatment interventions, they present with more severe symptoms of substance dependence than men. Accordingly, Brady and Ashley (2005) found that the

biological ways in which women “absorb, distribute, eliminate, and metabolize alcohol increase their vulnerability to alcohol related problems” (p.10). One respondent from this study reported similar findings and believed that this led to a more difficult withdrawal process for women, which exacerbates preexisting medical concerns.

A women’s unique physiology may also affect the way alcohol and drugs are processed internally. Previous literature revealed mixed findings on the role that estrogen and the menstrual cycle played in women with substance use disorders (Epstein et al., 2006; Evans & Levin, 2011; McKay & Share, 1999). On one hand, Evans and Levin (2011) indicated that differences in response to alcohol use across the menstrual cycle were moderate; however, behavioral changes in female substance users were greater during specific phases of their menstrual cycle. On the other hand, two respondents from this research believed that a women’s unique physiological makeup, including hormonal changes, impact their substance use. In addition, a finding from this research revealed a possible correlation between gastric bypass surgeries among women and implications on alcohol absorption, as three respondents made specific mention to the medical complications this surgery, most often performed on women, has on their female clientele.

The affects of prescribed medications did not present as a significant concern in the literature reviewed regarding women with substance use disorders. This study revealed that women accessing detox are presenting with a significant increase in prescribed medications. Three respondents spoke to the havoc this is playing on women’s physical health and further complicating their substance use concerns. This unique finding has implications for medical providers and prescribers, who should be acutely



aware of the noticed increase, and ensure that effective substance use screening tools are being used when prescribing medications to women.

With the high rate of comorbid mental health concerns among women with substance use disorders, it was no surprise that respondents' highlighted common diagnoses they see among women who access detox services. As prior research has suggested, women with substance use disorders are more likely to meet diagnostic criteria for comorbid mental health disorders specific to depression and anxiety, posttraumatic stress, and eating disorders (Hudson, Hiripi, Pope, & Kessler, 2007; Piran & Robinson, 2006; Tolin & Foa, 2006). Participant responses mirrored these findings, as they believed depression, anxiety, and PTSD were the most prominent co-occurring mental health diagnoses in women who utilized detox. As five of the eight respondents elaborated on their belief of high rates of PTSD in the women they serve due to a significant trauma history, past research suggests that between 55 and 99 percent of women in substance abuse treatment have experienced comorbid trauma issues (CSAT, 2009).

The study's findings on emotional responses about both mental health conditions and substance use were consistent with past studies. In one study, Brady and Ashley (2005) found that substance use is more highly stigmatized among females than males, which results in higher rates of social stigma, labeling, and feelings of guilt and shame, all of which create barriers for women to acknowledge a problem and seek help. This study paralleled these findings, as three respondents believed that women exhibit more feelings of guilt and shame than their male counterparts. This could have significant recourse for women who struggle with substance use disorders, as it supports stigmas

attached to addiction and creates barriers to seeking help. This could be especially damaging for women who, both in past studies and this study, have shown to deteriorate faster than men with substance use disorders. If reluctance to seek help continues among women due to feelings of guilt, shame, and social stigma, the consequences could be quite severe.

Unique to this study, three respondents spoke to the high rates of Borderline Personality Disorder among women in detox. Given the nature and characteristics of the diagnosis, it is not surprising that providers reported this as a prevalent mental health disorder, which is most commonly diagnosed in women. There was little mention to this specific diagnosis in the literature; however, given the pervasive nature of Borderline Personality Disorder and the associated features/disorders including suicidality, co-occurring mood disorders, substance disorders, eating disorders, and posttraumatic stress disorders (American Psychiatric Association, 2000), the findings illustrate what comorbid mental health conditions common to women with substance use disorders have been found in past research (Hudson, Hiripi, Pope, & Kessler, 2007; Piran & Robinson, 2006; Tolin & Foa, 2006). In addition, past studies revealed high rates of eating disorders among women with substance use disorders (CSAT, 2009; Greenfield et al., 2010), while this study had no participants that made mention to eating disorders among the women they serve. It can be noted that there were no questions specific to eating disorders in the study, and participants may have overlooked this issue when describing more prominent mental health diagnoses they have experienced among the women they serve.

