Barriers to Substance Abuse Treatment in Barbados:

Factors Hindering Women's Use of Treatment Services

NCSA
National Council on Substance Abuse

Author:
Laura Lee Foster, Research and Information Officer, National Council on Substance Abuse

Published by:
The National Council on Substance Abuse
Cnr. 1st Avenue Belleville & Pine Road, St. Michael, Barbados

Tel: (246) 535-6272
Email: ncsa.info@barbados.gov.bb
Website: www.ncsa.gov.bb

July 2023

Reference as:
National Council on Substance Abuse (2023). Barriers to Substance Abuse Treatment in Barbados: Factors Hindering Women's Use of Treatment Services. Government of Barbados

ACKNOWLEDGEMENTS

The National Council on Substance Abuse (NCSA) is grateful to all persons and agencies that contributed to the successful conduct of study.

In particular, the Council extends gratitude to the United Nations Office on Drugs and Crime (UNODC) for funding the data collection process. The NCSA also thanks the participating treatment centres for sanctioning the conduct of the study at their facilities and for their support throughout the research process. Special thanks are also extended to all participants.

Lastly, the following members of the data collection team are acknowledged for their diligent work and commitment to the project:

- Ms. Charmaine Belgrave
- Ms. Allison Medford
- Ms. Asha Phillander

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ABSTRACT

Anecdotal reports suggest that women in Barbados are underrepresented in drug treatment centres due to barriers beyond their control. These reports formed the basis of this qualitative study which explored the internal and external barriers to treatment for women on island. Semi-structured individual interviews were used to collect data from four drug treatment providers, while a focus group discussion was conducted with seven female clients in residential drug treatment. The results suggest that most of the barriers affecting women are external, and are related to: their children, a lack of family support and knowledge about addiction, having a drug using partner or one who sells drugs, unmet basic needs, stigma and stereotypes, the absence of workplace drug policies, and the characteristics of treatment facilities/programmes. Internal barriers included denial and a lack of motivation to change, fears, co-occurring disorders and lack of information about available treatment services. A number of corresponding recommendations aimed at reducing the impact of these barriers are offered. In addition to providing a useful roadmap to improve treatment access and utilization among women in Barbados, this study also provides much-needed local literature on the topic and serves as a springboard for future studies in the area.

INTRODUCTION

Substance abuse and addiction are public health problems which affect millions of persons worldwide (Allen, 1995; Khalsa, Treisman, McCance-Katz & Tedaldi, 2008). They have a range of adverse effects on physical and mental health, family relationships, and the job/school performance of individuals with addiction (Al-Kandari, Yacoub & Omu, 2007). Not only do they affect the individual and their family, when left untreated they also place large burdens on a country's workforce and its health and legal systems (Myers, Louw & Pasche, 2010).

Treatment programmes mitigate substance use disorders and by extension, the associated negative consequences. While treatment services are recognized as essential and beneficial for substance abusers, they must be accessible and utilized if they are to be effective.

Research has shown that there are a number of factors, also known as barriers, which hinder access to, and use of, treatment services. The current study explores and describes barriers to treatment for women in Barbados. This population was selected as anecdotal reports from local treatment providers suggest that females are underrepresented in Barbadian treatment centres for various reasons, including a lack of childcare (National Council on Substance Abuse, 2019).

Barbados Drug Information Network (BARDIN) reports for the years 2011 through 2021 show that males seeking substance abuse treatment in Barbados continuously outnumber their female counterparts. The most recent report shows that females account for between 10% and 25% of non-incarcerated, local treatment seekers depending on the reporting treatment centre (National Council on Substance Abuse, 2023). Treatment providers in Barbados suggest that these statistics do not accurately represent: (1) the magnitude of problematic drug use among local females, and (2) the true number of females in need of substance abuse treatment in the country.

While there is no official research to support these anecdotal reports, their value cannot be discounted as the treatment providers interact with the treatment seeking population on a daily basis and are therefore familiar with their challenges and realities. Thus, the aforementioned anecdotal reports formed the basis for this qualitative, exploratory research. Data was collected by means of interview from treatment providers in the four main centres which cater to non-incarcerated persons in Barbados, as well as treatment clients at the lone residential facility for women on island.

Research Problem and Rationale for the Study

Barriers to substance abuse treatment (SAT) are particularly problematic for women, as evidence shows that while they typically consume less alcohol and illicit substances than men, they tend to develop substance-use related problems more rapidly and with greater severity than their male counterparts (Green, 2006; National Council on Drug Alcoholism and Drug Dependence Inc., 2015). Likewise, when compared to men, women also experience more severe consequences as a result of their substance abuse, including health-related problems and difficulty functioning within their various life domains (Green, 2006). It is therefore imperative that women's access to treatment be facilitated and promoted in an attempt to prevent the progression of their substance use disorders and mitigate the associated adverse effects.

Treatment barriers for women generally differ from those experienced by men and are often related to their specific needs, roles and responsibilities as well as societal norms and expectations regarding women (United Nations Office on Drugs and Crime [UNODC], 2004). To improve treatment utilization by women in Barbados, the barriers must be removed or at the very least reduced. For this to happen, they must first be identified.

While extra-regional studies have explored treatment barriers for women, there is a dearth of local and regional information on the topic. In fact, a search of journal databases suggests that no such studies have been conducted in Barbados or the wider Caribbean. This is a significant problem as what exists may not be culturally relevant and, as such, may not lend itself to the local situation. The current study therefore attempts to address this problem by providing much needed local research on the matter.

Armed with the findings, policy makers and practitioners will be better placed to craft appropriate responses which cater specifically to the needs of, and issues affecting, women with substance use disorders in an effort to increase their uptake of the available services.

In addition to filling the data gap and providing useful decision-making information, the current research also serves as a springboard for additional studies on the topic, by identifying areas for further investigation.

LITERATURE REVIEW

Research has shown that women across the world face many of the same barriers to treatment despite obvious cultural, religious or geographic differences (UNODC, 2004). These barriers can be classified as either internal or external. The following review outlines a selection of the most common barriers within these two broad categories. It should be noted that while some may also apply to men, they tend to have a greater impact on women.

External Barriers

External barriers are those outside of an individual's control and include treatment programme characteristics as well as social, cultural and environmental issues (Allen, 1995; Xu, Rapp, Wang & Carlson, 2008).

Treatment Programme Characteristics

Cost. The cost of treatment can be prohibitive for some women. This is particularly the case when treatment is self-funded. In such cases, a lack of insurance coverage and an inability to pay treatment expenses are among the main issues encountered (Rosen, Tolman & Warner, 2004; Xu et al., 2008). While the cost of treatment can be a barrier for both men and women, it may be more problematic for women as studies have shown that a greater proportion of men self-pay while more women depend on public insurance to finance their treatment (Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2006; O'Neil & Lucas, 2015). This suggests that women are less likely than men to have the financial means to fund their treatment.

Treatment Location. Geographic proximity to services and the distance which persons must travel in order to access treatment can hamper women's use of treatment services (Priester et al., 2016; Rosen, et al., 2004; Xu et al, 2008). More specifically, treatment location can be problematic when women are reliant on programmes outside of their communities or have to travel considerable distances to access treatment within their own communities (UNODC, 2004). The issues posed by location can be compounded by a lack of, or inability to afford, transportation to and from treatment (Browne et al., 2015), as well as domestic responsibilities

and cultural norms which prohibit women from leaving their communities (UNODC, 2004). The latter are of greater significance when residential treatment is involved.

Waiting Periods and Lack of Immediate Response Capacity. It is not unusual for persons seeking treatment to encounter waiting periods before assessment and treatment entry, and these are usually the result of organizational issues, such as staff shortages (Redko, Rapp & Carlson, 2006). Such delays have been identified as a common barrier to treatment, with longer waiting periods being associated with the reduced likelihood of persons following through with treatment (Festinger, Lamb, Kountz, Kirby & Marlowe, 1995). This is due in part to their continued use of drugs during the waiting period; or alternately, their view of any sobriety during the waiting period as evidence that they do not need treatment (Redko et al., 2006). Waiting periods and a lack of immediate response capacity within treatment centres is of particular relevance for women, who have been found to experience longer wait times than men, particularly for residential treatment (UNODC, 2004).

Lack of Wraparound Services. Women in need of substance abuse treatment often have additional issues which require specialized assistance, such as: mental health treatment, prenatal services, welfare services, as well as education and skills training to enhance employability (UNODC, 2004). They also often have practical needs regarding childcare, transportation, food and housing (UNODC, 2004). Research has shown that women are more likely to enter and be successful in treatment when their specific needs are addressed through the incorporation of wraparound services within treatment programmes which facilitate access and improve retention (Oser, Knudsen, Staton-Tindall & Leukefeld, 2009). Conversely, a lack of wraparound services can be a treatment barrier for some women. While this is known, funding and resource deficits prevent the inclusion of such services within all treatment programmes.

Gender Composition and Associated Characteristics of Treatment Programmes. Women-only treatment programmes typically differ from mixed-gender programmes in terms of philosophies, approaches, services and staffing (Prendergast, Messina, Hall & Warda, 2011). The former are generally more reflective of the gender norms within society and tend to be more responsive to women's needs, realities, interaction styles and patterns of substance use. Some

studies have revealed greater treatment retention and better outcomes for women in same-sex programmes (e.g. Dahlgren & Willander, 1989; Greenfield et al., 2008; Grella, 1999). However, this is not always the case as others have shown no difference between same-sex and mixed-gender programmes (e.g. Kaskutas, Zhang, French & Witbrodt, 2004). Therefore, further research is needed to settle the debate. However, in the interim, it is noteworthy that women-specific programmes typically offer more wraparound services than mixed-gender programmes and such services are treatment facilitators for women (Brady & Ashley, 2005; Oser, Knudsen, Staton-Tindall & Leukefeld, 2009).

Social, Cultural and Environmental Barriers

Lack of Support and Encouragement from Family and Friends. Relationships are of great significance to women (UNODC, 2004) and therefore their family and friends can serve as a powerful impetus for treatment entry and recovery or they can serve as a significant deterrent (Poole & Isaac, 2001). In fact, active support from a trusted family member has been shown to be one of the most important factors making it possible for women to access treatment (Poole & Isaac, 2001). Alternately, a lack of support and encouragement from family and friends can serve as a treatment barrier for women.

Having a Substance Using Partner. Research has shown that the intimate partners of drug users influence their treatment options and this is particularly true for women (Simmons & McMahon, 2012), who are more likely than men to have substance using partners (UNODC, 2004). A study by Riehman, Hser and Zeller (2000) found that addicted women with a partner who had been in treatment had an increased interest seeking treatment themselves. Conversely, there was a decreased interest among those with a drug using partner who was not in treatment (Riehman et al. 2000). This may be due in part to the drug-using partner discouraging the woman from seeking treatment, threatening violence or threatening to leave the relationship if she seeks treatment (Brady & Ashley, 2005; Otiashvili et al., 2013; Shulga, Tokar, Smirnov & Dvinskykh, 2011).

Lack of Childcare. A lack of childcare has continuously been cited as a treatment barrier for women, who are more likely than men to have dependent children in their care (Brady &

Ashley, 2005). This may be related to the fact that addicted women are also more likely than men to come from families with substance using problems, have substance using partners, and have been childhood victims of abuse or neglect (UNODC, 2004). As a result, they often lack the traditional sources of childcare and support found within the family (UNODC, 2004). This is compounded by the fact that many treatment programmes do not offer childcare services and therefore fail to accommodate the needs of women with children (Brady & Ashley, 2005; UNODC, 2004).

Possibility of Losing Children. One of the most powerful barriers to treatment for women is concern over the custody of their children. Particularly, the possibility of child protective services becoming involved, leading to the removal of their children (Allen, 1995; Elms, Link, Newman & Brogly, 2018; Stone, 2015). In the case of pregnant women, these issues are compounded by the fact that substance use during pregnancy can result in criminal charges in some jurisdictions in addition to child removal at, or shortly after, birth (Angelotta & Appelbaum, 2017; Stone, 2015). As such, it is not uncommon for some substance using mothers and pregnant women to avoid seeking treatment (UNODC, 2004) and take steps to avoid detection (Stone, 2015).

Work and Domestic Responsibilities. Responsibilities at work and home can serve as treatment deterrents for women. This is particularly the case when women cannot get/take time off of work or do not get the needed support with their domestic responsibilities (e.g. childcare and household duties) to allow them to attend treatment. Such issues are further compounded by treatment programmes which lack flexible hours that allow access to services outside of normal business hours e.g. in the evenings and on weekends (Browne et al, 2015).

Stigma and negative stereotypes. Substance abuse is commonly stigmatized and this stigma can serve as a deterrent, preventing those with substance use disorders from seeking treatment due to feelings of embarrassment, shame and guilt (Hammarlund, Crapanzano, Luce, Mulligan & Ward, 2018). Common negative stereotypes include the belief that such persons are mad, weak, dangerous, violent, manipulative, lack self-control and are poorly motivated to change (Hammarlund et al, 2018; Myers, Fakier & Louw, 2009). While stigma and negative

stereotypes can be barriers for both men and women, they tend to be more impactful for women as female substance use is more highly stigmatized (Brady & Ashley, 2005; Myers et al, 2009; Stringer & Baker, 2015; UNODC, 2004). As a result, women may find it difficult to acknowledge their substance use problems and may choose not to seek treatment in an attempt to avoid being negatively labelled by society.

Internal Barriers

Internal barriers arise from within the individual and include their personal beliefs, feelings and thoughts (Allen, 1995; Xu, Rapp, Wang & Carlson, 2008). It should be noted that internal barriers have been found to be of great significance and are often even more powerful than external barriers (Xu, Wang, Rapp & Carlson, 2007).

