

The Needs of Patients with Substance Use Disorder Who Presented at Treatment Centers (AMATEM)

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Main Points

- Patients who apply for treatment of substance addiction in Turkey were mostly supported by their families.
- Patients with substance use disorder (SUD) need a job they can perform and a sufficient amount of income to provide a livelihood.
- Patients with SUD need rehabilitation programs, which can develop their professional and social skills, allow them to discover their own areas of interest, and develop physical exercise habits.

Abstract

The purpose of this study was to determine the psychological, social, and economic needs of patients who presented at the Alcohol and Substance Addiction Research, Treatment, and Training Centers in Turkey. This study was conducted with patients who presented at the Alcohol and Substance Addiction Research, Treatment, and Training Centers in six provinces (Adana, Konya, Gaziantep, Manisa, Samsun, and Elazığ) between 2017 and 2018. The data were collected using a sociodemographic form and a structured questionnaire to assess the needs of patients. The evaluation was made of 328 participants, comprising 314 males, 9 females, and 5 of unstated gender. Of these, 83.5% were inpatients and 16.5% were outpatients, and 42.1% were using more than one substance, reported as opiates by 30.1% and alcohol by 15.5%. The results of this study showed that the patients who sought treatment for substance addiction were mostly supported by their families and also needed a job they can perform with sufficient income to provide a livelihood. These results also suggested that patients with substance use disorder need rehabilitation programs to be able to develop professional and social skills, allow them to discover their own areas of interest, and develop physical exercise habits.

Keywords: Addiction treatment, drug addiction, psychosocial needs, psychosocial support, substance addiction

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Introduction

Substance use disorder (SUD), according to the American Psychiatric Association, is a chronic brain disease that is difficult to control, which, despite its behavioral, cognitive, and social damage, demands repeated use of the substance (American Psychiatric Association [APA], 2021). Substance use disorder has become a common public health problem which

negatively affects the mental and physical health of the individuals, family relationships, quality of life, and financial and social situation and leads to significant problems in almost every society (Karakaya & Ersöğütçü, 2016; Karatay & Kubilay, 2004). Diseases and mortality rates due to SUD are increasing throughout the world compared to other psychological disorders (Gezek, 2007).

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According to the World Drug Report (WDR) announced by the United Nations Office on Drugs and Crime (UNODC) annually, there are approximately 275 million substance users and 36 million patients with SUD in the world (United Nations Office on Drugs and Crime [UNODC], 2021). Compared to the United States and Europe, Turkey has low rates of substance usage and addiction but the growing rate of SUD in the general population has been reported to be quite high (Albayrak & Balci, 2014). According to European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), there has been a rapid increase in the number of patients with SUD admitted to clinics for treatment in Turkey (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2018). Due to its strategic geographic location, Turkey is a major transit point for drug trafficking and the high youth population of Turkey is becoming an important target in the drug trade (Turkey Monitoring Centre for Drugs and Drug Addiction [TUBİM], 2021).

A rapid increase of SUD in Turkey brings various imperatives that need solutions. Many treatment centers (AMATEM) have been opened in different provinces in Turkey to investigate, prevent, and treat SUD. In these centers, medical and psychosocial treatments are applied to patients with SUD who use various substances (Karakaya et al., 2019). It is possible to make all these treatment modalities more effective and increase treatment success by better recognition of patients and their conditions. In Turkey, while the numbers of patients and addiction treatment centers have increased rapidly, many new studies related to SUD have been conducted. These studies have investigated the psychosocial causes of addiction and other psychological variables related to addiction (Karakas & Ersögütçü, 2016; Tamar-Gürol et al., 2008), sociodemographic characteristics, frequency, and type of substances used (Bilici et al., 2012, 2018; Evren et al., 2003). However, there are very few studies in literature that have focused on the psychological, social, and financial needs of patients with SUD who present at treatment centers in Turkey or throughout the world (Muthulingam et al., 2019). The aim of this study was to determine the psychological, financial, and social needs of patients with SUD in Turkey.

Methods

This study was conducted with patients who presented at AMATEM, with the aim of assessing the needs of patients with SUD in Turkey. Six AMATEMs in different regions were selected as a sample representative of the population. An invitation was sent to eight AMATEMs by the Ministry of Health and six participated in the study. These six were in the cities of Konya (Central Anatolia region), Manisa (Aegean region), Adana (Mediterranean region), Gaziantep (Southeast Anatolia region), Samsun (Black Sea region), and Elazığ (Eastern Anatolia region). Through coordination with the Ministry of Health, data were obtained from both inpatients and outpatients who presented at AMATEMs in a 6-month period.