## **Barriers to Further Treatment Interventions**

The main functions of detox programs are to stabilize individuals, assess the severity of their substance use, and provide recommendations for treatment interventions based on individual need (CSAT, 2006). Past research statistics through the Minnesota DAANES report indicate low numbers of recommendations to further treatment interventions for substance use, mental health disorders, and medical concerns (Minnesota Department of Human Services, 2013). Respondents in this study noted several factors that they believed to be barriers to women accessing further treatment interventions. These barriers are of significant concern, as research has found that a major gap in the continuum of care for substance use disorders among women is the engagement of patients in treatment or rehabilitation services after an initial detox services (Mark et al., 2002; McLellan et al., 2005).

Detox functions as a short term intervention to safely withdraw individuals from illicit substances. As defined by the Substance Abuse and Mental Health Administration, detox services are not considered to be a treatment modality for substance use disorders (CSAT, 2006). This “short term” stay was seen by providers as one of the most significant barriers to engaging women in further treatment interventions. Seven of eight respondents mentioned the limited amount of time spent with the women, and did not believe that comprehensive care was even possible without longer stays. As research indicates that women often have more accelerated medical concerns and more difficult withdrawal experiences (Brady & Ashley, 2005; CSAT, 2009; Greenfield et al., 2010; Hecker & Hesse, 2009), the detox stay is often used solely for stabilization and no time remains for engagement in treatment and recovery. One respondent even mentioned that

a detox facility can have the most highly educated staff, but without time to engage women, it makes little difference.

This study revealed that children were a major barrier for women to seek further treatment interventions with regard to lack of childcare or fear of losing their children. This relates to findings from previous studies that illustrated that women have been found to often be the custodial parent (CSAT, 2009). Respondents also noted the lack of programs that accept women and their children or provide child care, and the fear of losing their children makes it difficult to engage women in recovery efforts after initial detoxification.

Limited resources for women with substances use disorders were also found to be a barrier for women in detox. Respondents spoke about the difficulties in finding adequate placements and were met with obstacles including long wait lists, lack of specialized services, such as programs that accepted children and gender specific programs, and the overall barriers of the “system”. Even in Minnesota, a state frequently dubbed as the land of 10,000 treatment centers, providers expressed difficulties in providing continuing care referrals to women who were discharged from detox. Prior research specific to Minnesota shows that the state has higher rates than the national average of individuals who “cycle back” to detox services multiple times. While this speaks to the chronic nature of addiction, it also highlights inadequate linkage to treatment interventions (McLellan et al., 2005). This in turn has found to be costly, both in terms of human life and financially (Mark et al., 2002; McLellan et al., 2005; Strang et al., 2003).

## **Integrated Care**

Despite early findings that there was a strong correlation between mental health disorders and substance use disorders (Woody & Blaine, 1979), it was not until recently that a focus on integrated care has been brought forward. Participants strongly believed that having an onsite mental health professional who could work with women to address mental health concerns and how they interplay with substance use would be beneficial. With past studies showing that roughly 50 to 75 percent of women have some type of co-occurring disorders (CSAT, 2004), onsite assistance of mental health providers to address these complications could vastly improve women's rates of recovery. Respondents also believed that integrated care would improve linkage to further treatment. One respondent strongly believed that integrated care would enhance the continuum of care for women. Echoing this, past studies have revealed that addressing psychosocial issues during detoxification significantly increases the likelihood that individuals will participate in further treatment interventions after being stabilized (CSAT, 2006). Alternatively, one respondent believed integrated care through an onsite mental health professional would lessen the need for ancillary services and the barriers put up by other agency's reluctance to work with a chronic population.

Although not addressed in the literature review, a pertinent finding of this study was respondents' beliefs that women are more willing to address biopsychosocial problems than men. Five of eight respondents believed that women would benefit more from integrated care due to their willingness to address concerns and acceptance of help. One respondent in particular spoke to the difficulties of finding adequate mental health care for detox clients, but noted that women are much more willing to get that help once

they do find it available. This is a crucial point for successful recovery, and leaves implications for future research on the role acceptance should play in the referral process, as well as gender differences regarding “willingness to receive help”.

### **Strengths and Limitations**

**Strengths.** This qualitative study examined the challenges unique to women in detox settings through the eyes of providers that work with the clientele and the system in which services are delivered. One strength of this study was its qualitative nature, which allowed participants to share their stories through descriptive experiences that quantitative data may not have otherwise captured. This method allowed for some spontaneous conversation to take place, and participants could share a depth of knowledge that was specific to their experience.

