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Initiation of Addiction Treatment and Access to Services: Young Adults' Accounts of Their Help-Seeking Experiences

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Abstract

Substance addiction in young adults is particularly problematic. Yet, much remain at stake in understanding the specifics of this population's access to services. The objective of this study is to explore young adults' initiation of substance misuse treatment. Our study sample was composed of 35 individuals aged 18 to 30 with problematic psychoactive substance use who have been identified in criminal courts, hospital emergency departments, and Health and Social Services Centers in Québec (Canada). A thematic analysis was performed on the 62 semi-structured interviews conducted with participants. Three components emerged. First, personal elements—expectations, individual motivations, perceptions of use, and capacity to control it—influence initiation of substance misuse treatment. Second, family and peers have noticeable influences. Finally, system characteristics and prior care experiences also shape the process. Consideration should be given to tailor interventions that can reach young adults and encourage them to initiate appropriate care.

Keywords

substance misuse; young adults; access to treatment; service use trajectory; qualitative research; phenomenological perspective; Canada

Introduction

There are multiple negative consequences associated with excessive use of psychoactive substances such as cannabis and alcohol: cognitive impairment, psychosocial development disorders, impacts on physical health, and so on (Brochu, Landry, Bertrand, Brunelle, & Patenaude, 2014). According to the Advisory Council on the Misuse of Drugs in the United Kingdom, substance misuse is a "condition that may cause an individual to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption, and/or dependence" (National Collaborating Centre for Mental Health, 2008, p. 23).

However, it should be noted that regardless of the country in question, few substance-dependent adults seek treatment to overcome their substance use problems (Perron et al., 2009; Saunders, Zygowicz, & D'Angelo, 2006). Over the past few decades, many researchers have looked at low utilization of health services. Several theoretical models have been developed to define the concept of access to care, especially in the medical, mental health, and addiction fields. More recently, Levesque, Harris, and Russell (2013) suggested a multidimensional conceptualization to better grasp the process of access to health care that takes into account interactions with multiple dimensions. These authors define access to health care as the intersection of structural aspects of the health system, service provision, and features of individuals.

Some studies have focused on access to treatment of young substance users—adolescents, emerging adults, or

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young adults (Hawkins, 2009; Wisdom, Cavaleri, Gogel, & Nacht, 2011). Those studies call attention to the real public health issues that substance misuse within this population constitutes. Moreover, in Canada, prevalence of psychoactive substance misuse is particularly important in young men aged from 15 to 24 years (Pearson, Janz, & Ali, 2013). Emerging adulthood is a significant period of human development during which solicitation of substance consumption—between peers, for instance—may be numerous. In addition, vulnerability to the consequences of substance misuse increases during transition to adulthood, a pivotal and stressful period in a person's social and neurobiological development (Leslie et al., 2015).

More precisely, some research have looked at trajectories of substance use and service utilization by comparing individual substance users' characteristics, including age (Evans, Li, Grella, Brecht, & Hser, 2013; Parthasarathy & Weisner, 2005). For instance, Parthasarathy and Weisner (2005), in their sample, showed that users aged 17 to 29 differ from older users: less utilization of primary care and less compliance to proposed substance abuse treatment. Mechanisms different from those present in older adults may influence younger users' substance misuse treatment trajectory (Hoeppner, Hoeppner, & Kelly, 2014).

Given these differences, young adult users can express particular needs and encounter specific difficulties that caregivers do not necessarily take into account and which may explain why it is particularly challenging for these users to come and stay in treatment (Hoeppner et al., 2014). Moreover, some personal, socio-familial (e.g., personal and familial beliefs on substance use and/or substance misuse treatment, etc.), and institutional factors (e.g., lack of early interventions tailored to young adults, direct and indirect costs of care, etc.) may act as barriers and hinder young adults' initial access to treatment (Adler, Pritchett, Kauth, & Mott, 2015; Choi, DiNitto, & Marti, 2014; Priester et al., 2016; Sterling, Weisner, Hinman, & Parthasarathy, 2010). On this subject, some researchers suggest that it is important to investigate these specificities to offer even more tailored interventions to young adults' needs (Hawkins, 2009). In addition, Orford (2008) regretted that substance users' own perspectives on their uses and their help-seeking behaviors were not sufficiently the focus of studies designed to better understand psychoactive substance misuse treatment services' trajectories.

Therefore, the aim of this study is to explore—considering the very own users' perspective—the process of substance misuse treatment initiation. Precisely, we will focus here on the first step of a treatment process—among perhaps multiple past service utilizations—of young adults with problematic alcohol or drug use.

Method

Study Framework

This qualitative study is part of a broader research program supported by the Community-University Research Alliance Program of the Social Sciences and Humanities Research Council of Canada (SSHRC; Brochu et al., 2014). The purpose of the program is to study links between addiction trajectories and service use trajectories from the users' points of view. The research protocol was approved by the Human Health Research Ethics Committee of the Sherbrooke University Hospital (n°09-188-R1) and the Addiction Research Ethics Committee (MP-CÉRT-CDC-IUD-009-001).

