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ORIGINAL ARTICLE

Barriers and Facilitators of Addiction Treatment: a Qualitative Study

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Abstract
Addictive disorders affect a considerable proportion of the population worldwide and in India. Treatment-related barriers and facilitators play a role in the processes of how patients seek care. This study aimed to understand the barriers and facilitators of addiction treatment of patients reaching an addiction treatment facility in India. This qualitative interview–based study included 49 adult patients with at least alcohol or opioid dependence. Interviews were transcribed, and thematic analysis was conducted using grounded theory approach. The common barriers of treatment were treatment-related, apprehension of the treatment of the setting, travel-related problems, work commitments, and inability to get leave and not feeling the need for treatment. The common facilitators of treatment were family-related, adverse consequences due to substance use, and treatment-related. The identified barriers and facilitators of treatment can be used to make care accessible to a larger numbers of patients with substance use disorders and bridge the treatment gap.

Keywords Alcohol · Barriers · Drug · Facilitators · India · Substance use disorder

Substance use disorders are an important concern worldwide (World Health Organization 2018) and are associated with significant health and economic burden (Degenhardt et al. 2013; Rehm et al. 2006). In 2015, about 18.4% adult population globally had heavy episodic alcohol use in the past 30 days, and 3.8, 0.77, 0.37, and 0.35% had past-year cannabis, amphetamine, opioid, and cocaine use, respectively (Peacock et al. 2018). Similarly, a recent nationally representative study suggests that 29 million Indians had alcohol dependence, and about 7.7 and 7.3 million individuals had harmful or dependent use of opioids and cannabis, respectively (Ambekar et al. 2019). This underscores the extent of the problem, and the need for suitable treatment approaches for patients with substance use disorders. Patients with substance use disorders can be helped with the provision of effective care. Treatment of substance use

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disorders follows a biopsychosocial approach, and many effective treatment options are available for the treatment of substance use disorders (Attilia et al. 2018; Connery and McHugh 2019; Gorelick 2016). Regular treatment can help patients to keep off addictive substances and lead to social and occupation reintegration with society. This may help the patients with substance use disorders, as well as the family members who are affected by substance user.

Not all patients with substance use disorders are able to receive treatment. 'Treatment gap' does exist due to which many patients with substance use disorders do not receive treatment (Gautham et al. 2020; Kohn et al. 2018). Patients experience several barriers and facilitators in the care process, which may deter them or help them in seeking professional help. The relevance of these barriers and facilitators lies in critical appraisal of the attributes of the services, considering the processes how and when individuals seek care and finding solutions to make services available to a larger number of people to improve their condition.

Literature worldwide has attempted to look at barriers and facilitators for the treatment of substance use disorders. While these barriers and facilitators of treatment have been categorized variously, certain recurring themes have emerged. Some of the barriers to treatment for substance are lack of awareness of the problem or the need for treatment (Barman et al. 2011; Rapp et al. 2006; Tucker et al. 2004; Yang et al. 2018), privacy concerns (Berridge et al. 2018; Owens et al. 2018; Rapp et al. 2006; Tucker et al. 2004; Wieczorek 2017), fear of treatment (Barman et al. 2011; Nebhinani et al. 2012; Rapp et al. 2006), financial and procedural issues in accessing care including timings of the hospital (Appel et al. 2004; Bobrova et al. 2006; Bojko et al. 2015; Russell et al. 2019; Verissimo and Grella 2017; Yang et al. 2018), and poor treatment availability or unawareness (Ashtankar and Talapalliwar 2017; Patel et al. 2020; Rapp et al. 2006; Russell et al. 2019; Wieczorek 2017). Certain facilitators have also been identified, which include problems associated with the substance (Tucker et al. 2004), poverty (Patel et al. 2020), family responsibility and support from the family (Patel et al. 2020), peer support (Yang et al. 2018), rapport with treatment providers (Berridge et al. 2018; Yang et al. 2018), simplified referral procedures (Gueta 2017), and stigma against substance use (Patel et al. 2020).

Previous studies have looked at the barriers towards treatment using a quantitative approach using instruments/questionnaires derived from an 'etic' perspective. While the advantage of such an approach lies in convenience and quantitative findings, the limitation is neglect or glossing over of unique issues in the local psychosocial construct. The service provision milieu, patient provider interaction and expectancies, and the health-care resource allocation are substantially different in India from other nations (Balarajan et al. 2011; Yip and Mahal 2008). A qualitative approach is more likely to gather more in-depth information that is applicable in the health-care contextual scenario of developing countries like India. There is a need to understand the barriers and facilitators of addiction treatment in India to provide administrative and policy directions of addressing the treatment gap. Thus, this study aimed to assess the barriers and facilitators of addiction treatment from the perspective of the patients using a qualitative approach in the Indian health care setting.

