Check for updates

Research Report

NAD

Nordic Studies on Alcohol and Drugs
1–22
© The Author(s) 2026
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/14550725261465209
journals.sagepub.com/home/nad
Sage

Service User Perceptions of Addiction Treatment Services in Barcelona: Barriers, Gender, Stigma, Employment, and Recommendations for Improvement

Fran Calvo[1], Catrina Clotas[2,3], Amaia Garrido[2,3,4], Xavier Ferrer[6], Daniel Urbina[5], and Montse Bartroli[2,3,4]

Abstract

Aim: As part of the development of Barcelona's new Action Plan on Drugs, this study explored the perceptions and experiences of individuals receiving outpatient and residential addiction treatment services, integrating service users' perspectives into service planning.

Methods: A qualitative descriptive design was employed, utilizing five focus groups (three with women, two with men) involving a total of 37 participants from outpatient and residential addiction treatment services. Data were analysed using thematic content analysis.

Results: Participants often initiated treatment during personal crises, primarily through self-referral. Women reported discomfort in mixed-gender treatment environments, highlighting feelings of unsafety and exposure to aggression. A pervasive sense of social and familial stigma was identified, with women disproportionately affected. Employment was viewed as critical to recovery, yet treatment programs often discouraged contact with prior environments, including those offering job opportunities.

Conclusions: Participants recommended service improvements, including increased availability of residential placements, especially for women; expanded emergency support; greater coordination

[1]Serra Húnter Program, Departament de Pedagogia, Institut de Recerca sobre Qualitat de Vida, Universitat de Girona, Girona, Spain
[2]Agència de Salut Pública de Barcelona, Barcelona, Spain
[3]Departament de Ciències Experimentals i de la Salut, Universitat Pompeu Fabra, Barcelona, Spain
[4]Institut d'Investigació Biomèdica Sant Pau (IIB SANT PAU), Barcelona, Spain
[5]Máster de Drogodependencias, Universitat de Barcelona, Barcelona, Spain
[6]Fundación Salud y Comunidad, Barcelona, Spain

Corresponding Author:
Catrina Clotas, Agència de Salut Pública de Barcelona, 08023 Barcelona, Spain; Departament de Ciències Experimentals i de la Salut, Universitat Pompeu Fabra, Barcelona, Spain.
Email: cclotas@aspb.cat

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (https://creativecommons.org/licenses/by-nc/4.0/) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access page (https://us.sagepub.com/en-us/nam/open-access-at-sage).

across services; specialized training for general practitioners; and gender-sensitive approaches to care. These findings underscore the need for user-informed, evidence-based, and gender-responsive addiction services to enhance treatment effectiveness and long-term recovery outcomes.

Keywords
addiction treatment services, substance related disorders, access to care, stigma, gender-responsive services, qualitative research

Received: November 26, 2025; accepted: June 18, 2026

Introduction

There is broad consensus that addiction treatments are both effective and cost-efficient (De León et al., 2020). However, the diversity of contextual and individual factors that shape treatment delivery leads to considerable variation in how effectiveness is defined and measured (Malivert et al., 2012).

Although treatment evaluation has traditionally relied heavily on quantitative indicators, such as abstinence, retention or program completion, many services now also use feedback and assessment tools completed by service users to monitor perceived quality, accessibility, and availability of care. However, these mechanisms do not always capture in sufficient depth the complexity of lived experiences during treatment. In this sense, qualitative research remains essential for understanding dimensions of the care process that may remain underexplored in other evaluation formats (Cerdà et al., 2006).

The perspectives and expectations of people receiving treatment are central to understanding the quality and effectiveness of care. These insights can shed light on key outcomes such as treatment engagement, retention, and dropout (Calvo, Carbonell, Turró, et al., 2018; Calvo, Carbonell, Valero, et al., 2018), particularly in long-term care settings where sustained adherence and the strength of the therapeutic alliance are critical (Calvo et al., 2016). In this context, user narratives can act as early indicators of barriers or facilitators to recovery. Incorporating these qualitative dimensions is essential not only for a more comprehensive understanding of the treatment process (Coombes, 2015), but also for identifying aspects of care that are not always reflected in other forms of evaluation, such as gender inequalities, experiences of stigma, structural barriers to access or difficulties in social reintegration.

In social and healthcare contexts, individuals' evaluations of services can be influenced by subjective factors, including prior expectations, social stigma, and the perceived prestige of the intervention. As such, services may receive favourable feedback even when they are poorly attuned to users' actual needs, particularly if they are associated with novelty or high-end presentation. Conversely, feelings of stigma, shame or dehumanization during treatment can reduce engagement and increase the risk of discontinuation (Crapanzano et al., 2019).

Understanding the perspectives of people in treatment is therefore essential. When integrated with clinical expertize and evidence from outcomes research, these perspectives can guide the development of more effective, responsive, and equitable care strategies (Rodríguez de Fonseca et al., 2006). From this perspective, the present study is situated within a service user-centred and recovery-oriented approach, assuming that the quality of care can be assessed not only through clinical or administrative indicators, but also through how access to treatment, the care received, stigma, continuity of care, and

opportunities for social reintegration are experienced. This framework is especially relevant in the field of addictions, where the care experience is shaped not only by therapeutic factors, but also by social inequalities, institutional barriers, and processes of exclusion.

In addition, previous evidence has shown that trajectories of access, retention, and recovery are not gender-neutral. Women with substance use disorders often face specific barriers related to violence, the care of children or other family members, lower levels of social and family support, and aggravated forms of stigmatization, whereas certain patterns of use and abstinence may be more socially normalized among men. Incorporating a gender lens makes it possible to interpret differences in treatment experiences more accurately and to avoid apparently universal readings that respond to models of care that are insufficiently sensitive to these inequalities (Webb et al., 2022).

In Barcelona, addiction care is mainly organized through a specialized system connected to the healthcare network, although, in practice, it lies at the intersection of healthcare, mental health, and social services (Parés-Badell et al., 2020). Central resources include specialized outpatient centres for assessment and follow-up (Centre d'Atenció i Seguiment a les drogodependències (CAS)), as well as a range of residential and community support services for people with more complex therapeutic and social needs. These resources coexist and coordinate, to varying degrees of intensity, with primary care, the mental health network, municipal social services, and other socio-educational and harm reduction services. Therefore, understanding service users' experiences requires situating treatment within a broader care framework, not limited to the clinical encounter or the specific resource that is accessed.

Within the framework of the development of the Barcelona Drug and Addictions Action Plan 2021–2024 (Bartroli et al., 2021), the Barcelona Public Health Agency promoted this study with the aim of exploring how service users perceive and experience the care received in specialized addiction treatment services, both outpatient and residential. More specifically, the study aimed to examine pathways into treatment, experiences of stigma associated with substance use and with the care received, difficulties linked to social and labour reintegration, and proposals for improvement put forward by the participants themselves. The study was conceived as a contribution aimed at incorporating the experience and voice of service users into reflection on the organization and improvement of services. Although it was not a co-production process in the strict sense, the design was based on the premise that the narratives of those who move through these resources can identify barriers, needs, and opportunities for improvement that do not always emerge from administrative or clinical indicators.

Based on this general objective, the study was structured around the following research questions: (a) how do service users perceive and experience access to and care within specialized addiction treatment services in Barcelona?; (b) what barriers, facilitators, and experiences of stigma do they identify throughout their care trajectories?; and (c) in what ways do gender differences appear in experiences of access, treatment, stigma, and social recovery?

Methods

Design

This was a descriptive qualitative study using focus groups and a phenomenological descriptive thematic content analysis to explore participants' lived experiences with addiction treatment services. Focus groups were chosen because this technique makes it possible to explore not only individual experiences, but also shared meanings, agreements, nuances, and contrasts constructed through interaction. Given that one of the objectives was to understand perceptions of services, barriers, and proposals for improvement, the group format was considered especially appropriate for facilitating the elicitation of experiences, the

comparison of trajectories, and the identification of relevant themes emerging from participants' exchanges (Katz-Buonincontro, 2022).

