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Delay among opioid users in seeking first addiction treatment

Retraso en el acceso al primer tratamiento para la adicción en usuarios de opiáceos

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Abstract

Early treatment seeking for opioid addiction is related to an increased chance of treatment success. New patients seeking treatment, and the time they take to seek it, have scarcely been described in Spain and Europe. The aim of the present study was to identify individual factors related to the delay in seeking treatment for opiate addiction for the first time. A cross-sectional study of opiate users admitted for the first time to treatment for addiction in public centers in the Community of Madrid between 2017-2019 ($n = 366$) was conducted. The time from the onset of consumption to treatment (TTT) was the dependent variable. A general descriptive analysis of users was performed, followed by a bivariate analysis after dividing the sample into two groups (TTT < 5 years and TTT $\geq$ 5 years). To identify those factors associated with an increase in TTT, a multivariate logistic regression analysis was performed. The main profile of the study population was: middle-aged, Spanish, unemployed, male, smoked heroin user. The median TTT was: 9.27 years for men and 4.75 for women. Factors associated with higher TTT were: > 49 years (OR: 5.87; 95%CI 1.73-20.00), unemployment (OR: 2.54; 95%CI 1.11-5.83), low educational level (OR: 2.18; 95%CI 1.04-4.59), homelessness (OR: 4.18; 95%CI 1.29-13.57), first use not at home (OR: 2.54; 95%CI 1.11-5.84) and HCV positive (OR: 2.97; 95%CI 1.00-8.82). Delays in seeking treatment are related to older users and lower sociocultural level. People at risk of social exclusion should be prioritized in interventions to facilitate their access to treatment services.

Keywords: opioids, heroin, treatment delay, new drug users, addiction

Resumen

La búsqueda temprana de tratamiento para la adicción a los opiáceos se relaciona con un aumento de las posibilidades de éxito en el mismo. Los nuevos pacientes que buscan este tratamiento, y el tiempo que tardan en demandarlo, han sido escasamente descritos en España y Europa. El objetivo del presente estudio es identificar los factores individuales relacionados con el retraso en acudir por primera vez a un tratamiento para la adicción a opiáceos. Se realizó un estudio transversal de consumidores de opiáceos admitidos por primera vez a tratamiento por adicción en centros públicos de la Comunidad de Madrid entre los años 2017-2019 ($n = 366$). Se estableció como variable dependiente el tiempo desde el inicio del consumo hasta el tratamiento (THT). Se realizó un análisis descriptivo general de los usuarios, seguido de un análisis bivalente tras dividir la muestra en dos grupos (THT < 5 años y THT $\geq$ 5 años). Para identificar aquellos factores asociados a un aumento en el THT se realizó un análisis de regresión logística multivariante. El perfil principal de la población de estudio fue: varón de mediana edad, español y desempleado que consume heroína por vía fumada. La mediana de THT fue: 9,27 años para varones y 4,75 para mujeres. Los factores que se asocian a un mayor THT fueron: > 49 años (OR: 5,87; IC95% 1,73-20,00), desempleo (OR: 2,54; IC95% 1,11-5,83), bajo nivel educativo (OR: 2,18; IC95% 1,04-4,59), no tener hogar (OR: 4,18; IC95% 1,29-13,57), primer consumo fuera del domicilio (OR: 2,54; IC95% 1,11-5,84) y VHC positivo (OR: 2,97; IC95% 1,00-8,82). El retraso en acudir a un tratamiento se relaciona con los usuarios de más edad y menor nivel sociocultural. Las personas en riesgo de exclusión social deben priorizarse en las intervenciones para facilitar su acceso a los servicios de tratamiento.