The current study uses a descriptive phenomenological perspective (Giorgi, 2005). It consists of a qualitative exploration of the subjective treatment access experiences of psychoactive substance users aged 18 to 30 years. The objective is to clarify the meaning of a particular phenomenon—in this case, access to treatment—to ultimately design tailored interventions.

Sample

The sample recruited for the larger project included 127 participants, whose problematic substance use was detected at one of the points of entry in Montréal (a highly urbanized area) and Mauricie-Centre-du-Québec (a mixed rural, semi-urban, and urban area): criminal courts, hospital emergency departments, and Health and Social Services Centers (HSSC). Those three places are known to be frequent contact points with problematic substance users. There, individuals are initially detected via standardized or homemade screening tools and clinical judgment of local stakeholders. Then, participants are referred to specialized structures, informed about the study, and later, if they showed interest in participation, contacted by the research team. During their first meeting with members of the research team, participants were reminded that it was important that they were capable to do the interviews to come. Before the interview itself, investigators searched for behavioral signs of intoxication: coordination disturbance, speech coherence, specific smells, and so on. No participant was excluded for such reason.

Concerning references from the court, two processes are to be distinguished. Sometimes, the defendant's lawyer or the attorney general asked for reference to a specialized treatment center. In other cases, references occurred under a Québec court-supervised drug treatment program. Before the judge, the defendant and his lawyer

demanded to initiate care under court supervision, in exchange of legal consequences reduction.

Among the entire sample, 41% reported one or less consultation among specialized addiction services during the last 5 years, mostly following the recent detection episode, despite long-lasting alcohol and drug problems (Brochu et al., 2014). However, nearly 60% were twice or more in addiction services during the same period (Brochu et al., 2014). For the present study—focusing on young adults—only participants aged 18 to 30 were retained ($N = 35/127$).

Supplemental table presents our sample's assorted demographic characteristics. The mean age is 24.68 years ($SD = 3.44$ years). In the sample, 74.3% of the participants are male ($n = 26$), 65.7% are single ($n = 23$), and 71.4% have no children ($n = 25$). The sample appears fairly distributed considering the area of recruitment: 48.6% of participants come from the area of Montréal and 51.4% come from the area of Mauricie-Centre-du-Québec. Most of the sample was presently involved with the criminal justice system (i.e., 65.7%).

Material and Procedure

A semi-structured—recorded—research individual interview lasting about 1½ hours explored different themes related to addiction trajectories and participants' service utilization (T1). Questions asked were about changes in young adults' consumption, impact of services on those changes, as well as their experiences with the screening process, referral and treatment at their initial involvement with substance misuse services, and during the previous 5 years. Most young adults in the sample (77.1%; $n = 27$) were met a second time, a year later (T2) for a total of 62 interviews (i.e., both T1 and T2 interviews). Eight participants could not be reached or refused to take part in T2 interview. The second interview used the same interview grid, which provided supplemental data and enabled us to add information about addiction and service-utilization trajectories since the first interview. Each participant signed one information and consent form before starting the interview. Details about the study aims and protocol (i.e., themes discussed, place and time of both interviews, etc.) as well as ethical commitment of the research team (i.e., freedom to participate, confidentiality, and anonymity, etc.) were especially offered. At the end, they were given CAN$25 as financial compensation.

To gain an extensive description of the sample, alcohol and drug use had been assessed with standardized free-to-use instrument, the *Dépistage et Évaluation du Besoin d'Aide (DEBA)-Alcool/Drogues* questionnaire (Tremblay, Rouillard, & Sirois, 2004). The scope of this questionnaire is the detection and assessment of the need for drug-related and alcohol-related support. The *DEBA-Alcool/Drogues* consists of two separate scales, one for alcohol and one for drugs, and takes around 10 minutes to complete. Its design included two validated scales—the French version of the *Severity of Alcohol Dependence Data Questionnaire* (Raistrick, Dunbar, & Davidson, 1983) and the French version of the *Severity of Dependence Scale* (Gossop et al., 1995)—and several questions especially created by the original authors (Tremblay et al., 2004). Finally, a descriptive questionnaire measured substance treatment services use (Fleury, Perreault, Bertrand, & Brunelle, 2009).

Analysis Strategies

A thematic content analysis of all interviews' transcriptions was performed using NVivo 9.0. Considering feasibility issues, participants did not read their own interviews' transcripts. However, interviewers validated a sample of the transcripts of the larger study. The objective of this analysis is to pinpoint recurring pertinent elements, group them into categories, and identify points of convergence and divergence in the discourses. As a result, a mixed—both deductive and inductive—coding grid predefined on the initial interview grid and able to integrate emerging themes from interview contents was set up (Miles & Huberman, 2003). A coding guide was designed for the analysts. An intercoder agreement was used on 9% of the total material collected (i.e., 18 interviews) to verify and adjust the coding grid and guide. Final percentages of intercoder agreement were high, varying between 90.1% and 98.7%. In-depth analyses were also performed considering the themes that had been coded (Brochu et al., 2014): reasons for variations in consumption, difficulties or obstacles to modifying consumption, detection/referral episodes and requests for help for consumption problems, service-utilization incidence, motivation for change and treatment, satisfaction or dissatisfaction with services consulted, reasons for stopping treatment or for non-utilization of services, and collaboration among network services. To meet our objectives, we then identified emerging themes that centered on participants' experiences and on their own interpretations of elements that influenced their initiation of addiction treatment, that is, those that had an impact on all stages and which led them to get help from a health or criminal justice professional, or from a substance use support group.