The characteristics of the participants are important to note in understanding their responses to the interview questions. Each respondent came with a different view point based on their own experiences and the roles they played in their detox facilities, under their specific licensure. All respondents expressed excitement to participate in research specific to women in detox settings, noting that it was often an ignored or overlooked area in social science research. It is likely that they were willing to share in research because of their nature to want to help others, as evident by their profession in the helping field.

A third strength of this study was that it reflects diversity among its respondents, who came from rural, suburban, and urban detox settings. This accounted for a well rounded depiction of experiences from different areas of the state, and ranged from

highly populated detox settings with a range of demographics to smaller settings with fairly homogenous clientele served.

**Limitations.** There were also multiple limitation of this study, with the first being the sample size. Due to a short time frame for recruitment, and the requirements for the purpose of this project being relatively specific, the sample size was small. The small sample size specific to Minnesota eliminates the ability to generalize the information among a larger population. In addition, it can be noted that all eight participants were female, which may signify that women are more willing to share their experiences socially, and or that they occupy a large portion of the jobs in the social sciences field. Nevertheless, the lack of perspective from a male provider further inhibits the generalizability of the study.

While qualitative methods is a strength of this research, it can be argued that this may hinder participants full disclosure, as respondents were either sitting face to face with the research, or speaking one on one over the phone.

Lastly, this qualitative study was based on participant's experiences, which are retrospective in nature, and reflect their subjective experience at the time of the interview.

### **Recommendations for Future Research**

Combined with previous research, there are several implications that can be extended from the present study to areas of future research and consideration. While past studies have addressed women specific treatment programs (non-residential and residential treatment), there is still very little information specific to chemical detoxification centers. With the high prevalence of trauma, abuse, and male dependency the need for gender specific detoxification centers is increasingly obvious. This study

found that providers tailor the way services are delivered to women due to trauma history. With pregnancy concerns and high rates of sexually transmitted infections due to sexual trauma, research in the area of gender specific detoxification services would have a significant impact on service delivery and effectiveness.

This research also highlights the importance of transitional or sober housing specific to women. Past literature and this study found that there is a staggering population of women that are highly vulnerable to abuse and male dependency, exchanging sex for housing (Brady & Ashley, 2005). Both quantitative and qualitative research on the benefits of increased sober housing that was more readily available to women who are currently exchanging sex for housing would likely show a reduction of abuse and trauma, as well as sexual health related conditions in women who are utilizing chemical detox services.

This study revealed several unique findings related to women's physiology that would inform future research. The first included the increase notice of women who have undergone gastric bypass surgery and how that affects alcohol absorption. Further research in this area could better inform patients who are considering the surgery and are at risk for alcohol related disorders. Another area of future focus would include the role that the menstrual cycle and related hormone changes in women can affect substance use disorders. Past research has indicated some behavioral changes in female substance users during specific phases of their menstrual cycle (Evans & Levin, 2011), and was also noted by two respondents in this study. Future research in this area could better inform women and providers of the role this may play in women's behaviors.



Lastly, additional research that would illustrate quantitative outcomes of integrated care within detox programs would help inform both the social sciences field as well as future policy. Past studies have confirmed that addressing psychosocial issues during detoxification significantly increases the likelihood that an individual will participate in further treatment interventions (CSAT, 2006). This research also revealed that providers believe that integrated care would enhance the continuum of care for women, highlighting women's willingness to receive such help. With hard data available, such research could help shape future policy to meet these needs.

### **Implications for Future Social Work Practice**

Social work practice can be enhanced through increasing knowledge of substance use disorders in women. Through the unique person-in-environment (PIE) perspective, the social worker can explore the culturally diverse manifestations of the disease of addiction and the multi-faceted ways it affects both the individual and the different systems of one's life. This research emphasized the importance of social workers having in depth knowledge of both addiction and the myriad of risk factors and consequences that accompany substance use in women who access detox services. Additionally, all respondents of this study strongly believed that providing integrated care through an onsite mental health professional would assist women connecting to services after detox stays.

Specific to implications for clinical social work practice that emerged from this study is implementing trauma informed practices with this population due to the extremely high rate of endured trauma. Trauma informed care is gaining momentum as a

highly reputable method to use when working with individuals who have been diagnosed with PTSD and other trauma related mental health conditions.