Failure to recognize or acknowledge having a problem with drug use

Personal denial may be one of the most significant barriers to treatment linkage and retention. This includes not recognizing that one has a substance use problem and consequently having little motivation to enter treatment (Xu et al. 2007). This barrier affects both men and women.

Fears

The literature highlights a variety of treatment-related fears. These include fears surrounding the effectiveness and confidentiality of the treatment process (Myers et al, 2009) as well as fears regarding the treatment itself, which may be the result of bad previous experiences, an aversion to specific types of treatment e.g. methadone maintenance, or simply the fear of the unknown due to never having been in treatment before (Allen, 1995; Xu et al, 2007). These, as well as fears of disappointing those who are offering help and being unable to stay away from drug-using friends, can be influential deterrents (Xu et al, 2007).

Lack of Knowledge about Treatment Options

Women and members of their support networks are sometimes unaware of the available treatment options and are therefore unable to make use of them (Otiashvili et al., 2013; UNODC,

2004). Likewise, persons in the helping professions sometimes lack the information needed to make the requisite referrals for women in need of substance abuse treatment (UNODC, 2004). Thus, in order to promote the use of treatment, efforts must be made to ensure that the target population, their support networks and health service providers are well-educated about the services and programmes on offer.

Previous Methodologies

While there is a death of local research on the topic, there is a considerable body of international literature which highlights the barriers to treatment for women the world over; and to date, various methodologies have been used to investigate the topic. Among the most common are surveys (e.g. Allen, 1995; Xu et al, 2007; Xu et al, 2008), individual interviews (e.g. Myers et al, 2010; Otiashvili et al, 2013) and focus group discussions (e.g. Jones, Hopson, Warner, Hardiman & James, 2014). The qualitative studies used specially designed interview schedules while many of the surveys incorporated existing scales designed specifically to measure treatment barriers, including: the Allen Barriers to Treatment Scale (e.g. Allen, 1995) and the Barriers to Treatment Inventory (e.g. Xu et al, 2007; Xu et al, 2008; Rapp et al, 2006). It should be noted that some researchers opted to use a mixed methods approach, making use of both interviews and surveys (e.g. Masson et al, 2013).

Studies have also varied in their sources of information. Some have sought information from the treatment seekers themselves (e.g. Myers et al, 2010; Rapp et al, 2006) while others focused on the views of treatment providers, programme directors and gatekeepers (e.g. Abraham, Lewis & Cucciare, 2017). A third group gathered data from both treatment seekers and providers (e.g. Masson et al, 2013; Otiashvili et al, 2013). Each of these groups offers a unique perspective and invaluable information.

Theoretical Framework

The current research was guided by the Behavioural Model of Health Services Utilization (BMHSU). This theory was designed: (1) to explain the uptake of health services, including substance abuse treatment; (2) to determine if access to healthcare is equitable and; (3) to

develop policies which promote equitable access to all (Anderson, 1995; Myers, Louw & Pasche, 2010).

It was selected as it is considered highly reliable and has been used extensively to study and understand treatment usage from a behavioural standpoint (Li, Nong, Wei, Feng & Luo, 2016; Myers, 2013). It also closely aligns with the current study as many of the potential barriers examined are captured within the model.

In accordance with the BMHSU, treatment usage is a function of an individual's predisposition to use the services, the presence or absence of factors which enable their use, and an individual's need for the services (Anderson, 1995; Li et al, 2016; Myers, 2013).

Predisposing factors include but are not limited to: demographics, culture, social networks and the attitudes, values and knowledge which persons have about health and health services (Anderson, 1995). While enabling factors include: the availability of services as well as an awareness of, and ability to access, the said services (Anderson, 1995). An individual's need for the services encompasses both self-perceived need and that determined via professional evaluation (Anderson, 1995).

CENTRAL RESEARCH QUESTIONS & RESEARCH OBJECTIVES

The current study was guided by the below-listed central research questions and research objectives.

Central Research Questions

1. What are the external and internal barriers to substance abuse treatment (SAT) for women in Barbados?
2. What possible solutions may be used to reduce the impact of SAT barriers for women in Barbados?

Research Objectives

1. To identify and describe the self-reported external and internal barriers to SAT for women in Barbados.
2. To identify and describe the external and internal SAT barriers for women in Barbados as perceived by local treatment providers.
3. To identify and describe possible solutions which may reduce the impact of the identified SAT barriers.

Conceptual Definitions of Key Terms

For the purposes of this study, a *substance abuse treatment barrier* was conceptually defined as "anything that serves as an obstacle to an individual receiving care or treatment for substance abuse or addiction." *Internal barriers* were considered to be "subjective phenomena, including beliefs or perceptions, which arise from within the person"; while *external barriers* were considered to be those caused by external factors, including the health care system, structural characteristics of programmes as well as social, cultural and environmental factors" (Allen, 1994).

METHODOLOGY

Research Design

A qualitative research design was used to gather the data for this exploratory research. Data was collected using individual interviews (treatment providers) and a focus group discussion (treatment clients).

Study Setting

Data collection took place in four SAT centres which cater to non-incarcerated individuals across Barbados, namely: (1) the Psychiatric Hospital (Day Programme in the Drug Rehabilitation Unit), (2) Marina House, (3) the Centre for Counselling Addiction and Support Alternatives (CASA) and (4) the National Council on Substance Abuse (NCSA). Marina House provides residential treatment exclusively for women while CASA, the Psychiatric Hospital and the NCSA provide out-patient treatment to male and female clients.

Study Population & Participants

The study population included SAT providers at all four target centres as well as female SAT clients at the lone residential facility. Appendix 1 provides an overview of the data collected from each group of participants.

A total of four treatment providers (one from each treatment centre) and seven female treatment clients took part in the study. Incidentally, all of the participating treatment providers were also female. They ranged in age from approximately 35 to 55 years. The treatment clients varied in age, and included both young and middle-aged adults.

Participant Recruitment & Selection

The study relied on purposive sampling for both categories of participants. Treatment centres were asked to recommend one treatment provider from among their staff who they thought would be most knowledgeable about the topic and who would be most likely to freely share their experiences and opinions during the interview. Similarly, Marina House was asked to identify six to eight participants for the focus group from among their enrolled clients. When

recommending potential participants, treatment centres were asked to identify persons who satisfied the study's inclusion/exclusion criteria.

Inclusion & Exclusion Criteria

The inclusion and exclusion criteria for the various categories of participants were as follows:

Inclusion Criteria

1. *Treatment clients*: Females, 18 years and older, currently enrolled in the SAT programme at Marina House.
2. *Treatment providers*: Male or female counsellors, 18 years and older, responsible for delivering SAT to women at one of the target treatment centres.

Exclusion Criteria

1. *Treatment clients:* Clients intoxicated, experiencing acute withdrawal or who have a cognitive impairment or psychotic disorder.
2. *Treatment providers:* Counsellors not actively engaged in treatment delivery as well as interns or student counsellors attached to the target treatment centres.

Data Collection Tools & Instruments

Interview Schedule for Treatment Providers

A semi-structured interview schedule was used to ascertain treatment providers' views on treatment barriers for women and possible solutions. The schedule was specially designed for use in the current study and consisted of seven main questions and one structured probe which focused primarily on treatment providers' views of the treatment barriers experienced by women, their impact on the treatment process and possible solutions (See Appendix 2). Allowances were also made for additional probes not included on the form. The probes were used to facilitate a deeper exploration of the initial responses provided. These were used as needed to enable the researcher to gain an even better understanding of participants' views and opinions.

It should be noted that all of the items emerged from a review of the existing literature on the topic.

Interview Schedule for Focus Group with Clients

A semi-structured interview schedule designed specifically for use in the current study was used to guide the focus group discussion with the SAT clients. The schedule consisted of four main questions and four probing questions, and focussed primarily on the treatment barriers experienced by the participants and their recommended solutions (See Appendix 3).

In addition to the planned probing questions, allowances were made for additional probes as needed. These were determined in vivo and depended on the responses initially provided by participants.

Like the interview schedule for treatment providers, the focus group questions also emerged from the literature review.

Procedure

Pre-testing of Data Collection Instruments

The focus group questions were pretested among a sample of clients within the target demographic at one of the treatment centres. Pre-testing helped to ensure that the questions were interpreted as intended. Based on the results of the pre-test, no changes to the focus group questions were needed.

Similarly, individual interview questions were pre-tested among a small number of treatment providers. The questions were accurately interpreted and required no modifications.

Requesting Permission from the Relevant Authorities

Ethical approval was sought from the Institutional Review Board/Research Ethics Committee of the University of the West Indies, Cave Hill Campus. This Board also serves the Barbados Ministry of Health and Wellness. The researcher also sought permission to conduct the study from the relevant officials at each of the research sites (treatment centres).

Data Collection

Individual Interviews with Treatment Providers. As previously mentioned, each of the treatment centres was asked to identify one treatment provider from their staff complement to be

interviewed for the study. They were asked to select persons in accordance with the study's inclusion and exclusion criteria.

Each interview was conducted by the researcher. Prior to the start, the researcher provided the identified treatment providers with an overview of the study and the various ethical considerations including but not limited to: matters related to anonymity, confidentiality, risks and benefits, and audio recording. Those who agreed to take part received an Informed Consent Form (ICF) (See Appendix 4) to complete upon receipt. The interview sessions commenced once the ICF was signed and returned.

The previously described semi-structured interview schedule was used to guide each interview. Each interview took approximately 40 to 60 minutes to complete.

At the end of each session, the interviewer provided a summary of the main points and allowed the interviewee the opportunity to provide clarifications as needed. The interviewees were then thanked for their participation.

Data collection for the interviews included both audio recordings and notes taken during the sessions. The audio recording was stopped immediately following the session.

The audio recordings and notes from the sessions were transported to the researcher's office where they were stored in a locked cabinet.

Focus Group with Residential Treatment Clients. As stated earlier, officials at Marina House were asked to identify six to eight participants for the focus group from among the list of clients currently receiving treatment at their institution. They were asked to: (1) pay special attention to the inclusion and exclusion criteria when recommending individuals and (2) ensure that the recommended persons had the capacity to provide informed consent. This circumvented the need to assess capacity to consent. A total of seven participants were identified by Marina House and all seven took part in the focus group session.

The focus group session was conducted by the researcher. At the start, the researcher introduced herself and explained the study, its purpose, the use of audio recorders, and the fact that all information provided would be kept confidential and would be anonymous due to the use of pseudonyms. The researcher then sought formal consent from those who agreed to participate.

The ICF (See Appendix 5) was read aloud to these individuals, as a group, and once they had all of their questionnaires answered, the researcher provided a copy of the ICF to each individual for their signature. After all of the forms were returned, the researcher began the discussion using the previously described interview schedule.

Discussion surrounding each of the items on the interview schedule was allowed to continue until responses appeared to have been exhausted. While the interview schedule was used to keep the discussion on topic, allowances were made for additional questions built upon participants' responses. The focus group lasted for approximately 90 minutes.

At the conclusion of the session, the researcher provided a summary of the major points of the discussion and gave the participants an opportunity to confirm or clarify as needed. The researcher then thanked participants for their time and feedback. Audio recording were stopped immediately following the end of the session.

It should be noted that data collection for the focus group included the audio recording as well as notes taken during the session. The notes also included any non-verbal cues observed throughout the discussion.

The audio recording and notes from the session were transported to the researcher's office where they were stored in a locked cabinet.

Data Analysis

To facilitate analysis of the data from both the focus group and the individual interviews, hand-written field notes and recorded interview sessions were transcribed into digital text. The transcripts were then analyzed using a hybrid form of thematic analysis[1]. While thematic analysis typically involves the exclusive use of either an inductive[2] or deductive[3] approach, this study combined both approaches. This complemented the research objectives by ensuring that there

[1] Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006).

[2] Inductive analysis is a process of coding the data without trying to fit it into a pre-existing coding frame or the researcher's analytic perceptions (Braun & Clarke, 2006).

[3] Deductive analysis involves approaching the data with preconceived themes that are expected to be reflected, based on theory or existing knowledge (Caulfield, 2022).

was a central focus on the categories of treatment barriers that were of interest in this study while simultaneously allowing sub-themes and codes to emerge directly from the data.

Deductive Analysis

The two overarching treatment barrier categories outlined in the objectives, namely "internal" and "external", served as the broad pre-determined themes into which all sub-themes and codes (identified using inductive analysis) were divided.

Inductive Analysis

The inductive analysis was carried out using the multi-stage process outlined by Braun and Clarke (2006). As such, the researcher familiarized herself with the data by reading and re-reading the transcripts and making notes of initial ideas, following which codes were identified based on commonalities within the responses received from participants. The researcher then identified potential themes which could be used to group/categorize the codes. The themes were refined as needed and then were sub-divided into the two core themes previously outlined.

RESULTS

The findings are presented in four broad sections. The first section identifies the characteristics of women served by participating treatment centres. Sections two and three present the barriers to treatment for women on island, and their impact on the treatment process, while Section 4 presents possible solutions recommended by the participants.

Characteristics of Women Seeking Treatment in Barbados

Demographic Profile

The treatment providers indicated that females represent the minority of persons seeking treatment for substance use disorders in Barbados.

> *"There are not many females [seeking counselling here] and not many females for drug abuse [in particular]."*

> *"Women [seeking treatment here] are so few."*

The demographic profile of clients varied from centre to centre, with the most notable differences being in the areas of age and occupational status. The representative from Marina House noted that their clients come from a variety of backgrounds, and include the homeless and professionals e.g. doctors, lawyers; while at the outpatient centres, the clients were generally reported to be unemployed or in the low income bracket.