This study was conducted on 328 patients with SUD who were admitted to AMATEMs in Turkey between 2017 and 2018. Male and female patients aged 18 – 69 years who were being treated for SUD were included in the study. Patients were excluded if they had an inadequate education level or any psychiatric disorders such as mental retardation or dementia that might lead

to difficulty in replying to the questions in the survey, if they were aged <18 years, were in the first week of hospitalization, and had concentration problems or delirium symptoms. A sociodemographic form and a structured self-report questionnaire consisting of 30 items assessing the psychological, social, informational, and financial needs of patients were given to all participants. Informed consent forms were obtained from all participants.

Data were analyzed with descriptive statistics using Statistical Package for the Social Sciences software™. Mean, standard deviation, median, minimum, and maximum values were used as descriptive statistical methods while number and percentage were used for categorical variables. During the statistical analysis, five patients who did not respond to the gender section were excluded from the related evaluations. The study was approved by the Clinical Research Ethics Committee of Erenköy Mental and Neurological Diseases Training and Research Hospital (Decision No: 14, dated: July 3, 2017).

Results

The study included a total of 328 patients (314 male, 9 female, and 5 unstated) with a mean age of 30.4 ± 10.1 years (range: 18 – 69 years). Education level was stated as secondary school by 48.8%, high school by 23.3%, primary school by 12.9%, 5.8% were illiterate, 8% had a university degree, and 1.2% had received no education. Around 56.2% of the patients were single, 32.4% were married, 7.4% were divorced, 2.2% were living separately from their spouse, and 0.3% were widowed (Table 1).

While 48.6% of the patients had an occupation, 32.6% did not define themselves in any occupation. Around 48.3% of the patients had an income, while 51.6% did not have sufficient income. The mean of not working in any job was 4.2 ± 4.3 years and 58.7% of the patients stated that they wanted to work but that they did not have any job and 23.6% thought that they were not able to work. Around 82.4% of the patients were living with their families and 78.3% stated that there was no housing problem after treatment (Table 1).

Around 83.5% of the patients were treated as inpatients and 16.5% as outpatients. Use of more than one substance was reported by 42.1%, while 30.1% used only opiates and 15.5% used alcohol. Problems due to SUD had been ongoing for 0 – 5 years for 39.8% of the patients, for 6 – 10 years for 31.2%, for 11 – 20 years for 19.4%, and for more than 20 years for 6.9%. Addiction treatment received was reported as 1 year or less by 43.4%, while 41.7% had received between 2 and 5 years, and 89.2% of the patients stated that they had applied to AMATEM between 1 and 5 times for SUD treatment (Table 2).

Of the total patients, 66.7% stated that they had sufficient knowledge about the physical and mental damage of SUD, 56.1% were aware of the legal consequences, and 49.1% stated that they had sufficient knowledge about how to overcome addiction. Around 64.9% of the patients thought that their families had partial or adequate knowledge about SUD, while 35.1% stated that their families did not have sufficient knowledge. Around 67.1% of the patients stated that they received moral support from their families and 60.3% received financial support (Table 3).

Table 1.
Sociodemographic Features of Patients Who Presented at
AMATEM

	N (%)	Mean \pm SD (Min – Max Years)
Gender		
Male	314 (97.2)	
Female	9 (2.8)	
Age group (years)		
		30.4 \pm 10.1 (18 – 69)
18 – 30	197 (64.6)	
31 – 60	98 (33.1)	
60 >	10 (2.3)	
Education status		
Illiterate	4 (1.2)	
Literate	19 (5.8)	
Primary school	42 (12.8)	
Secondary school	159 (48.5)	
High school	76 (23.2)	
Associate degree	13 (4.0)	
Bachelor degree	13 (4.0)	
Marital status		
Married	105 (32.4)	
Single	182 (56.2)	
Divorced	24 (7.4)	
Separated	7 (2.2)	
Widow	1 (0.3)	
Other	5 (1.5)	
Having a child/children		
Yes	110 (37.7)	
No	182 (63.3)	
Having social security		
Yes	209 (64.5)	
No	115 (35.5)	
Income per month (Turkish Lira)		
<1000 TL	127 (40.3)	
1000 – 1999 TL	95 (30.2)	
2000 – 2999 TL	54 (17.1)	
3000 – 4999 TL	20 (6.3)	
5000 TL +	19 (6.0)	
Duration of unemployment		4.2 \pm 4.3 (1 – 27)
Reason for not working		
Student	6 (2.9)	
Retired	6 (2.9)	
Disabled	6 (2.9)	

	N (%)	Mean \pm SD (Min – Max Years)
Not able to work	49 (23.6)	
No occupation	122 (58.7)	
Other	19 (9.1)	
Housing situation		
Homeless	13 (4.0)	
Living alone	22 (6.8)	
Living with family	267 (82.4)	
Living with relatives	4 (1.2)	
Living with friends	4 (1.2)	
Other	14 (4.3)	

SD = standard deviation.

