Psychiatr. Pol. 2017; 51(1): 125–138
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/60345

Barriers in the access to alcohol treatment in outpatient clinics in urban and rural community

Łukasz Wieczorek

Department of Alcoholism and Polydrug Use Studies, Institute of Psychiatry and Neurology

Summary

Aim. The aim of the study was identification of the barriers making it notably more challenging to access clinics in urban and rural communities.

Material and method. The method, which was used in this study adopts the qualitative research perspective. The research tool was an interview with a standardized list of desired information. The interviews were conducted with alcohol dependent patients and therapists. 64 interviews were performed in two outpatient clinics located in Warsaw, and in rural area.

Results. Respondents identified similar barriers for the clinics located in Warsaw and in the rural community. Those were: shame associated with seeking help, waiting time for stationary support, meeting intensity, and general clinic condition. Barriers identified by respondents from Warsaw were associated with long waiting time for outpatient treatment and individual appointment, therapeutic offer excluding deaf and mentally ill individuals from the therapy, and unattractive program requiring complete abstinence. Barriers in access to treatment spotted by the respondents from the rural community related to the lack of anonymity of treatment associated with too low number of clinics in the district, lack of choice in terms of preferred facility, commutation time and costs, as well as no inter-institutional cooperation.

Conclusions. The barriers identified in the study were similar to the ones specified in the research conducted in Poland in the 1990s, and at the end of first decade of 21st century. Barriers were psychological in character and had the form of internal withdrawal and anxiety to start treatment. Certain structural barriers were indicated as well.

Key words: alcohol dependence, alcohol treatment, outpatient clinic

Introduction

Social institutions serve the function of organizing social life of members of a given society, facilitating the maintenance of proper social order of the group they are the

The study was not sponsored.

representatives of. Moreover, they also fulfill the needs of both separate individuals and the group as such [1, 2].

Alcohol treatment in Poland is offered within the scope of services provided by psychiatric care facilities. Addiction treatment facilities may be further divided into three groups basing on the structure of the psychiatric sector: outpatient clinics, intermediary facilities (day-care centers), and inpatient (stationary) centers. Outpatient treatment covers both psychiatric clinics and facilities specializing in treating alcohol, as well as other psychoactive substances addictions. Intermediary organizations are mainly day-care wards and hostels. When it comes to stationary facilities, one should predominantly indicate detoxification centers, rehab wards in general and psychiatric hospitals, as well as self-sufficient alcoholism treating centers [3, 4].

Major tasks the achievement of which is attempted by alcohol treatment-oriented undertakings are: increasing ability to maintain abstinence, solving personal problems of the patients, promoting healthy lifestyle, as well as improving family relations and somatic health condition [5].

Most frequent therapy methods are psychological education, group therapy, as well as problem solving and prevention-oriented training sessions in the sobering up process. The aforementioned methods almost completely overshadow pharmacological treatment which is currently limited to detoxification alone [6]. The period of time required for a therapy to be successful (i.e., to increase ability to maintain abstinence) circulates around 18–24 months. The dominant form of therapy, mainly in inpatient and outpatient facilities, is group therapy [5]. Aside from the professional treatment institutions, facilities providing support for alcohol dependence are Abstinence Clubs and Alcoholics Anonymous.

Addiction treatment sector incorporates approximately 700 units. 500 of them are outpatient clinics, 90 of them – day-care wards, and about 100 – inpatient clinics. Moreover, there are almost 60 detoxification wards nationwide [4]. More than three thousand professionals are employed in the addiction treatment sector. Two-thirds of them are therapists. Over 90% of the said specialists graduated from secondary or higher education facilities. The highest level of education is observed among outpatient clinics employees, where 80% of the workers has a higher education completed. Among therapists, the individuals with psychological education are predominant [3, 7], even though in the mid-90s the professionals employed in the addiction treatment sector mainly had medical education as they were, for example, nurses or doctors [8].