Results

On frequencies of alcohol and drug use, 20 participants—57.1% of the sample—use cannabis 3 times or more per week. Cocaine and other stimulants are more frequently used by individuals detected via the criminal court (i.e., 34.8% and 30.4% of them use it 3 times and more than 3 times per week, respectively) than individuals coming from other points of entry. Use of cannabis and alcohol is more common for young adults from hospital emergencies (i.e., nine use cannabis at least 1–3 times per month and 10 use alcohol at least less than once a month). Table 1 displays full details concerning frequencies of use of main substances (e.g., alcohol, cannabis, cocaine, etc.), depending on the point of entry.

A majority of the participants present an exclusive drug use, notably cannabis, cocaine, and other stimulants (62.9% of the sample). Nine young adults show an associated alcohol and drug use (i.e., 25.7% of the sample). Specifically, according to the *DEBA-Alcool/Drogues* terminology, 48.5% of the participants show at least a *low dependence* on alcohol. In contrast, 68.6% of the participants present a *high dependence* on drugs. A more exhaustive view of the data can be found in Table 2.

The next section focuses on results from the thematic content analysis. Three components emerged from the analysis: personal elements linked to treatment initiation, the roles of immediate family members and peers, and influences of system characteristics, including health and social—as well as criminal justice—professionals. All discourse extracts from T1 and T2 presented thereafter were translated from French to English. Six randomly selected extracts were back-translated by an external bilingual PhD candidate. Then, authors compared the different versions for potential meaning discrepancies. No significant loss of meaning was found.

Personal Elements Linked to Treatment Initiation

Personal motivation and expectations. Some participants demonstrate a firm will to stop using substances from the very beginning of treatment. The idea of changing their lives and feeling better is crucial to clearly formulate a request for help. Despite their young age, many participants talk about being genuinely exhausted, an outcome of the negative effects of early onset of, and heavy involvement with, substance misuse during adolescence.

> I feel like changing everything . . . my lifestyle, myself, I want to find myself, get my self-esteem back, . . . because when I got here, I wasn't talking to anybody, I walked around with my head down, and . . . I was really a wreck . . .

Sometimes initiation of treatment is precipitated by a life event undermining their integrity or that of someone around them. At that point, they perceive they "need to change":

> When I got out of there [emergency department], I told myself that really, that was enough, . . . it's not that I want to change, now I have to change. That's really different. The doctors told me they'd never seen a 21-year-old in this condition.

Another interesting element is that several young adults said they wanted to prove to people close to them and to themselves they can get through it. Their motivation to change was related to their perception that they have the capacity to reduce their substance use problems. The positive anticipation that they could accomplish their goal also consolidated their sense of self-efficacy for related personal objectives.

> I want to show that I can do it, that I can finish something. I never finished anything because I was high. . . . If I manage to get sober, I'll be able to succeed at other things when I'm sober . . . and then maybe do something with my life.

Finally, for some people, the severity of the addiction to the substance can make them feel like they are out of control, which jeopardizes the process of asking for help despite their desire to stop using. Although in the literature, substance misuse severity was associated with problem recognition and help-seeking behavior (Edlund, Booth, & Feldman, 2009), here, the loss of control accompanying a high severity of substance misuse undermines care initiation of users.

> Yes, I always intended to change or stop, but I couldn't help it and so I kept doing it. Because actually, I couldn't manage anything.

Consumption and ability to control. As a whole, participants' denial—or at least, the lack of perception—of substance use problems and lack of self-confidence in their capacity to change have a negative impact on seeking treatment. During interviews, a large majority of participants first talked about prioritizing the pleasures and advantages of using:

> It's . . . It's . . . It's so good! It's so bad! The really good aspects of drugs are the reason why I didn't go to get help.

Then, some participants emphasized the idea of not having experienced negative consequences significant

Table 1. Sample Frequencies of Main Substances Use Depending on the Entry Point (N = 35).