Methods

This qualitative interview–based study was conducted at the National Drug Dependence Treatment Centre (NDDTC) in the National Capital Territory of Delhi and its community

clinic. The NDDTC is the apex national institute for substance use disorders in India and has clinical care, research, education, and policy under its mandate. The NDDTC is affiliated with the All India Institute of Medical Sciences, New Delhi. The NDDTC outpatient and inpatient medically oriented care, supplemented with psychological and social interventions. More than 8000 new patients register at the centre annually, and there are about 1000 inpatient admissions annually. Patients with alcohol and/or opioid use disorders primarily form the clientele. Patients from several north Indian states seek services at the centre. Treatment is provided by a team of doctors, clinical psychologists, social workers, and nurses. For alcohol dependence, treatment comprises of detoxification (i.e., getting rid of substances in the body) and relapse prevention (i.e., preventing against getting back on the substance). For opioid dependence, treatment is either detoxification and then the continuation of treatment with an antagonist medication (naltrexone), or agonist treatment in the form of opioid substitution treatment. Treatment is largely subsidized in this publicly funded centre. Many of the medications are provided free at the centre. Patients can be either referred or they may seek care directly at the centre.

The study followed a grounded theory interpretative approach; i.e., we did not have a predefined theoretical framework to be tested through this research. This approach is suitable when a-priori assumptions are not made, and we considered this to be a suitable approach for ascertaining a wide range of barriers and facilitators of treatment. For this study, adult patients seeking care at the NDDTC or at its community clinic at Trilokpuri, who were dependent at least on alcohol or opioids, were recruited by purposive sampling after obtaining informed consent. Those who are unable to participate in an interview due to intoxication or withdrawal or due to psychiatric or medical illness were excluded. The selection of the participants was purposive, and we aimed to gather representative population attending the clinical setting. After informing the purposes of the study, the interview was conducted in the local language (Hindi). The interviews were audio-recorded using an electronic device. Pre-determined probes were used to facilitate the interview, but the interviewer could choose whether to use these or not. Only the socio-demographic part was semi-structured, and the barriers and facilitators of treatment were asked through in-depth interviews. The interviews were conducted in a single session by one of the investigators (AT). The interviewer was from sociology background with considerable field experience and has worked in addiction. The interviews lasted between 20 and 60 min, and on an average were about 35 min. Data collection lasted from July 2019 to December 2019. The study was conducted after approval by the Institutional Ethics Committee (IEC-273/03.05.2019). The study was conducted in accordance with Ethical Principles for Medical Research Involving Human Subjects as laid down in the Helsinki declaration.

The interviews were transcribed into a text document by the investigators. The initial transcription was done in Hindi language. Ten percent (i.e., five) of the audio-recordings were re-transcribed and checked for fidelity with original transcription and were deemed to have acceptable match. The participants were anonymized during the transcription process. After transcription, the data were read through for the emergence of themes. After several rounds of immersive reading of the text by one of the authors, the themes of the barriers of treatment and facilitators of treatment were synthesized. Using the grounded theory approach, the themes were sub-classified into categories and domains (Strauss and Corbin 1990). The overarching categorization was presented, exemplified using the excerpts of the participants. To ensure consistency of the transcription five interviews were re-transcribed and the two versions were compared for equivalence.

Results

A total of 49 participants were included in this study. Among them, four were women. The demographic characteristics of these participants are presented in Table 1.

Barriers of Treatment

Several themes of treatment-related barriers were identified in this study. A summary of these is presented in Table 2, and further examples are presented subsequently.

Treatment-related issues (treatment setting) Many treatment setting–related issues were identified. A few participants remarked about the limited timings of the hospital as a problem. Some others reported difficulty following the treatment schedules and processes at the setting.

> Patient 1: And the day we came to this hospital, the time [of registration] was over here. He had an old card, so he left with the medicine, so I told him that you have brought me here for the first time and now you are leaving, that you should stop. But he did not stay. But I decided that since I have come, I would take the medicine and then go. I came on a Tuesday and sir said that since time is over, do come tomorrow. Then I thought that now who would come from Delhi again, I was hesitant, so I stayed at the roadside tea shop at night.
> Participant 10: Coming here involves a lot of drama, look it is 1 o'clock and now [I] have been called. … and then they are saying, come everyday. Who will come everyday spending 100 rupees of fuel a day.)
> Participant 45: As if by chance ever happens, then the day here [for follow up] is like Friday, then one has to come on Friday, and if it is missed, assume that your Friday has gone and Saturday has come, so your 6 days are gone. Now if it is a matter of one or two days, then one can bear [withdrawals]. But how can one bear [withdrawals] for 6 days, and hence goes again towards substance.)

A few participants reported impoliteness of the staff as a concern, or a long wait for their turn.