Problems with their spouses or partners were reported by 44%, and 48% had problems with their relatives. Around 45.7% of the patients stated that they did not know how to prepare a curriculum vitae (CV) and 76.1% had problems in managing a personal financial budget. Around 55% of the patients did not have any hobby and 84.8% did not play any sports regularly. Around 68.9% of patients stated that they needed support to be able to change their social environment. Groups supporting SUD treatment [Alcoholics Anonymous (AA) and Narcotics Anonymous] were said not to be easily accessible by 29.5% of the patients, 30.1% had partial access, 40.4% had easy access, and 44.3% of the patients stated that they had no knowledge at all about these groups at all. The total 30 questions assessing the problems and needs of the patients related to SUD are shown in Table 3.

Discussion

This study was conducted with patients admitted to AMATEMs in six provinces in Turkey. Sociodemographic data, the type of substance used, and the duration of treatment were evaluated to determine the psychological, financial, and social needs of the patients. In this study, the majority of the patients were inpatients (83.5%), in the 18 – 60 years age group (64.6%), male (97.2%), with a middle school level of education (48.5%), and unemployed (58.1%). These results were consistent with UNODC WDRs (2018) which indicated that the highest substance use and addiction rates are seen in the 18 – 25 years age group. More than one substance (42.1%), opiates (30.1%), and alcohol (15.5%) were frequently used by the patients. According to TUBIM (2018), the majority of patients in treatment centers in Turkey are users of more than one substance and opiates.

Psychological, financial, and social support from family or relatives is effective at every stage of SUD treatment (Harrison & Asche, 2001). Family relationships, financial status, and the attitudes of parents to the patients may be seen as a risk or protective factor in SUD (Küçükşen et al., 2016). The family is a positive role model for addicted individuals and providing them with adequate social support has a positive effect on the success of addiction treatment (Çifci & Uluocak, 2011). In this study, 67.1% of the patients stated that they had moral or motivational support from their families, 60.3% had financial support, and 78.4% had a relative who could take responsibility in the treatment process after

Table 2.
Substance Use, Substance Type, and Treatment

	N (%)	Mean \pm SD (Min – Max Year)
Department receiving treatment		
Inpatients	264 (83.5)	
Outpatients	52 (16.5)	
Substance types		
Opiate (heroin)	95 (30.1)	
Alcohol	49 (15.5)	
Synthetic cannabinoid (bonzai)	10 (3.2)	
Amphetamine/ metamphetamine	10 (3.2)	
Cannabinoid	6 (1.9)	
Cocaine	3 (0.9)	
Crack cocaine	2 (0.6)	
Ecstasy	1 (0.3)	
Volatile substances	2 (0.6)	
More than one substance	133 (42.1)	
Problematic substance use		9.2 \pm 7.6 (1 – 45)
0 – 5 years	131 (39.8)	
6 – 10 years	102 (31.2)	
11 – 20 years	64 (19.4)	
21 years +	23 (6.9)	
Addiction treatment duration (years)		
1 year and less	128 (43.4)	
2 – 5 years	123 (41.7)	
6 – 10 years	33 (11.2)	
10 years +	11 (3.5)	
Receiving inpatient treatment		
1 time	107 (34.7)	
2 – 5 times	168 (54.5)	
6 – 10 times	22 (7.0)	
11 and more	11 (3.4)	

SD = standard deviation.

starting to use the substance again or in the course of treatment. However, 32.9% did not receive social and motivational support from their family, 23.8% did not receive sufficient financial support, and one in five of the patients stated that there was no one to take responsibility in the treatment process after starting to use the substance again. According to these results, although it was seen that most patients received social and financial support from their families during the treatment process, the rate of patients not receiving sufficient support was quite high. Social

support is an important predictor of success in the treatment of addiction (Harrison & Asche, 2001). Therefore, it can be said that it would be useful to evaluate the needs of patients in these areas at the beginning of treatment and to meet these needs in the patient's treatment processes.