Participants and Recruitment

In total, 37 individuals from the city of Barcelona, who were undergoing either outpatient or residential treatment for addictions, participated in the study. They were divided into five focus groups, which were conducted between March and April of 2021. Participants were receiving care in specialized addiction treatment services addressing different substance-related problems, including alcohol, illicit drugs, and, in some cases, benzodiazepine dependence. Accordingly, the study was not restricted exclusively to services oriented toward illegal drug use, but rather to a broader set of specialized addiction resources. Some groups were more homogeneous in terms of predominant substance use, such as the groups focused on alcohol or benzodiazepines, whereas others included more diverse consumption trajectories, especially within the residential services.

Of the 37 participants, 21 were in residential resources and 16 in specialized outpatient centers for assessment and follow-up in addictions (CAS). Of the total sample, 62.2% identified as women and 37.8% as men, with a mean ± SD age of 42.7 ± 13 years, ranging from 28 to 68 years. Participants were receiving either residential treatment or outpatient care, with treatment durations ranging from 1 week to 9 years. Sociodemographic details for each group are presented in Table 1.

Participants were recruited from three Substance Use Care and Monitoring Centres (in Catalan: Centre d'Atenció i Seguiment a les drogodependències (CAS)) and various residential services in the province of Barcelona, including two therapeutic communities, two therapeutic flats, a supported independent living program, and two day centres. Researchers visited each site to offer individuals the opportunity to participate in focus groups, either in person or virtually.

The sample was predominantly composed of women and had a relatively older mean age, reflecting the qualitative recruitment process rather than the overall distribution of users of addiction services in Barcelona.

The focus groups were organized separately by gender to facilitate the expression of potentially sensitive and differentiated experiences in relation to access to treatment, stigma, caregiving responsibilities, exposure to violence, and the experience of certain care settings. This decision also sought to foster a greater sense of comfort and safety for participation.

A cumulative, sequential approach was used to achieve thematic saturation defined as the point at which no new themes emerged, with a discretionary selection of individuals based on their ability to meaningfully describe their treatment experiences (Rodríguez et al., 1996). This was a non-probability convenience sample. Inclusion criteria were: receiving either outpatient or residential treatment at the time of the study (depending on the group) and sufficient fluency in Spanish to participate in group discussions. Participants in residential care were also required to be residents of the city of Barcelona.

Two researchers with backgrounds in psychology, psychopedagogy, and social education conducted the focus groups. One had specific expertize in qualitative research and focus group facilitation; the other specialized in addiction services. A third expert in qualitative methods and substance use supported the data analysis.

Importantly, none of the three researchers were involved in the delivery of treatment services at the participating sites, helping to reduce bias. Although some members of the team had previous experience working in specialized addiction services and knowledge of the addiction field, they did not maintain a direct clinical relationship with the participants or the services included in the study. Their role was to ensure methodological rigor throughout study design, data collection, and analysis. The team

Table 1. Description of the Groups and Their Participants.

Group Code	Group Typology	Participant Range Coding	Gender, *n* (%)		Age, *M* (SD)	Time in Treatment
			Men	Women		
GF1	Virtual. Residential services	U1–U9	9	–	38.8 (14.2)	6 months to 3 years
GF2	Virtual. Outpatient CAS. Benzodiazepines	U10–U13	–	4	55.5 (4.1)	5 months to 2 years
GF3	Virtual. Residential services	U14–U25	–	12	44.2 (11.1)	2 months to 9 years
GF4	In-person. Outpatient CAS. Alcohol	U26–U30	5	—	28.0 (1.6)	11 months to 4 years
GF5	In-person. Outpatient CAS. Alcohol	U31–U37	–	7	48.3 (12.6)	1 week to 7 years
Total			14 (37.8)	23 (62.2)	42.7 (13.0)	1 week to 9 years

Outpatient CAS: acronym for Centres d'Atenció i Seguiment a les drogodependències, specialized outpatient addiction care centres, including problems related to alcohol, illicit drugs, and other substances with addictive potential.

maintained continuous oversight of group dynamics and the analytic process to ensure transparency and objectivity in coding, theme identification, and interpretation.

The study was promoted within the context of the development process of the Barcelona Drug and Addictions Action Plan 2021–2024 by the Barcelona Public Health Agency. However, the study design, the conduct of the focus groups, the data analysis, and the interpretation of the results were carried out by the research team. None of the researchers was involved in the provision of care at the centres included in the study.

Data Collection

At the beginning of each focus group, participants were asked to anonymously provide their age and length of time in treatment. They were informed verbally about the objectives of the study, the approximate duration of the session, and the voluntary nature of their participation. All participants provided verbal informed consent and all of them were informed of their right to withdraw at any time without penalty, agreeing that their anonymized and aggregated data could be used confidentially for research purposes.

No circumstances arose during the data collection process that required changes to the initial protocol. The information obtained was deemed sufficient in both quality and depth to address the study's research questions.

Focus group sessions lasted between 65 and 115 min, with an average of 94 min. They aimed to promote natural, open dialogue among participants. Each session began with a general introduction to the study objectives and a presentation of the facilitators. A semi-structured discussion guide was used to explore perceived barriers and facilitators to service access, as well as participants' suggestions for improving care.

To promote clarity and inclusivity, facilitators periodically summarized key points and invited participants to revisit or expand on topics that had been discussed only briefly or left open.

At the conclusion of each session, participants received a €15 voucher for a local sporting goods store as a token of appreciation for their time and contributions.

The research team engaged in ongoing reflexivity throughout the study design and

Table 2. Organization of Codes and Subcodes.

Codes	Subcodes
Access to treatment	Self-initiative
	Detoxification
	Family support
	Private sector care
	Referral by other services
Stigma	Social stigma
	Family stigma
	Double stigma
	Type of drug
	Illness
	Stigma for abstaining
	Professional stigma
Social and occupational reintegration	Integration programs
	Legal status
	Engagement with the service
Resource improvements	Shortage of staff
	Follow-up support
	Urgent and helpline support
	Coordination among services
	Prescribing practices
	Limitation of subsidized spots
	Professional training
	Internship students

implementation (De la Cuesta-Benjumea, 2011), with particular attention to how prompts, openings, and closings were framed during data collection. After the first focus group, the team reviewed the session and confirmed that the discussion guide and facilitation style were appropriate and effective. No modifications were required, as the protocol supported participant-led discourse and was in accordance with the ethical and methodological goals of the study.

The focus groups were conducted in Spanish. For the preparation of the English version of the paper, the selected verbatim quotations were translated into English by the research team, seeking to preserve the original meaning and tone of the interventions, and were subsequently reviewed by a professional scientific translator with bilingual competence who verified that the translation chosen by the researchers corresponded to the meaning of the Spanish version.

With participants' permission, all focus group sessions were audio recorded and later transcribed verbatim. Transcripts were imported into Atlas.ti version 7 (https://atlasti.com) for thematic analysis because the software was deemed appropriate for managing qualitative data in a phenomenological framework.

Analysis Strategy

A qualitative study with a descriptive and phenomenological approach was conducted using thematic content analysis. The thematic analysis facilitated the systematic identification, organization, and examination of patterns (themes) through repeated readings of the data by the research team (Braun & Clarke, 2006). This method allowed the identification of cross-references between themes, which were then compared with other units of analysis to gradually develop a comprehensive list of codes and themes, culminating in final consensus among the researchers (Alhojailan, 2012). Data were coded using open, axial, and selective coding procedures, which were subsequently grouped into subcategories and broader themes through constant comparison and discussion among the researchers (Gibbs, 2007; Strauss & Corbin, 1990).