The availability of alcohol addiction treatment is of significant importance not only with regard to the limitation of the scope of the problem, but also in terms of the nullification of social and health-oriented outcomes associated with harmful drinking. While conducting the research on the addiction treatment system at the beginning of the 90s, its condition was assessed poorly. At that time, the said system was improperly organized, rather non-flexible, not adjusted to the needs of the patients, and centrally funded, causing uneconomic management [9, 10]. Treatment availability was also affected by uneven distribution of proper facilities, especially in rural areas [9]. At the beginning of the 90s, the infrastructure of stationary treatment units was poorly developed. Not every province had all-time addiction treatment as a part of

its disposal. Working hours of the outpatient clinics severely limited the access to the said institutions. Approximately 90% of the said clinics was open 4–5 days a week, from which 30% of the units could be accessed before midday only. The remaining facilities were open 1 to 3 times a week [11]. According to the analyses conducted in 2011 by the State Agency for Prevention of Alcohol-Related Problems (PARPA), waiting time in the case of all-time clinics was several weeks. It was even longer for the individuals with the compulsory treatment order. In over 30% of the outpatient clinics, the treatment initiation was preceded by a relatively long waiting period [12].

The outcomes of the surveys on the improvement of the access to treatment for alcohol and drug dependence individuals (IATPAD Project) showed that there was a number of barriers associated with therapy organization (narrowed-down treatment offer, insufficient support, improper working hours of the designated institutions, no treatment-related information provided for the patients, bureaucracy), as well as with social and cultural factors that in combination influenced the attitude of the patients to therapy [13]. Even though every year the number of addiction treatment units increases, the newly created facilities are established in urban areas, where therapeutic institutions or organizations have been already operating. Therefore, the treatment offer in rural areas and in smaller communes is significantly limited. What is more, the indicated state of affairs does not improve together with the increase in number of available care-oriented units. Due to the lower availability of treatment in outpatient clinics (lower number of such units, no properly qualified personnel, commutation-related problems such as distance, travel duration, or costs), the citizens of villages and small towns are rather inclined to take advantage of inpatient clinics [12].

Improved access to treatment directly translates into the better utilization of resources offered by the system, as well as it creates the participation possibilities for the patients who have not been granted the chance or have not been willing to take part in such care-related undertakings. A notable number of individuals decide not to use the offered support due to the encountered barriers on their way to treatment [14]. Thanks to their elimination, more people with alcohol-related problems may feel included and granted the chance to take advantage of the prepared offer while at the same time limiting severe social and health-oriented damages caused by harmful drinking. The survey discussed in the article aimed at the identification of the barriers making it notable more challenging to access clinics in urban and rural communities:

Two main research questions were formulated:

1. What treatment-preventing barriers are identified by the addicted individuals and therapists?
2. What are the differences between limitations in urban and rural areas?

Material and method

The research took advantage of the qualitative method, making it possible to take into account the point of view of the respondents while assessing certain phenomena. Qualitative techniques were predominantly based on personal experiences of the examined individuals through which the person shared the information with the researcher.

The qualitative analysis methods showed important matters in the local context, allowing for the free exchange of thoughts between the researcher and the respondent.

Place of research

The survey was conducted in two outpatient clinics situated in two localities differing in terms of size and the number of citizens. Within the borders of Warsaw, there were 22 outpatient clinics available for the patients. The one I had chosen for my examinations was situated in one of the biggest districts of the city. The second one was located in a county town in which the number of inhabitants circulated around 20 thousand people. It was the only clinic in the district being the place of residence for approximately 80 thousand people.

Sample selection

Respondents had been chosen in a purposeful manner. The aim of such selection was to choose only such respondents who would, in the opinion of the researcher, provide the most accurate and valuable pieces of information with regard to the assumptions of the research. The researcher had chosen the respondents basing on the knowledge of the examined phenomenon [15]. In the case of the conducted study, the sample consisted of alcohol dependence who had started therapy in one of the clinics, as well as therapists employed therein. Such a choice of analyzed individuals allowed for obtaining crucial data from two different sources, facilitating the maximization of the theoretical benefits of the utilized research method [16]. The inclusion criterion for the patients was the fact of being treated in the outpatient clinic and for the therapists – treating their patients actively. 64 interviews were performed. Fifty of them were done with the patients (25 interviews per locality) and 14 with the therapists (7 interviews per locality).

Research tools

While conducting the research, two interviewing patters were utilized: one for the patients and one for the therapists. The patients were asked about the motivations behind choosing the given clinic, difficulties with seeking and receiving help, beneficial solutions in access to the treatment, as well as recommendations concerning the improvement of service availability. The therapists were asked about the difficulties that the individuals starting treatment had to encounter, as well as the solutions that would make the access to treatment easier. Similarly to the patient scenario, they were also asked about service availability-related recommendations.