Palabras clave: opiáceos, heroína, retraso en tratamiento, nuevos usuarios, adicción

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At the end of the last century, the use of opioids (essentially heroin) represented a true epidemic throughout Europe, especially in Spain (de la Fuente et al., 2006). In this country, 10.1% of all deaths between 15 and 39 years of age in the early 1990s were attributed to heroin use (de la Fuente et al., 1995). There were two main causes: overdose and infections derived from parenteral use, especially HIV/AIDS (de la Fuente et al., 2003). Although consumption seems to have stabilized in recent decades (Cicero et al., 2014; Mur Sierra & Ortigosa Gómez, 2014; Observatorio Español de las Drogas y las Adicciones, 2022; Sánchez-Niubò et al., 2009; Sanvisens et al., 2014), the widespread increase in the use of opioid drugs (Salazar et al., 2020) makes it especially important to improve both the early detection systems of possible increases in use, as well as to improve the treatment and harm reduction systems for users. Needle exchange programs, changing from injecting to smoking, and the arrival of highly active antiretrovirals were factors which helped to reduce the morbidity and mortality rate drastically starting in the mid-1990s (Torrens et al., 2013). Nevertheless, it was starting treatment, especially treatment with opioid agonists, that was the key element for these users. It reduced overdoses and disease transmission (HIV, HBV, HCV) and improved the quality of life of users (Brugal et al., 2005; Torrens et al., 1999). However, many patients in need of treatment do not seek it, and when they do, they take a long time, which is related to a worse prognosis in the development of the disease (Molist et al., 2018). The causes that users point out as being barriers to seeking treatment range from their feeling of being able to deal with their use issues on their own, to the stigma associated with treatment and the distrust regarding its effectiveness or the lack of flexibility (Farhoudian et al., 2022; Hall et al., 2021; Mowbray et al., 2010). However, there are few studies (Larance et al., 2018) that attempt to determine the demographic or clinical factors linked to the delay in seeking treatment, and none in the European context. Knowing which predictors are related to the delay in seeking treatment would allow us to identify populations in which to prioritize interventions. The objective of this study is thus to identify the factors related to the delay in seeking treatment in new patients who use opioids.

Methods

Design, population and data collection

This is a cross-sectional study of all patients who requested treatment for opioid addiction for the first time in any of the public CAD/CAID centres (treating addictions and substance-dependent users) in the Community of Madrid during the years 2017, 2018 and 2019.

User information was extracted from data from the cumulative registry of drug addicts (CRDA) protocol. The

CRDA protocol is a questionnaire administered to every individual requesting treatment after the diagnosis of their addiction on their first visit to the centre.

The inclusion criteria in this study were being addicted to heroin and/or another opioid (ICD-10) and not having been previously treated in a CAD/CAID centre. The addiction diagnosis is made by the CAD/CAID doctor treating patients on reception. Of the 4,040 patients who sought treatment in the three years mentioned, 3,325 had opioid addiction as an ICD diagnosis. Of these 3,325, only 393 declared that this was their first treatment, and the main variable (TTT) was recorded for 366 of them, who therefore constituted the study population.

Design and variables

In the patients selected, considering the age of admission to treatment and the age of onset of use of the main drug, the dependent variable could be calculated: time elapsed from initial consumption to starting treatment (time to treatment, TTT).

After establishing that the distribution of this variable was non-normal, it was converted to a categorical variable, taking as a reference greater than or equal to, or less than 5 years of TTT. This figure has been used in previous articles in similar populations and healthcare contexts (Bargagli et al., 2006; Larance et al., 2018) and has been shown to be a point in time separating better and worse prognoses (Molist et al., 2018).

The independent variables analyzed were those collected in the CRDA on completion by the doctor taking the first visit of each user. These were 1) sociodemographic variables: sex, age, nationality (Spanish or foreign), employment status (in work or unemployed), place of residence (house/flat/apartment or absence of own home), living arrangements (with a partner and/or children, family of origin or alone), marital status (married/with a partner or single), presence/absence of children, referral source (voluntary, social-health referral or compulsory) and level of education (above or below secondary education); 2) variables related to substance use: main drug of use (heroin or other opioids), route of administration (parenteral or other), frequency of administration (daily or non-daily) and use of other drugs in the last 30 days (alcohol, cannabis, cocaine, other opioids, benzodiazepines and other stimulants); 3) characteristics related to the onset of use of the main substance: the person who provided it for the first time (family/partner, friends or others) and the place of first consumption (home or others). Finally, 4) clinical variables: serological status for HIV (negative, positive or unknown), HCV (negative, positive or unknown), HBV (non-immune, immune or unknown) and presence of sexually transmitted diseases (negative, positive or unknown).

