

“I’ve Never Seen It as a Real Problem”: Experiences of Access to Care for People Who Use Methamphetamine

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Purpose: People who use methamphetamine can experience significant barriers to access treatment, care, and support. This study aimed to explore the experiences of access to care using a conceptual model, for this population.

Patients and Methods: This descriptive qualitative study was embedded within an Australian telephone-delivered intervention trial for methamphetamine use problems. Twenty-seven participants were interviewed about their experiences of access to care (prior to enrolment in the trial). Interview transcripts were analysed using framework analysis, and data mapped to a patient-centred access to care framework.

Results: Three themes were identified: (1) the “problem” of methamphetamine use; (2) beliefs about treatment; and, (3) the impact of stigma. These themes were aligned to relevant determinants of access to care. Access to care was experienced through participant perceptions about the need for care, the ability to engage in the care process, and the acceptability of service providers.

Conclusion: Stigma and beliefs about problematic use, and knowledge of treatment options dominated participants’ experiences of access. Clear information about available treatment options, particularly to address fears of engaging in treatment that is viewed as stigmatising, are important considerations for policy makers and service providers.

Keywords: methamphetamine, access to care, qualitative, stigma, treatment

Introduction

Harmful use of psychostimulants, particularly methamphetamine, remains a significant problem internationally, with notable increases in methamphetamine drug-related deaths.^{1–3} Methamphetamine is a widely available high-potency amphetamine, with repeated use often leading to rapid development of dependence.⁴ Despite multiple research trials of potential treatment approaches,^{5–8} effective medication options are limited, and significant barriers to accessing care remain.

In a meta-analysis examining barriers to accessing methamphetamine treatment,⁹ it was found that these barriers were predominantly psychosocial in nature. These included perceptions of the need for care, stigma, preferences for participants to withdraw from methamphetamine on their own, and privacy concerns. A more recent survey-based study by Kershaw et al¹⁰ explored perceived barriers to help-seeking from the perspectives of people who use methamphetamine, their families, and healthcare workers. Although all participants identified stigma and discrimination as major barriers, participants who used methamphetamine and their families additionally expressed a general distrust in the healthcare system. In contrast, healthcare professionals highlighted the importance of knowledge-related barriers in accessing treatment. While these studies offer invaluable insights into the obstacles encountered by people who use methamphetamine in seeking care, they reveal a need for more comprehensive qualitative data to fully grasp the nuanced experiences of access to care.

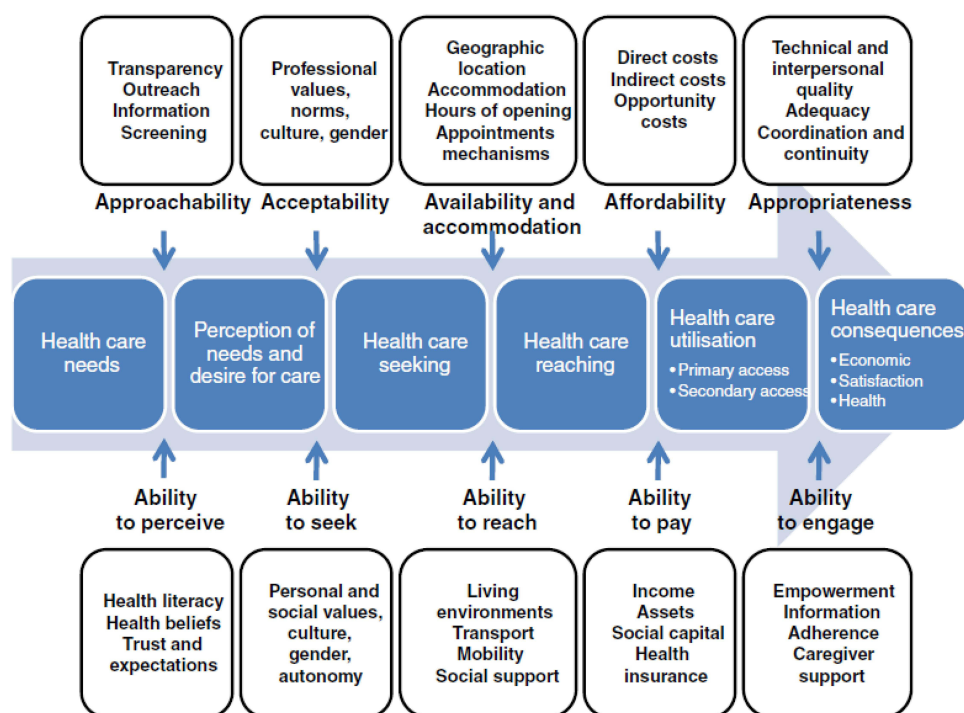


Figure 1 A conceptual framework of access to healthcare.¹¹ (Used with permission).

