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Accessibility of substance use treatment: A qualitative study from the non-service users' perspective

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ABSTRACT

Introduction: Despite having effective treatments for substance use disorders, the majority of people with a substance use disorder do not receive treatment, which leads to adverse personal, health, and social consequences. Experiences of non-service users have hardly been investigated in the literature. This study, which we conducted in the Netherlands, assessed the barriers to and facilitators of accessibility to substance use treatment for non-service users with substance use disorders.

Methods: The study team conducted a total of 10 individual, semi-structured interviews with participants recruited with the help of assertive outreach teams and public health services. A topic list guided the interviews. The interviews were transcribed, and the study team performed a thematic analysis.

Results: Six main themes related to the health care accessibility of substance use treatment emerged: treatment factors, stigmatization, personal factors, consequences of use, knowledge deficits, and social support. Personal factors, especially the non-service users' motivation, was a central determinant of whether they accessed substance use treatment. Social support and consequences of the substance use were perceived as facilitating access to treatment. Stigmatization and knowledge deficits had an important negative impact on the substance users' intrinsic motivation and thus on their ability to access health care. Specifically, stigmatization by health care professionals contributed to suboptimal treatment and recovery.

Conclusions: This study recommends interventions for health care professionals aimed at decreasing their stigma toward and knowledge deficits about substance use disorder. This study highlights the key role that primary health care providers can have in identifying substance use problems and facilitating the pathway to health care services for those with substance use disorders.

1. Introduction

Relatively few people with a substance use disorder receive the treatment they need, although psychosocial and pharmacological interventions for alcohol and other drug use are effective in decreasing the negative impact on the individual and society (Dutra et al., 2008; van den Brink, 2012). Left untreated, people with a substance use disorder are at risk of developing a serious illness, dying by suicide, or otherwise having an early death (Chi et al., 2006; Center for Behavioral Health Statistics and Quality [CBHSQ], 2016). Besides preventing life-threatening illnesses, the right treatment is necessary to decrease the rising costs due to crime, imprisonment, homelessness, traffic accidents, and absenteeism from work (CBHSQ, 2016).

The global prevalence of substance use disorders (including alcohol, cocaine, opioid, cannabis, amphetamine, and other drug use disorders) is about 164 million people, while only a minority of them undergo treatment (Global Burden of Disease [GBD], 2018). Nevertheless, we know little about the determinants of health care accessibility of substance use treatment. In the Netherlands, an estimated two million people have some form of substance use disorder, but in 2015 fewer than 65,000 of them received treatment (van Laar et al., 2014; Wisselink et al., 2016). Research on this treatment gap increased in the last 10 years, although insights into its causes remain limited.

In the Netherlands, people with a substance use disorder can receive treatment on the basis of a referral, usually by a general practitioner. Depending on the severity and complexity of the complaints, treatment

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will take place according to low-intensity mental health care or regular mental health care. Within low-intensity mental health care, treatment mainly focuses on psycho-education and cognitive behavioral therapy with a blended approach. In addition to low-intensity mental health care, the regular mental health care offers more intensive treatment options, such as pharmacological interventions, group therapy, inpatient treatment, detoxification programs, and crisis interventions. Overall, providers adopt a request-oriented approach, with a strong preference for home and restorative interventions. Substance use treatment was, until recently, organized separately from mental health care. In recent years, however, more than half of the substance use health care became part of mental health care institutions (Rutten & Schippers, 2013). This integration is necessary, as psychiatric comorbidity is the rule rather than the exception (Franken et al., 2019). In the context of the health care accessibility of substance use treatment, substance use treatment in the Netherlands is fully reimbursed by basic health insurance.

A number of studies have reported that people with a substance use disorder have experienced difficulties with access to health care services (Gilburt et al., 2015; Priester et al., 2016; Van der Pol et al., 2013; Wagner et al., 2017; Wisdom et al., 2011). For example, personal barriers exist, such as seeking to avoid stigma and having a wish to resolve one's substance use problems alone (Saunders et al., 2006; van der Pol et al., 2013; Wagner et al., 2017). Important organizational barriers also exist, such as staff shortages and a scarcity of health care services, long waiting lists, and a focus on detoxification instead of treatment (Gilburt et al., 2015; Neale et al., 2007). On the other hand, support by one's family, friends, and peers can have a positive influence on someone accessing health care. Within the treatment relationship, patients experience an understanding, unprejudiced approach and a flexible, patient-oriented attitude as supportive (Gilburt et al., 2015; Neale et al., 2007; Wagner et al., 2017).