With regards to age, the representative from Marina House stated that they treat persons across the lifespan, starting at 18 years - and one of their oldest clients was reportedly 72 years old during her time in their programme. At NCSA, the women seeking treatment for substance use disorders are typically young adults (in their 20s and 30s), while those at CASA are generally between 40 and 45 years of age. Alternately, the women seeking treatment through the Psychiatric Hospital's Drug Rehabilitation Unit are somewhat older, spanning middle to late adulthood (40s – 70s).

In terms of family dynamics, most women seeking treatment are single. Some have children while others do not. There were also reports of a small number of women seeking treatment while pregnant.

Drugs of Choice

The treatment providers identified alcohol and marijuana as the main drugs of choice for women seeking treatment at their facilities. Very few seek treatment for other drugs, such as cocaine or ecstasy. Age-related trends were also noted, with the representatives from all Centres suggesting that marijuana use was more common among the younger population – and cocaine to a lesser extent. For the older population, alcohol was the most common substance motivating the need for treatment.

> *"… the older women were alcohol, the younger women were mainly marijuana and a few on cocaine."*

> *"Well with the younger generation this will be marijuana… if you are 40 plus, it's mainly alcohol."*

Reasons for Drug Use

Participating treatment clients were asked why women use drugs, and they revealed that women in Barbados initiate drug use for a variety of reasons. One such reason is the experience of violence e.g. domestic violence or bullying within the school environment.

> *"…because they experience a violent boyfriend or family member…"*

> *"I definitely think domestic violence is one [reason] and…. ummm bullying like with younger children… like in school. That would start somebody taking drugs"*

Additionally, some women face financial hardships and turn to prostitution to support themselves and their children. In such cases, drug use can serve as a coping mechanism and can eventually lead to addiction.

> *"…when you can't find work… you got certificates… then somebody introduce you to some type of work. You got your kids then you go along… even like… dancing or prostitution where you can get that fast dollar to help pay your bills and live…..And then you use the drugs to help bring out yuh esteem. Yuh understand? So you get addicted, so you tell yourself I good for now… I getting this money, I getting through… till one day you spiral down… That is how it start off with me."*

Drug use is not only used as a coping mechanism for the reliance on prostitution. It is also sometimes used as a means of escape from daily stressors or strong emotions, and the likelihood of this appears to be greater when women lack an adequate social support network or have self-esteem issues.

> *"Some use it as a mask or a suppressant drug… they need to get over emotions and basically not face daily living… some [people] are more isolated than some… Some may be more open-minded and willing to talk [to others or counsellors], but some on the other hand will go on with their battle in their own minds."*

> *"[Identification of domestic violence and bullying as reasons for drug use]… That would start somebody taking drugs… Also, having low self-esteem…. Ummm and having no one to turn to."*

It should however be noted that not every woman uses drugs to cope. There are also some who simply use drugs for fun.

> *"I believe some do it for fun."*
>
> *"When you say doing it for fun…. You mean using substances?"*
>
> *"Yeah."*

External and Internal Barriers to Treatment

Both treatment providers and participating clients were asked to discuss the barriers to treatment for women in Barbados. These are presented in two broad categories: (1) external barriers and (2) internal barriers.

External Barriers

Barriers Related to Children. A lack of childcare options was one of the barriers raised by treatment clients, particularly when there is a lack of family and social support.

> *"If you have five or six children, you not going to be studying to come in here. You would be studying your children. You have nowhere to turn, if you have no help from family… you would not know what to do. The first choice would not be to come in here [treatment], the first choice is going to be your children."*

> *"So, if some of them [single mothers with substance use disorders] decide to come into treatment, they do not have nobody differently otherwise to take care of their children because they were taking care of their children all along by themselves… you know what I mean."*

A lack of childcare is particularly impactful for women with very young children. One participant was the mother of an infant who was granted permission to bring her child into treatment with her. She revealed that:

> *"One of my biggest fears was her not being able to come into treatment with me. I actually said to my advocate 'if she can't come with me, I am not going'."*

For women who are able to identify viable childcare options, concerns about their children's safety and welfare while they are in residential treatment can still serve as a barrier.

> *"So, a lot of women out there would love to come in [to treatment] but they are worried about their children… worrying about the abuse out there. What they went through, they don't want them to go through. So them ain't coming in no safe haven and leffin' their kids."*

These concerns can persist – or even emerge - while in treatment and, as such, the resulting worry can hinder the process; and in extreme cases, can lead some women to terminate treatment before completion.

> *"For women like me, I would say… I be like worrying about my girl children and my boy children… I does be like are they as shielded as they supposed to be? Because I know I am in a shielded environment [in residential treatment]. Even if they are in the care of their father or in a government institution or wherever, I does be like …. Are they being treated the way that they would love to be treated?"*

> *"I stop taking them to church, I stop socializing the right way with my spouse. So my children would just tend to live the way how I live - and then I start being in treatment and worrying about them now. It's like a reflection in the mirror now… like how my mother was worrying about me and wouldn't go and get help. I worrying about them but I getting help. So I am giving the programme half and not all because half of me here and half out there worrying… you just feel like you would go long back out."*

> *"Like my son, I just found out that my son was giving problems within the children's home he was in, and I do not know what could cause that. I still yet to find out what it is. It has me a little on edge with being here… cause if I was out, I could go at my own convenience and visit him to find out what really going on… Now you have issues on the outside going on and you in here… and you trying and you can't… your mood is not strong enough or not focused to deal with it at that point in time. You'll be like 'what really going on?'. You can't get there right*

> *away so it will give you a craving or a doubt in your mind like so… 'I got to find out what going on with my child so I signing out of this treatment. I ain't able to endure this no more and my child out there.' In that kind of way. So it does be hard."*

The participating treatment providers supported the view that a lack of childcare and women's concerns about their children can be a barrier to treatment in Barbados and can also hamper the treatment process, particularly in the context of residential treatment.

> *"Some of the main barriers would be stigma associated with a woman who has an addiction… and child care… A lot of them do not want to have their children go into care [of the state], while they are in treatment and sometimes that is the only option because they don't have a healthy relationship with their family… all of that would have disappeared because of the active use. So they fear that if the child has to go into Nightingale Home or into the care of the state that they would not be able to get back their child after they leave treatment….*
>
> *… and sometimes you would find that they [women with children who are in treatment] want to leave treatment if they think that the child is not being cared for appropriately. And now that they would have regained some of their feeling and they are no longer numb, they begin to recognize 'I'm not there, I've not been there for my child'. They begin to have that maternal instinct arise. Some of them have left treatment prematurely, saying they are leaving to go take care of their children."*

A lack of childcare is not only a hinderance to residential treatment. It can also deter women from seeking outpatient treatment and affect their ability to focus during sessions. In fact, one outpatient treatment provider indicated that:

> *"When they have children and … their mother and grandmother at work and the children have different fathers, if they know who the fathers are... who are they*

> *going to leave them with? When they leave them in the house by themselves, they are looking for the police to come for them. One thing we do know about females is that the mother's instinct kicks in, and to leave children alone [in the house] is not something that women do easily. [If they do leave them home alone] they can't always focus when they come to treatment [sessions]. When we first started, we had some toys and there were so many of us, we encouraged them to bring their children so that a counsellor will be there to look after the child until the session finishes. We don't have that now."*

Lack of Family Support and Lack of Family Knowledge about Addiction. Women are less likely to pursue treatment if their family and friends dissuade them from getting help. Though this was not raised by the participating treatment clients, it was posited as a potential barrier for some women by the treatment providers. In fact, one provider stated that:

> *"If you decide you are going to step out and you tell your parents or partner [that you want to get help], they may say, 'What you going down there for? Them can't help you. You too far gone.' Or the slightest mistake that you make, because don't forget, people do not understand relapse, so once that happens, you are wasting your time. 'I tell you don't go down there'. So those ones become barriers."*

It was suggested that the lack of familial support for treatment may stem from a lack of knowledge about addiction.

> *"There are a lot of women… whose families do not understand the addiction. They think that they can go to church, or they can just stop on their own… Some will show support but some of them don't want to come to sessions, the family workshops and stuff like that so they can get a better understanding."*

Having a Substance Using Partner or a Partner who Sells Drugs. It is not unusual for women with substance use disorders to have partners who also use drugs, and, in some cases, the

relationships are tumultuous, negatively affecting their welfare and safety. One of the participating treatment clients spoke about their personal experience.

> *"… I was living with a man and get unfair and everything just through drugs… he used to smoke marijuana and living with he was not easy. The only time I could've gotten away from he was when I go prison, cuz in the middle of the night he would go search for where I is… he would walk from Bush Hall to Nelson Street. He would walk Bridge Gap and everything. It does be abusive… yuh understand?"*

While the treatment clients did not expressly identify having a substance using partner as a barrier to treatment, all of the participating treatment providers suggested that it can in fact be a barrier. They also posited that having a partner who is involved in the drug trade can be a related barrier.

> *"Yes [a drug using partner may discourage them from coming]. Some of them also have to help cut it up and help sell it. So how can you get into treatment? You have to participate in it because that now has become the family income."*

Addiction Stigma and Stereotypical Perceptions of a Drug Addict. Some women identified the stigma and stereotypes surrounding addiction as barriers to treatment. In fact, one treatment client highlighted how, together, these two factors made it difficult for her to recognize that she needed help and to get the necessary support when she finally did.

> *"For me, I think stigma is a big thing – and judgement. Just because for me, my family has a lot of expectations of me… so I was in denial for a long time with regards to addiction. And then, even when I realized that something wasn't right, I didn't know who to turn to for support… People have this picture of 'who is an addict' in their head… which I did too. It's just really a lot of stigma… I think a lot of people need education, so it would not be so stigmatized and that there*

> *would not be so much judgement – and then people would be able to come forward."*

Stigma was also cited as a barrier to treatment by all of the participating treatment providers. In fact, one provider even suggested that the fear of being stigmatized can be so powerful that the inclusion of "substance abuse" or "addiction" in a facility's name can prevent some persons from seeking treatment there.

> *"An individual called and didn't want to come here… they didn't want to go to a treatment facility where the name includes substance abuse or addiction. They wanted something more neutral like a doctor's office, a medical clinic or a health clinic that would be like a one stop shop that you just go there, and nobody knows which department they are going to."*

This is likely related to the fact that, not only are there negative connotations surrounding addiction, society views women with addiction differently to their male counterparts, particularly those who are mothers. As such, women are often afraid of how they will be treated if persons find out that they have an addiction and need help.

> *"An alcoholic father is different to an alcoholic mother, and that fear of disrespect that you might get… the fear of stigmatization of the community or society – that one is real to me…They might call the men alcoholics, but they may add on another bad word to it because you are a female. So that is stigmatization, you don't want everybody to know."*

Societal Stigma Attached to the Psychiatric Hospital. Much like the stigma surrounding institutions that include "substance abuse" or "addiction" in their name, there is also a stigma related to the Psychiatric Hospital. This is significant given that, in addition to treating persons with mental illnesses, the Psychiatric Hospital is one of the main outpatient treatment providers and is also the clearing house for residential treatment. As such, persons receiving outpatient treatment will attend sessions on the Hospital compound. Alternately, those in need of

residential treatment, and who are desirous of having their treatment costs sponsored by the Government of Barbados, must first be assessed by the Psychiatric Hospital, and then referred for residential treatment at Marina or Verdun House. It should be noted that assessment typically takes place onsite at the Psychiatric Hospital but can also be done at the community psychiatric clinics which operate within the island's polyclinic system.

Patients who attend the Psychiatric Hospital are often labelled as 'mad' or 'crazy' by others in society. For this reason, many women – and men – are hesitant to seek treatment for their addictions through this institution, thereby making the stigma associated with the Psychiatric Hospital a powerful treatment barrier. One client expressly highlighted this and suggested the need for an alternate facility.

> *"… a lot of women don't like to go to the Psychiatric Hospital."*

The treatment providers also had a similar view. They too believed that the delivery of assessment, detoxification and outpatient treatment services at the Hospital can be a barrier to treatment for substance use disorders.

> *"People do not go to 'Psychie' although they need help. Probably because it's called the 'Psychiatric Hospital', 'the Mental Hospital', 'the Green Gates' and 'Jenkins'. They ain't going there. That still happens in Barbados, and it happens all over the world. So people are not going to want to be seen going through those gates."*

> *"I think a lot of women get turned off by the state of the Psychiatric Hospital. So if we could have a detox centre that is outside of the Psychiatric Hospital, that would be helpful. I don't think Barbadians are as educated as they need to be about what the Psychiatric Hospital is for. A lot of persons think that you are there because you may have some challenges… as Bajans say that you are 'mad'. But they are not aware that there is a detox facility there. So that stops a lot of persons from going to the Psychiatric Hospital… The main thing is about getting past that stigma associated with the Psychiatric Hospital and 'madness'."*

For those who do attend, some take steps to prevent persons from knowing they are going to the Psychiatric Hospital.

> *"I am not sure if they are being judged [for having an addiction], but the fact that they are coming to the 'Mental', people might feel they are mad. Fear of what is represented, being labelled. Normally, they say when you come to the 'mad house', you gonna be mad. For anybody. That is a thing out there. A labelling thing. It can cause issues. I know people who would get off at the bus stop a stop ahead of time and then come in."*

Lack of Knowledge about Addiction in the Workplace and Absence of Workplace Drug Policies. Stereotypes and stigma are often perpetuated due to a lack of knowledge about a particular population or situation. The area of addiction is no exception. The impact of this extends into the workplace and can affect how employees with substance use disorders may be treated by management and/or their colleagues. In fact, one treatment client stated that:

> *"I think a lot of the problem is, workplaces aren't really acquainted about addiction. So as soon as people find out, they are like 'Oh my God, she takes drugs!'. You like straight away let her go you know. So, I think definitely a lack of education."*

This is compounded by a lack of workplace drug policies and procedures. Workplaces can be a valuable source of support for women with substance use disorders, but without the necessary education [about addiction] and/or protocols, the help may be delayed or not provided at all.