During the Last 12 Months, How Often Did You Use . . .	Entry Points							
	Criminal Justice System (n_1 = 23)		Hospital Emergency Rooms (n_2 = 11)		Health and Social Services Centers (n_3 = 1)		Total	
	n	%	*n*	%	*n*	%	*n*	%
Alcohol								
Never	2	9.1	1	9.1	0	0.0	3	8.8
Less than once a month	7	31.8	2	18.2	0	0.0	9	26.5
1–3 times per month	5	22.7	1	9.1	0	0.0	6	17.6
Weekly or semi-weekly	3	13.6	2	18.2	0	0.0	5	14.7
3 times or more per week	5	22.7	5	45.5	1	100.0	11	32.4
Cannabis								
Never	2	8.7	2	18.2	0	0.0	4	11.4
1–3 times per month	3	13.0	1	9.1	0	0.0	4	11.4
Weekly or semi-weekly	4	17.4	2	18.2	1	100.0	7	20.0
3 times or more per week	14	60.9	6	54.5	0	0.0	20	57.1
Hallucinogens								
Never	11	47.8	11	100.0	1	100.0	23	65.7
Less than once a month	7	30.4	0	0.0	0	0.0	7	20.0
1–3 times per month	2	8.7	0	0.0	0	0.0	2	5.7
Weekly or semi-weekly	1	4.3	0	0.0	0	0.0	1	2.9
3 times or more per week	2	8.7	0	0.0	0	0.0	2	5.7
Cocaine								
Never	5	21.7	9	81.8	0	0.0	14	40.0
Less than once a month	6	26.1	0	0.0	1	100.0	7	20.0
1–3 times per month	2	8.7	1	9.1	0	0.0	3	8.6
Weekly or semi-weekly	2	8.7	1	9.1	0	0.0	3	8.6
3 times or more per week	8	34.8	0	0.0	0	0.0	8	22.9
Other stimulants (excepting cocaine)								
Never	7	30.4	6	54.5	1	100.0	14	40.0
Less than once a month	7	30.4	0	0.0	0	0.0	7	20.0
1–3 times per month	1	4.3	2	18.2	0	0.0	3	8.6
Weekly or semi-weekly	1	4.3	2	18.2	0	0.0	3	8.6
3 times or more per week	7	30.4	1	9.1	0	0.0	8	22.9

Note. Answers to the *DEBA-Alcool/Drogues* questionnaire (Tremblay, Rouillard, & Sirois, 2004). DEBA = Dépistage et Évaluation du Besoin d'Aide.

enough to justify changing. Thus, they express a sort of denial and tend to conceal or rationalize the scope of substance use.

> And she asked me questions to find out if I was using too much, maybe it was a problem. But I always convinced myself, saying, "I . . . I have a social life, I work, I clean my house, I eat well enough, I'm not, I don't have problems . . . "

However, although other young adults were aware of the harmful nature of substance use, they still did not seek help. One person recalled being somewhat removed from his problem:

> I didn't see that I had a problem, but I saw that my substance use was starting to cause problems. But it was like, how can I say . . . It didn't affect me.

Conversely, many participants stated being confident that they could control themselves; they could stop on their own. Saunders et al. (2006) also noticed that main barriers to treatment had to do with trust in one's capacity to deal with the substance use disorder through personal means, outside any official health organization.

> Because I say to myself, if I want to stop getting high, I'll just stop. And if I want to stop drinking, I'll just stop. You just have to have the will.

Table 2. Sample Levels of Substances and Substance Treatment Services Uses (N = 35).

	Entry Points							
	Criminal Justice System (n_1 = 23)		Hospital Emergency Rooms (n_2 = 11)		Health and Social Services Centers (n_3 = 1)		Total	
Variables	*n*	%	*n*	%	*n*	%	*n*	%
Alcohol use[a]								
Not at risk use	13	56.5	5	45.5	0	0.0	18	51.4
No or low dependence[b]	2	8.7	1	9.1	1	100.0	4	11.4
Moderate dependence[b]	4	17.4	3	27.3	0	0.0	7	20.0
High dependence[b]	4	17.4	2	18.2	0	0.0	6	17.1
Drugs use[a]								
Not at risk use	0	0.0	2	18.2	0	0.0	2	5.7
No or low dependence[c]	1	4.3	1	9.1	0	0.0	2	5.7
Moderate dependence[c]	4	17.4	2	18.2	1	100.0	7	20.0
High dependence[c]	18	78.3	6	54.5	0	0.0	24	68.6
Drug most used/drug with most negative consequences[a]								
Cannabis	5	21.7	5	55.6	1	100.0	11	33.3
PCP	1	4.3	0	0.0	0	0.0	1	3.0
Hallucinogens	2	8.7	0	0.0	0	0.0	2	6.1
Cocaine	6	26.1	0	0.0	0	0.0	6	18.2
Other stimulants (excluding cocaine)	6	26.1	4	44.4	0	0.0	10	30.3
Opiates	3	13.0	0	0.0	0	0.0	3	9.1
Alcohol/drug associated use[d]								
Drug use only	15	65.2	6	54.5	1	100.0	22	62.9
Alcohol use only	1	4.3	3	27.3	0	0.0	4	11.4
Alcohol and drug use	7	30.4	2	18.2	0	0.0	9	25.7
Number of substance treatment service use during the last 5 years[e]								
1 or less	5	21.7	6	54.6	0	0.0	11	31.4
2 and more	18	78.3	5	45.4	1	100.0	24	68.6

Note. PCP = phencyclidine; DEBA = Dépistage et Évaluation du Besoin d'Aide.

[a]Answers to the *DEBA-Alcool/Drogues* questionnaire (Tremblay, Rouillard, & Sirois, 2004).

[b]Scores on the French version of the Severity of Alcohol Dependence Data Questionnaire (Raistrick, Dunbar, & Davidson, 1983): No or low dependence = 0–9; moderate dependence = 10–17; high dependence = 18–45.