Table 1 Demographic characteristics of the included sample ($n = 49$)

Variable		Mean (SD) or N (frequency)
Age		33.7 (± 12.3)
Gender	Male	45 (91.8%)
	Female	4 (8.2%)
Marital status	Married	32 (65.3%)
	Not married	17 (34.7%)
Years of completed education		8.8 (± 4.8)
Employment	Currently employed	39 (79.6%)
	Not employed	10 (20.4%)
Family type	Nuclear	28 (57.1%)
	Extended/ joint	21 (42.9%)
Monthly family income in Indian rupees		27,487 (26,975)
Residency of National Capital Region of Delhi		29 (59.2%)

Table 2 Barriers to treatment

Barriers	Reported by the number of patients
Treatment-related	
Treatment setting	16
Treatment regimen	11
Apprehension of treatment and setting	13
Travel-related problems	12
Work commitments and inability to get leave	12
Did not feel the need for treatment	11
Need to go somewhere	8
Distance	6
Meeting friends and other substance using peers	5
Laziness	5
Family events and commitments	4
Intense craving	4
Other reasons: Unaware of treatment/Family member unable to come/expense in treatment	4

> Participant 32: Sir, when I come, they scold me, take advantage of my helplessness, give medicine, women doctors, then they scold me, then I do not like it. Now I am not a child, I will not be scolded. It is my fault that I am not coming, and besides this, it is their thinking.
> Participant 34: Till the time they call, you have to sit, this is a problem, with the children, the children start crying, the little boy starts crying, if it is too late, then I have to tell them to hurry please.

Treatment-related issues (treatment regimen) Many treatment regimen–related issues were also identified in the study. Limited amount or duration of medicines being given to the participant was a deterrent for a few.

> Participant 1: It happens that sometimes you have to go out, like you have to go to a wedding somewhere, they do not give [medicines] for too many days, they give for two days.
> Participant 46: Sometimes they give less, and the medicine does not work well, sometimes they give the right pill, at times they do not have the correct effect when it [medicines] is of less mg, then there is craving for the substance.

Participants reported ineffective treatment or side effects of medicines as a concern and barrier.

> Participant 11: I used to get something like capsules, I used to get nervous after taking them, those capsules were hot [figuratively], I felt nervous, felt suffocated, I felt itchy with them.
> Participant 19: Medicines used to work, but to a limited extent, not entirely.

A treatment regimen which required participants to come frequently was seen as a problem for continuation of treatment.

> Participant 2: Yes, there is some problem in coming every week, as my Monday is off, earlier I did not know that I would have to come every week, but now I have called after two weeks.

Apprehension of treatment and setting Some of the participants were apprehensive of a restrictive setting and hence did not come for treatment initially.

> Participant 18: No, I have never gone, I was afraid, once I said in anger, take me there now and I will quit, but I was afraid that I would be detained, like in a prison. I could not understand and I felt suffocated
> Participant 28: Sir had heard, it is said that there is a lot of problem, they make you do bad things, they beat. One or two boys, who had stayed, those who were forcibly admitted said that they were beaten, made to sweep and clean, and other unpleasant things.
> Participant 31: Yes it felt [apprehension] the first time. I felt that the doctors would be angry about what is this, why are you doing like this this, the guards would chase me away. Do not think like that now.

Patients also had apprehensions about confidentiality and about the medicines.

> Participant 33: I have been contemplating quitting [substances] for at least 6-7 months, but I did not know this hospital. And I would not have dared to go in private, I was expecting to meet many known acquaintances there, would have been humiliated, and that is why did not go.
> Participant 37: Because it is the same problem with medicines, even taking medicine for long is not good, it can become habitual, then one will have to use it again and again.

Travel-related problems Many patients had reported on financial difficulties in travel.

> Participant 1: It happens that due to the distance, I feel a little lazy, and if I do not have the money, then I cannot get a ticket, and there are many TTs [ticket checkers] here, and if I come without tickets then I will be locked up for a few months. Hence, because of the financial problems, I stop [treatment] thinking that how will I go. Hence, I am unable to come.
> Participant 37: Sir, it costs 200 rupees to come and go. It is quite an amount for people like us Sir. 200-300 rupees is our full day's wages, so even if you start including food, then 300 rupees is needed, and 300 rupees is our daily wage. In response to: Does it cost more to come here

Other problems related to travel was also reported by patients. One participant reported difficulty in the means of transport (i.e., trains), and another reported needing to finding accommodation. A couple of participants remarked about boredom while travelling.

> Participant 8: There is a lot of problem for the poor man sir, you know about the reservation [in trains], there are only two general compartments in the front, and two are at the back, all the other [compartments] are reserved. So tell me that there are so many people, there is no place to stand, what can be a bigger problem than this. This is the biggest problem.

Work commitments and inability to get leave Many patients reported work commitments or inability to get leave as barriers to get treatment.

Participant 12: [there is difficulty] In taking leave, no one knows so I have to come up with an excuse that I have work in Delhi, or something like that, touchwood my drug license has just expired, so I have come to Delhi with the same excuse.
Participant 32: Whenever I have not been come here or there has been a problem, it has been due to work.
Participant 42: I felt like coming, but about that leave, leave was available only on Sunday, and the Sunday is off here, and so I could not come.