Although previous research has investigated care for methamphetamine use, few studies have applied a theoretical model to the multi-factorial barriers to care. Access to care is defined as the opportunity to reach and obtain healthcare services when there is a perceived need for care.¹¹ In the Levesque et al conceptualisation, access to care is depicted as an interaction between factors relating to people seeking care (the “demand” side), and factors relating to services providing care (the “supply” side). Central to this model is the process of seeking care, which includes five abilities of a person (or population) to access care: the ability to perceive, seek, reach, pay, and engage. Correspondingly, there are five dimensions of service accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness.¹¹ The model is depicted in Figure 1.

Only one known study has used the Levesque et al¹¹ access to care model as a guiding conceptual framework to examine primary care providers’ understandings of access to care for people who use methamphetamine. Ward et al¹² interviewed eight primary care providers in rural Victoria, Australia, and found that service dimensions, particularly availability, acceptability, and appropriateness of care across and within organisations were associated with access to care.

To further understand the experiences of accessing care in people who use methamphetamine, we drew upon qualitative data obtained from a sample of participants enrolled in an Australian trial of a telephone-delivered intervention for methamphetamine use problems.¹³ We analysed interview data collected during the trial, focusing on participants’ experiences of access to care before receiving the intervention, using the Levesque et al¹¹ conceptual model.

Materials and Methods

Study Design

The study was a descriptive qualitative study embedded within a trial, using semi-structured interviews to collect data. This study was approved by the Eastern Health Human Research Ethics Committee (E20/011/61428) and the Monash University Human Research Ethics Committee (25907). This study complies with the Declaration of Helsinki.

Participants

Participants from across Australia were recruited to the parent trial via social media, responding to an advertisement inviting participation in a study of two types of support for methamphetamine use problems. Trial eligibility included being aged 18 years or over, experiencing mild-to-moderate methamphetamine use disorder (assessed at enrolment using the Structured Clinical Interview for DSM-5 Research Version, SCID¹⁴), and a desire to reduce their methamphetamine use. Interview participants were drawn from the group of participants receiving the active trial intervention. For detailed trial inclusion and exclusion criteria, refer to Lubman et al.¹³

Researchers used convenience sampling methods to invite participants to participate in a telephone interview three months after their commencement to the trial (ie, once primary outcome data were collected). Informed consent was obtained, which included the publication of de-identified quotes. Participants were offered an AUD\$10 retail voucher as additional reimbursement for the qualitative study. Recruitment continued until information power¹⁵ was achieved.

Twenty-seven participants were interviewed, consisting of 15 men and 12 women, with an average age of 42 years (SD = 10.7; range 27–63). Participants reported a mean SCID score of 5.8 (SD = 1.5), indicating severe methamphetamine use disorder. Most participants (n = 21, 77.8%) had not previously sought treatment for their methamphetamine use (Table 1).

Data Collection

The interview schedule was semi-structured, and included open-ended questions about experiences and impacts of the intervention, and experiences of access to care prior to enrolling in the intervention. Examples of questions included, “have you received any treatment for your substance use before the study?”, “What, if any, barriers have you experienced in accessing treatment for your ice use?”, and “What other forms of support have you had?” Interviews were audio-recorded, anonymized, and later transcribed by an external transcription company. The mean duration of the interviews was 26.8 minutes (SD = 10.6).