> *"I guess my main problem was with my workplace. When I told them I had a problem, they didn't know how to handle it because they did not have a policy in place… So like, I told my workplace in a January and they did not come up with a*

solution for me [suggestions for assessment and treatment] until August. And they still do not have a policy."

The absence of workplace drug policies can make some women – and men – apprehensive about seeking treatment. Given the lack of protocols, there are concerns about the repercussions should their colleagues and employers find out that they use drugs and/or have an addiction. Of particular concern is the possibility of being fired.

"For me, I was worried if I was gonna lose my job if my boss or colleagues found out what I was doing. That was one of my biggest worries. And other people too. When you take drugs, you try to hide it. So it was a big thing just people finding out. If I lose my job, how am I gonna support myself? How am I gonna support my children? So all that stuff, you still got to think about. That would prevent me from coming in here."

"… like people who work, we see how they treat addicts, you know what I mean? So… you want to approach your boss as an honest person to let them know you have a situation, you have an issue and you will be going to seek help, but then they may look at you different. They would want to be too harsh and rash. Like, as in to fire you from your job rather than taking time to help you deal with the issue or look at the options you may have. Or even if they do not know how best to deal with it, they could still ask for some sort of advice."

"So, I mean, I think they've had others in my workplace as well that need help, but they just frighten to come forward because they do not know what is going to happen. They are afraid to lose their job. Up to now I don't know what is happening with my job and stuff like that."

The treatment providers supported the view that stigma within the workplace combined with a lack of guiding policies and procedures can hinder the use of both residential and outpatient treatment.

> *"Now for those who work, it is like - can I get time from work [to attend treatment]? Am I going to lose my job if my boss knows that I use marijuana or alcohol? Because depending on the job that you do, you need to focus. Especially in this climate… you need to hang on to your job."*

Treatment Facility and Programme Characteristics. The participating treatment clients identified a range of treatment-related characteristics as potential treatment barriers. Of particular note were the length of time the (residential) treatment programme takes and the restrictions they have while in the programme.

> *"Time span. A lot of women not accustom' being station. Yuh know what I mean? They are not in one place for a long while. For me it's a challenge, but I am still here."*

> *"We don't get to watch the news, we don't get to hear the radio. So we don't know what is going on within the world. Unless a newspaper comes. Even if it comes, it's way behind."*

> *"We don't really get to go out. We only get to go out once a month and umm so basically we just in this facility – every day."*

They also suggested that if they were to tell other women about how restrictive the residential treatment process is, it would discourage them from seeking help.

> *"It feels like you are more in a jail than a rehab. Yuh understand? So when we go out there now, we ain't got nothing to tell nobody. It don't give nobody any sort of inspiration [to come into treatment]."*

Similarly, the participating treatment providers highlighted operational issues such as the location of the treatment facility, hours of operation, services and type of treatment offered.

> *"And then the location – because society has changed too. So where your facility is located, the accessibility to transportation and all of those things will determine [if clients come]… The days and times will also affect persons coming in for treatment."*

Outpatient treatment facilities which only operate during regular working hours can also hinder persons access to treatment.

> *"One [issue] that came up this year, was her [a potential client] being able to come in terms of her work schedule and my office hours. They were just not working out. So definitely the hours of operation and her work schedule… so we never got started for the intake. We filled out the paperwork but when it was time to get started for the intake, things never happened because of the schedule."*

Also impactful was the reduction in opening hours at some facilities due to the COVID-19 pandemic. In some cases, these have not yet reverted to pre-COVID times.

> *"Before we opened five days a week 9 – 9. Now (since COVID) we open three days a week, and we are open from 9:00 to 4:00."*

> *"Would you say that these reduced hours have made a marked difference on a person's ability to attend?"*

> *"Yes…. If she (a client) works in Christ Church… she finishes work at 4:00 or 4:30. She may get here by 5:00 or 5:30, and by then nobody would be here."*

The COVID-19 pandemic also resulted in the cessation of inpatient detoxification at the Psychiatric Hospital. At the time of writing, inpatient detoxification had not restarted. Instead, persons are required to detox on an outpatient basis with the support of individual counselling sessions. The participating treatment provider from the Hospital suggested that outpatient detoxification can be very difficult for the client and, as a result, many drop-out without

completing the detoxification process and before they can be admitted to the Drug Rehabilitation Unit for treatment.

> *"With COVID… we can't do [inpatient] detox anymore. Detox has to be done on a one-on-one session. The programme has changed now because of COVID. When a person is being detoxed, you have to do individual sessions first for the detox. I would not have done it with women but I have done it with men and a lot of people can drop out because that is not an easy thing."*
>
> *"How was it done before?"*
>
> *"You would…. spend the detox on the ward then you come to us [Drug Rehabilitation Unit]… Now they have to battle with the feelings while at home."*
>
> *"So detox is now done at home as opposed to here?"*
>
> *"In a way yes, but you come back to do sessions here. I may do a detox session for someone for three days. Sessions are now done half day… detoxing is done as an outpatient."*

In addition to the foregoing, one treatment provider also suggested that the type of treatment offered within the outpatient setting (group versus individual sessions) is another programme characteristic which has the potential to reduce treatment uptake.

> *"It is more the type of programme… when you are doing group therapy, I find that women don't like to talk about themselves in a group setting. So when you extend that type of treatment, that morning in group therapy, some just don't turn up."*

Unmet Basic Needs. Both treatment clients and providers suggested that competing needs – such as the need for housing and food - reduce the likelihood that a woman will seek

treatment or that treatment will be successful. In such cases, getting their basic needs met is their primary focus.

> *"Yes, [the need for housing and food can prevent some women from focusing on their problem and getting help]… A lot of them are unemployed and a lot of them are dependent on the using partner, or dependent on other men or sometimes their families. And they are struggling to get those [housing and food] for their children, and not wanting their children to be taken."*

Medical Professionals Having Insufficient Knowledge About Addiction and Available Treatment Options. The issue of health care providers having insufficient knowledge about addiction and the available treatment options was alluded to by both treatment clients and treatment providers. In fact, one client shared that:

> *"A lot of people don't know about Marina exactly. My doctor, he wanted me to stop drinking and I couldn't. I needed rehab. But he didn't know about here."*

When medical professionals are not aware of the available treatment options and the protocols for admission, this can lead to undue delays in persons receiving much needed treatment.

In addition to an awareness about available options, one treatment provider also suggested that there is a need to educate healthcare providers about the most appropriate ways to manage patients with particular conditions (e.g. pain, sleep disorder) who also have a substance use disorder. More specifically, she suggested that some medical practitioners and dentists may not be aware of the most appropriate drugs to use in such situations, and which ones should be avoided.

Internal Barriers

Denial and a Lack of Motivation to Change. While a person may indeed have a substance use disorder and need treatment, there are times when the individual does not believe that they have a problem, i.e. they are in denial, and as a result, will not be inclined to seek the necessary help. Furthermore, the experience of denial can be prolonged, thereby delaying

treatment for a protracted period of time. This was the experience of one client who revealed that:

> *"…I was in denial for a long time…"*

The treatment providers confirmed that, from their experience, denial is a powerful treatment barrier which keeps women out of treatment.

> *"In the beginning, a lot of people don't think they have a drug problem. Most of the time they don't recognize that they have a problem. They [think they] are smoking because they like to smoke and they don't see the other ramifications."*

> *"They (some women with substance use disorders) don't think they have a problem when it's clear that they do have a problem. And they are not willing to come to get that support (treatment). So yes, some individuals are in denial – male and female."*

> *"Some of them (women with substance use disorders) are still in denial. They don't see that they have a problem. Therefore, they don't seek help, although family members and friends are concerned about them."*

It was suggested that denial and the related lack of motivation to change is stronger when women are court-ordered to attend treatment or if their family is the driving force behind their treatment entry.

One treatment provider shared the following:

> *"… Sometimes when they are sent from the Court, then that is when denial more so occurs, or if the family really pushes them when they come in…"*

This was supported by the experience of a client who revealed that:

> *"…The Court send me here a year before, but the way the judge was so adamant in her decision for me to go – I was rebellious and I did not come 'cause she set the date for like the 1st…the same day I was to be in Court, I was to come into rehabilitation. And I was like 'stupse' and I put it off and ignored it. And I went back out and I left the Court and went straight and use and I continued."*

She further suggested that if the Court could be more flexible with the treatment start date, persons may be more inclined to attend Court-mandated treatment:

> *"They (the judge) were like, the same day she lef' Court, she would have to go and sign in (to treatment) and that makes people rebellious. After explaining to them I would like a little week or two, I have no problem going but just give me a little week or two to explain to my people who live around me, whoever I lived with that is what I am doing, and not just push the decision onto me."*

Fears. Fear is another significant treatment barrier which emerged during the discussion with the clients. The most dominant fears appeared to be those related to the safety and well-being of their children while in treatment, potential job loss and potential stigmatization, all of which were discussed in detail earlier.

Other notable fears were related to the treatment process. For example, a fear of the unknown (the treatment process) as well as a fear that treatment would not be successful. One client revealed that:

> *"The hardest thing that stopped me from coming here is… I didn't know that Marina House would have been able to allow me the opportunity [to get sober] because I have been using for a while. And I did not know how it would feel just being here…"*
>
> *"So is it more of a fear that it wouldn't work for you that was keeping you out?"*
>
> *"Yes. A lack of confidence [that the treatment would work]."*

This was supported by one treatment provider who stated that:

> *"Well fear of the unknown. If I don't know what counselling or treatment is about, one would say I am not coming there or why would I come down there for? So fear of the process is one thing, and I am not going to agree to go somewhere when I am not sure that it will work…"*

The fear of having to face past hurts during the treatment process can also prevent women from seeking help. One client shared that:

> *"… to come in and hear someone got to be counselling you and like asking you all the questions [about your past], all the time. A lot of people don't be about that. Because people does be like opening back up a lot of hurtful parts, things they have been through… that they experience."*
>
> *"So you'd rather protect yourself than re-experience those things?"*
>
> *"Yea"*

Another client cited fears related to communicable diseases they may have contracted and related sense of hopelessness.

> *"One of the reasons why women don't come in too is because [they have] a sense of hopelessness, because of sickness… especially if they transmit (contract) any sickness out there during active addiction and they actually suspect [that]. Sometimes you don't even know because when I thought that I would probably have transmitted (contracted) something… I was just drugging more and not wanting to go to actually find out the truth. Then some that actually know that they are sick tell themselves they are dead already…"*

Lack of Knowledge About Available Treatment Services. A lack of knowledge about the available treatment options can prevent or delay women from seeking treatment. Some participating treatment clients revealed that, in many cases, they did not know where to turn for help or what options were available; and when they did find someone to confide in, be it at work or in the medical fraternity, those persons also did not know what options were available.

Treatment providers were of a similar view. They indicated that persons, women included, are less likely to seek treatment if they are not aware of the various treatment facilities and services offered. They also suggested that there is a widespread lack of knowledge about drug treatment services in Barbados.

> *"Right [a lack of knowledge about addiction and even about the available treatment services is a barrier]… We need to let people know that there are facilities out there, because they don't know."*

> *"Up to this day a lot of people don't know that the Psychiatric Hospital has a drug rehab service. They only know when they get here. The service has been around since the 1980s, but it has gone on a wider scale now."*

Co-occurring Disorders. The literature reveals that, across the globe, substance use disorders commonly co-occur with mental illnesses; and Barbados is no exception. In fact, one of the participating treatment clients revealed that she has a diagnosed mental illness, and she acknowledged the role which drug use can sometimes play in the development of such illnesses.

> *"… and then issues like if you have mental illness in your family and you ain't get to the stage to develop it, drugs now can bring it on earlier. So I have Bipolar and I worrying about my kids out there developing Bipolar with the drugs too."*

Co-occurring mental illnesses are of significance as they are a well-documented treatment barrier and can also reduce the success rates for persons in treatment. All of the participating providers identified co-occurring mental illnesses as a barrier to treatment for women in Barbados.

"Definitely, those [mental illnesses] can be barriers because some persons may not want to come in because their mental health issues are more so than their addiction. They may think it is not going to be addressed as fully as it needs to be or some women may be in denial and they would say they don't have an addiction… so yes, definitely those [mental illnesses] can be [a barrier]."

"We had a lady who was to be in the [treatment] programme… She never came back [after the assessment] because she had a psychiatric problem as well… You find a lot of comorbidity."

"There was one young lady, I guess she might have had some mental health condition whether it was depression or something like that…"

> *"Do you think that co-occurring disorders, like depression, can be a barrier to treatment?"*

"Sure."

Impact of Barriers on Treatment

The treatment providers were asked to describe how the various barriers impact the treatment process. They suggested that they could: 1) prevent women from seeking treatment altogether; 2) result in women attending the initial assessment session but not returning to commence treatment sessions; or 3) contribute to women missing (outpatient) sessions or prematurely terminating treatment (dropping-out).

"It (barriers) prevents treatment from happening… They (women) don't turn up, and if they are not coming they don't get the help they would need. Or you could be at a particular stage [of treatment] at some point in time and it (the particular barrier) could set you back. If you go weeks without coming, you could regress or stepping back in terms of getting the progression. So it would make the change more difficult. Dropping out [of treatment] as well."