Did not feel the need for treatment Some of the participants did not feel the need of treatment at some point of time. Hence, they were reluctant about coming for treatment. A couple of patients reported that they believed that they could be able to quit substance by themselves. A few excerpts from the participants are presented as follows.

Participant 9: Yes, I felt that way, I did not show anywhere, tried to leave [substance] myself, but I mean, I had left it [substance] for only two days.
Participant 29: It seemed that I can control myself, then after two, two and a half or three months, then it [drug use] becomes a routine.
Participant 41: I can quit [substances] myself, I have self-confidence over myself, so why will I take further treatment.

Distance Some patients reported distance from the treatment facilities as one of the major barriers of treatment. These are described as follows.

Participant 5: We have to come from so far, it would have been very nice if we were in Delhi, because there are so many addicts there [in Delhi]. This place is pretty far away, I have come out of the house for the first time, I have never come so far.
Participant 10: No, I don't feel like coming again, it is far away
Participant 18: There was no problem, but it was far away, I had to change three trains, I could have understood if there was a direct train, but you have to change again and again, [I] find it bothersome because it is pretty far away

Needed to go somewhere Sometimes, patients were unable to come for treatment as they needed to go away for some work or family event.

Participant 11: Then I had to go to the village for some reason, my grandparents had passed away, then I had to go there, then I had to live there, I had some work related to land, I had to live there, then I could not come to Delhi for a year. Medicines were not available there.
Participant 40: I had gone to Hoshiarpur for some work. To take medicine, there was not much time, someone had died, because of this I had to go in a hurry.

Meeting friends and other substance using peers Meeting substance using friends was seen as a reason of re-initiation of substance use, which led to cessation of treatment.

Participant 4: I was not able to have will-power, sometimes a friend would meet up, sometimes someone else would meet up, someone would go out with someone else with

a vehicle, it used to happen like that, the biggest reason [of taking substance again] was friends only.
Participant 18: It happens, in friendship, while meeting them, there is nothing like that, I feel like it, it starts with one or two days and then it [substance use] keeps on going.

Laziness A few patients reported laziness and procrastination as a reason of not seeking any treatment.

Participant 8: The gap [in treatment] happened due to laziness, I thought that let's take the substance, will take medicines later, but now am thinking that I will come on the date I am called on.
Participant 18: Then in the middle it happened that I was not able to come, did not come just like that, I used to think to keep it in pending, I will go tomorrow, the day after tomorrow, I will go tomorrow, I will go the day after tomorrow; it just kept on pending.

Family events or commitments Some of the participants reported some family events or illness in the family as reasons of inability to come to the centre.

Participant 19: I left [treatment] in the middle, like I had gone to the village for sister's wedding, I have stayed there for two months. I got some rest there sir, I did not get substances there.
Participant 44: Yes, the date was missed, and then had night shift, and then health of wife worsened a bit, so the last time had not come.

Intense craving was reported by a few patients as a barrier to treatment.

Participant 13: No one had stopped [to come for treatment], the family member had given money two or four times, but I got also intoxicated with it [money used to buy substance].
Participant 45: And when money is there in the pocket, and there is no medicine, then sometimes they go to that side [where people take substances]. One tried to stop, stop, stop, but then a time comes when one thinks that let it be, what will happen if we do take it once, but taking it once has consequences [relapse].

Other reasons Being unaware of treatment facilities and expenses were deemed barriers of treatment.

Participant 24: And I had a problem with money too, because the medicine I get from here is not available, only 2-3 medicines are available from here and most of the medicine is 400-500, every time I have to buy from outside. So, I was having some financial difficulty. Then I have just come from the village, I have to pay the room rent, everything has to be done, just starting the treatment means that you have to think, you have to take all the medicines, if you take one and do not take another one, then it is useless, no.
Participant 47: Earlier I used to leave this thing in my mind, but I did not know about medicines to quit drugs, so my brother had told me about this thing in Ghaziabad.)

Table 3 Facilitators of treatment

Facilitator	Number of patients reporting
Information about treatment	24
Family related	
Influenced by family members	18
Family responsibility	17
Family support for treatment	14
Family members are aware	3
Adverse consequences	
Financial issues/ problems	15
Health impairment	13
Feeling of guilt	6
Social derision/ stigma	5
Treatment-related	
Effective medicines	10
Approach of care providers	6
Possibility of admission	3
Withdrawals symptoms substance	9
Others-Brought by peers/overall damage/being in relationship/inability to work/threat of arrest/seeing condition of others/change in mind/commitment to others/transport facility/awareness of harmful effects	15

Facilitators of Treatment

The themes which highlight the reasons why patients with substance use disorders come for treatment are presented as follows. The themes are summarized in Table 3.

Information about treatment Patients got information about treatment from various sources which were considered as a facilitator of treatment. Information was obtained from other family members, relatives and friends, and the internet. Oddly, even the peddlers provided information about treatment.