[c]Scores on the French version of the Severity of Dependence Scale (Gossop et al., 1995): No or low dependence = 0–2; moderate dependence = 3–5; high dependence = 6–15.

[d]For every use excepting not at risk one and for every drugs assessed (i.e., cannabis, PCP, hallucinogens, cocaine, other stimulants, opiates, and sedatives).

[e]Answers to a homemade questionnaire (Fleury, Perreault, Bertrand, & Brunelle, 2009).

With the benefit of hindsight, some young adults said their self-confidence might have been somewhat excessive. For them, such belief may have contributed to, for instance, their relapse.

> I dropped out. This is what "killed" me, to my mind, because I overestimated myself. I had an appointment every week. . . . I thought I was cured, then I overestimated myself and I did fail. . . . I felt a lot of shame, of guilt. . . .

As for the notion of stopping on their own, a few young people linked the idea of seeking outside help to acknowledging a form of weakness, admitting they were sick. Similar results are found in previous studies (Wisdom et al., 2011).

> Going for help, it's like a form of weakness. . . . It's really rooted in my head that no matter what I do, if I need help to do it, it's because I'm not good enough to do it on my own. . . . It's really humiliating, not to be able to do it on your own.

Role of Relatives and Others in Treatment Initiation

Influences of immediate family. An analysis of the data revealed that a young substance user's immediate family often has a positive effect on treatment initiation. In our sample, the term *immediate family* included parents, siblings, and spouses; it could also include other relatives (e.g., cousins), insofar as some young users were able to develop close emotional bonds with them.

First, parents and lovers are the ones who worry about substance misuse. Occasionally, some initiate the process and then present it to, or impose it on, the young user. Subsequently, few users agree to contact health services, not for their own benefit, but first and foremost to please their relatives, redeem themselves, and/or ease tensions.

> Really, though, I went to (Treatment Center A), I agreed to go, just for my parents.

We also note that participants are committed to contacting a professional in response to a relative's or friend's distress or sadness. Guilt toward family, a lover, or children is also sometimes used to justify and facilitate a request for help. Having good family relations encourages treatment initiation. Conversely, if family ties are severed—for instance, a young consumer is rejected by his parents—this can also lead to asking for care.

> At the same time, you know that . . . even if it's not your decision, you know that your family, my mother, my sister, they really do love me . . . . Really, I was starting to see the problem and to think of myself, of my family.

Less often, some participants said they are afraid to seek care because of the reactions of the people around them. Acknowledging the problem is a source of family conflict or amplifies this conflict.

> For my parents too. . . . So I said to myself that if I start detox, the result . . . it proves to my parents that I really have a problem. . . . as much as it made me feel better to tell myself it's okay, I'm in good hands, I'm doing what I have to do, I also knew that it freaks them out: their daughter, to have them ask how long has this been going on, right in front of our eyes? That this, and that . . . the tension it'll cause between them, and my little sister.

Most young adults perceive their parents as useful sources of information and support when they first seek treatment. In addition, some youth find it helpful when their relatives do not try to minimize the scope of their problems and accept that they are using and difficulties coming with substance misuse.

> When it comes to my relatives and to the professionals at (Treatment Center D) and at (Treatment Center D1) . . . compassion, I think that was . . . I think that was the most helpful thing. The fact that people don't minimize the problem, that they empathize with the fact that something's going on and. . . . The fact of not minimizing it, really, is to understand the problem, to show that yes, it's a problem.

Influences of friends and other people. Aside from relatives, young adults also consider that friends and colleagues have an impact on seeking treatment. Most participants insist that being around other users makes it difficult to stop consumption, seek help, and prevent relapses.

> I happened to meet some friends once . . . friends! People with who I was using cocaine at the time. They looked like they were still using a lot. So, of course, I can't . . . I can't avoid them and pretend that I don't know them.

On a more positive side, support from these peers is more specifically expressed through help finding quality therapy or a competent specialist. Initial referral can also originate, in the prison system, through another inmate. This first-step stage can then be a catalyst for a user to voluntarily initiate treatment.

Having been able to keep working despite their problematic substance use can sometimes go against young adults' initiating treatment. Some participants recall being afraid their colleagues would find out about their substance misuse, which would lead to the former losing their jobs, especially if they worked in the health sector. Others prefer not having to explain their situation to employers or colleagues. In those cases, asking for help is perceived as harmful to a person's career.

> That's a drag. Working in psychiatry, I could have had very good doctors, very good psychiatrists at (Hospital H) who are really well known, have really good reputations. But, of course, it made me a bit uncomfortable. . . . If you get fired from (Hospital H) because of substance use, it doesn't look too good on your CV, that's for sure. . . . I didn't take any chances, despite the fact that for sure it's confidential, but at the same time, I told myself that . . . my colleagues will see that . . .