> *"You might get just the assessment and don't come back. You might have to call them one or two times to see what is happening, and when you remind them of the reason why they are there – because Probation or Court send them – they would come."*

> *"Sometimes you would find that they may want to leave (residential) treatment – if they think the child is not being cared for appropriately… and a lot of them think the treatment process may be too long."*

Participant Recommended Solutions and Measures to Reduce Impact of Barriers

The participating treatment clients and providers were both asked to provide recommendations with a view to reduce or eliminate the identified barriers. Those provided by the clients are discussed first.

Recommendations from Treatment Clients

Provision of Wraparound Services. The clients recommended the provision of various wraparound services by treatment facilities.

Education and Training. It was posited that skills training and other educational opportunities would be particularly helpful for those in treatment, so as to provide them with the ability to make money without depending on prostitution.

> *"And like courses, classes they can go to, to learn to do hair, simple courses… hair dressing or massaging or cake making. These lil' classes will help boost their self-esteem and also give them a dollar in their pocket."*

> *"I think we should be able to do free online courses… that would be a big help."*

Housing. Assistance with housing was also highlighted as a possible solution for persons at various stages in the recovery process. For example, transitional housing was recommended for women who have completed the primary stage of their residential treatment.

> *"Some of them (women in need of treatment) not working and can't pay rent. If they can get a building for like second stagers when they go out [of primary residential care], that they can house us until we have further reintegration ourselves… a reintegrating house that we can work and pay bills and thing."*

Similarly, there was a consensus among the group of participating clients, that assistance with housing would also be beneficial for those who have not yet entered treatment and have nowhere to live. This was confirmed based on the response received to the following question from the interviewer:

> *"Before you come into first stage … if you are trying to make ends meet and… you are struggling… if there were facilities to help you get housing so you don't have to think about housing… is that something that would help you come into initial treatment?"*
>
> *"Yes, Yes." (Main group agreement)*

Childcare and Interaction with Children while in Treatment. A lack of childcare and concerns about their children's safety were some of the greatest treatment barriers identified. As such, it was not surprising that the clients recommended the provision of childcare facilities.

> *"And if you can get an area where you have a nursery for women with young children. Because of the abuse that they may have endured, they are frighten' to lef' their children out there to come in here…"*
>
> *"… that is where the facility for children would come in handy. Because they (mothers in need of treatment) would also maintain custody. It ain't have no*

> *reason for the Child Care Board or nobody else to come and take up the children away from them. They are addicts but still yet they would fill some part of being a parent to the children. Yuh understand?"*

In addition, the women also suggested that provisions be made to allow mothers in treatment to be involved in the daily lives of their children, or at least have regular visits with their children, where possible.

> *"Until we get better, it would be good if the parents could go and visit (their children). To reassure them they still have a parent and let them see that mommy is getting better and trying."*

> *"…having more interaction with your children is number one. If you are in treatment, even if it's like two days a week where you can go like… to take them to school or pick them up… spend a day with them. Whatever… more interaction with them, so you can make sure they are safe and OK."*

Public Education about Addiction and the Available Treatment Options. Public education surrounding addiction was suggested as one approach that can be used to combat stigma and the stereotypical views of drug addicts which persist in society.

> *"… And to let people know that addiction is a disease. It's not just like a prickle in the street, that is how people see it."*

In addition to raising awareness about addiction, the clients recommended that efforts should also be made to educate persons about the available treatment options on island.

> *"… more local education because there is so much (about treatment options)… on the internet with regards to like the States and stuff and I don't really hear a lot [about Barbados]. I know there are organizations but I don't really hear a lot about addiction when it comes to Barbados. So that then goes back to the stigma*

> *and then fear of actually trying to get help 'cause you don't know where to turn…"*

Suggested public education approaches included:

> *"… health fairs, give out brochures, volunteer work"*

As well as social media campaigns given the popularity of social media today.

> *"…even if wunna do it (educate the public about addiction and treatment) via the computer, cause people always on social media."*

The clients also indicated their willingness to be involved in the public education campaign and highlighted the importance of sharing their stories with persons who may need treatment.

> *"Let we (treatment clients) go for a day or night to hand out brochures to these women (who need treatment)."*

> *"… and then you would got like some of the women in treatment as like guest speakers, yuh understand. So more like seminars to educate, different from the people who would organize it. Get some of the women in treatment as guest speakers and … [get them to talk about]… how treatment has been and what they gain from treatment…"*

> *"Where there is people [women in recovery], you know that would be talking – sitting down and talking – you hand out leaflets and stuff like that. Make it look like something interesting. Not something boring or stigmatizing."*

> *"I think it is important for people to hear the stories [from women in recovery]. Because then they would know that they are not alone and addiction is not the end*

> *of their life. So, just to hear the stories of different women who have gone through that and who are clean."*

> *"Just like how the Diabetes Association have seminars. You could like, once a year, host a seminar for the rehabilitation centres. Yuh know what I mean? Where you can get like guest speakers, now past addicts and like more people fresh in treatment and people who need treatment."*

> *"A health fair that we can know where these women (who need treatment) are, and the actual [recovering] addicts like ourselves can go and talk to them. I mean the ones that in second stage and let them know how good Marina [House] is and how it can help, and what it offers. A little advertisement, rather than saying 'do not use dope'. We will be the attraction, to let them see 'if they can do it, we can do it too'."*

Also suggested was the possibility of treatment facilities advertising their services and letting the public know that they have spaces available for those who want to enroll.

> *"You can put an ad out."*

> *"You can let them know, 'We are taking women'. Some kind of ad. Let them know… 'come in and get access'. 'Come and get a plate of food and let's talk'….something simple like that….Them just need a push or pull forward."*

Provision of Drug Education Tailored Towards Drug-Users. In addition to educating the general public about addiction and treatment, the clients also emphasized the importance of providing drug education specifically for persons who are already using.

> *"If there is so much focus on drug prevention, then people would look at it and be like, 'well, I am already there, so'…"*

They suggested the importance of including the health harms associated with drug use in the education campaign in the hopes that it would resonate with these individuals.

> *"Sometimes yuh does have to give them examples too. Let them know this thing killing yuh. It giving yuh AIDS, it giving yuh heart disease, it giving yuh strokes… I think if I did hear it and had somebody scare me, I would be glad…"*

Reduced Restrictions to Prevent Residential Treatment from Feeling Like a Prison. The highly restrictive nature of residential treatment was identified as a treatment barrier by the clients who likened it to being in a prison. To mitigate this feeling, they suggested the relaxation of some restrictions or the provision of certain privileges. For example,

> *"It would be nice, maybe once a week, to take a little bus ride somewhere. Walk to the beach. Just like anything just to get out, so you don't feel like you are trapped."*

Design and Implementation of Workplace Drug Policies. The absence of workplace drug policies was another critical barrier, with women being hesitant to seek treatment as they feared losing their jobs. Therefore, one of the clients suggested that the implementation of such policies may be useful.

> *"I guess if my workplace had a [drug] policy too it would have made it easier for me… I'd feel more comfortable approaching them with regards to getting help."*

Alternate Medical Facility for Assessment. In order to circumvent the stigma associated with the Psychiatric Hospital, it was suggested that an alternate medical facility be established where women – and men – could be assessed for onward referral.

> *"I think we need a medical facility 'cause a lot of women don't like to go to the mental."*

Recommendations from Treatment Providers

The recommendations offered by the treatment providers were notably similar to those put forward by the clients. For example, they also highlighted the need for wraparound services and public education.

Provision of Wraparound Services. The wraparound services suggested by the treatment providers included:

Childcare. Childcare facilities were seen as necessary by three of the four participating treatment providers. To emphasize the need, one provider not only stated her agreement with the recommendation, but also recounted a number of times clients had to bring their children with them to counselling sessions.

> *"Do you think that having some kind of childcare facility and childcare arrangement for here would be beneficial?*
>
> > *"Yes, and you would need somebody to supervise the children too. I have had a few – if I think back – at least three or four female patients who have had to bring their children a few times. I remember one day I even recognized that the young girl (daughter) was outside in the car by herself, and I said 'No, no. You come inside.'... Up to yesterday, a parent came, and she had to bring her daughter to the appointment. And you wouldn't want the little girl exposed to the topics that we would have been talking about."*

It was further suggested by another treatment provider that *onsite* childcare services would be most beneficial:

> *"It would be easy if you have it attached – the daycare – to the [treatment] services."*

Despite the general agreement with the need for childcare, it was noted that funding for such services would be essential - particularly the funding needed for human resources e.g. nannies, babysitters, etc.

> *"We would have recognized that childcare is a concern, but volunteers, nannies or whoever to assist – everything boils down to funding. Because we can have a wonderful facility but then we would need funding to pay persons to assist."*

Education and Training. Education and training were recommended as a means of providing clients with marketable skills thereby increasing their employability. As such, it was suggested that female clients could benefit from:

> *"… basic courses… Some people might want to do something with their hands, but do they know where to go? It might not be that expensive, but are they aware of the facility or places that are carrying those things? … A lot of times you have to tell persons (clients) what is happening because they are not aware of social things happening in the country. Drugs have taken away a lot of that. Their focus is on using."*

> *"Training for work or educational training – whether it is vocational or whatever – to develop them so that they are marketable to get a job."*

This was further supported by one treatment provider who stated that:

> *"You can't tell some person that they can't sell marijuana or you shouldn't gamble cuz where are they going to get their money from? Are you going to teach them to make some pepper sauce and sell or to make their own clothes? They go hand in hand."*

While there was unanimous support for providing training and educational opportunities, it was noted that funding would be critical:

> *"We do try to assist [with training].. As I said, that is also part of our programme. But more funding is needed so that we can offer them more. That (funding) would definitely assist. When we do our intake, we also ask what they would be interested in doing after treatment in terms of providing for themselves, and our case managers assist them with finding classes. Some persons already come in skilled so it's just a matter of finding them jobs. But definitely more funding in terms of getting them the assistance educationally would be an asset."*

Partnering with agencies who can provide free or discounted training was suggested as one possible way to address funding issues.

> *"Already existing organizations who do this (provide skills training), you can target them (organizations) so they know you (treatment centres) have these people (clients who are interested in training). They (organizations) send the information when they have courses, so you (treatment centres) can say 'I have some person but they can't pay that $50.00 registration fee'."*

Employment Assistance. The importance of employment was underscored by one treatment provider who suggested that having a job can provide clients with a sense of purpose and help them to successfully navigate the recovery process.

> "…If you don't see yourself as somebody worthwhile, your past can sometimes dictate your life. Some people are stuck and cannot move [forward]. It's hard sometimes for people to move… If you clean them up, and let them see life has meaning, then they can pursue the dreams they want to pursue if they are motivated enough to do it…I have a young lady that came here, two of them, they are now doing security work. One never worked in her life, or worked very little, but now she is making something out of herself."

Unfortunately, many persons find it difficult to secure a job once their drug use history becomes known. For this reason, one treatment provider thought that it would be useful for

treatment centres to offer employment assistance. She also acknowledged the role which social agencies and corporate Barbados would need to play in order to make this a reality.

> *"In terms of assisting [clients] more, this would include giving our clients a chance at working. Because a lot of persons are afraid to employ our clients and so that is one of the huge barriers they have. We have clients who have been clean and sober over four years and finding a job is very difficult because persons see them in a previous light… like when they were in active use… so [social agencies and employers] giving them that opportunity to start earning for themselves [is needed]."*

Assistance with Basic Daily Needs. As was mentioned earlier, many women in need of treatment – or who are currently in a treatment programme – are unable to afford the expenses of day-to-day living. As such, one treatment provider reiterated the reality that:

> *"… for treatment to be successful we have to look at … satisfying their basic needs."*

She further suggested that this may require offering assistance with:

> *"…housing or getting food stamps.. and for people who have challenges with bus fare."*

At present, there appears to be an adhoc attempt by treatment centres to assist clients in need. This was confirmed by two treatment providers who revealed that:

> *"We try to meet their needs… we will give them bus fare to get back home and get them help via Welfare, Kiwanis, Lions – whoever we know that offers services our clients are in need of. We see best how we can help them. Even if it means writing a letter to the Salvation Army and calling ahead to let them know there is a client we are sending for some food. Or calling someone to assist in finding a place for a client to sleep for the night. And of course, we don't turn back anybody."*

> *"What I did was a food bank at one point in time…I would collect donations for food to help with satisfying that basic need."*

When probed, more than one treatment provider indicated that they have no direct partnerships with such agencies - they simply make referrals when they identify a need. For example:

> *"No, I wouldn't say I have a relationship established that I can call up someone and say 'I have a client here that I would like to refer to you, please help her out, do what you can.' That is not established. You might tell them (the client) by word of mouth 'there is a place you can go to get back on your feet'... I can say to them, 'There is an application form and guide them and show them what the [training] courses are or tell them where to apply for welfare."*

As such, the need for a formalized inter-agency collaboration was acknowledged by all of the treatment providers and is highlighted in the below statement:

> *"Well certainly more of a formalized structure for inter-agency collaboration is needed, where you can probably pick up the phone and say I am sending this client here and she is not working, she has this number of kids."*

Public Education. All participating treatment providers recommended the provision of public education surrounding the topic of addiction. Like the clients, they too saw this as a key tool which could be used to combat societal stigma.

> *"… Barbadians need to get more education… Put more videos out there sharing about what addiction is. A lot of them think that it's only the bad apples that go to drugs. You know, educating the public more about addiction. Let them recognize that any person can be affected by this disease."*

This statement was supported by another treatment provider who also suggested the importance of letting the public know that addiction does not discriminate and can affect anyone.

Her recommended approach included emphasizing the fact that addiction "has no face", using a campaign similar to that previously used for HIV/AIDS.