> Participant 1: And then a relative who had initiated us on smack, had seen this hospital. Someone had shown him this, and he used to take medicine from here.
> Participant 6: I have come for the first time today, here, my maternal uncle is a doctor, so he said that if it is for deaddiction, then it is better to show up there.
> Participant 20: From where I used to take this smack, then there was a lady who used to sell, she consulted me that you leave [drug] son, still nothing is spoilt, this is just the starting, liker her own son, then she talked to my father and she gave the address of this place.
> Participant 44: Initially, when I was thinking that where to get treatment, where to show myself, I searched the net, then this name came up.

Multiple family–related aspects facilitated entry into the treatment. One of them was a sense of responsibility towards the family members.

> Participant 2: …before the baby is born I would like to quit, to give a better life to the baby, I would have to be better. It will not happen that we are coming intoxicated and he/she is studying. Environment also makes a difference, I will not leave now and I will

keep coming intoxicated daily, then he/she will also get addicted to it and would learn it, so I am thinking that this dirty habit of mine should not befall onto him/her.
Participant 29: So I have come this last time thinking that now I have to work for my family and save every single penny and add it for them, today I have come thinking that.
Participant 44: After marriage a child was born, then I realized that enough is enough, child is born and responsibilities are there.

Sometimes, the influence or pressure of the family members brought patients into treatment.

Participant 31: Now that it [substance use] has increased too much, now it has happened that the wife has told clearly to give up drug or leave her
Participant 33: The children have been saying to me for two years now, since they have come to know that mother is also taking [substance]. A few people also tell the children, they has also seen me drunk many times, so they say that mother, it [substance use] is not a good thing, it is wrong. If we see you like this, what will be the effect on us, how will the neighbourhood look at us. They also said a good thing, if you want to take it [substance], then take it at home.

Sometimes, family support was a key factor for treatment facilitation.

Participant 9: There is full support from the family, they sent me by the way, father asked to go and bring the medicine. I had in my mind that I would go some other day, but when he saw the condition that I was consuming more [substances], then he said to go and get the medicine.
Participant 20: Medicine father had started, when I had a lot of problem and realized that I should leave [substances] now, I told my parents on my own that this is a problem with me and I am having trouble leaving [substances]. Please help me. Then next day father consulted some doctor, then we were referred to a neuro surgeon in Moradabad.

Family members being aware also brought some patients into treatment.

Participant 11: Now everyone in the house knows that I used to take substances, mother knows, father knows, after marriage the wife also came to know, in-laws also found out, then after that took some medicine to quit, but wasn't able to quit.
Participant 19: Have made a decision to leave when the family members came to know, when I take money, the family asks if you take so many thousand rupees, what are you doing, then I told her that such a thing has happened , Still the mother knows only, and in the rest of the house and no one knows

Several adverse consequences of substance use lead patients to seek treatment. One of the common ones was the financial problems experienced with the continuation of the drug.

Participant 17: There is every kind of problem from them, I am unable to give them money, whatever I earn goes into it [substance], they see that as I have gone to work, some money will come at the end of the month. I would have cleared the month's pay before them. The fees of the children, household expenses, for which they require money stays as it is; where is the money? The money is used up.
Participant 26: I ask them to give me money, and the take from me tomorrow. But no one gives any, they say what you earn, why don't you keep it with yourself, why should we give you [money]? To take drugs?

The health impairment occurring due to substance use brought some patients to the treatment fold.

> Participant 3: I thought of quitting [substance] as I felt that my body was getting spoiled, weight went down from 105 kg to 72 kg within 6 months, and had problem during sex.
> Participant 18: I felt that I would have to leave it or else it would increase the problem. The substance is causing problem from all sides, money is also going, time is also going, body is also going, I am falling prey to all the three things.

Some of the patients expressed a feeling of guilt that made them consider treatment.

> Participant 10: There is no one, even in the whole family, only I am the only one [drug user], I even do not go to the relatives, left meeting them, I feel ashamed of myself. I started feeling guilty that I am no longer equal to them, now not worth sitting with them
> Participant 43: I am so ashamed of this thing in front of my wife and children, Sir, I want to leave it in any way possible.

Social derision and stigma due to substance taking behaviour led some people to seek treatment.

> Participant 8: Our uncle is a pradhan [village head], that is why, the drug has loss of image, that the men who dare not look would hold the collars. I feel very deeply about it, and that is why I want to leave [substances].
> Participant 18: I am slowly becoming infamous in the place where I live, I am coming in the eyes of people, as a boy who does wrong things, they say that he takes drugs and does wrong things.

Some treatment-related aspects like effective medications, professional approach of health care providers, and the possibility of getting admitted were seen as facilitators of treatment.