In addition to the two pre-identified topics (barriers/facilitators to treatment access and care improvement proposals) two inductively derived codes emerged, encompassing 23 subcodes, which were grouped under two overarching themes: stigma, and social and occupational integration (Table 2).

Two researchers independently developed the codes and subcodes, meeting at several stages to discuss their decisions and reach final consensus. The codes were then analysed both independently and collaboratively to enhance the reliability of the process (Saldaña, 2013). This approach helped minimize bias associated with the researchers' individual perspectives.

Additionally, five meetings (both in person and virtual) were held to standardize the analysis and strengthen the overall rigor of the process. An external specialist in substance use disorders supervized the study, conducting a cross-sectional audit of the process to ensure transparency, objectivity, and to promote consensus in defining the units of analysis.

No significant contradictions or discrepancies were identified that could not be resolved during the analysis process.

The study adhered to the standards of the American Psychological Association for conducting qualitative research (Levitt et al., 2018). This included maintaining an audit trail, ensuring transparency in coding procedures, and emphasizing analytic reflexivity. In addition, the manuscript revision drew on recent guidance by Hellman (2021, 2025) on the presentation and evaluation of qualitative research, particularly with respect to coherence between objectives, analytical strategy, manuscript structure, and the explicit articulation of the interpretive value of the findings.

Results

The results were organized into four main thematic areas: access to treatment, experiences of stigma, social and occupational reintegration, and proposals for improving services. Within these areas, both elements shared by men and women and relevant gender-based differences were identified, especially in relation to access, the experience of stigma, and recovery conditions.

Category 1: Barriers and Facilitators to Treatment Access for Service Users

Participants described their experiences initiating access to treatment, detailing the clinical pathways they followed to reach outpatient treatment centres or various residential treatment services. They also highlighted the importance of identifying potential barriers and facilitators encountered along the way, such as the presence of supportive figures or, conversely, the absence of such support or the existence of family or personal obstacles that hindered or complicated their access to care.

Self-Initiated Access to Treatment. Several participants described having initiated access to treatment on their own initiative, generally at moments of intense distress, exhaustion or a sense of having reached a personal limit in relation to substance use. At this point, no clear differences emerged between men and women, since in both groups there were accounts of seeking help motivated by the impossibility of continuing to sustain the situation without professional support:

> I went to the CAS, desperate, asking for help because I was hooked on heroin, cocaine, and pretty much every drug you can think of. (U9, woman, 50 years)

> I went straight to the CAS, I asked for help myself. (U9, man, 34 years)

> I came here on my own. I tried quitting by myself, but it was just impossible. I couldn't do it. (U36, woman, 48 years)

Outpatient and Inpatient Detoxification. Access to resources by detoxification was emphasized as an essential step in continuing treatment and maintaining abstinence. Some participants mentioned receiving detoxification treatment at the outpatient centre, with no notable gender differences noted. In contrast, men reported far more inpatient detox admissions (with or without a dual diagnosis process).

Women cited caregiving duties and limited family support as barriers to inpatient detox, making outpatient options more feasible:

> It was tough for me because I had bills to pay, two kids, and had to leave my apartment. My daughter, who's 21, has been really supportive, always there for me. But with my older son, it's been difficult. We're just starting to reconnect now. My

> relationship with my dad is complicated: he's 80, and I haven't had his support. It's been a really tough experience for me, and honestly, I think it's easier for men. (U23, woman, 50 years)

Family Support. Some participants shared that they entered treatment feeling motivated, often with the support or encouragement of their families. As is common in cases of drug dependency, it is often the families who notice the problem before the individuals themselves. In these cases, families take the initiative to learn about the treatment process and accompany their loved ones to the service:

> In my case, it was my family … They saw I was using a lot, and through a psychologist we knew, I ended up coming here to the CAS. (U30, man, 64 years)

In the groups analysed, a gender difference emerged in the way family support at treatment entry was mentioned. Whereas several men reported having accessed treatment with the support or encouragement of family members, among women this type of support appeared much less frequently in the narratives:

> I started 8 years ago … my wife made me go. (U28, man, 44 years)

> My sister called the green hotline, and they sent me to the CAS in Gràcia. (U14, woman, 38 years)

> I haven't had any support … it's been really tough. I think it's easier for men. (U23, woman, 50 years

This finding should be interpreted as a trend observed in the narratives rather than as a conclusive difference that can be extrapolated to all individuals receiving care in these services.

Treatment Initiation in Private Sector Care. Some participants with previous residential treatment experience opted for private-sector care because of faster access, shorter wait times, and fewer preconditions compared to public services.

However, few participants sought private services, and most were men. Few women reported accessing private treatment, largely because of insufficient financial resources to cover the costs:

> I got into a therapeutic community through [private clinic], where I was seeing a private psychiatrist covered by my insurance (…) I spent 5 months paying more than 3,000 euros a month. (U22, woman, 32 years)

Referral to Specialist Treatment by Other Services. Approximately half of the participants were referred to specialized addictions treatment through other services, including the mental health network, primary care centres (CAP), child and adolescent care teams (EAIA), and various social and healthcare services.

Two main gender differences emerged at this point. First, women reported being referred by other services more often than men. Second, referrals from the EAIA to initiate treatment were made exclusively for women. No men were recommended or referred to addictions treatment services by these teams:

> I was referred from the CSMA [Adult Mental Health Centre] (…) The psychologist advised me to go to the CAS for my benzodiazepine addiction. (U11, woman, 52 years)

> The EAIA took my kids because of my addiction and the domestic violence I was going through (…) they offered me a chance to join a service to get help with my addiction … (U25, woman, 40 years)

Some women also pointed to specific barriers related not so much to the decision to initiate treatment, but rather to the configuration of certain services and care procedures. In particular, mixed-gender programs and certain supervisory practices were at times experienced as uncomfortable, intrusive or unsafe, especially

among participants with previous experiences of violence:

> I refused to join treatments with men. Because of the violence I'd been through, I just couldn't talk about my problems in groups with them … I asked to switch professionals for the urine test because a man was going to do it. The woman who ended up doing it got really mad and asked me why I didn't want a man to do the test. I felt so offended and judged. (U25, woman, 40 years)

Category 2: Experiences of Stigma and its Impact on Treatment

Beyond the logistical aspects of care access, participants reflected on the stigma surrounding substance use disorders. They also shared personal experiences of social stigma, either experienced themselves or observed in others who were also diagnosed with substance use disorders and were close to the participants.

Social and Family Stigma. First, most participants reported feeling excluded from society during their substance use, and many continued to experience stigma even while in treatment or maintaining abstinence.