Process of the study and data analysis

The study was conducted since June 2010 to the end of May 2011. The proper research was followed by a short pilot study (4 interviews with therapists employed

at the Warsaw clinic and 9 interviews with patients from the same centre), after which the instructions to the interviews were verified. Interviews from the pilot survey were included to the study material.

The research was anonymous, opinion of the respondents were denoted only by a number, personal data were not collected. The interviews were recorded on a voice recorder and then transcribed. After that records were deleted.

Each interview was analyzed separately. The beginning of the data analysis was followed by reading whole interview and making notes on the margin which were the basis for establishing codes and categories. For this purpose the open coding technique was used by assigning codes to the logical statements of the respondents (sentences, paragraphs).Then selective coding was made, limiting codes to the amount that was interesting from the perspective of the goals of the study. When interesting statements were identified, codes were aggregated into thematic categories which were assigned to the broader categories – dimensions. Coding and data analysis was made manually, without using software.

Results

Barriers in the access to treatment were psychological (internal) and structural in nature. The latter was associated with the organization of the therapy, widely understood infrastructure, personnel, and therapeutic program.

Psychological barriers

In the opinion of therapists working in two examined units, the feeling of shame was the most common inhibiting factor making the initiation of the therapy more difficult. The addicted patients were frequently ashamed of their illness and the risk of being somehow associated with the facility. They cared not to be seen in a close proximity to the unit. Visit in such a place was humiliating for an alcohol dependent persons: "There is a kind of shame, of unwillingness to admit that one is sick and where he or she has been seeking treatment". (T7.K.S.[1]); "Visit in an outpatient clinic is associated with an unimaginable shame and humiliation" (T5.M.W.).

Patients being treated in a clinic located in a rural community were afraid of the lack of anonymousness of the treatment. In their opinion, one facility in the district town was not the warranty of intimacy and confidentiality on the part of the other patients. While undergoing the treatment, the patients were afraid that some aspects of their lives might not be treated as private by other addicted individuals: "I have been unable to speak my mind freely there [at the clinic – Ł.W.]. Well, it might not have been inability in the strict sense of the word. I have been afraid that patients visiting the place once have been listened to. But if I told the other patients everything, I might have become the talk of the town" (P14.M.S.).

[1] The method of coding: P – patient; T – therapist; X – number of the interview; M – male; K – female; W – Warsaw; S – local community

According to therapists, addicted people were ashamed of starting treatment, as they did not want to create any link between them and the care facility. Professionals from both Warsaw and a rural community noticed the feeling of humiliation in the patients enrolling for the therapy. From the point of view of the patients from the small-sized locality, accepting therapy was associated with the loss of anonymity. The said respondents were afraid that the intimate details concerning their lives might be disclosed to other citizens.

Structural barriers

The group of structural barriers incorporates: geographical location of the facility, duration and costs of commutation to the facility, therapy organization, treatment offer, waiting time, general conditions of the facility, as well as the lack of institutional cooperation.

Geographical location of the facility, duration and costs of commutation to the facility

Structural barriers that are inseparably associated with the geographical localization of the treatment facility were mainly noticed by the patients who had been treated in the rural community. In the district, there was only one treatment unit and this fact greatly affected the availability of alcohol treatment: "There is no other unit here" (P10.M.S.). "It seems that it is the only clinic, the only unit in the district" (T1.M.S.). In the large city, where the number of outpatient clinics and their branches was notably higher, the identified factor was not considered in terms of limiting treatment opportunities.

For some respondents from rural community, the closest treatment facility was located several kilometers away from their place of permanent residence: "There is the closest unit in Poland. (…) 20 km. (...) It is quite a distance" (P25.M.S.).

The geographical localization of the clinic or other treatment-related unit was inevitably associated with other barriers making it more challenging for the patients from the rural community to receive proper support, such as the duration of travel and the costs of commutation. They had to spend a lot of time to reach the place. Getting to the facility frequently took more than an hour, which was way too long in the opinion of the examined individuals: "How do I get to Ciechanow? It's thirty-something kilometers away. Warsaw is even further away. There are only fifteen kilometers to reach this facility. But I need to travel more than an hour. It takes an hour and a half to get to my house, leave here, take my bike and travel to my house. And it is only one way" (P20.K.S.).