Data Analyses

Interview transcripts were analysed using framework analysis.^{16,17} Framework analysis outlines several steps for data analysis: data familiarisation, data indexing, data charting, and data mapping and interpretation. This method enables the identification of themes using both inductive and deductive approaches. Data were analysed by three authors [AP, JS, RP] and commenced prior to the end of data collection. Data familiarisation involved reading transcripts, coding against broad themes derived from interview schedule headings, and entering key extracts into Microsoft Excel to create a draft

Table 1 Participant Characteristics

	Count
N	27
Age (mean, SD ^a)	42.0 (10.7)
Gender	
Man	15 (55.6%)
Woman	12 (44.4%)
Geographical area	
Metropolitan	19 (70.4%)
Non-metropolitan	8 (29.6%)
Methamphetamine use disorder severity (SCID ^b score; mean, SD)	5.8 (1.5)
Years of regular methamphetamine use (mean, SD, range)	13.6 (11.9, 2–51)
Previous treatment for methamphetamine use	
Yes	6 (22.2%)
No	21 (77.8%)

Notes: ^aSD = standard deviation. ^bSCID = Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-5) Substance Use Disorders.¹⁴

framework. During data indexing, we applied the framework to all study data and worked iteratively to introduce or remove codes where necessary. The main themes were clarified through the data charting process, which was achieved through manual handling of the data, discussion, and agreement between AP, JS, and RP. Finally, in the mapping and interpretation step, we consolidated key codes and themes. Themes were triangulated through discussion and agreement between AP, JS, and RP and seeking feedback from author JG, and mapped to the access to care framework.¹¹

The results are reported using pseudonyms to protect participant confidentiality. During recruitment, participants were informed that any published data or quotes would involve the use of pseudonyms to ensure they could not be identified.

Results

Through analysis of the interview transcripts, we identified three themes: 1) the “problem” of methamphetamine use; 2) beliefs about treatment; and, 3) the impact of stigma. The three themes align broadly with the access to care determinants of: (a) ability to perceive the need for care; (b) ability to engage in care; and, (c) acceptability of care.¹¹ How these themes map to the access to care framework is displayed in Table 2.

Theme 1: The “Problem” of Methamphetamine Use

The first theme draws together participant accounts of the “problem” of methamphetamine use. Levesque et al¹¹ describe the notion of the *ability to perceive* the need for care as determined by health literacy, knowledge about health, and beliefs about health and illness. Participants discussed whether they considered their methamphetamine use as problematic, and how they addressed this “problem”, succinctly illustrated by Linda (age 52, woman [W]): “I’ve never wanted to seek help for it [methamphetamine use] because I’ve never seen it as a real problem”.

Providing more context to his problem, Charlie (age 32, man [M]) started using methamphetamine after a relationship breakdown, and his use escalated following a traffic accident that subsequently resulted in unemployment. Charlie stated he had been thinking of reducing his methamphetamine use for a while, but had not accessed treatment, as “it’s hard to reduce yourself where, you’re like, you don’t think [methamphetamine’s] that bad to begin with”. Carl (age 57, M) reported using methamphetamine on and off for a number of years, describing “not seeing the problem [with his methamphetamine use], or not seeing it as something that needed to be carefully observed”. While Carl did not see a “problem”, he acknowledged that care and caution were needed:

But, at this stage, now I recognize it’s like the ocean, and you can swim in it occasionally but you’ve got to respect it or it will chew you up and spit you out like a lot of people.

Lachlan (age 32, M) reported that, even though he had been using methamphetamine regularly for 16 years, and was attempting to reduce his use, he did not view his use as problematic as it was not affecting his finances or work performance. However, this situation changed when he obtained custody of his son:

Table 2 Access to Care Framework Dimensions¹¹

Theme	Access to Care Determinant	Description of Dimension	Example Quote
The “problem” of methamphetamine use	Ability to perceive	Concepts of perceiving one’s need for care determined by health literacy, knowledge about health, and health and sickness beliefs	<i>I have never wanted to seek help for [methamphetamine use] because I have never seen it as a real problem.</i>
Beliefs about treatment	Ability to engage	Participation and involvement in decision-making and treatment decisions	<i>... if I got the treatment, then I’d be totally cut off from everyone and that I’d be totally alone.</i>
The impact of stigma	Acceptability	Cultural and social factors determining the possibility for people to accept the service and its appropriateness	<i>I always thought that if I ever did go through any rehabilitation program, that it would be recorded somewhere against my name.</i>

Notes: The conceptual framework of access to health care¹¹ comprises five dimensions of access capturing supply side and demand-side determinants. Not all are relevant to the data analysed in this study.

... for a very long time if it wasn't something that I consider a problem or an inconvenience, or like it wasn't something that, say, costed me all my money or affected my work or anything like that ... I was sort of able to incorporate a, I don't know, a pretty heavy ice addiction into my life ... I would only have my son on the weekends and stuff like that and once I got full custody of him I – I want to sort of do the right thing for him and myself...