Impact of the Health and Criminal Justice Systems on Initiation of Substance Misuse Treatment

Health and criminal justice professionals. Health and criminal justice professionals have a definite impact. Our sampling strategy of recruiting through criminal court enabled

us to document the experiences of many participants who, despite their young age, had repeated dealings with the criminal justice system. These delinquency trajectories should be considered concurrently with substance use trajectories and utilization of addiction services. In such contexts, some participants seem to greatly appreciate their relationships with their lawyers. A lawyer who simply mentions that it would be good to seek treatment has a significant impact on a user and ultimately plays a role in a user becoming aware something is wrong and then in developing a therapeutic plan.

> I took it to heart because I thought that a defense lawyer doesn't work for the good of his . . . of his clients. He works to defend his client, but also to make money. . . . I really took it seriously, like . . . like an affirmation, a decision. I told myself, Ok. God, when it gets to the point that your defense lawyer tells you "Go get treatment, go get help . . ."

Probation officers, who straddle the health, social, and criminal justice systems, are also very important to users. Participants understand probation officers can guide them from prison to treatment and provide support. As highlighted in the following extract, some participants feel that their probation officers are really involved with their situation. They can be seen as important actors of the overall care process as they provide significant support to patients. However, some young adults think that sometimes, probation officers complicate procedures more than facilitate them, or that their role is essentially correctional.

> Just the fact that she calls me and leaves me a message . . . she didn't say, "I'm gonna call the police!" But she said to me, "Call me." Your mother called me . . . Blablabla . . . Of course it proves that even though it's my [probation] officer, someone takes care of me and . . . When I first got here, she called me and said, "I'm proud of you." And . . . that felt good.

Various health and other professionals can also play important roles. Participants think of the specialist and non-specialist physicians they see somewhat regularly as people they can trust. Users' perceptions of their family doctors are often positive, and consequently, those professionals have positive impacts on users' acknowledging their problems as well as on guidance to the appropriate facilities.

> Then yesterday, my doctor said, "Barbara, you're not admitting it but you really have a problem with substance use. It's not only psychologically that you're not well, so you use. And then when you use, you're not well. The point, really, is your substance use. You need to come to terms with it, to admit that you're not well." This is something I've always denied. . . . I think that it's time that I admit it.

Conversely, initial negative contacts with formal services adversely affect the desire to seek professional help. Some young adults emphasize that the professional must suit them well. They focus on the person's being late or lacking respect for them. Other participants deplore a lack of knowledge or judgments on people with addiction problems.

> . . . It's terrible to be judged when you're looking to get help. . . . You need help, and then you're judged like that, it's . . . it's really . . . It makes you want to leave and use, and you don't feel like going . . . going elsewhere for help, you know? . . .

Access to substance misuse treatment facilities and interventions. Two sets of components link access to substance misuse treatment facilities with addiction interventions: first, waiting times, whether or not they are linked to complex administrative procedures that must be followed, then, costs of access to care.

Waiting times and administrative procedures. Young adults perceive waiting times, for instance, preceding the first meeting with a substance misuse professional, as especially frustrating. This result is congruent with findings from previous studies. For instance, Redko, Rapp, and Carlson (2006) found that more than half of their participants indicated waiting time as a significant barrier to treatment initiation.

> Really long. Because you've made up your mind and you have to wait . . . so I find the waiting time super long.

According to a few participants, procedure—particularly referrals and evaluations that must sometimes be done before accessing care—contributes to lengthening waiting times. Some participants are frustrated by these compulsory steps and simply give up and go back to using.

> Yeah, I know all about paperwork . . . , then, 6 months later, they call, and I said, "I've been waiting for 6 months. What's going on?" . . . She asked again for a doctor's paper so I can be referred to a psychologist. . . . So it's more paperwork, I have to wait some more to see the doctor . . .

Lack of information and costs for services. A few participants also deplore the lack of information about substance misuse treatment facilities, or that the information is not clear. Previous studies already highlighted that only a small portion of substance users seeking treatment may face such accessibility barriers. As suggested by McCoy,

Metsch, Chitwood, and Miles (2001), drug users usually know health care options at their disposal.

> In the beginning, I didn't know that such service existed nor where it was. Or anything else. When I arrived, everything was all new for me.

The financial cost of substance misuse treatment does not appear to be particularly problematic for participants. Even if Canada's public health care system provides substance misuse treatment free of charge, a number of young adults referred to the ease of getting funding to access private facilities—typically residential facilities—through social assistance or health insurance provided at their workplace. However, a few participants insisted that some group insurance policies only cover a limited period of care, which restricts their choice of treatment, especially facilities in the private sector.

> Of course it's offered through work, but the insurance only covers 21 to 28 days, which is really minimal. . . . I said to myself, "With the problem I've had, the years that I've been doing this, I'm sure that I need more than 28 days."

Several young adults expressed a specific need for psychological support for their substance misuse problems. They regret that such service is difficult to access in the public system and much too expensive in the private sector.

> . . . I had four short meetings in a month which was really worthless because she . . . she always referred me to psychologists which, at the time my salary was low, I was getting minimum wage, so I couldn't afford it . . .