The therapists stated that the cost of traveling between the place of residence and the treatment facility might be a burden for the patients and it might discourage the said individuals from starting or prolonging treatment. Traveling associated with the therapy on daily basis was costly. What is more, some participants of the study did not have these costs refunded by the communal authorities: "It is one of the reasons. They tend to say: Miss, I am not going to commute here as I have no funds to do so. Patients visiting the day-care center everyday must cover tremendous travel expenses" (T2.K.S.).

Barriers related to the geographical location of the treatment facility, as well as the duration and costs of reaching the place were identified by the patients from the rural community only as they had access to a single unit in the whole district. Therefore, the addicted individuals from the area had no choice as to which healthcare center to choose. A notable distance of the said facility from the place of residence of the patient generates additional costs which might be burdensome for less well-off people. Additionally, the time that have to be spent to reach the facility (in some cases – the necessity to travel several kilometers) make the respondents unwilling to visit the facility.

Organization of therapy

The utilized therapeutic program is too intensive for respondents. Both patients and therapists are of that opinion. The perspective of group meetings taking place few times a week might be problematic for the individuals starting therapy and might additionally discourage them from its continuation, especially when the presence is virtually obligatory. "I also see the attitude of other people, such as my friends – they are willing to start the therapy, but after being informed that the sessions are organized three times a week they say that they simply do not have enough time. They are immediately rejecting the offer stating that the period of time to be spent on meetings is too long" (P7.M.W.).

Days and hours of meetings are scheduled in advance and the patients are unable to adjust them to their own timetable. If the patients work full-time, there might be certain problems with regular and full participation. Therapeutic sessions frequently take place on working days, excluding Saturdays and Sundays. On the other hand, a number of patients would be glad to participate in the meetings organized during the weekends. *"Work is also a problem, as some patients work on shifts, even those managing their own households. They commute to Nowy Dwor, Warsaw, or Lomianki – in some cases they work on three shifts and are unable to participate. Some clients work from 7 A.M. to 6 P.M. and the presence during group meetings is virtually impossible" (T5.K.S.).*

The duration of the therapy (estimated to be two years) might also be a barrier limiting the access to the offered care. People who had been already undergoing treatment were familiar with the necessity to make such a devotion beforehand. Information about two years of treatment might, however, discourage some. The failure to take into account the needs of the patients in terms of therapeutic meetings organization eliminates those who are unable to visit the unit on given dates from the group treatment. Professional work, as well as other chores might interfere with regular meetings and in consequence – lead to discontinuation of the treatment. Lack of meetings organized during the weekends limits the availability of treatment for those who could attend the meetings then.

Treatment offer

The surveyed individuals also indicated barriers directly related to the treatment offer. Patients from the clinic in Warsaw claimed that the therapeutic program was

simply old-fashioned. It had not been modified for many years and it lacked a number of newly explored facts concerning the addiction. They stated that the provided pieces of information were not attractive, and the therapists failed to consider new therapeutic approaches and treatment techniques.

In the outpatient clinic are treated the individuals the major health problem of whom is the addiction to alcohol. Nevertheless, according to the therapists working in the facility located in Warsaw, heavy drinkers with mental problems and deaf ones experience limited availability of required support. Deaf individuals are unable to fully participate in therapy, as there are not enough professionals using sign language. "They have not much to offer for deaf-mute people, for example. There may be some specialists using the sign language, but there are not many of them (…) They know that their services are not required" (T1.K.W.).

No available offer for the aforementioned addicted individuals lead to the situation where they cannot take advantage of the treatment or can benefit from it only partially. Limited availability of the services for deaf and mentally challenged individuals marginalizes the representatives of the discussed groups in terms of addiction treatment.

Other barriers resulting from the therapeutic program are its assumptions, especially the necessity to maintain continuous abstinence. It is required from the very beginning of the therapy and constitutes one of the requirements for its continuation. The said problem is identified by the therapists from the clinic in Warsaw. In their opinion, the aforementioned requirement disqualifies the alcoholics who do not want to stop drinking from the very start of the treatment: "In its assumptions, the method excludes individuals unwilling to stop drinking (…). The traditional program, at least at the very beginning, is oriented towards complete abstinence. One must take into account the fact that there are people who do not want or simply cannot stop drinking" (T5.M.W.).