The concept of health care accessibility is important, health policy and health services research commonly use the concept; nevertheless, because it cannot be unequivocally defined, studies have operationalized it in several ways. A definition that is frequently used for health care accessibility is “the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services, and to actually have a need for services fulfilled” (Levesque et al., 2013, p. 1). The majority of people with a substance use disorder delay seeking treatment or avoid doing so altogether (Roper et al., 2012). Researchers have used different terms to refer to people who avoid seeking treatment; for example, care avoiders, non–service users, non–treatment seekers, or drug use avoiders (Finn et al., 2014; Gilburt et al., 2015). In this paper we use the term *non–service users* to refer to people who are in need of care but who do not or cannot ask for help, dropped out of treatment, or avoid seeking help because they believe they do not need it.

Research has hardly investigated the health care experiences of non–service users with a substance use disorder (Gilburt et al., 2015; Van der Pol et al., 2013; Wagner et al., 2017). However, knowing these people's experiences could be helpful for understanding why they do not take advantage of the health care services that are available to them. In the last two decades, the number of people with an alcohol or a drug use disorder has increased substantially, largely because of population growth and aging populations (Global Burden of Disease [GBD], 2018). These developments underscore the need to better understand the non–service users with substance use disorders. The aim of this study was, therefore, to explore the health care views and experiences of this population. We did so to gain insight into treatment barriers and facilitators to be able to improve access to health care services. The specific research question that we addressed was, What are the barriers and facilitators to seeking substance use treatment among non–service users with a substance use disorder?

2. Methods

To fulfill the aim of the study and to answer the research question, the study team interviewed individuals based on a list of topics. Consequently, the interviews examined complex topics, such as feelings, experiences, and opinions that non–service users had encountered (Tong et al., 2007). The research team modeled the interviews on retrospective, transversal research, which involves the interpretation of data based on thematic analysis. “Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 6). The study, therefore, did not aim to unravel phenomenological constructs, but only to compile an inventory of the contributing factors (Boeije, 2009; Braun & Clarke, 2006). The study is reported according to the Coreq checklist 1; Coreq checklist 2, whereby the reader is provided with all the details necessary for assessing the quality of the study (Tong et al., 2007).

2.1. *Sampling and procedure*

The study recruited participants through assertive outreach teams and public health services, such as homeless shelters, in several small cities and in a rural area in the Netherlands. The study used purposive sampling, which aimed to have maximum variation in gender, age, substance use, and treatment experiences. The study team established inclusion and exclusion criteria to recruit information-rich cases that would allow us to gain insight and an in-depth understanding of issues that were of central importance to the aim of this study (Patton, 2007). Inclusion criteria were for the participant to be older than 18 years and to have daily use of alcohol and/or drugs, a comprehensive understanding of the Dutch language, and a willingness to be audio-recorded. The study used daily use of alcohol and/or drugs as the criterion for determining whether the participant could be diagnosed as having a substance use disorder (American Psychiatric Association, 2013). Exclusion criteria included having a measured or estimated total IQ $<$ 70, currently receiving treatment for a substance use disorder, familiarity with the researcher, inability to interact with the researcher because of being under the influence of a substance, and being in a crisis situation whereby the person was a danger to himself or herself or others.

The primary researcher (LC) informed the health care providers in the assertive outreach teams and homeless shelters, either in person or by telephone, about the study and its purpose. Thereafter, the health care providers (including social workers, nurses, and homeless shelter staff) approached people who met the study's inclusion and exclusion criteria. If these people expressed an interest in participating, the health care provider then gave the person an information sheet about the study. The study team then selected fifteen participants, but five of them dropped out because of demotivation, hospitalization, or personal circumstances. After the remaining participants gave their consent, the researcher contacted them by telephone within 1 week to provide further details about the study and to further assess their willingness to participate. When the researcher deemed a participant willing to participate, the researcher scheduled an interview for a date and location that was suitable for both the participant and the researcher. This agreed-upon location was intended to ensure that the participant would feel at ease in a familiar environment that would enable him or her to speak openly (Guba & Lincoln, 1994).