Participants reported that this social stigma led to difficulties in forming trusting social relationships outside of the substance use environment and in rebuilding relationships lost because of their addiction. This impacted social recovery, which is a key component of holistic recovery according to the biopsychosocial model:

> I've always felt really embarrassed telling my closest friends that I have issues with alcohol. (U36, woman, 48 years)

> It's hard to say you're going to the CAS because you have an addiction problem. It's not like going to the dentist. (U37, woman, 58 years)

Second, reports of stigma from family members were infrequent, but when mentioned, they came exclusively from women. This suggests a gendered pattern in familial reactions to substance use:

> I've felt stigmatized by my family. (U10, woman, 56 years)

Third, several female participants reported experiencing a "double stigma": being judged more harshly as mothers who use substances, compared to men in similar situations:

> Yeah, women really feel the social stigma of using, and it's even worse if you're a mom. In my case, being a mom, I got a lot of criticism for being a single mother and a user. I've had people say things like, 'Oh, look, they took her kid away because she was a drunk,' or 'That woman is always drinking; that's why she doesn't have her daughter.' I've had to put up with hurtful stuff like that. I had to leave the neighborhood where I lived just to stop hearing comments like that … And honestly, I don't plan on going back to that neighborhood because everyone knows they took my daughter away because I drank, and no one sees what you're doing now, only what you've done. I really think the stigma can drag you down … For me, it even caused a relapse because those comments just hit me so hard. (U34, woman, 37 years)

Stigma Associated with the Type of Drug. Some participants noted that the intensity of stigma varied by substance. Although alcohol was seen as normalized, heroin use carried heavy stigma. Women, in particular, pointed out that cocaine use, especially among higher-income groups, was often perceived as less shameful. Hypnotics and sedatives, however, were increasingly stigmatized:

> I remember when I was using heroin, the stigma was way worse than with any other drug (…) and when you're using heroin, it really shows – you can't hide the way you look. (U37, woman, 58 years)

> We reckon the most looked-down-on drugs are heroin and pills (…) Cocaine's pretty normal these days – you see politicians, chefs, all sorts using it. But with parents, it's different. If they see their kid with a few bottles of booze hanging out with friends, they don't bat an eye. But if they caught them with little bags of coke, they'd freak out. (U30, man, 64 years)

Stigma Related to Abstinence and Suggestions for Reducing Stigma. In contrast to stigma associated with drug use, a substantial number of men described facing social judgment for abstaining. In the accounts presented, this social pressure appeared mainly in contexts of socially normalized alcohol consumption, where not drinking was interpreted as strange or uncomfortable behaviour within the group. As a result, the social ritual of substance use emerged as both a risk factor for relapse and a challenge to maintaining abstinence, particularly for those with limited social support. In this sample, this type of pressure was described mainly by men and chiefly in relation to alcohol consumption contexts. Therefore, the finding should be interpreted with caution and limited to the social consumption rituals that emerged in these narratives:

> I think people who don't drink get more judgment than those who do (…) once, someone said to me, 'Oh, why aren't you having a glass of wine with the snacks? That's weird.' In this society, it's totally normal, even seen as fine, to have a beer, a glass of wine, a drink, or a coffee with a shot. (U30, man, 64 years)

> "For me, the few times I've been told, 'Oh, you're a bit boring,' it was because I wasn't drinking. Another time, I was with someone who was having a drink, and they just couldn't handle that I wasn't joining in. (U27, man, 51 years)

> Here, it's like you have to have a beer, because if not, you can't get the snack down. (U28, man, 44 years)

Importantly, none of the women mentioned feeling pressure or stigma for maintaining abstinence or for not participating in socially established consumption rituals. In this sample, these accounts suggest gendered differences in socially normalized drinking rituals, particularly around alcohol, rather than a pattern that can be generalized to all substances.

On another note, participants emphasized the need to reduce stigma by raising awareness of the challenges faced by individuals with substance dependence and the difficulties involved in their recovery. They suggested that if society understood that addiction is a disease, much like diabetes, the social stigma surrounding people with substance dependence would likely disappear.

> It's a matter of not understanding that it's an illness. If people knew this isn't just a bad habit but a real disease, maybe the stigma would go away. (U35, woman, 68 years)

Stigma Within Treatment Services. Lastly, many participants reported feeling judged or mistreated by professionals within the treatment system itself. These experiences included stigmatizing language, dismissive attitudes, and, in some cases, psychological abuse:

> In one place, they'd say things like, "you addicts are" or "you addicts have" (…) and they used language that made it sound like they weren't part of that group, which really pissed me off because most of the professionals (like 80%) smoke. So, they're addicts too (…) If you can't control your smoking, you're an addict. I felt discriminated against because it was like they couldn't admit they were addicts too. I felt singled out. When I said it, they didn't like it at all. It was like: I could tell they were thinking, "you're an addict, but I'm not," and on top of that, they were rejecting it with everything they had. I thought: wow, it really bothers you when I point this out, doesn't it? So yeah, they definitely give addiction a negative vibe. (U9, male, 34 years)

> We felt singled out by a health professional at one of the places. The treatment is really bad towards us (…). The way they view addicts is really

> negative. We've overheard comments from the office like: "this bunch of clueless idiots," "headless chickens," that sort of thing. When they talk to the rest of the team, they use really insulting terms for us. (U3, man 58 years)

Category 3: Social and Occupational Reintegration

When asked about their short- and medium-term plans, many participants identified labour market integration and, to a lesser extent, access to educational opportunities as key elements for rebuilding everyday life and sustaining recovery. Rather than secondary objectives, these aspects emerged as central components of social inclusion. Most of them had faced social and employment barriers because of their history of substance use. Despite not being considered therapeutic in the traditional sense, employment integration programs were seen as essential components of recovery in all treatment stages. Participants shared their thoughts on the employment integration programs offered at different services.

Perceptions of Occupational Integration Support Offered by Treatment Services. Some participants expressed satisfaction with the employment support provided by their treatment programs. Positive feedback was consistent regarding therapeutic housing, outpatient services, and day centre:

> Here at the [service], they've got things set up really well. We talk about the timelines, the resources available, and how they're working for each person. You can really see how much the staff care about things like courses, work, and so on. (U5, man 55 years)

Participants also highlighted significant challenges in entering the job market outside the supportive context of treatment. Some felt that reintegration programs were too focused on technical skills, such as CV writing or interview preparation, at the same time as overlooking how many jobs are obtained through informal networks. They noted a contradiction: distancing from past social circles for therapeutic reasons often meant losing these job-related connections. This gap, they felt, was inadequately addressed by outpatient services:

> When it comes to getting back into social life, I've pretty much ended up on my own. I had to let go of a lot of the friends I used to use with, and honestly, I wish there was something out there to help you meet new people or make friends. I haven't really hung out with anyone outside of that scene, and I feel kind of left on my own (…) If you don't get the chance to meet new people while you're in treatment, it's really easy to slip back to your old crowd when you start feeling lonely, especially if there's no support from the service to help with that. (U1, man 27 years)

Legal Status and Employment Access among Migrant Participants. Participants with irregular legal status identified the lack of documentation as a critical barrier to employment. They emphasized the need for treatment centres to offer support with immigration processes to facilitate timely access to the job market. Many noted the lack of professionals with legal expertize in outpatient and residential services:

> I wish there was more legal support throughout the whole process of getting my papers. (U32, woman, 31 years)

Regularizing legal status was seen as essential not only for employment but also for broader social reintegration. Participants explained that undocumented status confined them to informal labor markets, exacerbating marginalization and complicating recovery. Many felt that services focused too narrowly on medical or psychological care, overlooking these critical social dimensions.

In this regard, a significant number of participants expressed feeling abandoned, highlighting that more support was needed throughout the recovery process. They emphasized that

this support should go beyond medical check-ups or medication reviews and include more frequent sessions with psychologists, social educators or social workers because these were often too infrequent:

> At the end of the day, getting a 20-min or half-hour session with the psychologist every month and a half or 2 months feels more like a token gesture than anything else. (U37, woman, 58 years)

> The social worker was always really overwhelmed and often couldn't give me the time I needed. She tried her best, but we didn't meet up much, even though it really helped me when we did. (U31, woman, 46 years)

> I was really looking forward to the session with the psychologist, but also a bit nervous. I'd never seen one before. When I saw how short the session was and that the next one wouldn't be for over a month, I felt pretty frustrated. (U32, woman, 31 years)

Ongoing Engagement with the Service. Participants emphasized the importance of maintaining long-term engagement with treatment services. This connection fostered a sense of security, supported identity reconstruction in recovery, and helped rebuild sober social networks through therapeutic groups:

> One of the things I'm really scared of is cutting ties with the CAS. I think it's super important to stay connected to the CAS, the staff, and the people there. (U27, man, 51 years)

Participants also noted that there were deeper issues, beyond the surface symptom of drug addiction, that required time to be properly managed:

> Since alcoholism is a chronic illness, I think it's important to stay connected at all times. We're chronic patients, and while the main focus of treatment is not drinking, there are other important things that need to be worked on in therapy. (U28, man 44 years)

Category 4: Resource Improvements

In this final category, participants offered suggestions to improve the quality of care and address limitations within current treatment services.