Lastly, as a licensed alcohol and drug counselor and emerging social worker, there is a strong belief that it is important to continue with efforts to reduce stigma associated with detoxification settings to increase research and funding. As the numbers show that an increased amount of women are experiencing substance use disorders, it is critical that the substance abuse and mental health fields work together to reduce negative stigma attached with needing such services in order to decrease barriers to reaching out for help.

### **Implications for Future Policy**

Grounded in the roots of social work practice is advocacy for change on behalf of the oppressed and voiceless. Women who struggle with substance use and mental health disorders often find themselves at the mercy of a fragmented system. Currently, Minnesota's Statute that governs chemical detox programs is known as Rule 32. While specific to Minnesota, each state has their own policies that mandate service delivery in detox settings. At this time, Rule 32 does not mandate such facilities to incorporate mental health professionals or advocates among staff. Given this research, it would be beneficial to embed social workers and or sexual assault advocates in a detoxification setting to assist with better screening for trauma, abuse, and health related issues to help connect female clientele with appropriate resources. While DHS is slowly moving towards integrated care, detoxification programs are often left out of such advances. Continuing to advocate for changes among detox programs is critical, as it is often the first foot in the door for chronic substance users.

Additionally, this research illustrated the importance of longer stays for detox clients. The standard three days (maximum) that is currently set in place is only enough to medically stabilize an individual. Participants in this research strongly believed that if funding for longer stays were not provided, little change could occur. Minnesota is currently working on the state of “detox reform” with the hope of providing better integrated care at the detox level and engaging clients to further treatment services on a path toward recovery. Additional research in this area could support this movement.

### **Conclusion**

The current research expanded previous literature on women with substance use disorders by looking at providers’ experiences with women who access detox services. This research found information that was reflected in previous literature including general demographics and percentage of women served, vulnerabilities including abuse history and sexual trauma among women, medical and mental health comorbidity concerns, and the perceived benefits of integrated care. Within the subtheme of admission contexts, referrals from health care providers were found to be in contrast to previous literature. There were also findings that emerged that were unique to this study and points of expansion for future research.

Women with substance use disorders who access detox services are simultaneously extremely vulnerable and persistently strong. The strength shown through their willingness to accept help despite the difficulties they’ve endured demonstrates a resiliency that deserves attention. The participants in this study shared their experiences working with women who access detox services in the spirit of hope for future improvements to integrate care for the women they serve. As the literature review

and this study showed, characteristics specific to women who engage in substance abuse include frequently low economic status, the likelihood that they are custodial parents, the greater incidence of trauma and violence, and the societal stigma of substance abuse (CSAT, 2009). These barriers such as cost of treatment, lack of child care, vulnerability to trauma and interpersonal violence, and stigmatization all present significant barriers that different systems have on a women's access to recovery interventions.

Understanding these factors will assist social workers when working with this population and provide them the context needed to provide trauma informed and culturally sensitive interventions.

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## Appendix A: Letter to Potential Participants

Dear (Name),

My name is Danielle Iano, and I am a graduate student at the School of Social Work at St. Catherine University/University of St. Thomas. I am conducting a study about the challenges specific to the female population in a detox setting and how these challenges affect linkage to further treatment interventions. I invite you to participate in this research. You were selected as a possible participant because of your current employment as a licensed professional at a detox facility (e.g. social worker, LADC, nurse).

The purpose of this study is to investigate the challenges specific to the female population in a detoxification setting using a qualitative interview design, which will give voice to the experience of working with this vulnerable population. The goal of the study is to identify challenges that are specific to the female population surrounding substance misuse and admittance to a detox facility, and how those challenges may affect linkage to further treatment interventions. Your insight and knowledge will be valuable to this research and is greatly appreciated.

Your participation in this study is entirely voluntary and confidential. The interview will take approximately 60 minutes and will include eleven primary questions. While care has been taken to reduce risks, it is possible that participation may cause some mild discomfort. To address this, you have the right to stop the interview at any time or skip any questions. A list of free counseling and support resources will be provided. There are no direct benefits, such as compensation, to participating in this study. Participating will provide you with a chance to share your experience working with this population, and will lend a platform to give voice to those who are often under-represented. If you are interested in being part of this study, I will send you an informed consent form that further details what is asked of you as a participant. Please know that interviews can be arranged at your convenience, either face to face or over the phone.

If there are any questions or concerns about this interview or the study, please feel free to contact my supervising research advisor, Dr. Kari Fletcher, at 651-962-5807, or myself at \_\_\_\_\_.

Thank you for your time and consideration. I look forward to hearing from you.