2.2. *Data collection*

The researcher (LC, female, advanced practice nurse, M.S.) conducted all of the semi-structured, face-to-face interviews. A list of topics (see Table 1), which were based on a review of the literature, served as a guide during the interviews. This approach ensured that the focus would remain on the research question, but also that the interviewees would have the opportunity for personal input while being guided by the open-

Table 1
Topic list used to guide the interviews.

Topics	Subtopics
Personal factors	Stigma avoidance
	Own responsibility
	Personal circumstances/life-events
	Adverse effects of substance use
Relational factors	Openness of substance use to significant others
	Emotional support
	Practical support
	Social rolls
Treatment-related factors	Healthcare provider aspects; attitude and professional ways
	Organizational aspects; treatment experiences

ended questions (Polit & Beck, 2012). Examples of open-ended questions are: "What experience do you have with substance use treatment?" "Which personal factors, like traits or beliefs, influenced your help-seeking behavior and in what way?" "Can you explain how your social network played a role in the guidance to health care/substance use treatment?" For the researcher to have an in-depth record of her observations and impressions during the interview, she wrote field notes right after each interview. In this way the researcher formed more meaning and understanding from the perspective of non–service users. In addition, the field notes helped the researchers to explore emerging signs/highlights or similarities.

The data collection phase of this research continued until the last two interviews yielded no new information that suggested that the study had reached data saturation.

2.3. Data analysis

The first step in the data analysis was to manually transcribe the recorded interviews verbatim. The study team then manually carried out a thematic analysis of the data according to Braun and Clarke's (2006) guidelines for using six phases. In the first phase, the researcher needs to familiarize herself with the data. Therefore, LC actively read through the entire dataset searching for meanings and patterns to form first ideas. The second phase involves generating initial codes. So the study team collected any data that could be of value or appeared interesting to the study and collated it into meaningful groups. Phase three focuses on identifying potential themes. LC wrote the name of each code on a separate piece of paper as an aid to sort the different codes into themes and subthemes. The fourth phase requires further refinement and review of the candidate themes and subthemes. As advised by Braun and Clarke (2006), the entire dataset was re-read to see if the themes fit the data and to identify any additional data that was missed in earlier coding stages. In phase five, the themes and subthemes then are further defined and refined. We have been able to summarize the contact and scope of each defined theme and subtheme in a few sentences. This confirmed to the researchers that no further refinement of the themes was required. The final phase involves writing the report. Within the report, we have strived to capture the essence of each theme and subtheme, using quotes to demonstrate the importance of the theme or subtheme.

In the stages of coding the data and defining themes, we used peer review to minimize subjectivity and to stay as close to the actual data as possible (Baarda, 2014). To reduce potential bias, a second researcher (TB, male, advanced practice nurse, pH.D. candidate) was involved to provide a critical review while drawing upon his experience in qualitative research (Beckers et al., 2019; Beckers et al., 2020). The second researcher reviewed all data (audio recordings, transcriptions, and field notes) and discussed all codes, themes, and subthemes until they achieved consensus. The involvement of a second researcher in the coding stage of the study was also useful because of his experience in qualitative research. This experience was important because researcher LC is less experienced in qualitative research, but she brought a fresh and open-minded approach to the study. The team carried out member checks to increase confirmability. From among the participants who gave permission to participate in the member check after the interview, the study team randomly chose two participants. They received a summary of the results to check whether the researcher's interpretation corresponded to the participants' intended meaning. Both of the participants confirmed that they recognized themselves in the summary.