> *"I think a lot of people are aware of the problem (drug use and addiction) but they don't pay attention to it, especially if it is not in their house. Only when things start to get close, then people pay attention. I think public education can be done – 'in their face' programmes, like billboards similar to HIV posters that used to be on the highways. That is something that could be talked about or thought about."*

The provision of public education tailored towards the drug users themselves was also proposed in an effort to provide them with:

> *"... a better understanding of what they are going through so that they can get the necessary help, because they may think that everything is OK, until they are educated – or rather than somebody saying, 'what are you doing?', and quarrelling with them. If something came up on the news saying 'are you doing this?', with education and information, then they would recognize 'that sounds like me'. For some people it could be an awareness for them to get help..."*

While general information about addiction was seen as critical, mention was also made about the need to provide information about available treatment options. And it was thought that this should include a special focus on those who are most likely to encounter persons in need of treatment within their line of work e.g. those working in social agencies.

> *"We need to do some promotions. We need to let people know that there are facilities out there, because they don't know. We need to do some linkages once again with the existing organizations and case conferencing so that whether it is Child Care Board or Welfare or whoever, they know the facilities and know where they can also get help [for clients]."*

This was further supported by another treatment provider who stated that:

> *"Not everybody knows where to go. So, helping people to be aware of their avenues, resources and anything like that would be helpful."*

In addition to educating the public about addiction, raising awareness about new and emerging drugs was also thought to be essential.

> *"I believe the face of drugs is going to change. People are going to find ingenious ways to mask how they get their money e.g. with pills, etc. If you are on to me with the marijuana, I will come up with something else so I can still get my money… That may be something you have to think about. To educate the population in relation to the newer drugs and the impact on society. Because they are out there and will have an effect on society in terms of how they affect children and the population… You need to make the population aware so that when their children bring it home, they know that it is something dangerous to them.*

However, it was cautioned that care should be taken when speaking about new drugs as the information may peek persons' curiosity, thereby leading to experimentation.

> *"How do you educate about these [new drugs]? It can be dangerous because if I tell you about something, you may want to try it… People get curious and want to try new things. And then they get hooked out of a lack of knowledge (about the harms and how addictive a substance may be). Especially if they have that kind of personality. But that will be a whole different campaign altogether."*

In addition to wraparound services and public education, a number of other recommendations were proposed by the treatment providers. These included efforts to increase the social support received by women in need of treatment through family interventions and the establishment of support networks and mentorship programmes, increasing the capacity of treatment centres through increased staff and extended opening hours, and increasing access to treatment by simplify the associated processes.

Interventions to Strengthen Family Support. Earlier, reference was made to the fact that women with substance use disorders often lack family support; and this support is essential as it increases the likelihood of treatment success. It is against this backdrop that one treatment provider highlighted the potential utility of family workshops:

> *"…Before [COVID] we would have family workshops where we would encourage their (clients') families to come and… gain a little more knowledge about addiction and mingle with their family members now that they are sober – to see them through a different lens. So that is something we provide and if we can get it on a bigger scale that would definitely be helpful."*

Not all women will have family members who are willing or able to support them throughout the treatment and recovery process. These persons may therefore benefit from the support garnered from other sources; and it is for this reason, that one treatment provider recommended the establishment of support groups and mentorship programmes:

> *"Maybe a support group for women like themselves that they can recognize that there are other individuals like them, that they can get camaraderie, that they can get support from similar individuals. And a mentorship programme that can help them develop themselves by gaining work skills, social skills and life skills."*

Extended Opening Hours, Increased Staff and Reduced 'Red Tape'. Extended opening hours and an increased staff complement were two recommendations put forward to meet the scheduling needs of clients and increase treatment capacity. Together, these have the potential to increase treatment access for women.

> *"I would say adequate staff to provide counselling and later work hours to accommodate people after they finished work. That (later hours) means you may need to have another staff member to run another shift to accommodate those in the daytime and after work…So longer office hours and more staff."*

Similarly, simplifying the process for persons to access treatment was also recommended with the view to increase treatment access.

> *"Sometimes it is too much red tape just to get things done. The process should be made easier for clients to get help."*

DISCUSSION

The current study identified a range of factors which hinder women's use of treatment services in Barbados as well as a number of potential recommendations. It should be noted that while both internal and external barriers were identified, the vast majority were external in nature.

External Barriers

Childcare and Related Issues

Childcare and related issues (e.g. children being placed in custody of the state, decreased access to children while in treatment) were major themes emerging from the discussions with both treatment clients and providers, and were thus shown to be powerful obstacles to treatment for women in Barbados. This finding corresponds with the anecdotal reports from treatment providers which formed the study's conceptual basis, as well as findings from international studies (e.g. UNODC, 2004; Brady and Ashley, 2005; Stone, 2015; and Elms, Link, Newman & Brogly, 2018).

The matrifocal nature of the Barbadian society may be a contributing factor in this regard. Women have traditionally been the main breadwinners and childrearers within many Barbadian households and this continues today (Ministry of Youth and Community Empowerment & United Nations Children's Fund, 2020). As such, day-to-day parenting/domestic responsibilities may make it impractical for mothers to engage in treatment (Seahy, Iachini. DeHart, Browne & Clone, 2017). Research suggests that this may be further compounded by a lack of assistance with childcare, having many children, and having fears about their children's welfare in their absence (Seahy et al., 2017). The latter can be particularly impactful for women who have been the victims of abuse and violence. This was underscored during the discussion with the treatment clients who revealed that many women with substance use disorders have, at some point in their lives, been the victims of violence/abuse and are therefore hesitant to leave their children for fear that the children will have a similar experience when they are not there to protect them.

Against this backdrop, childcare can be seen as an important support service which, when offered by treatment centres, can potentially increase the treatment participation rate among

women with children, as well as the length of time they remain in treatment, by satisfying the practical needs of mothers and reducing anxiety over separation from their offspring (Seahy, Iachini, DeHart, Browne & Clone, 2017). For these reasons, the childcare recommendations posed by participants should be considered and possibilities for such services explored within the local treatment context.

Lack of Family Support & Having a Substance Using/Drug Dealing Partner

Two other barriers which were identified from the discussions included a lack of family support and having a substance using/drug dealing partner. This is an expected finding given that social factors have long been shown to influence a variety of treatment-related variables, including treatment entry, retention and recovery (Lookatch, Wimberly & McKay, 2019).

In fact, individuals in active treatment have been found to perceive higher levels of social support from their partners, families, friends and community at admission when compared to those who were not in treatment (Kelly, O'Grady, Schwartz, Peterson, Wilson & Brown, 2010). Similarly, those with strong social support networks have also been found to remain in treatment longer, have better recovery outcomes and a reduced likelihood of relapse (Lookatch, Wimberly & McKay, 2019).

On the contrary, having a drug-using partner reduces the probability that a woman will access treatment, and this is likely due to her partner's lack of support for treatment and potential attempts to dissuade her from seeking help (Brady & Ashley, 2005; Otiashvili et al., 2013; Shulga, Tokar, Smirnov & Dvinskykh, 2011). Likewise, having a drug-using partner also increases the possibility of premature termination (drop-out) and relapse.

The above highlights the importance of social support for treatment entry and success. However, it is recognized that not all women will have the necessary support network. As such, the recommendation for interventions to foster family support proposed by one treatment provider should be explored, as should the recommendation for establishing peer support groups. The latter can provide much-needed support for those who lack encouragement from family and friends. In addition, it is also recommended that active involvement in 12-step mutual aid groups be further encouraged as an adjunct to a structured drug treatment programme. While many of the local treatment programmes promote attendance at 12-step meetings, at least one study has

suggested that *active participation*[4] is a better predictor of improved treatment outcomes than simple attendance (Weiss et al, 2005).

Stigma

The identification of stigma as a barrier to treatment for women in Barbados corresponds with international research which consistently shows that stigma and discrimination prevent individuals across the globe from seeking and receiving treatment (Mora-Ríos, Ortega-Ortega & Medina-Mora, 2017). In this instance, gender is likely to be a contributing factor, as women who use drugs are more highly stigmatized than their male counterparts. This is due to the fact that drug use is not consistent with society's expectations of female behaviour (Lee & Boeri, 2017). Furthermore, those who are mothers tend to experience even greater stigmatization (Lee & Boeri, 2017). This was supported by the treatment provider who indicated that "An alcoholic father is different to an alcoholic mother… they might call the men alcoholics, but they may add on another bad word to it because you are female…".

Targeted interventions have the potential to reduce the stigma and marginalization associated with substance use disorders (Livingston, Milne, Fang & Amari, 2012). However, in its 2020 assessment of demand reduction efforts in Barbados, the Inter-American Drug Abuse Control Commission (CICAD) noted with concern that the island does not promote such measures (Inter-American Drug Abuse Control Commission [CICAD], 2021). This therefore highlights a gap that should be addressed with immediacy. It is suggested that initial efforts be focused on addressing the route causes of stigma.

Stigma often results from a lack of understanding or fear brought about by misinformation shared among individuals, in the media, etc. (American Psychiatric Association, 2020), as well as the inaccurate view that addiction is a moral failing rather than a chronic, relapsing disease which can be treated (National Institute on Drug Abuse [NIDA], 2021). As such, attempts should be made to increase societal awareness about addiction. To achieve this, participants' recommendations for widespread public education campaigns and educational initiatives which target those who may encounter persons with substance use disorders in their line of work (healthcare workers, social workers, etc.) should be acted upon. These can

[4] Active participation includes: speaking at meetings, working on one or more of the 12 steps, having a sponsor, or performing duties at meetings, e.g. making coffee (Weiss et al, 2005).

incorporate the use of traditional or social media as well as public lectures, workshops, etc., and should include the dissemination of information on: the nature and causes of addiction, its impact, and those who may be affected.

In addition to a one-off educational campaign, consideration can also be given to hosting an annual National Recovery Week or Month with a view to highlighting the issues of addiction, treatment and recovery on a continuous basis. Similar initiatives are conducted extra-regionally and can be used as a planning and implementation guide. It should be noted that the proposed National Recovery Week or Month differs from the current Drug Awareness Month which is celebrated in January of each year in Barbados, and which seeks to increase awareness of the dangers associated with drug use and related issues, as well as raise the profile of the work carried out by the National Council on Substance Abuse (NCSA).

Yet another strategy which can be used to combat stigma is the promotion of language that reduces negative bias[5] when discussing addiction with those who have substance use disorders, their families and the general public (NIDA, 2021). This would be particularly useful among prevention and treatment professionals as well as healthcare and social workers, just to name a few; and can be achieved through the use of sensitization workshops.

Related to the issue of stigma, are clients' concerns about attending treatment sessions at centres with "substance abuse" or "addiction" in their name. This can be addressed, at least in part, through the use of co-located outpatient treatment centres. Co-location refers to services that are located in the same physical space but are not fully integrated (Rural Health Information Hub, n.d.). In this instance, consideration can be given to having outpatient treatment centres located in buildings or clinics where medical or paramedical services are offered. This would afford clients some level of privacy, as onlookers would not necessarily know what service they are receiving within the building or clinic.

Like drug use, mental illness is also highly stigmatized (American Psychiatric Association, 2020). As such, it is not surprising that the need to be assessed for residential

[5] Language that reduces negative bias includes using: "person with substance use disorder" rather than "addict"; "person in recovery" rather than "former addict"; "substance use disorder" or "drug addiction" instead of "habit" (NIDA, 2021). Additional examples and reasons for the proposed language changes can be found in the NIDA article *'Words Matter – Terms to Use and Avoid when Talking about Addiction'* at https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

treatment[6] or attend outpatient drug counselling sessions at the Psychiatric Hospital was identified as yet another treatment deterrent. Of note is the fact that the community psychiatric clinics which operate within the island's polyclinic system also offer the assessment/referral service. However, this does not appear to be widely known by the public and may be limited by the number of days on which such clinics are offered[7] as well as a client's need for detoxification[8]. As such, it is recommended that this service be publicly promoted to raise awareness of its availability and, where possible, increase the number of days on which psychiatric services are offered within the polyclinics. Similarly, it is also suggested that outpatient drug counselling sessions, like those offered by the Psychiatric Hospital's Drug Rehabilitation Unit, be incorporated into the suite of services offered by the community psychiatric clinics. This should increase drug treatment access and uptake but would also require expanding the operating days of the community psychiatric clinics as well as the hiring of trained drug counsellors.

Unmet Basic Needs

The results suggest that if a woman's basic needs (e.g. food, housing, day-to-day living expenses) are not met, she will be less inclined to seek treatment for her substance use disorder. This stands to reason when considered against the backdrop of Maslow's Hierarchy of Needs and suggests how deprivation could potentially affect an individual's treatment and recovery potential.

Maslow's five-tier motivational theory is pictorially represented by a pyramid. Each level of the pyramid must be satisfied before the subsequent levels can be attended to. Physiological needs (air, water, food, shelter, sleep, clothing, reproduction) are the most basic, and form the foundation of the pyramid (McCleod, 2023). According to Maslow, having these needs met is a prerequisite for pursuing and attaining a fulfilling life (Henwood, Derejko, Couture & Padgett, 2015). Therefore, it is proposed that, in the context of this study, if a woman does not have food

[6] Barbadians desirous of having the cost of their residential drug treatment sponsored by the Government of Barbados must be assessed via the Psychiatric Hospital and subsequently referred to the Substance Abuse Foundation. This can be done onsite at the Psychiatric Hospital or at the community psychiatric clinics which operate within the island's polyclinic system.

[7] Community psychiatric clinics are not available on a daily basis within each polyclinic. They only operate on scheduled days each week/month e.g. every Wednesday or every 1st and 3rd Thursday, etc.