The said obligation directly translates into the inability of alcohol intoxicated individuals to take part in the therapy. Drunken patients are sent away, even if they clearly express the wish to have support provided to them.

The complete abstinence assumption made it impossible to incorporate controlled drinking education into the therapeutic program even though the therapists had observed that there had been the need for such an approach. Responsible drinking education would possibly encourage some patients to start the therapy. "In the case of at least some of alcohol addicts, it is possible to revert to drinking moderately, in a controlled manner, with friends. It depends on the phase of the dependence. However, there is such an option" (T5.M.W.).

Limitations of therapeutic programs followed in the facilities where the examination was conducted are, in the opinion of both patients and therapists, of major importance and can affect the decision about starting therapy. Intensity of the therapy, its long duration, are obstacles that discourage individuals from starting the treatment. Assumptions of the program that opt for complete abstinence exclude individuals who want to just limit the amount of consumed alcohol and revert to controlled, moderate drinking. The lack of a program designed for harmful drinkers willing to drink in a controlled manner disqualifies those who would like to learn how to do so.

Waiting time for the treatment

According to the examined individuals, time they needed to wait for the therapy also narrowed-down the availability of therapy offered in outpatient, stationary, or individual manner. In Warsaw, waiting time for group therapy was considered too long. As assessed by the therapist, that factor was important when the motivation of the person visiting the facility was low. "There are facilities where you need to wait a week or two to see the doctor and it may be a significant barrier. Some need to wait over a week for an appointment with a therapist. (…) Motivated clients will wait, those reluctant ones will not" (T7.K.W.).

In the case of the outpatient treatment, patients have to wait for a few weeks to receive individual support.

Major difficulties were associated with the attempt to start stationary treatment. This form of support is popular especially among the citizens of rural areas. Alcohol dependent persons have to wait for at least few weeks to receive the help they need: "To get a bed in this hospital in a stationary manner, I need to wait three months" (P14.M.S.).

The prolonged waiting time might be, in accordance with the opinion of the therapists, a barrier determining the willingness to start therapy. Few weeks of waiting might discourage the interested individuals, leading to the resignation from the support or its complete abandonment. Patients from Warsaw have to wait for an outpatient treatment for longer than those from the rural community. The period of time required to start individual therapy is equally as long. Several weeks of waiting for the stationary treatment is a similar period for both groups of examined patients.

General conditions of the facility

According to the respondents, the condition of the clinic and the place where the treatment is administered might also be considered structural barriers. Unkempt objects might discourage individuals in need from seeking help. "First impressions are rather poor. It brings to mind the early communist era" (P2.K.S.).

Treatment availability might also be limited by the infrastructure. Disabled people have a hard time trying to take advantage of the provided services, especially due to the fact that the units are not properly adjusted to their requirements. There are no lifts or platforms facilitating people on wheelchairs to reach the place. "*As far as I know there are not many such facilities in Warsaw. As far as I know, the majority of them do not have a special platform for wheelchairs. In our facility it is simply impossible for a disabled person to go inside the building"* (T2.K.W.).

The poor condition of the facilities identified by the examined individuals have a notable impact on the perception of alcohol addiction treatment as such, which may in turn prevented the interested parties from initiating the therapy. In particular, maladjustment of the units to the needs of disabled individuals lead to their inability to participate in meetings.

Lack of institutional cooperation

For the therapists from the rural area, the barriers limiting the treatment availability was the lack of cooperation between particular institutions. As assessed, such collaboration would facilitate covering wider groups of people struggling with addiction with proper care. Transferring information about treatment methods, indicating the possibilities of care seeking by the workers of healthcare units and social welfare institutions would increase the awareness of the addicted individuals in terms of the available treatment options, which may lead to starting therapy. In the rural area, the cooperation between the institutions responsible for helping people struggling with harmful drinking is not sufficient. External institutions seldom direct individuals seeking help to the outpatient clinic. For example, the Center for Prevention of Alcohol-Related Problems which is contact point for families of alcohol dependent persons does not disclose information about the possibility of being treated in the clinic, nor refer the patients to therapy. Moreover, also the collaboration between the clinic and the social welfare center is rather unsatisfactory. The personnel of the said unit do not direct the patients directly to the outpatient clinic. "All centers [for prevention of alcohol-related problems – Ł.W.] in all communes and in the town know that we do exist. They do not inform their patients that they can come here. Social welfare representatives do not ask people to come to us, they rather choose the center for prevention of alcohol-related problems to refer their patients to" (T6.K.S.).