Staff Shortages and Limited Access to Follow-up Care. Participants reported a severe shortage of staff across both outpatient and residential treatment services. In residential facilities, they described instances where a single direct care professional was responsible for 30–40 users at a time:

> It would be good to have at least one more staff member at the therapeutic community. We're overwhelmed in the afternoons and on weekends when it comes to running groups and planning things. On the days when there's only one staff member on duty, it's just not possible to run the groups and keep up with all the users' plans. (U3, man, 58 years)

> Right now, I go to the service in the afternoons, and what I really miss is longer opening hours (it's just too short) and there aren't enough staff. There's only one person, and obviously that person can't keep up with all of us. (U4, man, 47 years)

These accounts indicate the need for greater professional support, particularly during afternoons and weekends, times when participants felt most vulnerable and underserved.

In outpatient services, staffing shortages also affected the frequency and length of follow-up sessions. Participants reported that appointments were sometimes limited to once a month, lasting no more than 30 min. Of that time, only a few minutes were spent on actual therapeutic work, with much of the session devoted to reviewing past progress or completing administrative tasks.

Participants linked these limitations, particularly the inability to address psychosocial crises promptly, to an increased risk of relapse. They described feeling exposed to high-risk situations without adequate follow-up support. Some even attributed relapses to the long gaps between sessions, shifting part of the responsibility from the individual to the shortcomings of the treatment system:

> Maybe a lot of the people we know who relapsed wouldn't have done so if the therapy sessions hadn't been so far apart. If they were closer together, a lot of relapses could have been avoided. (U28, man, 44 years)

To address these issues, participants recommended increasing staff numbers to enhance direct care and extend the opening hours of residential facilities. For outpatient services, they proposed more frequent and longer follow-up visits, with shorter intervals between sessions. Participants also highlighted the need for better public outreach to inform people about available services and their functions:

> (…) there's a real lack of publicity about the CAS service. People don't know what the CAS is. There's just not enough information out there. Most people don't have a clue; they don't understand what CAS is, and if this service were made more visible, it could help a lot of people. (U26, man, 46 years)

Need for Urgent Support: 24-hr Contact Options. Participants reported repeated difficulties contacting services by telephone. They noted that, given the widespread use of information and communication technologies in other sectors, similar tools should be adopted in addiction treatment to improve accessibility and support.

To address this gap, they proposed a 24-hr helpline, or a similar mechanism, to provide timely assistance during high-risk moments, particularly when the risk of relapse felt imminent. Several participants described feeling isolated during such moments and believed that access to an on-demand support service could serve as an important protective factor in such situations:

> A mobile service (24 h) where you could call if there's an emergency. It would prevent a lot of relapses. (U27, man, 51 years)

Lack of Coordination among Services. Participants expressed frustration with poor communication among and within services. They reported having to repeatedly recount their experiences, not just to each new service, but also to different staff members within the same service. Having to repeat sensitive or personal information triggered emotionally distressing situations, which participants found difficult to manage. They also described feeling unheard and misunderstood, attributing this in part to poor coordination among professionals and services involved in their care.

To address these issues, participants proposed a shared digital database accessible to both public and contracted services. This system would allow professionals in different mental health and addiction networks to track user progress more efficiently. Such a system, they argued, would help break the cycle of repetitive questioning. It would also reduce the emotional burden of repeatedly disclosing sensitive information, thereby improving the overall quality of care:

> There should be a shared database across different public health services because every time you go to a different CAS or another health service, you have to start from scratch and explain everything all over again, and that's not helpful. It's frustrating to have to go over your whole history with a professional you don't even know yet. (U31, woman, 46 years)

Inconsistent Prescribing Practices and Medication Oversight. Many female participants, particularly those with histories of benzodiazepine dependence (although not exclusively) expressed dissatisfaction with how easily

psychiatric medications could be obtained. They specifically criticized how readily these medications were prescribed and the lack of caution shown by some healthcare professionals, who they felt often ignored the addictive potential of such drugs:

> What really needs to change is how ridiculously easy it is to get these meds. You go to the doctor, say you're feeling bad, and they just hand you a prescription. But they're not actually fixing the problem; they're just slapping a band-aid on it. (U12, woman, 53 years)

Limited Access to Residential Treatment, Especially among Women. Participants reported a shortage of subsidized spots in therapeutic communities, leading to long waiting lists. This issue was especially pronounced for women. As a result of the low number of women in residential programs, they often experienced additional delays caused by gender-specific rooming arrangements. This created a compounding barrier that disproportionately affected women seeking residential care:

> A therapeutic community is meant for 28 people, but a therapeutic flat only takes 15, so there's a big gap in places. I had to wait 3 weeks to get into the flat, and some people waited even longer. The treatment's crazy expensive if you don't get a subsidy. It's more than €3,000; there's no way most people can afford that every month. (U22, woman, 32 years)

Need for Ongoing Training and Professional Consistency. Participants reported receiving conflicting messages from different professionals within the same service. For example, a message delivered in group therapy might contradict guidance given in an individual session. Participants viewed these inconsistencies as a serious barrier to effective care, particularly in intensive residential settings.

Participants stressed the importance of specialized training in addiction treatment, not only for newer staff but also for experienced professionals whose knowledge had become outdated. Participants noted that, based on their lived experience, they could readily identify inconsistencies, uncertainty, or improvised responses from less experienced professionals. These perceptions undermined the development of trust, which is an essential component of any therapeutic relationship:

> The staff here at CAS really need to keep up with their training. They should be proper specialists who know what they're doing. (U28, man, 44 years)

Concerns About the Presence of Interns in Therapeutic Settings. Several female participants expressed discomfort with the presence of internship students during individual therapy sessions. They noted that while consent was typically requested by professionals, it was often done in the presence of the intern, thus creating pressure to agree. Participants reported feeling unable to decline the request due to the social pressure of being asked in front of both the professional and the intern:

> I didn't even go to the group because I found it hard to open up in front of everyone, so just imagine how it felt with the students there too. (U35, woman, 68 years)

Finally, participants not only described the emotional strain of repeatedly recounting painful experiences (as noted in earlier sections), but also emphasized the added difficulty of doing so in the presence of interns, which is something they felt occurred far too often. In response, participants recommended that any request for an intern's presence be made privately, without the intern in the room, and that professionals avoid assuming automatic consent or the client's ability to assertively decline.

Discussion

The findings of the present study show that the experience of addiction treatment can be

understood not only in terms of formal access to resources or clinical outcomes, but also through how service users experience the care process, the treatment they receive, the structural barriers that shape their recovery, and the inequalities that modulate that experience (Cerdà et al., 2006). In this sense, the results particularly underscore the relevance of stigma, gender, and supports for social and occupational reintegration as central elements for understanding the perceived quality and effectiveness of services.

Barriers and Facilitators to Treatment Access for Service Users

Rather than depicting exceptional trajectories, the narratives collected reflect that access to treatment often occurs in contexts of heightened vulnerability, when problems associated with substance use have already intensified and support networks are insufficient or fragile. This suggests that part of the system continues to function in a predominantly reactive way – responding when the situation has already reached a critical level – instead of facilitating earlier detection and intervention. Added to this are persistent structural barriers, such as waiting lists for residential resources or the lack of services sufficiently adapted to the needs of some women (Boyle et al., 2000), as well as stigma associated with substance use, which can discourage patients from seeking helpand stigma.