2.4. Ethical considerations

Formal ethical review of the study was not required according to the guidelines of the Dutch Medical Research Involving Human Subject Act (WMO) for the following reasons: No infringement was made on the physical or mental integrity of the participants. The study placed only a slight burden on the participants inasmuch as the data collection consisted of a single interview (Central Committee on Research Involving Human Suspects [CCMO], 2020). The scientific board of the specialist mental health service that was involved in the study approved it. Each participant gave signed or verbal (via an audio-recording) informed consent before their interview started. Because participation was voluntary, participants were allowed to discontinue their participation at any time without being required to provide a reason. The study processed all of the data anonymously, and the study gave each participant a voucher worth ten euro's as a token of appreciation. Participants could exchange these vouchers in various shops and cultural attractions.

3. Results

The study conducted ten semi-structured, face-to-face interviews with voice recordings between September 2017 and February 2018 (a period of 6 months). The interviews lasted, on average, 42 min (range = 34 to 51 min). The majority of the interviews were conducted at the participant's residence. The study interviewed eight men and two women, and their mean age was 48 years. Cannabis and alcohol were the most common substance use disorders among participants, followed by heroin, cocaine, and amphetamine (see Table 2).

The study identified six major themes, and we divided half of them into subthemes. The major themes included treatment factors, stigmatization, personal factors, consequences of substance use, knowledge deficits, and social support (see Fig. 1).

3.1. Treatment factors

Treatment factors, which comprises two subthemes, is the first theme. Participants reported reluctance to ask for help because they had experienced inflexibility in the treatment options that were available,

Table 2
Characteristics of the participants.

Socio-demographic characteristics	N
Number of participants	10
Gender	
Male	8
Female	2
Age	
Mean	48
Standard deviation	10
Substance use disorders	
Alcohol	6 (60%)
Cannabis	6 (60%)
Heroin	3 (30%)
Amphetamine	2 (20%)
Cocaine	2 (20%)
Treatment experiences	
Yes	5
No	5

inadequate follow-up, and the care providers' stigmatization of substances users, which contributed to a bad image (subtheme: negative experiences). In addition, the participants encountered practical barriers to entering substance use treatment, including difficult requirements for treatment, long waiting times, and limited patient participation (subtheme: organization of care).

Subtheme: negative experiences

> "For me, the weed was replaced with sleeping pills but that no longer works the way it used to. It's only for a short period of time because I now suffer from terrible sleep problems again… Substance use treatment is a strange thing. People are addicted to weed, and then they manage to get rid of the addiction, but then they are addicted to Oxazepam. So they actually replace their addiction with another one. Then why would people let themselves be helped? That's how it is and that's why a lot of people don't let themselves be helped because the real problem, the cause, is not addressed."
>
> Interviewee 2

> "I get to hear during therapy: 'I will remain addicted forever, it will be difficult every day'. Yeah, thanks for rubbing that salt in the wounds. What good is it to hear that? That doesn't make me happier. I'm leaving with even more craving."
>
> Interviewee 3

Subtheme: organization of care

> "Well, it takes quite a while [receiving treatment]. You will be put on a waiting list and back then I had to wait five to six weeks. That's too long, at least I think so, because you can change your mind again. Then I can still withdraw or lose more control over my substance use. In the meantime you can lose your motivation, at least it works that way for me. I was always inclined to postpone treatment. I had a very hard time with the uncertainty. I made so many calls to inquire, but I just had to wait. I felt lost and not taken seriously at all."
>
> Interviewee 5

> "It was always a long wait. And I do regret that. If you break a leg, you get help immediately. However, if you need this kind of help they leave you stranded in the rain. Also the long distance to the location and many questions/questionnaires made it difficult to me. Every time I get the same series of questions, even though they know me. I think it saves money and time, and even annoyance on both sides, to shortening an re-intake. Take the old data and go through it together to see what needs to be changed. Do some preparation."
>
> Interviewee 9

3.2. *Stigmatization*

Participants saw stigma and self-stigma as important obstacles to gaining access to substance use treatment. According to the participants, public stigmatization was apparent in labeling, negative stereotyping, and devaluation of people with a substance use disorder, and this led to participants having a feeling of shame and a loss of self-esteem. The substance users' fear of a loss of face, among other things, led them to withhold information about their substance use.