However, Lachlan did recognize a tension between continuing his methamphetamine use and his desire to stop at some point in the future:

I'm comfortable with my... use now. But don't get me wrong, I do eventually want to completely stop but for right now, as I said, I'm not spending great amounts of money on it. I'm not, it's not stopping me from working or doing the things I need to do around the house.

Similarly, Max (age 33, M), who had been using methamphetamine “on and off” for eight years, also reported that he did not perceive his use to be “a huge issue”:

... I maintain a relatively normal life. It's easy to just carry on rather than seek out those ways of treatment where, you know, also work is busy, life is busy, and trying to fit in around work and what not ... it's easy to just, I guess, ignore it and push it into the back of my mind and go, 'oh, I might as well carry on'.

Mina (age 42, woman [W]) had been using methamphetamine for 10 years, with two years of regular use, and reflected on the reasons for not previously perceiving a need to seek support, noting that she used methamphetamine within the context of an otherwise healthy lifestyle:

I still maintain a healthy life, I think, usually. Like I eat well, I sleep well, I guess, so I walk a lot, always worked. it's something I enjoy, to wind down, you know, or even ramp up. Yeah, so, I guess that's been a barrier... that's why I haven't reached out or tried to access. [support]

Two participants described the framing of their methamphetamine use in relation to the concept of “change”. Sarah (age 27, W) discussed how making a change regarding her use had been on her mind for some years. For Sarah, there was some evidence of problem awareness, particularly relating to her lack of motivation and being out of work:

I have been meaning to change, I have been wanting to change for a while now because, you know, for the past three years I have just been existing. I have no motivation ... I don't have a job, you know, it's horrible.

Anna (age 27, W) acknowledged a need to change, and an awareness of a “problem”, linking this to the challenges of actual behaviour change:

I always had at the back of my head that I probably needed to quit for a long time. But, you know, having it in your head and actually doing it are two different things.

Theme 2: Beliefs About Treatment

In the second theme, beliefs about treatment, participants described their perspectives about accessing treatment – based on prior experiences or their preconceived ideas – even if they had not accessed treatment before. Beliefs about treatment commonly included doubts about the success of treatment, weighing the perceived pros and cons of entering treatment, and participants' understanding of available treatment options. The theme aligns with the Levesque et al¹¹ dimension of the *ability to engage in care*, which encompasses concepts such as participation and involvement in decision-making and treatment decisions, determined by capacity and motivation to participate and commit to its completion.

Participants viewed treatment as isolating, describing being cut off from family or work supports. For example, for Sarah (age 27, W), who had received treatment in the past for her methamphetamine use, entering treatment meant isolating herself, only to face personal difficulties when she returned home:

... so you go to rehab for three months, at the start you cut communication with everybody, you're not allowed to speak to anybody et cetera, et cetera. But when you come out of rehab, you are then faced with all those problems again. Like you're

faced with the people that use that you used to speak to. Why waste money on going to a rehab? It's in your mind. You have to want to stop. You can lead a horse to water, but you can't make it drink.

Sarah described how she had previously enacted autonomy and choice to cease methamphetamine use without formal support, again in isolation:

I handed my phone to my mum ... and I said, "That's it. Don't let me go out, I don't want my phone to contact anybody". And I did it on my own. It was hard, it was lonely.

The perception of treatment as an act of isolation was reinforced by Tom (age 36, M), who had not received treatment in the past. The idea of seeking treatment was concerning for him, as doing so meant breaking social bonds, not only during treatment but also after treatment had ended, with friends who were still using drugs:

I was constantly around people who were on it and I felt the need to talk to people all the time, just to have friends ... whereas they weren't actually friends ... if I got the treatment, then I'd be totally cut off from everyone and that I'd be totally alone.

Drew (age 42, W), who had been using methamphetamine regularly for eight years, spoke of the pragmatic barriers she faced in seeking treatment; in her case, being new to the city she was living in created challenges, particularly the lack of social support to enable her to enter treatment:

... wanting to do it but wanting the right structure behind me, I suppose, or the right, not so much support, I know I could do it anywhere, but just, support's actually important. But, where would I put my things?