Influence of past substance misuse treatment experiences. Finally, we found that young adults' past substance misuse treatment experiences can sometimes negatively influence the decision to initiate treatment again, when past experiences were unsatisfactory. Some participants' bad experiences with care in the past, whether general care or substance misuse treatment, have left them with a negative view of the usefulness of services or their capacity to successfully go through treatment. Those individuals express feelings of guilt and shame which, based on what they say, tend to drain their energy for seeking help, energy already difficult to muster.

> . . . I've seen a lot of social workers, psychologists, psychiatrists in my life and honestly, it's never really done much. I'm a bit disillusioned with all that. I don't see the point. I don't see the point: each time I go, you tell them the same things every time, and there's absolutely no change. Nothing ever happens . . .

However, repeating these inconclusive care experiences can also contribute to making some of these people aware that they have a substance use problem and that treatment really is useful. When young consumers finally get suitable treatment, their entire perception of the health care system can change. Experiencing real progress during treatment can make people more confident that treatment is a reliable and useful source of help.

> Over time, I did learn how it [services] worked. . . . One of them really worked for me, it was the (Resource 9). I had all the help I needed.

Discussion

The objective of this study was to investigate initiation of substance misuse treatment by young adults using a phenomenological perspective. Contents of 62 semi-structured interviews conducted with 35 participants aged 18 to 30 years have enabled us to highlight a set of elements that facilitate or hamper access to care.

First, we noticed that young adults frequently struggle to be conscious about risks of substance use. Sometimes, they are convinced they can deal with the problem on their own, and their abilities to perceive the need for care and to seek help are inadequate. Occasionally, they identify the problem and their need for help, but then acceptability of treatment poses a problem, that is, seeking addiction services raises fears that this action may bring unwanted consequences, especially at work. Indeed, study participants sometimes expressed being afraid of how others see them. This raises the issue of users' accepting they have a disease and seeking treatment. Young adults may not want to start treatment because they do not want to confirm to their social environments they are sick (Wisdom et al., 2011). Gulliver, Griffiths, and Christensen (2010) noted that fear of stigma was a predominant barrier in the mental health care access of adolescents and young adults. Furthermore, Choi et al. (2014) noticed that stigma impact was potentially more important for younger adults than for older adults, perhaps because of the emerging professional career. Finally, the fact that some participants of our sample present such fear about their professional activities is congruent with results from the review of Clement et al. (2015). This article indeed highlights that stigma affect even more young men working in health field.

Some comments paint a portrait of young adult users' feelings of invincibility about their substance use. Even though young users are aware of the harmful nature of their consumption, some of them admit being too confident in their capacity to self-regulate and overcome their problem, which hinders their actions toward seeking

professional help. This confidence could be linked to fears of self-stigma (Drapalski et al., 2013). We can also hypothesize that accepting external assistance or treatment goes against those feelings of invincibility and can damage self-esteem of young people—who can easily feel shame or culpability (Barry, Pickard, & Ansel, 2009; Drapalski et al., 2013). Major role of personal beliefs as treatment barriers has already been noticed in the literature (see the review of Priester et al., 2016).

This first part highlighted personal factors. However, considering how challenging is the transitional age constituted by the end of adolescence, other factors can intervene. Environmental factors—associated with family or peers—and institutional factors (i.e., health care system characteristics, appropriate interventions, etc.) need to be taken into account. Indeed, those factors can affect personal perceptions and beliefs about health (Leslie et al., 2015). In our sample, users who reported low motivation to seek treatment during their addiction trajectory perceive mostly pressure from people around them. The important but sometimes nuanced role of friends and family is evident. However, if a user feels too much social pressure, treatment engagement can be adversely affected (Goodman, Peterson-Badali, & Henderson, 2011).

Health and social services—as well as criminal justice—professionals play special roles in young adults' access to treatment. As key stakeholders and trustworthy experts, they can contribute to raising awareness about the need for treatment and seeking help. In addition to the expertise provided, relations with those professionals can foster or hinder young substance users' access to treatment. Meyer, Tangney, Stuewig, and Moore (2014) noted that inmates are a population particularly at risk, expressing multiple needs. However, in their study, only 18.5% of inmates with a problematic substance use followed a specialized treatment. As the vast majority of our sample comes from the criminal court, it may affect data. In the context where commitment in care can lead to a reduction of judicial charges, some individuals might easily accept to be referred to specialized substance misuse services. Moreover, as they remain under judge's supervision, they may hold their discourses as relapse or non-observance of treatment could lead to additional judicial consequences. However, even if some of them can show an external motivation in the beginning of the treatment process, experience of care and services may raise awareness of their situation and need for care.