It is known that housing status alone is not sufficient for the rehabilitation of patients (Livingstone & Herman, 2016). Nevertheless, a reliable accommodation environment and employment are the most common needs of patients with SUD for adaptation to social life after treatment (Manuel et al., 2017). In this study, 82.4% of the patients stated that they lived with their families and 78.3% of the patients stated that they did not have any housing problems after the treatment. These results showed that families have an important role in the patient's life and that patients had adequate support from their families in respect of housing, and these findings were compatible with the results of similar studies (Küçükşen et al., 2016). However, there were also patients who stated that they would have a partial or significant housing problem after treatment or discharge. Although the 1:5 ratio was lower than that of patients who stated that there was no housing problem, it was still seen as a remarkable rate that needed more consideration.

Healthy, adequate, and strong relationships established by the family and patients with SUD have been shown to reduce the relapse rate of the patients (Matthew et al., 2018). In this study, 69.4% of the patients stated that they had problems with their spouse or partner and 70.6% had problems with their families. According to those results, it can be said that these results clearly reveal the need to provide training in communication skills to patients and their families in the process of addiction treatment.

In studies of substance-dependent individuals, it has generally been stated that patients are aware of the harmful consequences of the substance but still experience difficulties in controlling their substance use (Galt, 1997; Keene, 1997; Selamu et al., 2017). In this study, the extent of the need to obtain information about the harmful results of SUD, how to overcome alcohol addiction, and legal consequences were investigated. Around 66.7% of the participants stated that they had information about the mental and physical consequences of SUD, nearly half of the patients stated that they knew how to overcome SUD and more than half of the patients stated they knew the legal consequences of SUD. According to these results, it was seen that patients think that they have sufficient knowledge about the mental, physical and legal consequences of SUD. However, it was seen that more than half of the patients needed to know how to overcome SUD, nearly half needed information about the legal consequences of SUD, and one in three needed information about the mental and physical results of SUD. Similarly, three-quarters of the patients stated that they thought their families did not have sufficient information about SUD. These results clearly indicated that patients and their families should be informed in all these areas. However, this study only investigated the patients' attitudes and evaluated their competence in these areas and their perception of their families in terms of SUD. Therefore, the level of knowledge of the families about SUD was not measured objectively. This was evaluated as a limitation of this study and it was thought that it would be useful to re-examine the patients with SUD in future studies using objective tests to obtain more accurate results in this respect.

Table 3.
Patients' Responses to the Needs Questionnaire

		Total Response	N (%)		
			Yes	Partially	No
1	Do you have enough information about the physical and mental damage of the substance?	321	214 (66.7)	76 (23.7)	31 (9.7)
2	Do you have enough information about how to eliminate substance abuse or how to overcome it?	322	158 (49.1)	109 (33.9)	55 (17.1)
3	Do you have enough information about the legal problems that substance abuse may cause?	322	184 (56.1)	87 (26.5)	51 (15.5)
4	Do you think that your family or civil partner has enough information about substance abuse and its treatment?	322	130 (40.4)	79 (24.5)	113 (35.1)
5	Do you see moral/motivational support from your family/ relatives for your treatment?	322	216 (67.1)	46 (14.3)	60 (18.6)
6	Do you receive financial support from your family/ relatives for your treatment?	320	193 (60.3)	50 (15.6)	76 (23.8)
7	Do you have problems with your spouse, fiancé or partner?	209	92 (44.0)	53 (25.4)	64 (30.6)
8	Are there any problems between you and your family?	323	155 (48.0)	73 (22.6)	95 (29.4)
9	Do you have any housing problems in this treatment process?	322	48 (14.9)	22 (6.8)	252 (78.3)
10	Do you have a job?	319	155 (48.6)	60 (18.8)	104 (32.6)
11	Do you still have a salary or income?	322	89 (27.6)	21 (6.5)	212 (65.8)
12	Do you have enough income to live on?	319	154 (48.3)	104 (32.6)	61 (19.1)
13	Do you currently have a job or will you have one after completing your treatment in AMATEM?	320	134 (41.9)	-	186 (58.1)
14	Are there children between 0 and 18 years of age that you are responsible or care for?	306	101 (33.0)	-	205 (67.0)
15	Do you have enough parenting skills?	172	87 (50.6)	43 (25.0)	42 (24.4)
16	Are you responsible for a person in need of care or with a disability?	287	56 (19.5)	-	231 (80.5)
17	Do you know how to prepare a CV?	311	115 (37.0)	54 (17.4)	142 (45.7)
18	Are you having trouble adjusting and managing your personal financial budget?	309	87 (28.2)	148 (47.9)	74 (23.9)
19	Are you having difficulty doing daily chores?	316	57 (18.0)	27 (8.5)	231 (73.1)
20	Are you having difficulty with kitchen tasks?	315	80 (25.4)	92 (29.2)	143 (45.4)
21	Do you feel you have sufficient communication skills?	314	182 (58.0)	97 (30.9)	35 (11.1)
22	Do you have easy access to healthcare workers when you need treatment?	315	195 (61.9)	79 (25.1)	41 (13.0)
23	Can you easily access inpatient treatment as soon as possible in any AMATEM service?	246	111 (45.1)	74 (30.0)	61 (24.8)
24	Do you have a social activity or hobby on which you spend your free time?	322	145 (45.5)	-	177 (55.5)
25	Do you play sports regularly?	323	49 (15.2)	-	274 (84.8)
26	Do you need support to change your social environment?	322	222 (68.9)	-	100 (31.1)
27	Do you have a significant physical illness for which you are receiving treatment or are currently under follow-up?	322	61 (18.9)	-	261 (81.1)
28	Do you have an important psychiatric disorder for which you are receiving treatment or are currently under follow-up?	322	60 (18.6)	-	262 (81.4)
29	Do you have a family member who can take responsibility for your treatment?	320	251 (78.4)	-	69 (21.6)
30	Can you easily access groups that support the treatment of substance addiction (anonymous alcoholics, anonymous narcotics, etc.)?	146	59 (40.4)	44 (30.1)	43 (29.5)