Data analysis

A descriptive analysis of the sample was carried out to establish the general characteristics of the study population. With the aim of identifying the factors associated with a delay in seeking treatment for opioid addiction, a bivariate analysis was first performed, estimating the odds ratio (OR) and 95% confidence intervals (95% CI) with the χ^2 test of each of the variables previously described in the groups according to TTT. Those factors with a significance of less than 0.05 in the bivariate analysis were entered into a multivariate logistic regression model to determine the predictors of delay in entering treatment. All analyses were performed with the SPSS 25 program.

Results

The study population's baseline characteristics were: 80.6% men, 43.4% aged between 36 and 49 years, with an average age of 39 (SD: 10.6 years), 33.9% foreigners, 73.8% unemployed, and 50.1% had completed at least secondary education. Regarding marital status, 28.7% were married or had a partner and 18.9% had a child (Table 1). In terms of substance use, heroin was the main opioid for 83.3%. In 77.1% of cases, the main opioid was used daily. Smoking was the most common route of administration (69.7%), with the parenteral route used in 10.5% of cases. In addition to opioids, 42.1% took more than one substance, with cocaine standing out (29.5%). In relation to the onset of use, 69.4% obtained the drug for the first time through friends and only 7.4% obtained it through family members or a partner. First use was in places other than home for 85% (Table 2). Those who did not know their serological status in relation to HIV and HCV comprised 46.7% and 45.6% of the sample, respectively, with 4.4% being positive for HIV and 12% for HCV (Table 3).

Regarding the dependent variable, 57.9% entered treatment 5 or more years after starting to use, with the

mean and median TTT being 11.8 years (SD: 11.4) and 8, respectively (Figure 1). Men had a mean and median of 12.7 years (SD: 11.8) and 9.21, while women had figures of less than 8.1 years (SD: 8.2) and 4.75, respectively.

According to the bivariate analysis, the factors correlating with a greater delay in TTT were: being a man (OR=1.66; 95% CI 0.98-2.79), being older, with an OR of those over 49 years of age versus those under 35 of 4.61 (95% CI 2.31-9.20), and being a native of Spain versus a foreigner (OR=1.56 (95% CI 1.00-2.41)). Unemployment, low level of education, lack of one's own home and living alone increased TTT by 1.9, 2.8, 3.25 and 4.44 times, respectively (95% CI 1.18-3.05; 95% CI 1.79-4.37; 95% CI 1.81-5.83; 95% CI 2.24-8.81) (Table 1).

Both non-daily use of opioids and the heroin as the main opioid were related to higher TTT (OR=1.69; 95% CI 1.01-2.83 and OR= 2.10; 95% CI 1.21- 3.67, respectively). The parenteral route also affected the delay (OR= 2.6; 95% CI 1.19-5.56) (Table 2).

Finally, in the bivariate analysis, positive HIV serology was linked to greater delay (OR=12.4; 95% CI 1.60-95.86), as was HCV positivity (OR=4.83; 95% CI % 2.03-11.49) (Table 3).

After multivariate logistic regression models were run, age was linked to delay. In the group of users over 49 years of age, there was a 5.87 times (95% CI 1.73-20.00) higher risk of seeking attention later compared to those under 35 years of age. A direct relationship was established between delay in seeking help and being out of work (OR: 2.54; 95% CI 1.11-5.83), the lack of education above primary level (OR: 2.18; 95% CI 1.04 - 4.59) and the lack of one's own home (OR: 4.18; 95% CI 1.29-13.57). Using the opioid in a place other than home also turned out to be decisive, with a 2.54 times higher risk (95% CI 1.11-5.84), as was HCV positivity (OR: 2.97; 95% CI % 1.00-8.82).

Table 1
Sociodemographic characteristics and years from onset of opioid use to treatment (TTT)