This initial motivation was frequently undermined by substantial access barriers, particularly long waiting lists for residential services. As a result, some participants reported seeking private treatment services. However, the high cost of these options rendered them inaccessible for many. They also noted that, because of the high cost of these treatments, they were financially out of reach for many people who required them. These findings are consistent with previous studies on perceived barriers to residential treatment for women (Martínez & Calvo, 2022).

In addition, many women in this study expressed reluctance and encountered difficulties when accessing mixed-gender treatment programs. This concurs with research indicating that women with substance use disorders face multiple and varied barriers to entering and remaining in treatment (Arostegui & Martinez, 2018), many of which were reflected in our findings.

Some barriers stem from the prevailing model of care, which has historically been androcentric and often neglects the specific needs of women. For example, participants noted a lack of diverse therapeutic options tailored to women (Motyka et al., 2022). Gender stereotypes and beliefs embedded in this model also influence how professionals deliver care, sometimes resulting in misunderstandings of women's needs or the reinforcement of power dynamics within the therapeutic relationship. Several female participants described feeling judged or violated during specific procedures, such as when a male professional was required to be present during urine sample collection.

The findings also reveal gender-related barriers linked to socially assigned roles, which further hinder women's access to treatment (Arostegui & Martinez, 2018). Existing research indicates that women undergoing detoxification frequently bear greater caregiving responsibilities than their male counterparts (Callaghan & Cunningham, 2002). This was echoed in the present study, where most female participants reported that family obligations limited their ability to engage in inpatient detoxification, making outpatient care the more feasible option.

Despite often serving as primary caregivers, particularly for children and dependents, women with substance use disorders tend to receive less family support than men (Kingree, 1995). This pattern was also evident in our findings: male participants were more often accompanied by family members, whereas women typically attended alone. In line with previous research (Grella & Joshi, 1999), women in our sample were more likely to be referred to

treatment through child protection or social services. In contrast, men commonly entered treatment via referrals from employment services, the justice system or family members.

Transversally, the findings suggest that gender does not operate as a secondary variable, but rather as a dimension that reorganizes the care experience. In the case of women, caregiving responsibilities, the lower availability of family support, prior exposure to violence, and discomfort in certain mixed settings configure specific barriers to accessing and remaining in treatment. Therefore, incorporating a gender-sensitive perspective is not an optional complement to care, but a necessary condition for services to respond equitably to the needs of service users (Mutatayi et al., 2022).

Stigma and Self-Stigma

One of the most consistent findings of the study is that stigma does not appear as a peripheral element, but rather as an experience that cuts across different phases of the recovery process. It is not limited to external social judgment because it also affects family relationships, the perceived legitimacy of the person in treatment, and, in some cases, the interaction with services themselves. This is relevant because it suggests that recovery depends not only on stopping or reducing substance use, but also on reconstructing bonds, identities, and social positions eroded by processes of disqualification and exclusion.

A substantial body of research has documented the high levels of stigma and social exclusion experienced by people who use drugs (Luoma et al., 2007; Room, 2005). This was echoed in our findings, with most participants reporting experiences of societal exclusion and stigma, both past and present, related to their substance use disorder. Female participants additionally reported experiencing stigma within their own families, emphasizing the existence of a double stigma. This concurs with previous research demonstrating the compounded discrimination frequently encountered by women with substance use disorders (Taylor, 2010).

Within this context, participants who consumed alcohol reported experiencing less stigma than those who used illicit substances. Female participants also noted a growing stigma associated with the use of sedative and hypnotic medications. This may reflect the broader pattern in which women who use substances face higher levels of stigma than men and are more frequently diagnosed with mental health conditions such as anxiety and depression. These diagnoses often lead to increased medicalization and more frequent prescription of psychotropic medications, potentially reinforcing the stigma surrounding their use (Bacigalupe & Martín, 2021).

Notably, some participants reported feeling stigmatized by professionals within the very services intended to support them. This is consistent with earlier research, such as that reported by Lloyd (2013), which found that stigmatizing attitudes toward people who use drugs are common among both the general public and non-specialized health professionals. More recent studies have further emphasized that individuals in treatment frequently experience stigma from healthcare providers themselves (Earnshaw et al., 2013; Thybaut et al., 2023).

Employment as a Path to Reintegration

Focus group testimonies revealed that addiction treatment services often prioritize medical and psychological care, while social dimensions, such as employment and housing, are frequently deprioritized. However, participants emphasized that addressing social factors is fundamental to achieving sustained recovery. Among these, employment integration emerged as a critical factor in promoting long-term stability and preventing relapse.

Extensive research indicates that entering the workforce supports social reintegration and is associated with longer periods of abstinence and significantly lower relapse rates (Holtyn

et al., 2014; Silverman et al., 2012). Employment programs facilitate skill development, enhance self-esteem, and foster supportive networks that contribute to both emotional and social stability (Smyth et al., 2018). Furthermore, employment in harm reduction settings may play a pivotal role in reducing stigma, enabling individuals with lived experience of substance use to participate meaningfully in society and reconstruct their identities (Austin & Boyd, 2021).

Participants generally viewed employment integration programs within addiction services positively. However, a paradox emerged: although treatment protocols typically encourage distancing from substance-using environments, these settings often represent the most accessible employment opportunities for service users. This contradiction highlights the need to re-evaluate reintegration strategies to provide alternatives that minimize exposure to high-risk contexts and promote access to stable, regulated, and mainstream employment sectors.

Individuals with irregular administrative status face compounded barriers because their limited access to formal employment often forces them into precarious and informal labor sectors. This dynamic not only perpetuates social exclusion, but also increases the risk of relapse and exposure to further marginalization (Soova, 2013). Accordingly, the implementation of policies that facilitate labor regularization and expand access to inclusive employment programs is essential for effective and sustainable reintegration.

The narratives analysed suggest that employment and educational opportunities should not be understood merely as desirable outcomes after treatment, but as active supports within the recovery process itself, insofar as they foster social belonging, daily structure, self-esteem, and future expectations (Walton & Hall, 2016).

These results expand the previous literature by showing that, from the perspective of service users themselves, recovery is not defined solely by abstinence or adherence to treatment, but also by the real possibility of sustaining a viable everyday life, with support, social recognition, and opportunities for labour market integration outside the circuits associated with substance use.

Service Improvement Recommendations

The proposals formulated by the participants should not be interpreted merely as operational suggestions or isolated demands, but rather as indicators of structural limitations within the care system. Taken together, their accounts show that the perceived quality of treatment depends not only on initial access to a resource, but also on the ability of services to offer continuity, real accessibility, professional coordination, and responses tailored to complex needs throughout the recovery process. In this sense, several of the shortcomings identified coincide with problems already described in the addiction care literature, such as the insufficiency of places and resources, the scarcity of post-treatment supports, the need for greater professional specialization, and difficulties in coordination among services (Ashford et al., 2018).

Among the most prominent limitations is the scarcity of residential places, especially relevant in the case of women. This finding points not only to a problem of resource availability, but also to the persistence of services designed according to logics that are insufficiently sensitive to gender. In the narratives analysed, the lower availability of places for women and the delays associated with the organization of mixed spaces appeared as concrete obstacles to access and continuity of care. This observation is consistent with previous studies that have identified the lack of resources adapted to women's needs as a relevant barrier in treatment (Martínez & Calvo, 2022).

Alongside this, the narratives point to a perception of insufficient follow-up, particularly at moments of greater psychosocial vulnerability. The distance between visits, the brevity of some sessions, and the difficulty in obtaining immediate support in crisis situations were interpreted by several participants not as simple organizational inconveniences, but as factors

that could increase the risk of relapse. From this perspective, proposals such as extending opening hours, increasing staff, or creating urgent contact mechanisms (e.g., a 24-h support line) should be understood as attempts to strengthen the protective capacity of the system beyond the classic model of scheduled visits.