Sincerely,

Danielle Iano  
iano3796@stthomas.edu

**CONSENT FORM**  
**UNIVERSITY OF ST. THOMAS**

Challenges specific to the female population in a detoxification setting and how they affect linkage to treatment.

I am conducting a study about the challenges specific to the female population in a detox setting and how these challenges affect linkage to further treatment interventions. I invite you to participate in this research. You were selected as a possible participant because of your current employment as a professional at a detox facility. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Danielle Iano, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Kari Fletcher, Ph.D., LICSW, from the St. Catherine/University of St. Thomas School of Social Work.

**Background Information:**

The purpose of this study is to investigate the challenges specific to the female population in a detoxification setting using a qualitative interview design. The goal of the study is to identify challenges that are specific to the female population surrounding substance misuse and admittance to a detox facility, and how those challenges may affect linkage to further treatment interventions.

**Procedures:**

If you agree to be in this study, I will ask you to do the following things: Participate in a semi-structured, interview, approximately 60 minutes long, which will include eleven primary questions pertaining to the research question. Interviews will take place in a private location determined with the researcher and the interviewee; this could be a private work office or pre-reserved room at a private location, such as a library, or over the phone. Phone interviews will need to be in private office or spaces and will be digitally recorded by the researcher. This interview will be digitally recorded, transcribed, and coded for the purpose of a qualitative research study.

**Risks and Benefits of Being in the Study:**

While care has been taken to reduce risks, it is possible that participation may cause some mild discomfort. To address this, you have the right to stop the interview at any time or skip any questions. A list of counseling and support resources will be provided. Please note that you (or a third party payer) will be responsible for the cost of any subsequent support services. There are no direct benefits, such as compensation, to participating in this study. The sole purpose of this study is to gather information related to the research question, providing you an opportunity to lend your voice and stories to inform the research.

**Confidentiality:**

The records of this study will be kept confidential. In any report I publish, I will not include any identifiable information. The types of records I will create include digital recordings, handwritten field notes, and typed transcriptions of the interview. Research records will be kept in a locked file cabinet that only I have access to. I will also keep the electronic copy of the transcript in a password protected file on my computer. Any data with identifying information will be destroyed before June 1, 2014. I will delete any identifying information from the transcript. Data without identifying information will be kept indefinitely.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time up to and until one week following the interview. Should you decide to withdraw, data collected about you will not be used.

**Contacts and Questions**

My name is Danielle Iano. You may ask any questions you have now. If you have questions later, you may contact me at \_\_\_\_\_. You may also contact Dr. Kari Fletcher, research advisor, at 651-962-5807. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

### **Qualitative Research: Interview Questions**

Research Question: What are the challenges specific to the female population in a detoxification setting? How do these challenges affect linkage to further treatment interventions?

1. Can you tell me a bit about your job?
2. Can you tell me a bit about the women you serve? In general, what appear to be defining characteristics among the women you see? (e.g. their age range, ethnicity?)
3. From your perspective, what are commonly contributes to detox admissions among women? (e.g. routes of admission)
4. How is care different for women clients than for men clientele?
5. What are some common experiences associated with women in detox?
6. What issues/challenges are specific to women being admitted to detox from physiological, medical, and mental health perspectives?
7. How can these physiological, medical and mental health issues/challenges complicate the referral process?
8. How do you address these issues/challenges?
9. From your perspective, how do you think integrated care will affect detox services for women?
10. In what ways could having a mental health professional who could address multi-faceted issues “in house” enhance care for women in detox settings?
11. Is there anything else you’d like to share that I haven’t asked you?

**Free resources on best practices:**

For resources on best practices related to detoxification services, addressing women's needs in chemical dependency services, or co-occurring disorders; please visit the Substance Abuse and Mental Health Services Administration website:

[www.samhsa.gov](http://www.samhsa.gov) and search TIP Series 42, 45, and 51, respectively.

**Counseling Resources:**

1. Disaster Distress Helpline

Call: 1(800) 985-5990

Text: 66746

2. Suicide Prevention Hotline

Call: 1(800) 273- TALK (2455)

3. Treatment Referral Line

1(800) 662-HELP (4357)

Please feel free to contact the researcher if you need further assistance accessing resources or helplines, post interview. You may contact Danielle Iano at [iano3796@stthomas.edu](mailto:iano3796@stthomas.edu) or \_\_\_\_\_.