[8] Detoxification is only offered by the Psychiatric Hospital.

or housing, she will be preoccupied with securing these and will be therefore unable to focus on seeking treatment. Additionally, the discussion with the treatment clients suggested that the associated financial stress, and/or the need to rely on prostitution as a means of financial support, could lead to continued use as a means of coping thereby further reducing the motivation for treatment.

Based on the foregoing, and the discussions with the treatment providers which highlighted the need for formalized partnerships with relevant social agencies, it is recommended that a coordinated national assistance mechanism be established to help meet the basic needs of treatment clients. At present, the assistance offered to clients is garnered through the relationships which treatment personnel have developed with persons working in the various agencies. However, it is envisioned that the proposed mechanism would have a point person responsible for creating and updating a Register of participating governmental and non-governmental agencies and the forms of assistance they are willing to offer. Likewise, there should be a formal process for referral and follow-up through the said point person, who would also be responsible for managing a centralized database which details the assistance provided to specific individuals. The mechanism would create the needed formalized partnerships and could foreseeably enhance the provision of assistance by facilitating access to a wide range of services and simultaneously avoiding the wastage of resources which can result if persons are receiving the same/similar help from multiple agencies at the same time. Lastly, such a mechanism would reduce the need for the direct provision of assistance by treatment centres and the associated financing from their budgets.

In addition to providing need-based social services and assistance to treatment clients, there should also be a focus on equipping them with the knowledge and skills needed to obtain/sustain employment. Employment has been found to be one of the best predictors of positive outcomes for persons with substance use disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Those who are employed are less likely to relapse and be in conflict with the law, as well as have higher abstinence rates and an improved quality of life (SAMHSA, 2021). They are also more likely to successfully reintegrate into society (SAMHSA, 2021; Williams, 2022). For these reasons, it is recommended that participants' suggestion for the provision of education and training courses be pursued.

Lack of Workplace Drug Policies

The absence of workplace drug policies was identified as a treatment deterrent for women in Barbados. Drug policies enable organizations to effectively respond to the issue of drug use in the workplace while simultaneously assisting employees with substance use disorders. This is essential as drug use can negatively affect productivity and job performance, contribute to accidents and injury to self and others on the job, and lead to increased absenteeism and high turnover rates (Bush & Lipari, 2014). It can also affect the morale of other staff members (Bush & Lipari, 2014).

Drug policies should set out the procedures to be followed as well as the available support and how it can be accessed (National Council on Substance Abuse [NCSA], 2023). Without such a policy in place, employers will often be unsure of what to do when faced with an employee who has a substance use disorder. This can delay access to treatment, as was evidenced by the treatment client who revealed that she sought help through her workplace, but they did not have a drug policy and therefore took many months before they could source the required assistance.

In addition to undue delays in treatment access, the lack of workplace drug policies can make employees hesitant to seek help – either on their own or through the company - for fear of losing their jobs or being ill-treated by their employers and co-workers when persons find out that they have a drug problem (Canadian Human Rights Commission, n.d.). Instead, they may attempt to hide or downplay their addiction, and thus ultimately not receive treatment. This too was borne out in the discussions with the participants and corresponds with the findings of the 2022 pilot workplace survey conducted by the NCSA which revealed that 50% of participants were afraid that they would lose their jobs if they admitted to having a substance use problem (National Council on Substance Abuse [NCSA], 2023b).

Based on the above, it is recommended that there be a national campaign directed at the establishment of workplace drug policies. The NCSA currently assists organizations with the development of such policies which are tailored to their unique circumstances, and which adhere to the island’s labour laws as well as the standards of the International Labour Organization (ILO). For this reason, it is suggested that the Council lead the campaign and expand their services to the wider business community in Barbados. The campaign should include carefully

crafted marketing messages and workshops designed to raise awareness about workplace drug policies including their purpose, benefits and general content.

The issues brought about by the absence of workplace drug policies can be compounded by the fact that employers, employees and trade unions often do not understand the complex nature of substance use disorders. As such, it is also recommended that the NCSA continue its workplace outreach and make inroads into organizations that have not yet benefited from the Council's drug education initiatives. In addition to raising awareness about drug use and related issues, such initiatives will also help to promote a culture of non-judgement within workplaces.

Treatment Characteristics

Treatment providers as well as their clients identified a number of treatment programme characteristics which serve as potential barriers to treatment for women in Barbados. The participating clients highlighted the restrictive nature of the residential treatment programme, particularly their inability to go out, watch the news, listen to the radio and access up-to-date newspapers. They suggested that these restrictions make the treatment centre feel more like a prison. It is recognized that treatment centres often limit access to television, the radio, etc. to prevent distractions during the recovery process and allow clients to focus on getting sober (Hinders, 2018). When this is considered against the backdrop of the views expressed by the clients, it is recommended that efforts be made to ensure that clients understand the rationale for such restrictions as this may prevent treatment drop-out.

If not already in place, consideration can also be given to allowing clients the opportunity to earn television time, radio time and even supervised outings as a privilege (during an appropriate stage of treatment) for following the programme's rules, staying sober, doing excellent work during therapeutic sessions, etc. The ability to access these things can serve as motivation for the clients during the treatment process and help them to feel connected to the outside world while in the residential facility. The latter may assist with their reintegration, rather than being isolated and learning about major changes in society on discharge.

The treatment providers identified hours of operation (for outpatient centres), geographical location and lack of onsite detoxification as treatment barriers. Research has shown that women are less likely to use treatment services if they are outside of their communities or are not easily accessible by public transport (Priester et al., 2016; Rosen et al., 2004; Xu et al,

2008). Similarly, limited opening hours can also restrict access – particularly for persons who work and are unable to negotiate the required time off to attend sessions. These are both particularly relevant for outpatient treatment centres where persons will come and go on a regular basis. For this reason, it is recommended that treatment centres conduct needs assessments to determine the outpatient treatment needs of target clients and ensure that that these can be adequately satisfied. Possible solutions for dealing with issues related to location and opening hours include the use of satellite centres, extended hours and tele-counselling.

The cessation of onsite detoxification at the Psychiatric Hospital was a result of the COVID-19 pandemic and has not yet been reinstated. Research suggests that while outpatient detoxification can be successfully used with persons who meet specific criteria and experience mild-to-moderate withdrawal symptoms, it is associated with higher rates of relapse and drop-out than in-patient detoxification due to clients: having easy access to their drugs of choice, not adhering to the detoxification regimen and missing required daily appointments during the detoxification period, etc. (Hayashida, 1998). As such, the resumption of inpatient detoxification is recommended and should be used with persons for whom outpatient detoxification is not suitable or is less likely to be successful. It is also recommended that clients be carefully screened to identify the best type of detoxification for their specific case. Factors that need to be considered include, but are not limited to, the client's: age and physical health, available social support network, access to transportation, living environment, and potential for severe detoxification (Psychiatric Times, 1997). Additionally, to increase the success of outpatient detoxification, it must be ensured that thorough psychosocial assessments and interventions as well as biomedical assessments and stabilization are available to the outpatient clients (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015).

Internal Barriers

Denial and Lack of Motivation to Change

Denial has been identified as one of the main hurdles in the treatment and recovery process as it prevents persons from recognizing and acknowledging that they have a substance use problem (Zafar & Farhan, 2020). Related to this is a lack of motivation to change (American Addiction Centers, 2023). Motivation to change is essential for behaviour change to take place

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2019), and therefore, it is not surprising that the participants in this study identified both of these factors as barriers to treatment for women in Barbados.

Persons who are in denial and who lack the motivation to change their drug using behaviour are unlikely to present for treatment. As such, other opportunities should be sought to intervene and encourage help-seeking behaviour among these individuals. One possible opportunity can be found within the healthcare sector. Specifically, among affected patients who may be seeking primary care for an unrelated issue. In such circumstances, primary care physicians (General Practitioners) can rely on screening, brief interventions and motivational interviewing to assist patients they believe may have a substance use disorder or related problem (e.g. problematic or risky drug use).

Screening[9] and brief interventions can be used by physicians to identify patients with current or potential substance use problems and motivate them to change their behaviour and/or seek treatment by helping them to understand that their drug use is putting them at risk (Henry-Edwards, Humeniuk, Ali, Monteiro & Poznyak, 2003). Within the primary care setting, brief interventions can range from five minutes of brief advice to 15 to 30 minutes of counselling and can be spread out over a period of time and form part of a number of consultations (Henry-Edwards, Humeniuk, Ali, Monteiro & Poznyak, 2003).

Motivational interviewing, on the other hand, is an approach to patient engagement aimed at strengthening a person's motivation and commitment to change. It involves the use of a collaborative conversational style through which the physician helps the patient to explore potential reasons for behaviour change based on what is important to them (the patient) rather the physician telling the patient what to do (Hershberger, Martensen, Crawford & Bricker, 2021). Motivational interviewing has a set of guiding principles and specific communication skills which are designed to help persons progress through the stages of change and is particularly useful with persons in the Precontemplation and Contemplation stages[10] (Henry-Edwards, Humeniuk, Ali, Monteiro & Poznyak, 2003).

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[9] Screening is a means of identifying persons whose substance use may put them at risk of health problems or those who are already experiencing substance-related problems (Henry-Edwards, Humeniuk, Ali, Monteiro & Poznyak, 2003). Examples of screening tools include: the CAGE questionnaire, the Alcohol Use Disorders Identification Test (AUDIT) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

[10] The Transtheoretical Model of Change (Stages of Change) is a widely accepted change theory which proposes that behaviour change occurs in five sequential stages: Pre-contemplation (unaware of problem and has no plan to

Primary care physicians are uniquely placed to identify and intervene with patients who may not otherwise be willing - or see the need - to change their behaviour/seek treatment as they typically have an ongoing relationship and established rapport which allows them to express a genuine concern for the individual (Henry-Edwards, Humeniuk, Ali, Monteiro & Poznyak, 2003). This increases the likelihood that the patient will feel comfortable discussing such a sensitive matter with the doctor and receiving their advice. For this reason, it is recommended that screening, brief interventions and motivational interviewing be introduced and promoted within the primary care setting as a means of addressing the issues of denial and lack of motivation to change. This will require physicians in both the public and private sectors to received specialized training in the associated techniques.

Lack of Knowledge about Available Treatment Services

Both treatment clients and providers suggested that a lack of information about available treatment services is a barrier to treatment for women in Barbados. This corresponds with the findings of a study by Ashtankar and Talapalliwar (2017) which showed that even when an individual acknowledges that they have a drug problem and want to change, a lack of knowledge about treatment options can serve as a major barrier to treatment. Therefore, efforts must be made to raise awareness of the various services available on island and how they can be accessed. This type of information can be included in the previously recommended public education campaign on addiction. Consideration can also be given to sharing the information through the means recommended by participants e.g. health fairs, seminars and advertisements as well as utilizing online marketing strategies e.g. pay-per-click advertising, and search engine optimization to improve persons' ability to find and identify treatment options via online searches, etc.

Participants also suggested that the lack of information surrounding treatment options permeates the medical fraternity. As such, efforts must also be made to ensure that this population is well-versed on the available options. The information can be included as part of

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change); Contemplation (ambivalent or thinking about change); Preparation (taking steps toward change); Action (attempting change); Maintenance (sustained behaviour change for more than six months and attempting to prevent relapse) (Laranjo, 2016).

continuing medical education initiatives and workshops, as well as pamphlets supplied to doctors' offices and medical facilities across the island.

Co-occurring Mental Health and Substance Use Disorders

The participants' identification of co-occurring disorders as a barrier to treatment is not surprising given that the co-occurrence of mental health and substance use disorders is very common across the globe as well as here in Barbados[11], and it poses obvious diagnostic and treatment complications (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). Furthermore, international research has identified large prevalence/treatment gaps. This can be seen in the results of a national survey conducted in the United States of America which revealed that 9.1% of the participants with co-occurring disorders received both mental health and substance use treatment, 34.5% received mental health care only, 3.9% received substance use treatment only, and 52.5% received neither mental health nor substance use treatment (Han, Compton, Blanco & Colpe, 2017).

The impact of co-occurring disorders on treatment is concerning as such disorders are associated with increased hospital admissions; premature death; greater likelihood of relapse into drug use; higher risk for homelessness, incarceration and suicide; and poor prognosis for both disorders (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2021; Han, Compton, Blanco & Colpe, 2017). Therefore, efforts must be made to mitigate this barrier to treatment in Barbados.

One possible approach is to ensure that persons presenting for mental health treatment are screened for substance use disorders and vice versa thereby making provision for the necessary treatment referrals. This coincides with the "No Wrong Door" policy and corresponding approach which is promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA). According to this Policy/approach, persons with co-occurring disorders can enter the treatment system through a range of avenues, and proactive measures must be taken to ensure that they are identified, assessed, and receive treatment, either directly or through appropriate referral, no matter where they initially present (Sacks & Ries, 2005). In accordance with this, it is

[11] The 2021 Barbados Drug Information Network (BARDIN) report revealed that during the period 2018 through 2021, between 21% and 33% of admissions at the Psychiatric Hospital involved co-morbid diagnoses which included a substance use disorder (NCSA, 2023).

recommended that routine screening for co-occurring disorders be carried out as part of the intake process at mental health and drug treatment facilities in Barbados.

In addition to screening, the treatment processes employed are also critical. The literature suggests that integrated treatment – which involves the simultaneous treatment of both disorders using a multidisciplinary approach e.g. pharmacotherapy and psychotherapy - is the most effective for co-occurring disorders, leading to a better quality of care and health outcomes for the individual (Kelly & Daley, 2013; SAMHSA, 2022). For this reason, it is further recommended that integrated treatment approaches be implemented in the mental health and drug treatment centres across the island.