> "… I would be ashamed [given the title of addict]. Who would not be ashamed? It feels like you lose things such as self-confidence and perseverance. I don't want to lose myself. I don't want other people looking down on me, you know?"
>
> Interviewee 4

> "One finds a junk just a junk. Immediately think I'm dealing. A junk always lies. [silence] That's horrible, because despite my drug use I haven't forgotten my decency standards."
>
> Interviewee 9

> "I have visited the general practitioner several times, but mostly for my physical complaints. I didn't talk about my alcohol and cannabis use. The doctor didn't ask about it either, so I left it that way."
>
> Interviewee 10

3.3. *Personal factors*

The theme *personal factors* has three subthemes. The need for autonomy and bearing personal responsibility emerged as strong personal beliefs. Participants generally saw asking for help as unnecessary or as a sign of weakness, so they made no contact with a health care provider for their substance use disorder (subtheme: beliefs). In addition, participants denied, accepted, or justified their substance use. That is, they had no desire to change. Participants saw intrinsic motivation as essential for successful treatment (subtheme: motivation). Participants found it valuable when health care providers expressed genuine interest and offered patient-oriented care and support for obtaining and maintaining positive social outcomes (subtheme: needs).

Subtheme: beliefs.

> "Because I believe I don't have an addiction. Others see my weed use as an addiction. I compare it to a pack of cigarettes every week. I never went into treatment for substance use, because I prefer to do it on my own. I get by just fine by myself"
>
> Interviewee 6

Subtheme: motivation.

> "Listen, I'm 53 years old. Who is going to prohibit me anything? I don't want to stop using. I do what I do, I live my own life."
>
> Interviewee 8

> "I have always been my own boss and I have always wanted to use too. If you want to quit you have to be really strong minded. If the will is not there, then it is useless."
>
> Interviewee 10

Subtheme: needs.

> "The contact with the nurses on the ward was really a hundred percent. Everyone liked me there. The nurse said to me: 'If things don't work out, you are always welcome again.' And it did something to me. I felt appreciated and heard. I didn't have that back home. I was even asked by the nursing as an expert by experience. I felt like an actual person!"
>
> Interviewee 1

> "They [healthcare professionals] mainly listened. Listening, helping and not judge you by the problems you have and may have caused yourself. It's not enough for or I mean… It's not a guarantee of successful treatment, but it's a good start."
>
> Interviewee 7

3.4. *Consequences of use*

The fourth theme is consequences of use. According to the participants, substance use resulted in health, financial, and social problems; loss of work, home, and social support; and a demand into their support system higher than the system could provide. The accumulation of problems caused them to have an aversion to substance use and a loss of hope for the future. The feeling of "not being able to continue" increased the likelihood that the participants would seek help.

> "My life was a mess. I could no longer finance my substance use due to debts and became sicker every day. I made a mess of it: went stealing and dealing, everything that God had forbidden to get my fix."
>
> Interviewee 5

> "I phoned the general practitioner, because I realized that it could not go any further. I was afraid of losing my child. I almost lost everything."
>
> Interviewee 8

> "We were threatened. I even got a gun pushed to my head. We got robbed. I didn't want to risk my life for dealing drugs. I reached the point of quitting cocaine when my best friends started stealing from me. We were very close, but since then I couldn't trust them anymore. I was being used as a cash machine and decided to break with them."
>
> Interviewee 6

3.5. *Knowledge deficits*

Participants had a lack of knowledge about substance use disorders and treatment options. In addition to the concrete statements they made, they expressed fears about the potential negative consequences arising from their uncertainty about treatment (subtheme: non–service user). Participants were of the opinion that the information that health care providers offered was inadequate. They felt that they had been inadequately informed before or during treatment, and this created uncertainty and disappointment. Attention to substance use in primary care was inadequate, and they also felt that substance use disorders had little social attention (subtheme: health care).

> Subtheme: non–service user.