Similar actions are performed by the General Practitioner working in primary care facilities. "*In a tremendous number of cases, doctors tend to say – you know, you would need to go there for two years; it will be better to prescribe you Anticol as a medication"* (T5.K.S.).

Cooperation of the outpatient clinic operating in the rural area with other institutions is poor. There are no frequent contacts between the workers of the said units, there are no information being disclosed on the treatment possibilities, as well as the said bodies fail to engage themselves in more widespread diagnostic and prevention-oriented activities. Therefore, the amount of people capable of taking advantage of the provided services, providing information to the community, as well as the awareness of the staff of other institutions responsible for providing support to addicts is limited.

Discussion

The barriers identified in this study are similar to the ones specified in other research conducted in the 90s [9, 11], IATPAD studies [13], and PARPA analyses [12]. Barriers were psychological in nature and were associated with internal unwillingness to start treatment. There were also structural limitations directly associated with the operational paradigm of the outpatient clinics.

Similarly to IATPAD studies [13], the main psychological barrier was shame to seek help. It was identified in the patients from both Warsaw and the rural community. The feeling of shame was associated with the negative perception of alcoholism by the society and the fear of being somehow associated with the outpatient clinic. Therefore,

the patients avoided being seen in a close proximity to the facility. They were also unwilling to start therapy out of anxiety to lose their anonymity.

Structural barriers identified in the study were also earlier spotted in the analyses concerning the availability of addiction treatment. They were conducted, among others, by Godwod-Sikorska [9], Ratajczak [11], and PARPA [12]. Similarly to the examinations from the 90s, the main limitations were the poor infrastructure of addiction treatment facilities on rural areas and the maladjustment of working hours to the needs of the patients. On top of that, the examined individuals indicated geographical localization of the clinic on rural areas and the organizational aspects of group therapy (days and time of meetings). The insufficiently developed infrastructure of the clinic was associated with the prolonged commute time and notable travel expenses. It was the case especially in rural areas in which, according to the PARPA analyses, there was still no identifiable increase in the number of outpatient facilities. Analogously, waiting time (for outpatient, stationary, or individual treatment) was indicated by the examined individuals in both cases. According to PARPA, in one third of outpatient facilities, starting therapy was preceded by a significant waiting time [12]. Basing on the IATPAD studies [13], the maladjustment of the program to the needs of clients of the facility was considered to be an in obstacle in starting the therapy. Within the scope of these analyses, the examined individuals specified the areas which they considered to be problematic. They mainly highlighted the lack of information on new scientific and therapeutic methods, as well as treatment techniques. Additionally, the program as such was considered to be overly long and intense, required the patients to keep total abstinence and discriminated those who would like to drink in a controlled manner.

Referring to structural barriers, the respondents also pointed out those related to the improper infrastructure and facility condition, especially in terms of availability for disabled individuals. The identified barriers were in line with those specified in IATPAD studies [13], where the general condition of the facilities was also a limiting factor in terms of starting treatment.

Even though inter-institutional cooperation was set forth in the Act on upbringing in sobriety and counteracting alcoholism [17], the lack of proper relations between the individual institutions is noticed by the therapists. Especially, the lack of collaboration with the institutions providing their services in the same area as the clinic is visible. Such units are not willing to establish and maintain proper relations (they do not direct people for treatment in clinic, they also do not engage themselves in a more widespread diagnostics and prevention-related undertakings).

The analysis of the research material made it possible to find similarities and disparities between the barriers identified by both patients and therapists from the clinic in Warsaw and in the rural community. The psychological barrier identified in the case of both units was shame to admit to the addiction resulting from the negative perception of alcoholism by the society. The negative opinion on the problem was also transferred onto addiction treatment facilities, resulting in fear of the alcoholics of being in any way associated with the outpatient clinic, regardless of its localization.

Structural barriers specified by the respondents from Warsaw and the rural community related were mainly related to the long waiting time in inpatient clinics, intensity

of the program, and poor condition of the facility, making it virtually impossible for disabled individuals to take part in the therapy. Group meetings organized few times a week were considered problematic and burdensome. Additionally, improper infrastructure of the facilities negatively affected the image of addiction treatment as such.