It is recognized that this may require the expansion of services offered and the hiring of additional staff. Where this is not possible due to budgetary or other constraints, consideration should be given to the establishment of partnerships between mental health and drug treatment facilities to enable the provision of simultaneous care for both disorders.

Limitations

While the current study provides useful local data on the topic, there were a number of limitations which should be considered. Firstly, the study was qualitative in nature, involving a small, convenience sample. As such, the participants were likely not representative of the wider target populations (female treatment clients and treatment providers), and therefore, the findings cannot be generalized.

In relation, there was a noticeable absence of data from outpatient female treatment clients. When the study was originally conceptualized, provision was made for outpatient clients to complete a related questionnaire on the topic. However, there were insufficient females in outpatient treatment to proceed with this aspect of the research. It should be noted that continuous attempts were made to avoid their exclusion e.g. extending the data collection period multiple times, contacting other social agencies who may provide services to women in need of/who have accessed outpatient treatment in the past for referrals – but these proved futile. Ultimately, the decision was taken to bring the data collection period to an end and proceed with the qualitative data which had been collected. While the lack of outpatient clients is a recognized shortcoming, we note the great similarity in the barriers and recommendations identified by both the participating residential clients and the residential/outpatient treatment providers.

The aging nature of the data is another limitation, and is due to the data collection extensions mentioned above. The data was collected approximately two and half years before the report writing process. While there may be obvious concerns about the continued relevance of the data, it should be noted that checks were made with the treatment centres at the time of writing to ensure that no significant changes had taken place.

A fourth limitation is that only clients currently accessing treatment were included in the data collection process. It is acknowledged that those who are in need of treatment but are not yet in contact with a treatment centre may have different barriers to those who are in treatment. Likewise, their recommendations may also differ. Unfortunately, they are a hidden population, and this hindered their inclusion in the present study.

Lastly, we relied on the treatment centres to recruit participants for both the client focus group and the provider interviews. As such, a level of selection bias may have crept into the final sample – particularly in the selection of treatment clients, as the Centres may have ultimately selected persons who are more articulate, more compliant with treatment and have a more positive view of treatment and the treatment centre. This in turn could have influenced their responses.

Directions for Future Research

The current study serves as a springboard for future research. It is recommended that a similar study be conducted among persons not yet in treatment as their experiences may reveal additional barriers which would benefit from intervention at the policy level. Likewise, while this study focused solely on women, future research can include men in Barbados to determine if their barriers to treatment are systematically different. In this regard, a comparative analysis would be particularly effective.

One of the most significant limitations of this study was its small, non-probability sample. As such, it is also recommended that the topic be investigated using a larger, representative sample to facilitate extrapolation of the findings to the wider target population.

Lastly, consideration can be given to investigating the relationship between unmet needs and motivation for treatment, using Maslow's Hierarchy of Needs as a theoretical foundation. The foregoing discussion on this topic was based on reason, but a study of this nature could reveal a potential pathway to treatment for persons who have not yet sought help – and in so

doing provide empirical support for programme initiatives designed to help persons with substance use disorders meet their basic needs.

CONCLUSION

Treatment clients and providers possess firsthand knowledge of the factors that help or hinder women's use of drug treatment services and, as such, this study's participants were able to identify critical barriers within the local context, as well as potential solutions. This is an important first step, given that for drug treatment to make a substantial public health impact, it must be utilized by a large percentage of those in need of such services.

Most of the identified barriers were external in nature and can therefore be more easily addressed by policy and programming initiatives, such as those proposed in this report. While the internal barriers may pose a greater challenge, initial efforts in this area can likewise be guided by the corresponding recommendations.

Overall, despite its limitations, this report provides a useful roadmap for improving treatment access and utilization among women in Barbados and serves as a foundation for further local research on the topic.

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Appendix 1 – Summary of Data Collection Methods & Related Information

Participant Category	**Data Collection Method**	**Type of Data**	**Analysis and Data Captured**
Clients enrolled in the residential SAT programme at MH	Focus Group	Qualitative	Thematic analysis. Self-reported barriers to SAT for women in Barbados; possible solutions to the barriers.
Treatment providers (one from each of the four SAT centres)	Semi-structured Individual Interviews	Qualitative	Thematic analysis. Perceived barriers to SAT for women in Barbados; possible solutions to the barriers.

Appendix 2 – Qualitative Data Collection Instrument: Semi-structured Interview Schedule for Individual Interviews with Treatment Providers

1. What do you think is important for us to know about the women your agency serves?
2. What are some of the challenges you face when providing substance abuse treatment services to women?
3. What do you think are the main barriers to substance abuse treatment for women?

    Examples:

    - Stigma (associated with drug addiction, having to source treatment via the Psychiatric Hospital, etc.)
    - Local culture
    - Financial constraints (cost of treatment and associated costs e.g. time off work, childcare, transportation, etc.)
    - Denial of a problem
    - Lack of familial support
    - Having a substance using partner
    - Fear of losing children
    - Logistical problems (transportation, child care, inability to get time off work)
    - Competing needs (housing, food, illness, etc.)
    - Presence of co-occurring disorders
    - Lack of knowledge about available treatment services
    - Limited space within treatment programmes
    - Characteristics of treatment programmes (staff complement, type of treatment delivered, presence or absence of wraparound services)
    - Other barriers not listed here
4. How do these barriers impact the treatment process?

    Examples:

    - Women do not present for treatment
    - Women do not return to start treatment after initial assessment
    - Women drop-out of treatment

- Women miss sessions
- Others not listed here

5. Are possible barriers to treatment assessed at intake and taken into consideration during treatment planning?
6. What do <u>you think</u> are some of the solutions to the treatment barriers facing women?
7. What does <u>your agency do</u> to alleviate the impact of potential treatment barriers?

   Examples:

   - In-house wraparound services e.g. childcare, transportation, healthcare,
   - Inter-agency collaboration to satisfy the needs of women e.g. childcare, transportation, health care
   - Help clients negotiate time off of work to attend treatment sessions
   - Provision of after-care treatment services
   - Others not listed here

   Probe: Would you say that these are successful?

Appendix 3 – Qualitative Data Collection Instrument: Semi-structured Interview Schedule for Focus Group with Treatment Seekers

1. **What unique issues affect women who misuse drugs and alcohol in Barbados?**

   Examples:

   - Physical, sexual, or other types of abuse
   - Stigma
   - Judgement from others
   - Direct consequences of drug use on children
   - Co-morbid disorders e.g. anxiety, depression, PTSD

2. **What are some of the challenges/barriers faced by women seeking substance abuse treatment in Barbados?**

   Examples:

   - Lack of information on available treatment options
   - Lack of childcare
   - Stigma
   - Lack of support from family members
   - Financial constraints
   - Inability to get time off of work
   - Denial of a problem with drugs and alcohol

   a. **What are the most significant barriers that <u>you</u> personally faced when seeking substance abuse treatment?**
   b. **How did you overcome these barriers?**

3. **What can be done to reduce the treatment barriers faced by women in Barbados?**

   Examples:

   - Flexible clinic hours
   - Provision for child care

- Assistance with housing
- Food
- Employment

a. **What would have made it easier for you to access substance abuse treatment?**
b. **What can be done to encourage women to access treatment for drug and alcohol misuse?**

4. **Based on your experiences, is there anything else you think we should know about substance abuse treatment for women in Barbados?**

Appendix 4 – Informed Consent Form for Individual Interviews

"BARRIERS TO SUBSTANCE ABUSE TREATMENT IN BARBADOS: FACTORS HINDERING WOMEN'S USE OF TREATMENT SERVICES"

INFORMATION FOR INTERVIEW PARTICIPANTS

Description and Objective of the Study

The purpose of this study is to explore the barriers to substance abuse treatment for women in Barbados.

Invitation to Participate

You are being invited to participate in this research because you are a substance abuse treatment provider in Barbados.

Participation

Your participation will involve being interviewed by a researcher from the National Council on Substance Abuse. She will ask about your views on the barriers to substance abuse experienced by women and possible solutions. The interview is expected to take approximately 60 to 90 minutes to complete.

Your participation is voluntary and you can stop at any time. You also have the right to refuse to answer any questions. Should you decide not to participate or to stop after having started, you will not experience any negative consequences.

Compensation

You will not receive any monetary compensation for your participation in this study.

Confidentiality & Anonymity

Participation in this study is anonymous and all of the information provided will be kept confidential. As such, no identifying information will be included in the resulting research reports. To ensure this, no names will be used during the discussion. Instead, pseudonyms (false names) will be used and no list linking the pseudonyms (false names) to identifying information will be kept. It will therefore not be possible to identify individual participants by their responses.

Only members of the research team will have access to the data. Voice recordings and notes made during the discussions will be stored in locked cabinets and electronic copies of the data will be password protected to prevent unauthorized access to the information. To further protect the confidentiality of your responses/contributions to the discussion, only the Principal Investigator will have access to the voice recordings.

Risks Associated with the Study

There is a small risk that some of the questions asked may cause you some distress. Therefore, you will be provided with contact information for counsellors upon request.

Benefits

Although your participation in this study may not benefit you directly, there may be indirect benefits. The findings of this study may allow for a greater understanding of the barriers to treatment for women in Barbados and be used to guide the development of policies, programmes and interventions tailored specifically for women in need of substance abuse treatment in Barbados. They may also serve to inform the practices of treatment providers when serving this population.

Access to the Results

It is anticipated that the results of this study will be ready by August 31, 2020. If you want to receive the results of this research, please provide an email address to which the final report can be sent. Your email will not be shared and will be kept separately. In addition, you will not receive additional messages.

Email address for sending: _____

Additional Information

If you have any questions pertaining to the study, which have not been answered by the information contained in this form, please ask them at this time. Should you have any future questions regarding the research, please contact the Principal Investigator Laura Foster of The National Council on Substance Abuse at telephone number 535-6272. You can also contact the Office of Research at the University of the West Indies, Cave Hill Campus at telephone number 417-4847.

AGREEMENT TO PARTICIPATE

I, _____, have read (or had read to me) the information for persons taking part in the study ***"Barriers to Substance Abuse Treatment in Barbados: Factors Hindering Women's Use of Treatment Services"***. The purpose of this study is to explore the barriers to substance abuse treatment for women in Barbados. My questions, if any, have been answered to my satisfaction. I understand that my participation is voluntary and that I have the right to stop answering questions at any time, and will not experience any negative consequences for doing so.

I agree to participate

_____, Date:_____

(Signature)

Person obtaining consent:

_____, Date:_____

(Signature)

I have been given a copy of this form to keep.

Appendix 5 – Informed Consent Form for Focus Group

"BARRIERS TO SUBSTANCE ABUSE TREATMENT IN BARBADOS: FACTORS HINDERING WOMEN'S USE OF TREATMENT SERVICES"

INFORMATION FOR FOCUS GROUP PARTICIPANTS

Description and Objective of the Study

The purpose of this study is to explore the barriers to substance abuse treatment for women in Barbados.

Invitation to Participate

You are being invited to participate in this research because you are a female receiving substance abuse treatment in Barbados.

Participation

Your participation will involve taking part in a focus group discussion with persons who are similar to you. The discussion will be led by a researcher from the National Council on Substance Abuse. She will ask questions about the barriers to substance abuse experienced by women and possible solutions. The discussion is expected to take approximately 60 to 90 minutes to complete.

Your participation is voluntary and you can stop at any time. You also have the right to refuse to answer any questions. Should you decide not to participate or to stop after having started you will not experience any negative consequences.

Compensation

You will not receive any monetary compensation for your participation in this study.

Confidentiality & Anonymity

Participation in this study is anonymous and all of the information provided will be kept confidential. As such, no identifying information will be included in the resulting research reports. To ensure this, no names will be used during the discussion. Instead, pseudonyms (false names) will be used and no list linking the pseudonyms (false names) to identifying information will be kept. It will therefore not be possible to identify individual participants by their responses.

Only members of the research team will have access to the data. Voice recordings and notes made during the discussions will be stored in locked cabinets and electronic copies of the data will be password protected to prevent unauthorized access to the information. To further protect the confidentiality of your responses/contributions to the discussion, only the Principal Investigator will have access to the voice recordings.

Risks Associated with the Study

There is a small risk that some of the questions asked may cause you some distress. Therefore, you will be provided with contact information for counsellors upon request.

Benefits

Although your participation in this study may not benefit you directly, there may be indirect benefits. The findings of this study may allow for a greater understanding of the barriers to treatment for women in Barbados. They may also be used to guide the development of policies, programmes and interventions tailored specifically for women in need of substance abuse treatment in Barbados.

Access to the Results

It is anticipated that the results of this study will be ready by August 31, 2020. If you want to receive the results of this research, please provide an email address to which the final report can be sent. Your email will not be shared and will be kept separately. In addition, you will not receive additional messages.

Email address for sending: _____

Additional Information

If you have any questions pertaining to the study, which have not been answered by the information contained in this form, please ask them at this time. Should you have any future questions regarding the research, please contact the Principal Investigator Laura Foster of The National Council on Substance Abuse at telephone number 535-6272. You can also contact the Office of Research at the University of the West Indies, Cave Hill Campus at telephone number 417-4847.

AGREEMENT TO PARTICIPATE

I, _____, have read (or had read to me) the information for persons taking part in the study ***"Barriers to Substance Abuse Treatment in Barbados: Factors Hindering Women's Use of Treatment Services"***. The purpose of this study is to explore the barriers to substance abuse treatment for women in Barbados. My questions, if any, have been answered to my satisfaction. I understand that my participation is voluntary and that I have the right to stop answering questions at any time, and will not experience any negative consequences for doing so.

I agree to participate

_____, Date:_____

(Signature)

Person obtaining consent:

_____, Date:_____

(Signature)

I have been given a copy of this form to keep.