	Total		TTT ≥5 years		TTT <5 years		OR (95% CI)
	n	%	n	%	n	%	
Sex							
Female	71	19.4	34	47.9	37	52.1	1
Male	295	80.6	178	60.3	117	39.7	1.66* (0.98 - 2.79)
Age							
≤ 35	142	38.8	66	46.5	76	53.5	1
36-49	159	43.4	94	59.1	65	40.9	1.67*** (1.06 - 2.63)
≥ 50	65	17.8	52	80.0	13	20.0	4.61*** (2.31 - 9.20)
Country of birth							
Foreign	123	33.9	62	50.4	61	49.6	1
Spanish	240	66.1	147	61.3	93	38.8	1.56** (1.00 - 2.41)
Employment							
In work	96	26.2	44	45.8	52	54.2	1
Unemployed	261	73.8	161	61.7	100	38.3	1.9** (1.18 - 3.05)
Place of residence							
House, flat or apartment	286	78.1	149	52.1	137	47.9	1
Institutions or on the street	77	21	60	77.9	17	22.1	3.25*** (1.81 - 5.83)
Living arrangements							
Partner and/or children	126	35.3	58	46.0	68	54.0	1
Family of origin	102	28.6	52	51.0	50	49.0	1.22*** (0.72 - 2.10)
Single	67	18.8	53	79.1	14	20.9	4.44*** (2.24 - 8.81)
Other	62	17.4	42	67.7	20	32.3	2.46*** (1.30 - 4.66)
Marital status							
Married, unmarried partner	103	28.7	52	50.5	51	49.5	1
Other/unknown	256	71.3	156	60.9	100	39.1	1.53* (0.97 - 2.43)
Children							
No	297	81.1	169	56.9	128	43.1	1
Yes	69	18.9	43	62.3	26	37.7	1.25 (0.73 - 2.15)
Referral source							
Voluntary	212	59.4	121	57.1	91	43.1	1
Social-health services	86	24.1	50	58.1	36	41.9	1.10 (0.63 - 1.74)
Compulsory	59	16.5	33	55.9	26	44.1	1.00 (0.53 - 1.71)
Level of education attained							
Secondary or higher	172	50.1	81	47.1	91	52.9	1
Primary or lower	171	49.9	122	71.3	49	28.7	2.80*** (1.79 - 4.37)

*p<0.10; **p<0.05; ***p<0.01.

Table 2
Substance use and years from onset of opioid use to treatment (TTT)

	Total		TTT ≥5 years		TTT <5 years		OR (95% CI)
	n	%	n	%	n	%	
Main opioid							
Other opioid	61	16.7	26	42.6	35	57.4	1
Heroin	305	83.3	186	61.0	119	39.0	2.10*** (1.21 - 3.67)
Frequency of main opioid use							
Every day	276	77.1	151	54.7	125	45.3	1
Not every day	82	22.9	55	67.1	27	32.9	1.69** (1.01 - 2.83)
Parenteral use ¹							
No	325	89.5	180	55.4	145	44.6	1
Yes	38	10.5	29	76.3	9	23.7	2.60** (1.19 - 5.66)
First use facilitated by							
Family/partner	26	7.4	15	57.7	11	42.3	1
Friends	243	69.4	152	62.6	91	37.4	1.23 (0.54 - 2.78)
Others	81	23.1	36	44.4	45	55.6	0.59 (0.24 - 1.43)
Place of first use							
Home	50	15	19	38.0	31	62.0	1
Other	283	85	175	61.8	108	38.2	2.64** (1.42 - 4.99)
Use of other drugs							
No	212	57.9	120	56.6	92	43.4	1
Yes	154	42.1	92	59.7	62	40.3	1.14 (0.75 - 1.73)
Use of other drugs ²							
Cocaine							
No	224	61.2	128	57.1	96	42.9	1
Yes	142	38.8	84	59.2	58	40.8	1.10 (0.71 - 1.66)
Cannabis							
Yes	28	7.7	14	50.0	14	50.0	1
No	338	92.3	198	58.6	140	41.4	1.41 (0.65 - 3.06)
Alcohol							
No	343	93.7	194	56.6	149	43.4	1
Yes	23	6.3	18	78.3	5	21.7	2.77** (1.00 - 7.62)
Benzodiazepines							
No	357	97.5	204	57.1	153	42.9	1
Yes	9	2.5	8	88.9	1	11.1	6.00* (0.74 - 48.47)

*p<0.10; **p<0.05; ***p<0.01. 1: For more detail on these variables, see Annex 1. 2: last 30 days.