Christopher (age 34, M), who had been using methamphetamine regularly for seven years, framed his limited capacity to access treatment around his work commitments, as well as the financial and emotional resources required to engage in treatment, reflecting a lack of awareness of the different treatment options available outside of residential rehabilitation:

... Ever since I started this habit, the whole time I've been either looking for work or in work. But still [being] the 'new guy' at wherever I would be working and unable [to] get annual leave, the perceived cost of full time, round-the-clock residential rehab, I might have assumed it was a lot. I might have assumed that it was going to be costly, that I couldn't afford it, that the waiting list was going to be so long that by the time my name came up, I wouldn't have the same conviction by then. I could be anywhere... by then.

Christopher's extract highlights the tensions between thinking about treatment, changing employment ("being the new guy") and needing work supports, yet due to this pattern of changing employment, was unable to predict the future if his name "came up". Other participants also spoke of the pragmatics of work commitments and perceived costs in the context of treatment. Paul (age 42, M), who was married with children and had a negative experience of admission for detoxification in the past, explained his experience of a self-perpetuating cycle, where he needed to work for financial reasons, yet needed methamphetamine to function at work and, further, that engaging in treatment was unfeasible while maintaining employment.

I can't stop work, not having an income to help myself ... I can't function without it for work, so if I have to work, there's no point, or I will fail. For me to have a serious attempt I have to be at a point where I don't have to work.

Max (age 33, M), who (in Theme 1) preferred "to just carry on" his methamphetamine use within the busyness of his life, spoke of an additional challenge of not knowing the treatment options available to him outside of acute services, which would be more "pre-emptive" and therefore better suited to him:

... just those fleeting thoughts in terms of not knowing where I can go to find the support that would suit my life, I guess, and my situation. it still feels like a lot of the support services are more for that acute stage where it is reaching crisis point, but in terms of that sort of pre-emptive type support ... I don't really know where to go for that.

Linda, who in Theme 1 described not seeing her methamphetamine use as a problem, described the reasoning process she used to determine whether to seek support for her methamphetamine use. She perceived that treatment services could

exacerbate the problem, as discussing methamphetamine use or participating in treatment with others could act as a “trigger” for her:

I’ve always thought of rehab as something that would probably trigger me, being around other people, talking about it. talking about it is a trigger. Thinking about it is a trigger. I’ve always been able to just shut it out when it’s required, but I’ve never been able to say, ‘never’.

Theme 3: The Impact of Stigma

The final theme describes how participants spoke of the stigma they had experienced or perceived in relation to their methamphetamine use, and its impact on accessing treatment. Some participants described the act of seeking addiction treatment as stigmatising, while others discussed their experiences of being stigmatized by others around them, or their internalized experience of stigma and shame. Participant data in this theme aligned with the *acceptability* of care dimension,¹¹ relating to cultural and social factors relating to a service (for example, service values and norms) that help determine if a person accepts the service, and judges it as appropriate for them, and wider cultural and social forces that influence service uptake.

Max (age 33, M) described the stigma and shame he associated with accessing treatment for his methamphetamine use, and hiding his addiction from his family:

There’s definitely hesitation in seeking treatment ... You hear the horror stories of people who try to get help and they end up just being tranquilized and sort of thrown into rehab or something like that. Whereas, yeah, I wanted to avoid that stigma and association and I think there’s a degree of shame in that as well because none of my family know or friends know ... and I wouldn’t want that to come about.

Christopher (age 34, M) described himself as living a double life, being a worker in a senior position while being dependent on methamphetamine. He expressed his concern about the stigma of undergoing treatment, and its role as a barrier to accessing treatment:

I always thought that if I ever did go through any rehabilitation program, that it would be recorded somewhere against my name. it would hamper my efforts to get work in the future. I’m not sure exactly why I thought that or what gave me that idea. But it was a very strong feeling.

Linda (age 52, W) attempted to reduce the internalized stigma associated with her methamphetamine use by distancing herself from others who use methamphetamine, emphasising her ability to maintain employment and use recreationally. Despite this, Linda discussed her experiences of leaving a regional town due to the stigma she experienced from others following a methamphetamine-related arrest.

... it’s got such a bad name and the majority of people who are on it are what I would call scum, but then there’s a portion of us that still go to work and pay for it ourselves and just do it for fun ... I just had a bad experience up in [regional town] after being arrested. I was really labelled up there by the community and I was ostracized and pretty much driven out. I’m not that person that they – up until then, I was loved by everyone, and then suddenly there’s this – ice, ice, ugh she’s a horrible – she’ll [stab] your mother-in-law to bloody – and that’s just not what goes on.