Another particularly relevant axis was the need for greater coherence and coordination among professionals and across services. Experiences of having to repeat one's personal history in different settings, or of receiving contradictory messages within the same resource, were experienced as a form of care fragmentation that undermines therapeutic trust and adds emotional burden to trajectories already marked by distress and stigma. In this sense, proposals related to improved interprofessional communication, the shared use of clinical and social information, and the adoption of more consistent intervention criteria suggest that continuity of care constitutes, from the user perspective, a central dimension of treatment quality.

Similarly, the findings suggest that services should strengthen their attention to labour and social reintegration not only through guidance or job placement resources, but also by recognizing that sustained recovery requires structural supports that allow the reconstruction of bonds, routines, and opportunities outside contexts associated with substance use.

Likewise, participants insisted on the importance of specialized and up-to-date training in addictions. This demand was not limited to inexperienced professionals because it also extended to more established profiles when their practice was perceived as rigid, outdated or insufficiently attuned to the complexity of substance use and recovery processes. This reinforces the idea that specialization in addictions should not be regarded as accessory knowledge, but as a basic competence that must be continually updated in services attending this population (Klimas, 2015).

Finally, the concern expressed by several women regarding the prescription and monitoring of benzodiazepines highlights an issue that goes beyond mere pharmacological control. Their narratives suggest that some prescribing practices may contribute to chronifying problems, medicalizing complex forms of distress, and generating new dependencies that are insufficiently problematized within the healthcare system. At this point, the recommendation to strengthen the training of primary care professionals and increase vigilance regarding the use of these drugs is especially pertinent, in line with research that has warned about the overrepresentation of women in psychotropic drug use and about the differential medicalization of distress in women (Bacigalupe & Martín, 2021). In this sense, the findings of the study can be understood as a practical contribution to service improvement, by making visible aspects of the care experience that are especially relevant to service users, such as real accessibility, the treatment received, gender sensitivity, continuity of support, and the need for more coordinated responses.

Limitations and Conclusions

The present study has several limitations that should be acknowledged. First, the sample size ($n = 37$) is relatively small, which may limit the diversity of experiences captured and reduce the depth and generalizability of the findings. Furthermore, because all participants were recruited from the city of Barcelona, the applicability of the results to other geographic or cultural contexts is limited. This highlights the importance of caution when attempting to extrapolate these findings beyond the local setting. In addition, the sample shows an overrepresentation of women and a relatively older mean age and therefore does not necessarily reproduce the overall profile of people attended in the Barcelona addiction care network. Although this does not invalidate the analytical value of the narratives obtained, it does recommend caution when extrapolating the findings to other profiles or care contexts.

A second limitation concerns the sampling method. Rather than employing a randomized

approach, the sample was selected based on convenience and stratified by gender, type of substance used, and participants' capacity to offer analytical and reflective input. Although this purposive strategy facilitated rich qualitative insights, it may have introduced selection biases. In addition, country of birth was not considered as a selection variable, and the sample included twice as many women as men. These factors affect the representativeness of the data, although it is important to note that achieving statistical representativeness was neither a goal nor a methodological possibility for this type of exploratory qualitative study.

A third limitation is the study's exclusive focus on service users' perspectives regarding stigma. Although participants shared valuable insights into their experiences of social and familial stigma, the study did not explore how stigma is perceived by family members themselves. This omission is important because research suggests that stigma experienced by relatives of individuals with substance use disorders may be more severe than that associated with other health conditions (Corrigan et al., 2006). Family members are often blamed for both the onset and persistence of a loved one's addiction, which may lead to social rejection and psychological distress. Such stigma can negatively impact family members' well-being and reduce their capacity to provide effective support (McCann & Lubman, 2018).

Despite these limitations, the findings of the study allow several relevant implications to be drawn for improving addiction treatment services. First, they show that access to treatment depends not only on the formal existence of resources, but also on their real accessibility, their capacity to respond to crisis situations, and the adequacy of services to diverse life trajectories. Second, they show that the care experience is shaped by gender inequalities that affect access, retention, lived stigma, and possibilities for recovery. Third, the results underline that combating stigma and strengthening structural supports such as employment, coordination among services, and continuity of care are central elements for sustained recovery. In this sense, systematically incorporating the voice of service users may contribute to designing services that are more sensitive, equitable, and better aligned with the real needs of those who use them.

ORCID iDs

Fran Calvo https://orcid.org/0000-0002-0300-8548
Catrina Clotas https://orcid.org/0000-0003-4976-3706
Daniel Urbina https://orcid.org/0009-0003-8786-3203

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

References

Alhojailan, M. I. (2012). Thematic analysis: A critical review of its process and evaluation. *West East Journal of Social Sciences*, *1*, 39–47.

Arostegui, E., & Martinez, P. (2018). Mujeres y drogas: manual para la prevención de recaídas con perspectiva de género. *Publicaciones de la Universidad de Deusto*, Departamento de Salud. Dirección de Salud Pública y Adicciones. Gobierno Vasco.

Ashford, R., Brown, A., & Curtis, B. (2018). Systemic barriers in substance use disorder treatment: A prospective qualitative study of professionals in the field. *Drug and Alcohol Dependence*, *189*(8), 62–69. https://doi.org/10.1016/j.drugalcdep.2018.04.033

Austin, T., & Boyd, J. (2021). Having a voice and saving lives: A qualitative survey on employment impacts of people with lived experience of drug use working in harm reduction. *Harm Reduction Journal*, *18*(1), 1–12. https://doi.org/10.1186/S12954-020-00453-5

Bacigalupe, A., & Martín, U. (2021). Gender inequalities in depression/anxiety and the consumption of

psychotropic drugs: Are we medicalising women's mental health? *Scandinavian Journal of Public Health*, *49*(3), 317–324. https://doi.org/10.1177/1403494820944736

Bartroli, M., Clotas, C., Barbaglia, G., Caballé, M., Garrido, A., Gotsens, M., & Pasarín, M. (2021). *Pla d'Acció sobre Drogues i Addiccions de Barcelona 2021–24*. Agència de Salut Pública de Barcelona.

Boyle, K., Polinsky, M., & Hser, Y. (2000). Resistance to drug abuse treatment: A comparison of drug users who accept or decline treatment referral assessment. *Journal of Drug Issues*, *30*(3), 555–574. https://doi.org/10.1177/002204260003000304

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Callaghan, R., & Cunningham, J. (2002). Gender differences in detoxification: Predictors of completion and re-admission. *Journal of Substance Abuse Treatment*, *23*(4), 399–407. https://doi.org/10.1016/S0740-5472(02)00302-1

Calvo, F., Carbonell, X., Turró, O., & Giralt, C. (2018). Connected in the street: The relation between social networks, selfesteem and satisfaction with life among individuals experiencing homelessness. *Aloma*, *36*(1), 21–28. https://doi.org/10.51698/aloma.2018.36.1.21-28

Calvo, F., Carbonell, X., Valero, R., Costa, J., Turró, O., Giralt, C., & Ramírez, M. (2018). Abandono precoz y retención en servicios ambulatorios de drogodependencias: Análisis transversal comparativo de factores que aumentan o disminuyen la adherencia. *Atención primaria*, *50*(8), 477–485. https://doi.org/10.1016/j.aprim.2017.06.006

Calvo, F., Costa, J., & Valero, R. (2016). Motivos de abandono temprano de pacientes en tratamiento ambulatorio de adicción a sustancias. *Revista Española de Drogodependencias*, *41*(1), 46–53.