> "I didn't know you could talk to a doctor about that. You also do not know at all that there is healthcare for that or that you have an addiction. That only came to me much later. Sometimes it takes a long time before you get help. I didn't know where to find help either."
>
> Interviewee 2

> "I knew you could be hospitalized for an addiction, but I had no idea what was involved. I feared what could happen. I don't know, but thoughts like that kept me busy."
> I would be afraid… Afraid of the detoxification. Am I going to get sick? How long will I stay sick? How long will it take? Who will I be without drugs?"
>
> Interviewee 3

> Subtheme: health care.

> "The last time I wanted to be admitted, I dropped out. We had made an agreement, but when I came to the intake I had to hand in my mobile phone, and I was not allowed to see my family for three months. They told me none of those things. Yes, I left immediately, because I cannot abandon my family. I was very sorry, because I was really motivated."
>
> Interviewee 7

> "I recently went to the general practitioner to discuss options for medical amphetamine treatment. I told him: 'I have been using it for over thirty years now.' Well, my general practitioner was completely surprised. I said: 'That must been known from my file.'
> It turned out that only my sensitivity for substance use was noticed in my file, but in practice no attention is paid to that."
>
> Interviewee 8

3.6. *Social support*

The last theme is social support, which includes the value that participants placed on the support they had received from their relatives. Most of the support of this kind had come from the participants' partner or their mother, and they experienced it as unconditional and free of judgments. In a practical sense, family members fulfilled an important solution-oriented function and a backup for participants' financial needs. In addition, participants' general practitioner played an important role in arranging admission when participants found themselves in situations that were unsustainable. Participants trusted their doctor to make the right decision for them. Participants' social roles as a parent or a grandparent proved to be a motivator for them to seek substance use treatment. Loneliness acted as an limiting factor.

> "I see it more in the doctor. Back then, he was at my home and said it was necessary and arranged my admission. Yes, and I am grateful for it afterwards."
>
> Interviewee 1

> "I had a brush in with the police and already had a criminal record. Everything went wrong. I wasn't fun to be around, but my mother has always stood hundred percent behind me. I'm genuinely grateful to her for that."
>
> Interviewee 6

> "My son was my driving force [motivation for treatment] and he still is. He keeps me on the right path."
>
> Interviewee 3

4. Discussion

Despite the availability of effective and integrated methods for treating substance use, the majority of people with a substance use disorder do not receive treatment, which leads to multiple, negative consequences. The results of the current study provide insights into the barriers to and facilitators of health care accessibility for substance use treatment that non–service users with a substance use disorder have experienced. The study team identified six primary themes. The study found the theme *personal factors* and the subtheme *motivation* in particular to be central to participants' views of substance use treatment. All elements of health care accessibility, as Levesque et al. (2013) have described, are negatively affected by these themes: *stigma*, *knowledge deficits*, and *treatment factors*. *Social support* and *consequences of use*, on the other hand, were mainly perceived by participants as facilitating. These findings corroborate previous results that identified the important facilitators of help-seeking and the initiation of treatment. These factors include having supportive relationships and significant social roles (e.g., becoming a parent) and having reached the point of being out of control (Gilburt et al., 2015; Neale et al., 2007; van der Pol et al., 2013; Wagner et al., 2017). At the same time, however, we should note that studies on this topic are scarce, especially studies that have included non–service users. Research has previously described personal barriers as key to preventing substance users from seeking the help they need (Saunders et al., 2006). Gilburt et al. (2015) argued that only those substance users who are strongly motivated and have a strong sense of self-efficacy are likely to succeed in obtaining treatment for their substance use. Factors such as the stigma associated with being a substance user and not knowing how to go about seeking help are likely to have a strong negative impact on substance users' motivation and whether they actually seek the treatment they need and engage in it.

The participants mentioned various forms of stigmatization as important barriers in the accessibility of substance use treatment. These factors include self-stigma, stigma by the general public, and stigma by health care professionals. Stigmatization for people with a mental illness is common, and it results in barriers to both social inclusion and access to mental health care (Thornicroft, 2008). Such stereotyping damages substance users' self-esteem, and this can lead to self-stigma (Corrigan et al., 2011). Participants indicated that their fear of a loss of face caused them to remain silent and to withhold information about their substance use, and this, in turn, caused them to delay or to avoid seeking help for their problem. The association between stigma avoidance and denying or withholding information about one's substance use has also been reported in another research study (Wagner et al., 2017).