Sarah (age 27, W) described the enduring stigma that she experienced from her family, despite previously participating in a treatment program:

[My family] were proud that finally [I was] doing something with [my] life, et cetera, et cetera ... and then obviously the program ended and they were like, ‘Oh well, guess you’re just gonna go back to being a junkie’. And I’m like [sarcastically], ‘Oh cheers guys, thanks for the encouragement, love ya, thanks for the support’. Mum’s like, ‘Yeah, well, you know, you’ll never change’, and it’s like, ‘Yeah, neither will you’.

Participants also referred to an internalized feeling of self-blame and shame in their current situation. This internalized stigma was reported by some participants to have a direct impact on seeking support. Sarah recognized the need for counselling, yet this was countered by her negative and critical internal self-dialogue:

... I have been needing to talk to someone. Whether was a counsellor, a psychologist, a therapist, whatever. But my mental health is so shot at the moment, I have days where I'm like 'I need to talk someone' and I say to myself 'I'm going to do this' ... But then my bad mood sets in and it's just like 'no one cares about your problems ... You've done it to yourself, you've got no one to blame but yourself.' I don't want to burden someone with my bullshit. So it's really hard. It's like I've got a devil and an angel on my shoulder and I fight between the two.

Finally, Jessica (age 37, W) spoke of a preference for seeking help from someone who has had lived experience of methamphetamine use, viewing this as more acceptable to her as a way to avoid stigma:

You can't relate to somebody that hasn't been in your position, does that make sense? ... You're not going to listen to them because they're never been – you can't – what's the right word? Mentally, you think, 'what am I doing here you don't know what you're talking about?'... we need to be able to relate to somebody so they understand and they can give their – you're going to listen to someone else that's been in your position before and bettered themselves.

Discussion

This is the first known study to explore experiences of accessing care for methamphetamine use through the lens of the Levesque et al¹¹ access to care model. This research provides new insights into the perceptions of access to care for people seeking support for methamphetamine use problems. The three themes – the “problem” of methamphetamine use, beliefs about treatment, and the impact of stigma – broadly align with the concepts of the *ability to perceive* the need for care, the *ability to engage in care*, and the *acceptability* of care.¹¹ These concepts are characterized by beliefs related to health and health care, knowledge about health care and treatment options (and perceived stigmatising elements of those options), and, to a lesser extent, personal autonomy and capacity to choose to seek care.

All participants in this study self-reported their methamphetamine use as indicative of a methamphetamine use disorder, and 78% reported they had not accessed treatment before the trial. However, during interviews it was evident that some participants did not perceive their use as a “real problem”. The ability to perceive the need for healthcare is influenced by health literacy, knowledge about health (and the harms of substance use), and beliefs related to health and sickness.¹¹ Low problem awareness is a significant barrier preventing access to alcohol and other drug treatment,^{18–20} as well as access to treatment for mental health problems more broadly.²¹ The fact that some participants did not view their methamphetamine use as problematic supports prior literature indicating this perception as a barrier to treatment, leading to the belief that treatment may be unnecessary.⁹ This perception is also consistent with the Health Belief Model,²² which suggests participants may take action when perceived benefits or external cues (for example, a study advertisement) prompt engagement, even if they did not view their methamphetamine use as problematic.

In Australia, evidence-based treatment options are available across the methamphetamine use and harm spectrum,⁴ however there remains limited awareness of these options and a significant unmet treatment need.²³ Quinn et al²⁴ surveyed 255 people who used methamphetamine in Melbourne, Australia, about their access to treatment. Forty-one per cent of participants (N=105) were categorized as “service avoiders” (those who did not perceive a need for services or treatment). Service avoiders engaged in less risky patterns of methamphetamine use and experienced less methamphetamine-related harm than “service-inclined” participants, yet most reported financial and relationship/social problems in the previous six months. While an analysis of harms was not included here, providing information about methamphetamine-related harms and treatment options (across the spectrum of care, including harm reduction and early intervention) at the first step of accessing care may support a change in the perception of the need for care.

The second demand-side access determinant relevant to this study, the *ability to engage in care*, was highlighted in the participant data through themes of “beliefs about treatment”. Knowledge of health care options and self-management are key aspects of the ability to engage in care.¹¹ Some participants reported doubting whether treatment would be successful and had limited understanding of the available treatment options. For some, engaging in treatment involved the perceived need to isolate from their family, community, and workplace, with treatment often being viewed through the lens of stigma and marginalisation. Participants worried that entering treatment would lead to encountering stigma from others (eg, “it would be recorded somewhere against my name”), as well as internalized stigma and shame that impacted their willingness to seek care.