Certain characteristics of the health system, such as waiting times, administrative procedures, lack of information, and costs affect initiation of substance misuse treatment. These elements define treatment accessibility and affordability (Levesque et al., 2013). For Saunders et al. (2006), they are external barriers that restrict users' access to treatment. Waiting time is a significant barrier for young substance users seeking treatment, especially when their request for help presents urgency. Waiting times and multi-step procedures that delay onset of treatment can be crippling, as several studies on adult and adolescent populations in the literature note (Redko et al., 2006; Wisdom et al., 2011). However, unlike other studies (Perron et al., 2009; Probst, Manthey, Martinez, & Rehm, 2015), the issue of cost is fairly marginal here. It is noteworthy to say that in Québec, private and public addiction treatment fields offer a complementary provision of services. Private services mainly include long-term residential care that takes care of more problematic health, judicial, and social situations. These centers are sometimes far from urban areas, but, as part of the reference process, travel expenses are covered by the court. Moreover, overall costs of private services could be partly covered by social assistance, but some drug users may still need to spend a lot of money for indirect costs on private facilities. On the contrary, detoxification and short-term residential centers are public and free services, but depending on how far they are from customers' residence area, indirect costs can still be expensive. Limits of health insurance coverage (i.e., number of sessions, treatment duration) will, therefore, have a negative impact on health care access (Sterling et al., 2010). Direct and indirect costs can remain a limiting factor for disadvantage populations—homeless or with justice issues—like some participants of our sample (Adler et al., 2015; Godley et al., 2000).

In a context of multiple use of substance misuse treatment services, data analysis highlights that deciding to get help for substance misuse problems is notably facilitated or hindered by prior significant care experiences. Substance misuse treatment is often an iterative process (Naughton, Alexandrou, Dryden, Bath, & Giles, 2013), even for young adults. Indeed, several participants of the sample already had a history of treatment for their alcohol or drug use. As it has already been seen elsewhere, if past experiences have been especially negative, young adults will not want to seek and/or enter treatment again (Wisdom et al., 2011). Conversely, positive past experiences and good relations with staff encourage users to obtain professional help again (Gulliver et al., 2010; Saunders et al., 2006). Providing treatment that meets the needs of young adults is especially important because of the influence it will have on their desire to seek help.

Inasmuch as access to care is particularly tenuous for young adults, it is necessary to develop tailored health practices focused on the specific needs of this population. If the traditional approach is not compatible

with the desire to change expressed by some young substance users, it may be advisable to provide tools to help reinforcing with self-control, self-reliance, self-efficacy abilities, and to offer programs improving mental health literacy and reducing stigma associated with drug misuse and help-seeking behavior (Gulliver et al., 2010; Kelly, Urbanoski, Hoeppner, & Slaymaker, 2012). Some young adults may be ready to change, but do not have the means to do it. To facilitate their access to a professional help, new ways—highly personalized—of information, prevention, and treatment integrating emerging technologies should be designed (e.g., text messaging/mobile applications interventions; Mason, Ola, Zaharakis, & Zhang, 2015). As seen in the literature, people may prefer online help when they face too many "external" barriers to traditional treatment (Townsend & Gearing, 2011). These solutions could contribute to promote help-seeking behaviors and to decrease belief and fear of stigma (Burns, Durkin, & Nicholas, 2009). Working on reducing delays may need pre-interventions to help before admission in a more formal structure or appointments. For example, offering support services such as self-help groups, stress management tools, and web- or telephone-based monitoring could reduce pre-treatment attrition. Another option would be to simplify procedure during care initiation and to improve collaboration between primary care, criminal court, and addiction-specialized services to offer an "integrated care" respectful of patients' needs (Babor et al., 2007; Carey et al., 2013). At another level, the help of various stakeholders (e.g., trusted physicians, mental health counselors, and probation officers) should be enlisted to create and sustain connections. Cross-training based on expertise sharing among various professionals helping individuals with addiction problems is an example of strategy that facilitate inter-professional collaboration to better support clients during the referral process (L'Espérance, Bertrand, & Perreault, 2016). Finally, for young adults whose working conditions are precarious and/or especially those working on mental health field, improving access to confidential substance misuse treatment in professional settings is important.

This study has limitations. First, one may notice that the saturation criterion does not seem to be fulfilled on points of entry or recruitment area subsamples. In qualitative data analysis, it is as important to have a diversified sample as to achieve saturation according to criteria deemed pertinent. Moreover, it would have been useful for our analysis to compare the views of young adults based on their point of entry into care. The pathway to treatment—and perception of the pathway—of users who have often interacted with the justice system may differ from that of users engaging in treatment for the first time. However, it was not the main objective of this research, and the heterogeneous distribution of the sample on the different points of entry (i.e., 23 individuals come from the criminal court vs. 11 from hospital emergency rooms, and only one from a HSSC) is not appropriate to make meaningful comparisons. Other sociodemographic characteristics could also have been used as filters for comparison, for example, geographical location, gender, as well as comparing these data with data from older adults on the larger sample.

Concerning the strengths of this work, a pertinent point to retain is sample selection of young substance users. Although older individuals may have more experience with services, fruitful or not, young users are often still unfamiliar with these settings; they can then express specific needs which, if they are met, will influence their treatment access experiences. In terms of the analysis, using a phenomenological perspective based on the views of young participants allows for sensitive interpretation of complex processes based on how individuals feel and what they have experienced. One factor, whether an individual, environmental, or institutional one, may act as barrier for some persons, and as facilitators for others (Naughton et al., 2013). It depends on the cultural context and on the health care system too (Probst et al., 2015). Finally, Gulliver et al. (2010) reasserted that those factors can affect the process of care at different moments.

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