Table 3
Health status and years from the onset of opioid use to treatment (TTT)

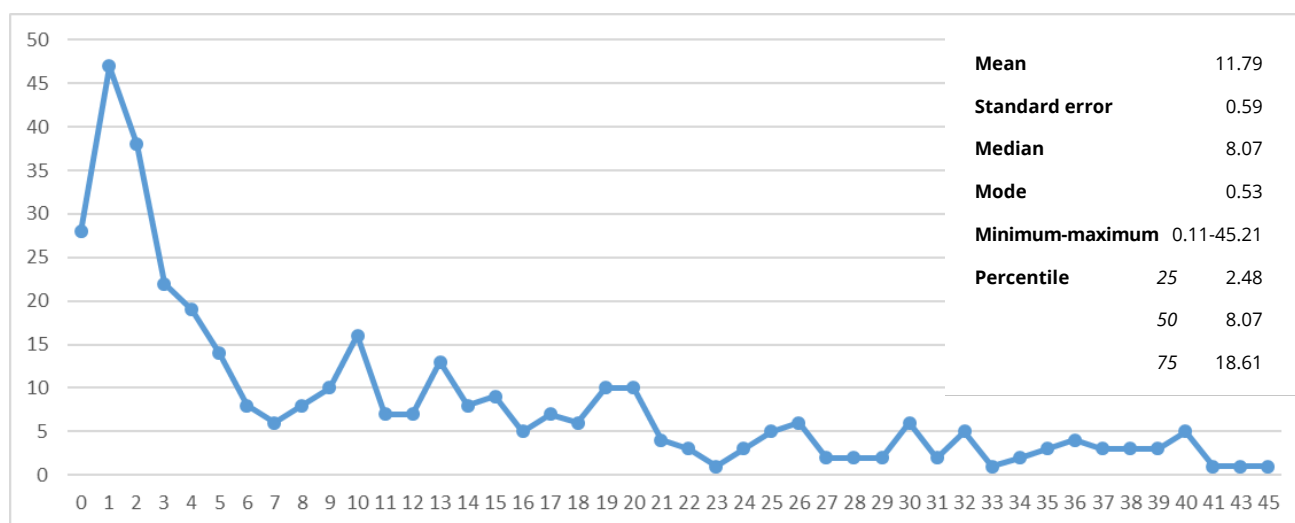
	Total		TTT ≥5 years		TTT <5 years		OR (95% CI)
	n	%	n	%	n	%	
HIV							
Negative	179	48.9	98	54.7	81	45.3	1
Positive	16	4.4	15	93.8	1	6.3	12.4*** (1.60 - 95.86)
Unknown	171	46.7	99	57.9	72	42.1	1.14*** (0.75 - 1.74)
HCV							
Negative	155	42.3	81	52.3	74	47.7	1
Positive	44	12	37	84.1	7	15.9	4.83*** (2.03 - 11.49)
Unknown	167	45.6	94	56.3	73	43.7	1.18*** (0.76 - 1.83)
HBV							
Not immune	86	23.5	46	53.5	40	46.5	1
Immune	60	16.4	35	58.3	25	41.7	1.22 (0.63 - 2.37)
Unknown	220	60.1	131	59.5	89	40.5	1.28 (0.78 - 2.11)
STD							
No	191	52.2	109	57.1	82	42.9	1
Yes	4	1.1	3	75.0	1	25.0	2.26 (0.23 - 22.10)
Unknown	171	46.7	100	58.5	71	41.5	1.10 (0.70 - 1.61)

*p<0.10; **p<0.05; ***p<0.01.

Table 4
Factors related to delay in entering treatment

Variables	Time from the onset of opioid use to treatment ≥ 5 years					
	β	OR	OR (95% CI)		p	
Age						
Age < 35 years	Ref.					
Age 35-49 years	-0.023	0.977	0.439	—	2.172	0.954
Age > 49 years	1.770	5.872	1.725	—	19.995	0.005
Hepatitis C virus positive						
Negative	Ref.					
Positive	1.089	2.970	1.000	—	8.820	0.050
Place of first use						
Home	Ref.					
Other	0.933	2.543	1.108	—	5.833	0.028
Place of residence						
House, flat or apartment	Ref.					
Institutions or on the street	1.430	4.179	1.287	—	13.566	0.017
Level of studies attained						
Secondary or higher	Ref.					
Primary or lower	0.780	2.182	1.039	—	4.586	0.039
Employment						
In work	Ref.					
Unemployed	0.933	2.543	1.108	—	5.833	0.028

Figure 1
Number of patients (y) by years from onset of use to treatment (X) (N = 366)



Discussion

This is the first study to examine at a European level the sociodemographic predictors linked to a longer period of time from the beginning of opioid use to seeking treatment in addicts to this substance. Among them, older age, unemployment, not having a home and having a low educational level stand out.