> Participant 2: Then when I came here for the first time, I felt that the medicines were effective, which means that craving ends with those medicines, and it provides internal help in control.
> Participant 20: When the first time came, there was a little fear, but then the father, the doctor did not say anything, then that fear subsided, so now I come on my own too.
> Participant 33: Fear was that, I will go inside, will be scolded about not being ashamed that you are a woman who drinks, but no one said anything, asked considerately what do you do, how long have you been taking substances, how do you take it, and didn't ask anything else. It was nice, and since then I started coming here, it feels good.
> Participant 37: There was good treatment there, great, I got medicine from there, from there I took medicine for at least two months continuously, and after that I left all substances completely, there was a problem for 2-4-10 days, and after that it was completely okay. I did not even take medicines after that. and It is from the admission that anxiety will be reduced, will get relaxed soon, will get rest, and will get regular medicine according to a time table advised by the doctor. If I tried on my own, may be I will take treatment, maybe I will not.
> Participant 44: So on the first day, I received a very good response, immediately everything was checked, everything was checked, everything happened, the doctor also talked very well, asked when do you get drunk, what do you do, he noted down on the paper.

Withdrawal symptoms experienced by quitting the substance(s) often led patients to consider treatment. Withdrawals of opioids were quite discomforting for patients, and they sought medical care to get relief from these symptoms.

> Participant 11: He stopped giving me [drug] again, then I started have withdrawals, I said what is happening brother, if you are not giving medicines, then I have withdrawals, I am not able to drive and do not sleep at night, and am not able to get up.
> Participant 22: Sir, I want to leave [alcohol], but I am saying that my body is demanding, now I would think who is this person, go out and take one quarter [alcohol], and if I take a quarter then I will talk normally.

Several other reasons were seen as facilitators of treatment. Some patients reported that they were brought into treatment by their peers. Overall damage due to substance was seen as a reason while being in a relationship/planning marriage were facilitators. Inability to work, and potential humiliation, was also seen as a facilitator. Having transport facilities facilitated one patient for treatment. Awareness of the harmful effects of substances was a facilitator, and reminiscing about life helped a few people.

> Participant 11: If got caught in front of four men with the goods [drugs], then there is a sense of disrespect, due to this I have been feeling bad.
> Participant 12: Life does not have to be spoiled with smack, smack is not a good thing. Now I know this, at first I did not know, slowly I came to know that I am going towards death.
> Participant 16: Some incidents occurred in between. I entered into a relationship, and quit due to that.
> Participant 20: So there was a one-day gap, it was in that one-day gap I was not able to sleep at night, so I was sitting on the terrace all night reminiscing my life. What mistake have I made, such as getting intoxicated due to friends' pressure, then I thought that yes, this is my one weak point that I get into other things and cannot keep confidence on myself, and face problems. I don't want to take the help of drugs. So that night, I thought, I thought that now stop the drug and get back to normal.
> Participant 24: Another thing is that marriage is being planned, so I thought that I should quit [substances]
> Participant 27: Saw others about what was happening to them, how their family was becoming vain, then I thought that it was correct time to leave, so I came, took medicine and quit [drug].
> Participant 31: Sir, some [people] of our area used to come here to take [medicines], brother brought me, took [medicines] and thought could quit [substances].
> Participant 36: The big reason is that I was someone else before and now I am someone else, I am ruined by this substance, all the brightness of the face is gone, neither is the pleasure of wearing clothes, nor there is consciousness taking meals.
> Participant 43: Here I am coming from the metro, the direct metro from Rithala comes to Shaheed Bhagat Singh Sthal Ghaziabad. There is no problem.
> Participant 45: My friend is from here, he told me that by getting treating like in this manner there, he was made to quit substances.

Discussion

The present study brings forth an account of the barriers and facilitators of addiction treatment of patients who accessed an addiction treatment facility in India. One of the important barriers for treatment was that the patients did not feel the need for any treatment at some point in time. This is an important aspect that has also been talked about in the previous literature (Mellinger et al. 2018; Owens et al. 2018; Perumbilly et al. 2019; Rapp et al. 2006; Tucker et al. 2004). The patient may be either unaware that they have a problem which requires attention and treatment, or they may think that they can control their substance use whenever they want, or treatment is not necessary for them. Of course, many patients are able to quit substances at home and/or without treatment. However, it could be dangerous for some substances like alcohol, where abrupt cessation without treatment may lead to life threatening seizures or delirium tremens (Eyer et al. 2011; Jesse et al. 2017). Even for opioid dependence, wherein the cessation of substances may not be fatal, but treatment can reduce the withdrawal symptoms and better cessation outcomes. Treatment also provides an opportunity for implementing psychosocial approaches. Many patients also think that they do not need any further treatment after a brief period of time. From the perspective of the clinician, the maintenance phase aims to reduce the chances of relapse, and hence, treatment would better be continued even after the cessation of substance use so that the patient does not fall into the habit of substance use again. However, from the perspective of the patient, the treatment is over as the goal of cessation has been attained, and hence, they feel that further treatment is irrelevant. Poor adherence rates to maintenance treatment have been observed elsewhere as well (Zhou et al. 2017).