Cerdà, J. C. M., Martín-Ruiz, E., Oviedo-Joekes, E., Sicilia, A. R., & Reinado, C. R. (2006). Percepción de usuarios de los Programas de Tratamiento con Metadona sobre la accesibilidad y atención recibida de los equipos terapéuticos. *Adicciones*, *18*(4), 359–369. https://doi.org/10.20882/adicciones.332

Coombes, L. (2015). Qualitative evidence in addictions. In *Handbook of qualitative health research for evidence-based practice* (pp. 187–201). Springer New York. https://doi.org/10.1007/978-1-4939-2920-7_12

Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame, and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, *20*(2), 239. https://doi.org/10.1037/0893-3200.20.2.239

Crapanzano, K. A., Hammarlund, R., Ahmad, B., Hunsinger, N., & Lockhart, R. (2019). The influence of stigma on triage decisions for patients with substance use disorders. *Psychiatric Quarterly*, *90*(2), 223–236. https://doi.org/10.1007/s11126-018-9611-z

De la Cuesta-Benjumea, C. (2011). La reflexividad: Un asunto crítico en la investigación cualitativa. *Enfermería clínica*, *21*(3), 163–167. https://doi.org/10.1016/j.enfcli.2011.02.005

De León, G., Perfas, F. B., Joseph, A., & Bunt, G. (2020). Therapeutic communities for addictions: Essential elements, cultural, and current issues. In *Textbook of addiction treatment: International perspectives* (pp. 697–707). Springer International Publishing. https://doi.org/10.1007/978-88-470-5322-9_52

Earnshaw, V., Smith, L., & Copenhaver, M. (2013). Drug addiction stigma in the context of methadone maintenance therapy: An investigation into understudied sources of stigma. *International Journal of Mental Health and Addiction*, *11*(1), 110–122. https://doi.org/10.1007/s11469-012-9402-5

Gibbs, G. R. (2007). *Analyzing qualitative data*. Sage Publications.

Grella, C., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. *The American Journal of Drug and Alcohol Abuse*, *25*(3), 385–406. https://doi.org/10.1081/ADA-100101868

Hellman, M. (2021). Dealing with qualitative work. *Nordic Studies on Alcohol and Drugs*, *38*(2),

105–111. https://doi.org/10.1177/14550725211003228

Hellman, M. (2025). Revisiting the quality criteria for qualitative research. *Nordic Studies on Alcohol and Drugs*, *42*(4), 277–288. https://doi.org/10.1177/14550725251358087

Holtyn, A. F., Koffarnus, M. N., DeFulio, A., Sigurdsson, S. O., Strain, E. C., Schwartz, R. P., & Silverman, K. (2014). Employment-based abstinence reinforcement promotes opiate and cocaine abstinence in out-of-treatment injection drug users. *Journal of Applied Behavior Analysis*, *47*(4), 681–693. https://doi.org/10.1002/jaba.158

Katz-Buonincontro, J. (2022). *How to interview and conduct focus groups*. American Psychological Association.

Kingree, J. (1995). Understanding gender differences in psychosocial functioning and treatment retention. *The American Journal of Drug and Alcohol Abuse*, *21*(2), 267–281. https://doi.org/10.3109/00952999509002694

Klimas, J. (2015). Training in addiction medicine should be standardised and scaled up. *BMJ*, *351*, h4027. https://doi.org/10.1136/bmj.h4027

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA publications and communications board task force report. *American Psychologist*, *73*(1), 26. https://doi.org/10.1037/amp0000151

Lloyd, C. (2013). The stigmatization of problem drug users: A narrative literature review. *Drugs: Education, Prevention and Policy*, *20*(2), 85–95. https://doi.org/10.3109/09687637.2012.743506

Luoma, J., Twohig, M., Waltz, T., Hayes, S., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors*, *32*(7), 1331–1346. https://doi.org/10.1016/J.ADDBEH.2006.09.008

Malivert, M., Fatséas, M., Denis, C., Langlois, E., & Auriacombe, M. (2012). Effectiveness of therapeutic communities: A systematic review. *European Addiction Research*, *18*(1), 1–11. https://doi.org/10.1159/000331007

Martínez, A., & Calvo, F. (2022). Tratamiento de drogodependencias en servicios masculinizados: Análisis de factores que dificultan o facilitan la adherencia de mujeres en recursos residenciales mixtos. *Investigaciones Feministas*, *13*(2), 719–733. https://doi.org/10.5209/infe.77481

McCann, T. V., & Lubman, D. I. (2018). Stigma experience of families supporting an adult member with substance misuse. *International Journal of Mental Health Nursing*, *27*(2), 693–701. https://doi.org/10.1111/inm.12355

Motyka, M. A., Al-Imam, A., Haligowska, A., & Michalak, M. (2022). Helping women suffering from drug addiction: Needs, barriers, and challenges. *International Journal of Environmental Research and Public Health*, *19*(21), 14039. https://doi.org/10.3390/ijerph192114039

Mutatayi, C., Morton, S., Robles Soto, N., Pálsdóttir, K. I., & Vale Pires, C. (2022). *Implementing a gender approach in drug policies: Prevention, treatment and criminal justice. A handbook for practitioners and decision makers*. Council of Europe.

Parés-Badell, O., Barbaglia, G., Robinowitz, N., Majó, X., Torrens, M., Espelt, A., Bartroli, M., Gotsens, M., & Brugal, M. T. (2020). Integration of harm reduction and treatment into care centres for substance use: The Barcelona model. *International Journal of Drug Policy*, *76*(2), 102614, https://doi.org/10.1016/j.drugpo.2019.102614

Rodríguez, G., Gil, J., & Garda, I. (1996). *Metodología de la investigación cualitativa*. Aljib.

Rodríguez de Fonseca, F., Aleixandre, R., Camí, J., Navarro, M., Torrens, M., Iraurgi, J., Oñorbe, J., De Andrés, R., Colom, J., Tomás, S., & Molina, M. (2006). La investigación en drogodependencias. *Trastornos Adictivos*, *8*(2), 115–321. https://doi.org/10.1016/S1575-0973(06)75111-X

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, *24*(2), 143–155. https://doi.org/10.1080/09595230500102434

Saldaña, J. (2013). *The coding manual for qualitative researchers*. Sage.

Silverman, K., Defulio, A., & Sigurdsson, S. (2012). Maintenance of reinforcement to address the chronic nature of drug addiction. *Preventive Medicine*, *55*(11), S46–S53. https://doi.org/10.1016/j.ypmed.2012.03.013

Smyth, B. P., Ducray, K., & Cullen, W. (2018). Changes in psychological well-being among heroin-dependent adolescents during psychologically supported opiate substitution treatment. *Early Intervention in Psychiatry*, *12*(3), 417–425. https://doi.org/10.1111/EIP.12318

Soova, M. L. A. K. (2013). *Undocumented migrants: rights and advocacy*. The encyclopedia of global human migration. https://doi.org/10.1002/9781444351071.WBEGHM552

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage Publications.

Taylor, O. (2010). Barriers to treatment for women with substance use disorders. *Journal of Human Behavior in the Social Environment*, *20*(3), 393–409. https://doi.org/10.1080/10911351003673310

Thybaut, R. J., de Jong, C. A., Pinxten, L., & van Rijn, L. (2023). Addiction does not rule out somatic disease: Don't let stigma influence diagnostic approach and treatment. *Nederlands tijdschrift voor geneeskunde*, *166*(3), D7109–D7109. PMID: 36943165

Walton, M. T., & Hall, M. T. (2016). The effects of employment interventions on addiction treatment outcomes: A review of the literature. *Journal of Social Work Practice in the Addictions*, *16*(4), 358–384. https://doi.org/10.1080/1533256X.2016.1235429

Webb, L., Fox, S., Skårner, A., & Messas, G. (2022). Editorial: Women and substance use: Specific needs and experiences of use, others' use and transitions towards recovery. *Frontiers in Psychiatry*, *13*(12), 1078605. https://doi.org/10.3389/fpsyt.2022.1078605