Additionally, the participants reported experiencing a third form of stigmatization, namely stigmatization by health care professionals, which caused them to be reluctant to seek treatment or otherwise ask for help. A stigmatizing attitude among health care professionals toward people with a substance use disorder can, among other things, have a negative effect on patients' recovery. It could, for example, negatively impact patients' self-confidence and their self-reliance and have a negative impact on the therapeutic relationship. It could, in addition, lead to a misattribution of symptoms of a physical illness to problems arising from one's substance use (Neale et al., 2007; Thornicroft, 2008). The results of the current study are consistent with results from previous studies that show how previous negative treatment experiences have had an adverse effect on the help-seeking behavior of people with a substance use disorder (Neale et al., 2007; Wagner et al., 2017). This consistent pattern of results underscores the need to take measures to counteract this barrier. However, it does not mean that all health care professionals are guilty of stigmatization. The finding means that stigmatization by health care professionals occurs and requires attention.

Primary health care professionals have a crucial role to play in identifying substance use disorders and improving substance users' access to treatment (Van Boekel et al., 2013; Muhrer, 2010). To reduce the stigmatization by health care professionals and improve their attitudes toward people with a substance use disorder, we suggest training, other education, and structured refresher courses. Such education would increase health care professionals' understanding of the factors that influence substance user' access to treatment and to better connect with this patient group. In general, reducing society's stigmatization of substance users would help to lower substance users' threshold for undertaking treatment.

In addition to stigma, deficits in substance users' knowledge might have an important negative impact on their personal motivation to seek treatment. The participants in this study mentioned two sources of the knowledge deficits: the deficit arises both from people with a substance use disorder and from health care professionals. Initially, multiple participants were not aware that health care services are available for people with a substance use disorder. Those who were aware had viewed themselves as having been inadequately informed prior to and during their treatment. The inadequate preparation led to feelings of uncertainty and disappointment. Multiple prior studies have confirmed that people with a substance use disorder have limited knowledge about the treatment process, and this, in turn, causes them to have irrational fears about potential obligations and/or consequences of the treatment (Finn et al., 2014; Staiger et al., 2011). The results of the current study suggest that primary health care professionals pay insufficient attention to substance use. This finding is worrying because people with a substance use disorder initially present with complaints to their primary care provider, and they often display recognizable signs and symptoms of substance use despite their denial of their substance use (Muhrer, 2010). This finding underscores the importance of using screening tools to detect the presence of substance use and to have a prevention program in place to prevent a developing problem from escalating into a full-blown condition. The deployment of an advanced practice nurse to undertake such duties would help in both the identification and treatment of substance use disorders, and it could also help to enhance substance users' motivation for treatment through a psycho-educational approach.

We also feel it is worthwhile to note the value of social support in facilitating substance users' access to substance use treatment. According to our participants, family involvement, social roles, and a therapeutic relationship with a health care professional all help to promote successful completion of one's substance use treatment. In guiding patients through their substance use treatment, attention should be given to the following points: (1) relatives of the patient should be actively involved, (2) the patients' recovery could be facilitated by increasing the patients' social involvement, and (3) an attempt should be made to meet each patient's individual need for care (Pickering et al., 2019; Staiger et al., 2011; Wagner et al., 2017).

Participants expressed confidence in their general practitioner, especially in times of crisis. This attitude once again emphasizes the important role that primary care can play in the accessibility that patients have to substance use treatment. Additionally, previous research suggests that patients' motivation to seek treatment is influenced by both internal and external factors (Roper et al., 2012). These findings suggest that it would be beneficial for both primary health care providers and substance users' loved ones to encourage the person to seek treatment. General practitioners should be aware of the key role they can play in both identifying substance use problems and facilitating the pathway to appropriate health care. Primary health care providers, in particular general practitioners, could make a difference by using a non-stigmatizing and patient-oriented approach. They should also pay particular attention to warning signs of an underlying substance use disorder and provide patients with education about substance use and information about different treatment options (Muhrer, 2010).