Distance and travel-related difficulty was another important issue faced by the participants. Many patients reported that the distance of the treatment facility was a barrier to the treatment-seeking process. Some patients had to take multiple modes of transport to reach the centre for treatment. Literature from other regions also has reported distance to be an important barrier to the treatment of addiction (Beardsley et al. 2003; Khampang et al. 2015; Timko et al. 2016; Zhou et al. 2017). One of the reasons of the distance is that opioid substitution treatment is not available easily outside of major cities, and substance users would have to travel long distances to procure their medicines (Stöver 2011). Lack of easier access to opioids has been found to be a deterrent in India as well (Rao 2017). Providing escort for treatment and incentives has been found to help the continuation of treatment (Chutuape et al. 2001). Distance is also linked with problems experienced with the arrangement of finances related to the travel, and hence, greater distances required more financial inputs for travel. This may be of particular relevance for those from a lower social and economic background, who might have a difficult time arranging preliminary finances for making the travel and seeking care. Hence, engagement in the treatment-seeking process entailed tough financial choices and predicaments, which could have a potential impact on swaying the decision making process for seeking treatment. Similar issues have been raised by clients in a methadone maintenance program (Khampang et al. 2015).

Treatment setting also had an impact on the care process and was seen as a barrier to seeking care by the patients. A restricted or limited time of registration of patients was seen as a problem by some of the patients, while some other patients reported difficulty in following specific regimen requirements (for example, need to come daily for specific medications like buprenorphine). Some patients reported that the staff (including the medical professionals) were rude and did not address their concerns adequately. Patients also were unhappy about the long wait for an appointment. Inability to get a consultation with professional of their choice or

privacy concerns was also reported as barriers by some of the patients. A few patients also came with the intent of getting admitted directly, and they were unhappy if they were unable to be admitted. Similar concerns have been noted as barriers of treatment in the literature previously (Owens et al. 2018; Redko et al. 2006; Wieczorek 2017) where it was reported that long waiting times and privacy concerns were seen as deterrents of treatment.

Treatment regimen–related barriers included limited duration of medicines being given or needing to come frequently, inability to get the correct medications from the stores, medications for treatment being ineffective, and side effects of medicines. Some medications like buprenorphine and methadone world over are restricted and are given for limited periods of time to the patient (Mackey et al. 2019). Logistic issue of daily or weekly dispensing has been talked about an important problem in ensuring patients take the medicines, while these medicines are not diverted away into the illicit market. Patients did report that timings to be an issue in getting the medicines and such concerns have been raised in other parts of the world (Khampang et al. 2015; Wu et al. 2013). Work commitments and the inability to get leave emerged as some other barriers to treatment. Many patients had to take leave from work to attend to treatment. With the improvement of their condition and with better engagement in their vocation, they found it difficult to make time for continuing treatment. Similarly, some patients had to discontinue treatment when they needed to travel elsewhere or were unable to come due to events in the family like marriage. Additionally, some patients reported meeting peers and having intense craving as barriers to treatment, as has been reported elsewhere (Owens et al. 2018; Zelenev et al. 2018).

Another barrier of treatment was laziness that deterred some patients to come for treatment. This has not been described previously. Some patients reported that they did not just feel like going at all, or going on the allocated day. This implied that they felt 'lazy' to continue the treatment. It could be surmised that they were not unwilling for treatment, but they did not want to make an effort on one particular occasion (though they may have made such efforts previously). The issue may have a cultural dimension as well.

Among the facilitators of treatment, family responsibilities were reported as one of the important reasons that impelled patients to consider treatment for their substance use disorder. These responsibilities could have been discharging the duty of getting the children married, planning for a child, consideration for growing children, and taking up the responsibility after death in the family. These responsibilities made individuals change their minds to consider treatment. They could be in one way considered as motivating factors for treatment. Similarly, on many occasions, patients reported that their family members had influenced them to seek the treatment and had supported them in seeking care. This reflects that family can be a strength in care-seeking process in the Indian scenario (Sarkar et al. 2016). In India and other developing world oriental cultures, families are collectivistic and provide support to family members who might be suffering from mental health issues, including addiction (Chadda and Deb 2013). Opinions from treatment providers and patients have also suggested 'informed and caring' family members could be an important facilitator for treatment (Kabore et al. 2016; Patel et al. 2020; Perumbilly et al. 2019).

Another facilitator of individuals attempting to quit substance use was the development of guilt feeling regarding substance use. Some patients thought that they were tarnishing the family name, while others were ashamed to face their near and dear ones). Social derision and stigma started to occur due to substance in some of the patients, which made them consider treatment for their substance use disorder. Financial problems among the patients contributed by the substance use itself often led them to consider treatment. Substance use had become

unsustainable financially for some of them that quitting by taking treatment was the most reasonable option for them. Additionally, health impairment due to substance use was considered as one of the reasons for seeking treatment. The patients were concerned due to these effects on the body and were quite sure that substance use was the cause of these symptoms. Withdrawal symptoms on substance cessation were important reasons for seeking treatment. The withdrawal symptoms are common when patients try to quit opioids or alcohol. Effective treatments for these withdrawal symptoms are available (Connery and McHugh 2019). Thus, many patients considered treatment when they became dependent upon the substances consequent to regular use. Then they experienced discomforting withdrawal symptoms when they were not able to get the substance.