In comparison to other user studies in this context (Puigdollers et al., 2004; Sánchez-Carbonell & Seus, 2000; Sanvisens et al., 2014), the present research yielded a novel profile by updating it to 2019 on the one hand, and by describing opioid addicts seeking treatment for the first time on the other. The average profile of this sample is a 39-year-old male, without children, who lives in his own home and who is unemployed when he comes to the centre. Although the population group is “new treatment seekers”, this pattern mostly overlaps with what has been described in previous studies. Being male, with a high rate of unemployment and low educational level have predominated in all studies (de la Fuente et al., 2005; Puigdollers et al., 2004; Sánchez-Carbonell & Seus, 2000; Sanvisens et al., 2014). We have new users, but beyond being somewhat younger than those who were already in treatment, it does not seem that the profile has changed a great deal up to 2019.

Apart from characterizing the population in question, the main findings of this study focus on the time from the onset of use to the time when treatment is first sought (TTT), a variable that requires discussion from the start. Studying TTT is an approximation to the study of treatment delay in which it is assumed that there is a direct population-based link between TTT and the time from the start of addiction to the start of treatment (Degenhardt et al., 2019; Kessler et al., 2001; Larance

et al., 2018). Despite some heterogeneity in studies on the life trajectories of users (Hall et al., 2021; Kessler et al., 2001), it has been described that an average of three years elapses from first use to addiction, and between five (Bargagli et al., 2006; Darke, 2011, Shand et al., 2011) and eight years (Best et al., 2008) to the start of treatment. It is also relevant to underline that the entire population of the present study attended treatment. It does not have a control group of people who did not attend; it compares those who sought help early to those who went late, a subject barely studied until now (Larance et al., 2018). In fact, only one previous Spanish study could be found which determined the time between the onset of use and start of treatment (Flórez et al., 2015) in first-time patients. While that study’s average of 10.9 years is very similar to ours, their objectives differ in not focusing on determining the associated factors.

One of the key findings of this study is that women sought treatment almost five years earlier than men. At a descriptive level, the finding that women had lower TTT corresponds to previous studies (Darke, 2011). This ‘advance’ in seeking treatment has been explained in different ways. One of them is that there are greater social expectations for women (the double standard hypothesis (Marks & Clark, 2018)) that lead to greater stigma about their addiction and the resulting earlier search for treatment. Another is the so-called telescoping effect (Marks & Clark, 2018; Ridenour et al., 2005), the acceleration in the addiction process from first use. However, when the multivariate analysis was performed in our study, gender disappeared. That is, the clear advance in women’s TTT is explained by factors other than gender. The factors of age, housing, education or unemployment are what seem to condition this reality.

While we cannot generalize much more than a context of universal healthcare and education, this is a striking result, although one that has been described before in different environments (Kessler et al., 2001; Larance et al., 2018; Stoltman et al., 2015). It seems that, indeed, women go to treatment earlier, but for reasons of differential characteristics compared to men.

Something similar was detected with the variable serological HIV status. It seems that being HIV+ is related to higher TTT, and yet it disappeared in the multivariate analysis. HIV infection was closely related to parenteral use, which is currently in very minor use both in this sample and in Spain (Observatorio Español de las Drogas y las Adicciones, 2022). We can thus surmise that HIV status is more a marker of older age (which does appear related to higher TTT) than a factor determining the delay in seeking treatment. Furthermore, HIV patients who have good adherence to antiretrovirals have good quality of life (González-Álvarez et al., 2019), and all our patients are of course in contact with the health services. However, it could be the other way around: greater delay in treatment facilitates the continuation of risky practices that entail the transmission of HIV.