Structural limitations identified by the examined individuals from Warsaw were mainly those associated with a prolonged waiting time for outpatient treatment, as well as for the individual appointment with a therapist. The said respondents also noted barriers arising out of therapeutic offer, excluding deaf and mentally challenged alcoholics from participation. Moreover, the implemented therapeutic program was assessed as a factor preventing interested parties from starting the treatment. As assessed, it was unattractive in terms of disclosed information which did not include new treatment methods and techniques. It is a subjective perspective of the respondents based, as it can be assumed, on the concept of addiction treatment presented in the mass media. In the interviews respondents did not clearly define the meaning of modern alcohol treatment program. It can be concluded that they focused on assumptions of therapeutic program where the primary objective is maintaining abstinence and lack of possibility to learn drinking alcohol in a controlled manner. Complete abstinence is required from the very beginning of the therapy, it is prerequisite of its starting, disqualifying individuals who do not want or cannot not stop drinking. Basing on the experiences of the therapists, a possibility to learn how to drink in a controlled manner would encourage the said group of people to start therapy without instantly giving up on drinking.

For the respondents from the rural community, the main psychological limitation was the feeling of lack of anonymity. According to the respondents, a single clinic in the town and in the district was not the warranty of intimacy and keeping confidentiality by other participants. The geographical limitation of availability was also associated with the limited number of facilities to choose from, as well as commute time and costs (especially for the patients of day-care wards). Individuals living in the rural area stated that the duration of the treatment itself, which is 2 years on average, might be considered an obstacle. While starting the treatment, they had hoped that it would last shorter. The availability of treatment was also limited by the insufficient inter-institutional collaboration which, while working properly, would make it possible to identify and help those with alcohol-related problems. Within the borders of the said community, there was no cooperation between the clinic and the healthcare or social welfare organizations. Individuals employed in the said institutions addressed directly to those with addictions (e.g., Center for Prevention of Alcohol-Related Problems, Social Welfare Center, and Healthcare Center) did not direct interested individuals to the clinic. Cooperation on such a small scale did not promote engaging various institutions in, e.g., diagnostics or prevention-related activities.

The presented study draws attention on the necessity to ensure patients greater anonymity while they start the treatment, increase the availability of facilities in rural areas by providing opportunities for outpatient treatment, for example, deployed in the numerous facilities of primary care. These could translate into reducing the time and costs required to reach the outpatient clinic as well as waiting time for the treatment. Impact on starting treatment has negative image of the addiction treatment sector which

could be changed by improving the condition of the facility and their adaptation to the needs of people with disabilities. Reformulation of the therapeutic paradigm and admitting to the therapy people who do not want to maintain abstinence but would like to learn drinking alcohol in a controlled manner could result in increasing the availability of the treatment.

The presented qualitative study is a stage after which the quantitative survey should be conducted. The aim of such survey would be to estimate the prevalence of different types of barriers considering the size of the locality.

It must be also mentioned that this research was limited in its nature. The examined sample included addicted individuals who have been treated in outpatient clinics. The alcohol dependent persons who had not decided to start therapy were not included. Their opinions on the availability of various treatment methods might supplement the opinions of the patients, as well as draw attention to the barriers perceived by the individuals reluctant to start therapy. Participation in the research was voluntary (the participants only had to meet the inclusion criteria). It is possible that some individuals with different experiences and opinions were afraid to take part in the examination. Additionally, the outpatient clinic, in which the patients had been treated, was the meeting point. Therefore, they might not feel comfortable while answering the questions. The feeling might be particularly strong for the surveyed individuals from the rural community, where the therapists organized meetings with respondents.

Limitations of the research might also be associated with the choice of clinics. The facilities were chosen mainly on the basis on the number of therapists and the easiness of access to the respondents.

Conclusions

1. The barriers identified in the study were similar to the ones specified in the research conducted in Poland in the 90s, and at the end of first decade of 21st century.
2. As assessed by the respondents, the barriers limiting the access to the therapy in clinics were psychological in nature and had the form of internal withdrawal and anxiety to start treatment. Certain structural barriers were indicated as well.
3. Respondents identified similar barriers for the clinics located in Warsaw and in the rural community. Those were: shame associated with seeking help, waiting time for stationary support, meeting intensity, and poor general clinic condition.
4. Limitations specified by the examined individuals from Warsaw were associated with long waiting time for outpatient treatment and individual appointment, therapeutic offer excluding deaf and mentally challenged individuals from the therapy, and unattractive program requiring complete abstinence.
5. Barriers in access to treatment spotted only by the respondents from the rural community were related to the lack of anonymity of treatment associated with too small number of clinics in the district. The aforementioned factor also led to lack of choice in terms of preferred facility, commute time and costs, as well as no inter-institutional cooperation.