An important facilitator of treatment is information about treatment. This is much more applicable in developing countries (Patel et al. 2020; Perumbilly et al. 2019), where the patients may not be much aware about where appropriate treatment is available. Information is generally obtained through peers and other acquaintances. Nowadays, individuals also seek information on the internet about the treatment services available. In such a situation, it might be more suitable that information about treatment services are available more widely. However, cognitive issues, if present in the patients, can lead to difficulties in attending to and processing relevant information (Farhadian et al. 2017).

The barriers and facilitators of treatment may have implications in the manner and extent to which individuals with substance use disorders seek services. While these may vary across individuals and settings, understanding them can be helpful in reduction of the treatment gap that currently exists. Many patients are deterred away from treatment, and it is important to consider each barrier and facilitator is not stand-alone, but as work in unison in a given individual. The push and pull factors acting in an individual at a given time would also be influenced by his/her personality and cognitive biases. Unique socio-cultural–economic–political scenario applicable in each case is likely to determine who seeks treatment when, where, and how, if at all. The overall availability of services (or lack thereof) is an important consideration for the individuals who intend to seek treatment. It has been seen that the treatment gap for alcohol use disorders may be as high as 97.2%, compared with global estimates of 78.1% (Dalal 2020). Only one in four prescription drug users have ever sought treatment in India, and even a lower proportion have been ever admitted (Ambekar et al. 2019). The treatment gap for addictive disorders may be higher in northern India, when compared with the treatment gap of country as a whole (Gautham et al. 2020; Kar et al. 2018). Services have been lacking in India in the field of addiction, and challenges in access and scaling up treatment have been noted (Mattoo et al. 2015; Rao 2017). One of the biggest challenges has been lack of manpower resources, with the number of psychiatrists per million population in India being 2.92, compared with 21.99, 105.42, and 135.25 per million in China, USA, and Australia respectively (GHO | By Category | Human Resources - Data by Country 2020). The budgetary outlay for mental health has been reported at 0.06% of health budget in India (Rathod et al. 2017), which is quite low as compared with many western developed countries. These have additional implications for the care process, even when the person with addiction considers treatment is necessary, and leads to perpetuation of the treatment gap.

The implications of the findings can be many. One of the important barriers is not acknowledging the occurrence of substance use disorder, which is potentially treated. More information in the community about signs and symptoms of substance use disorders would be helpful to make people aware about substance use disorders and benefits from treatment. Additionally, to counter the issue of distance and travel related expenses, services should be

spread geographically, and travel reimbursements can be considered. Improvement in care processes can be made by streamlining patient flow and emphasis on communication and professionalism. Unawareness of treatment facilities can be addressed by adequate information–education–communication (IEC) through digital and print media. Family support in treatment can be better utilized for motivating the patient for treatment, supervision of the medication, rehabilitation endeavours, and providing company to prevent engagement with peers. The implementation of some of the approaches may be constrained due to resources and resource allocation presses.

The findings of the study should be interpreted in the context of some limitations, which include single-centre experience in north India providing medically oriented care and catering to a considerable proportion of patients with opioid use disorders. The results may not be generalizable in other areas and settings. The standard limitations of qualitative methodology do apply, including sampling issues, variable interpretability of the qualitative material, and unanticipated and unquantifiable biases in framing questions and answering them by participants. Information was obtained from only participants as key interview participants, and triangulation from other sources could not be done in the study. Thematic analysis was done by one person. Also, a limited number of females were included, which is in line with females being a minority of the treatment-seeking population in addiction treatment facilities in India.

To conclude, the present study has shed some light on the barriers and facilitators of addiction treatment as perceived by the substance users themselves. The information from the patients has the potential to be used for improving care processes and facilitating ways in which treatment can reach the masses. Programmatic changes can be made to make treatment accessible far and wide. The cascading effects can translate into an improvement in the condition and quality of life of a patient with substance use disorder and their family members. Cognisance by the health and social welfare authorities can help to improve the care delivery, processes, mechanisms and agenda, especially after taking views of the stakeholders into consideration. Future work can relate to the implementation of different policy directions and assessing the impact using specific, measurable, attainable, reliable, and time-bound objective parameters. Budgetary overlays and economic modelling can be done to assess the cost–benefit of different interventions to improve treatment access and uptake of patients with substance use disorders by reducing the barriers and enhancing the facilitators of treatment. Also, assessment of barriers and facilitators across a range of settings would be more helpful to get a more comprehensive view. The complementary views of the treatment providers, family members, administrators, and policymakers can also be documented to bring different perspectives together. It is hoped that the discussion and discourse would, directly and indirectly, help to improve the lives of patients with substance use disorders in the longer run.

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Compliance with Ethical Standards

Disclaimer The funder did not have any role in study design, conduct and reporting of the findings.

Conflict of Interest The authors declare that they have no conflict of interest.

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