In connection with age as a risk factor, we must highlight the possibility of an important cohort effect in these studies. Starting to use in the 1990s or in 2010 conditions many of the subsequent characteristics of use, as well as possible related infections. Our study indicates that greater age means greater TTT delay. It shows us on which population to focus interventions, but it also tells us that certain generations of users may have differential characteristics on the basis of the time they starting using (Degenhardt et al., 2019). Beyond the possible cohort effect, previous studies have described that the youngest patients seek treatment the most (Kessler et al., 2001). The present study offers a further nuance to this result: it is not just that they look for it more, but rather that they look for it sooner.

In contrast to HIV, there was a relationship between delay in seeking treatment and positive hepatitis C. It may be thought that this result is linked to the fact that the infection is now curable: it is therefore the patients who have not been treated for it who have been more distant from healthcare services or have been reinfected (Valencia et al., 2019). It could be interpreted as them delaying treatment for their addiction in the same way that they did for hepatitis C, which is available and free in Spain. It may be that this infection is a marker of worse care follow-up or greater separation from society (Vallejo et al., 2015). In any case, in this study, seropositivity to hepatitis C is more indicative than HIV as a marker of delay.

It is not easy to interpret how first use outside the home is related to greater TTT. There are articles that discuss the places where heroin is first injected (Day et al., 2005;

Roy et al., 2002), but there are no references to first non-injected use. It could indicate that use in environments with greater normalization delays the demand for help. It is precisely these environments in which structural or contextual factors would also contribute to making access to treatment difficult (Farhoudian et al., 2022). Therefore, such first use outside the home could be a marker of the environment in which users live, but it is a hypothesis that must be confirmed by further research.

Our analyses have shown that having a low educational level, being unemployed and not having a home are independent markers of delay in seeking out centres, just as they were for not going to them in other studies (Blanco et al., 2015). These variables all reflect a situation of social exclusion. In this case, the relevance of social determinants on the health of the population, such as access to health services, is once again highlighted, both before and after the COVID-19 crisis (Bonifonte & Garcia, 2022; López-Pelayo et al., 2020).

There are several limitations of this study. In addition to what has already been said about the meaning of TTT, the age of onset of use was self-reported, i.e., not exempt from possible memory biases, although there does not seem to be any other way to find out the age of first use. Secondly, it is a cross-sectional study, which therefore limits causal relationships. Thirdly, caution must be taken when generalizing from the results obtained. The scope of this study is patients undergoing treatment in public centres, so its results cannot be generalized to private settings. However, Madrid is a region in which access to treatment is both widely available and predominantly used, thanks to a 'diversified public healthcare network' (Subdirección General de Adicciones, 2017). Finally, perhaps the most relevant limitation is that the data originated in a registry used as an epidemiological indicator and therefore does not contain all the variables that could have been of interest.

The present results point out those factors that were associated with a delay in attending treatment. As a common element, these seem to reflect a situation of marginalization or social degradation, most likely related to a certain style of long-term heroin use, while at the same time serving to identify a group at high risk of delay in seeking treatment. These findings suggest the need to improve active case search strategies, as well as the analysis of access barriers, especially in disadvantaged neighbourhoods and environments. This is a time of uncertainty given the increase in the use of medicinal opioids (Salazar et al., 2020) and the fear of a possible transfer to an increase in addictions. This is why healthcare services must remain extremely accessible and have the fewest possible barriers, so that patients may be cared for and, at the same time, possible increases in their number may be detected.

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Conflict of interests

The authors declare no conflict of interests.

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Annex 1. Development of variables related to substance use

	Total		Use ≥5		Use <5		p
	n	%	n	%	n	%	
Opioid administration							
Parenteral	38	10.5	29	76.3	9	23.7	Ref.
Oral	46	12.7	21	45.7	25	54.3	0.002
Smoked	253	69.7	139	54.9	114	45.1	0.006
Intranasal	23	6.3	18	78.3	5	21.7	0.560
Other	3	0.8	2	66.7	1	33.3	0.578
Use of other substances (last 30 days)							
No	212	57.9	120	56.6	92	43.4	Ref.
Alcohol	13	3.6	10	76.9	3	23.1	0.123
Cannabis	6	1.6	3	50	3	50	0.530
Cocaine	108	29.5	60	55.6	48	44.4	0.475
Other opioids	24	6.6	18	75	6	25	0.042
Benzodiazepines	2	0.5	1	50	1	50	0.681
Other stimulants	1	0.3	0	0	1	100	0.436