Strategies to address the limited understanding of treatment options available to people who use methamphetamine, in concert with increasing the availability of different treatment types, would ensure that care meets the needs of this population. This includes promoting and increasing awareness of treatment, as well as providing a range of options that enable them to seek care and support without needing to self-isolate or take considerable time off work.

Similarly, our third theme, the impact of stigma, highlighted how participants evaluated the acceptability of treatment options they perceived as stigmatising. Stigma about methamphetamine use is widespread in Australia²⁵ and is a known barrier to accessing care for people who use methamphetamine,^{9,25,26} associated with delays in help seeking and increased rates of withdrawal from treatment.²⁷ We mapped the impact of stigma to a supply-side dimension of access, acceptability,¹¹ being cultural and social factors influencing a person's decision to accept aspects of a service and judge its appropriateness to meet their needs. Acceptability was also identified as a factor influencing the initiation of treatment in a study of young adults with problematic substance use in Canada.²⁸ These participants identified a need for care but raised concerns that accessing treatment may bring unwanted consequences, such as stigmatising impacts on their work. Efforts to counter stigma, through public education campaigns that provide accurate, evidence-based information, have been recommended in previous research.²⁵ In addition, given the few studies focusing on barriers to care for people with methamphetamine use disorder, further research into identifying factors that influence acceptability, and the extent to which these can be mitigated to improve access to care is indicated.

Our findings build upon previous work undertaken through survey studies.^{10,29} Through qualitative analysis, we provide more nuanced perspectives of people who use methamphetamine. The participants in Kenny et al survey²⁹ also did not perceive their use as problematic, and reported an awareness of, but lack of confidence in, treatment options. The participants in the Kershaw et al study¹⁰ reported distrust in the healthcare system generally. Similarly, the participants in our study doubted that treatment would be effective.

Having confidence in treatment efficacy, and understanding potential benefits, as conceptualized in the Health Belief Model,²² may explain in part these findings. Within the concept of access to care, little research has been undertaken relating access to the Health Belief Model. However, participants in a residential substance use disorder treatment program in the United States were interviewed regarding their motivations for treatment *engagement*.³⁰ In that study, 30 participants in long-term recovery were interviewed about their substance use initiation, treatment engagement, recovery, and maintaining post-treatment abstinence. Participant data indicated that treatment engagement was motivated in part by their perception of the severity of their substance use disorder. Engagement in care is the final determinant of the Levesque et al model.¹¹ Further exploration of the Health Belief Model and its association with access to care for people seeking treatment for their methamphetamine use is recommended.

There are three main limitations to this study. First, participants were recruited to participate in a trial of an intervention, so the findings are not transferable across contexts and settings. Second, this qualitative study used convenience sampling, limiting representativeness. Third, while participants were asked about barriers they experienced prior to the intervention, the study's qualitative design was not focused on access to care but on participants' feedback about the intervention. Therefore, participant recall of experiences outside of the intervention may have been challenged, especially for those who had been using methamphetamine for many years and had not accessed care. In addition, the study relied on self-reported data, which may introduce recall or social desirability bias. However, the use of semi-structured interviews allowed for the gathering of participant perspectives beyond the confines of fixed response approaches such as surveys, providing more depth and breadth to our understanding of their experiences.

Our approach to analysis meant that the findings were reported around two determinants related to the "demand side" of the model, and one related to a "supply-side" dimension. Future research with service providers could further explore the "supply side", examining the determinants of approachability, availability and accommodation, affordability, and appropriateness. Our findings also did not go beyond the *ability to perceive* and the *ability to engage* demand side determinants. Future research could provide further understanding about the pragmatics of access, including the *ability to seek*, *ability to reach*, and *ability to pay*.

Conclusion

The experiences of people who use methamphetamine accessing care in this study were observed according to a framework describing the perceptions of the need for care, the ability to engage in care, and the acceptability of service providers. Stigma and beliefs about problematic use, and knowledge of treatment options dominated participants' experiences of access. Clear information about available treatment options, particularly to address fears of engaging in treatment that is viewed as stigmatising, are important considerations for policy makers and service providers.

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