This study had a number of strong points. First, we were able to recruit non–service users with a substance use disorder who have been underrepresented in similar studies. The study showed that it was important to include non–service users because of their comprehensive experience and knowledge. Second, the research design was such that we included a representative sample of participants with a wide variation in gender, age, and substance use and treatment history, until we had achieved data saturation. Further, the study is being reported according to the Qorec checklist 1; Qorec checklist 2 to ensure that we have included all of the important aspects of the research. Like all studies, in addition to its strengths, the current study has some limitations. First, the sample was limited in size and it was drawn from a single province in a single country, so generalizability of the results is limited. Nevertheless, the area from which we sampled included a catchment area that provided several different health care services. The current study excluded other addictive disorders, such as gambling disorders and sex and social media disorders. Research that includes these disorders would be desirable inasmuch as it would allow us to compare health care accessibility for treatment of substance use disorders with that of other addictive disorders.

5. Conclusion

In conclusion, personal factors, primarily motivation, play a central role in the accessibility of substance use treatment from the perspective of non–service users. Participants perceived both social support and the negative consequences of the substance use that they endured as important facilitators of treatment accessibility. On the other hand, stigma about the substance use; a deficit in the substance users' knowledge about how to access treatment; and treatment factors, such as inflexible treatment options, healthcare professionals' stigmatization, and limited patient participation, emerged as clear barriers to health care accessibility. Factors such as stigma and knowledge deficits have an important negative impact on substance users' intrinsic motivation, and they thus affect whether the person actually seeks and engages in treatment. Specifically, stigmatization by health care professionals themselves contributes to suboptimal treatment and recovery. This study recommends interventions for health care professionals (such as additional training, education, and structured refresher courses) aimed at decreasing stigma and their knowledge deficits. The results of this study highlight the key role that primary health care providers, especially general practitioners, can fill in identifying substance use problems and guiding patients along the pathway to appropriate health care services. Future research should seek to further understand the nature and extent of health care professionals' stigmatization.

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CRediT authorship contribution statement

Laura Caris: Conceptualization, Methodology, Validation, Investigation, Data analysis, Visualization, Writing - original draft and Writing - review & editing, Project administration

Thijs Beckers: Conceptualization, Methodology, Validation, Data analysis, Writing - review and editing, Supervision.

Appendix A

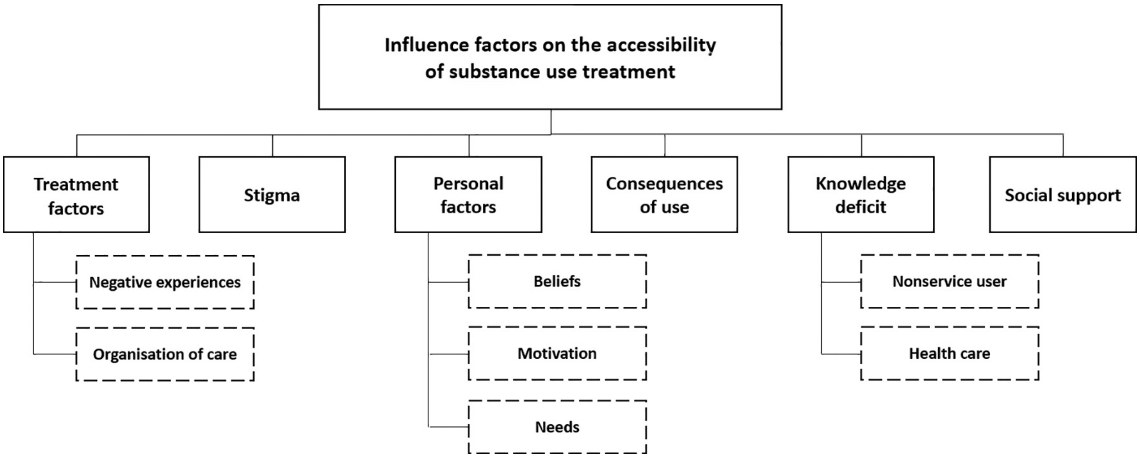

Fig. 1. Factors that influence the accessibility of substance use treatment.

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