References

1. Szczepański J. *Elementarne pojęcia socjologiczne.* Warsaw: Polish Scientific Publishers PWN; 1970.
2. Skąpska G, Ziółkowski M. *Instytucja społeczna*. In: Kojder A, Koseła K, Kwaśniewicz W, Kubiak H, Mucha J, Szacki J. et al. ed. *Encyklopedia Socjologii*. Vol. 1. Warsaw: Scientific Publishing House; 1998. p. 317–321.
3. *Poprawa dostępu do leczenia dla osób z problemami związanymi z alkoholem i narkotykami. Projekt IATPAD*. Warsaw: Institute of Psychiatry and Neurology; 2009.
4. *Zakłady psychiatrycznej oraz neurologicznej opieki zdrowotnej*. Statistical Yearbook 2009. Warsaw: Institute of Psychiatry and Neurology; 2011.
5. *Metody leczenia uzależnień*. As at 06.01.2015. http://www.parpa.pl/index.php/ lecznictwo-odwykowe/metody-leczenia-uzaleznienia-od-alkoholu [retrieved: 17.01.2017].
6. Habrat B. *Leki stosowane w leczeniu uzależnienia od alkoholu*. Alkohol. i Narkom. 1994; 1(15): 7–14.
7. *Sprawozdanie z realizacji Ustawy o wychowaniu w trzeźwości i przeciwdziałaniu alkoholizmowi w okresie 1 stycznia – 31 grudnia 2009*. Warsaw: State Agency for Prevention of Alcohol-Related Problems; 2010.
8. Kasprzak J. *Kadry i system podnoszenia kwalifikacji w lecznictwie odwykowym*. In: Woronowicz B, Fudała J, Kasprzak J, Kędzierski H, Muszyńska A, Ratajczak B. et al. ed. *Raport o stanie lecznictwa odwykowego w Polsce za lata 1994/1995*. Warsaw: Institute of Psychiatry and Neurology, State Agency for Prevention of Alcohol-Related Problems; 1997. p. 67–98.
9. Godwod-Sikorska C. *Lecznictwo odwykowe w Polsce. Diagnoza: kierunki reform*. Alkohol. Narkom. 1992; 10: 39–62.
10. Klingemann JI. *Horyzonty zmiany zachowania nałogowego w Polsce*. Works of the Chair of the Sociology of Norms, Deviance and Social Control, vol. 11. Warsaw: IPSiR UW; 2010.
11. Ratajczak B. *Stan bazy materialnej zakładów lecznictwa odwykowego*. In: Woronowicz B, Fudała J, Kasprzak J, Kędzierski H, Muszyńska A, Ratajczak B. et al. ed. *Raport o stanie lecznictwa odwykowego w Polsce za lata 1994/1995*. Warsaw: Institute of Psychiatry and Neurology, State Agency for Prevention of Alcohol-Related Problems; 1997. p. 15–30.
12. Fudała J. *Polskie lecznictwo odwykowe w liczbach*. Świat problemów 2012; 11: 5–9.
13. Bujalski M. *Bariery w dostępie do leczenia uzależnień*. Serwis Informacyjny Narkomania 2011; 1: 42–46.
14. Gilchrist G, Moskalewicz J, Nutt R, Love J, Germeni E, Valkova I. et al. *Understanding access to substance treatment services in Europe: a multi-country users' perspective*. Drugs Educ. Prev. Polic. 2014; 21: 120–130.
15. Wasilewska E. *Statystyka opisowa nie tylko dla socjologów*. Warsaw: SGGW Publishing House; 2008.
16. Flick U. *Jakość w badaniach jakościowych*. Warsaw: Polish Scientific Publishers PWN; 2011.
17. Act of 26 October 1982 on upbringing in sobriety and counteracting alcoholism (Dz. U. (Journal of Laws) 1982 No. 35 item 230).

Address: Łukasz Wieczorek
Institute of Psychiatry and Neurology
02-957 Warszawa, Sobieskiego Street 9