CV = curriculum vitae.

Occupation, working status, income, and education level are important factors determining socioeconomic status (SES) and evaluating the financial needs and quality of life of the participants (Dişsiz, 2015; Galea & Vlahov, 2002). Socioeconomic status is a significant risk factor in SUD, affecting health directly or indirectly (Galea & Vlahov, 2002). According to the results, 68.3% of the participants had a secondary school level of education or below. Around 32.6% of participants did not have any occupation, 65.8% did not have a regular income, and 58.1% of participants also stated they did not have any work after the treatment. These results, which were consistent with the findings of other studies in the literature, indicate that participation of the patients with SUD in social, vocational, and educational life has an important role in the treatment of addiction (Sherba et al., 2018). It has been shown that employment is an effective predictor of treatment in achieving positive results, and low rates of relapse and crime (Ritter & Cameron, 2006). Therefore, it can be considered that social studies and policies such as creating new occupation, jobs, and education opportunities would decrease the relapse rates while also increasing SES, quality of life, and participation in the social life of the patient (Arria & Topps-II Interstate Cooperative Study Group, 2003; Ritter & Cameron, 2006).

Daily routines such as budget allocation, preparing a CV, communication skills, physical exercise, social activity, daily chores, and cooking are important needs in terms of self-efficacy and social functionality (Karakaş & Söğütçü, 2016). According to the findings of this study, the majority of patients (45.7%) experienced deficiencies in CV preparation, physical exercise (84.8%), participation in social activities (55.5%), budget allocation (76.1%), and culinary tasks (26.5%). Considering the prognosis of drug addiction, patients gradually distance themselves from social life for individual and social reasons such as social isolation, exclusion, stigmatization, unemployment, and lack of self-confidence throughout the process of substance use and treatment (Ahern et al., 2007). Therefore, psychosocial rehabilitation to increase the social functioning and psychological well-being of the patients, and increasing the number of social facilities and centers where patients can explore their own areas of interest and spend their free time are important needs in the treatment of substance dependence (Ahern et al., 2007; Manuel et al., 2017).

Inadequate education and parenting skills of parents with SUD have important risks for their children as well as their psychosocial and physical development (Cicchetti & Handley, 2019). In this study, the needs of the patients receiving SUD treatment were evaluated. It was stated that 32.4% of the patients were married and 9.6% were divorced or separated. One in three patients had children aged 0 – 18 years, and one in five had children or relatives in need of nursing care. Nearly half of the patients stated that they had inadequate or partial parenting skills. Considering these results, it was seen that a significant majority of dependent patients need support in the area of parenting. During the identification of patients in need of support in these matters, it was considered that patient education regarding the administration of supportive parenting would support the self-efficiency of patients and improve self-esteem and social functioning. At the same time, parenting education for parents with SUD would be beneficial for the psychological and physical health of the spouses, children, and relatives of the patients (Johnston et al., 2011).

In the addiction process, it is known that patients move away from activities they previously enjoyed and spend a large part of their time seeking or using substances (World Health Organization [WHO], 2021). Studies have reported that drug addicts gradually withdrew from social and cultural life and moved away from opportunities to improve their personal skills (Ströhle et al., 2007). In this study, 84.8% of the participants stated that they did not do any regular physical exercise, while 55.5% stated that they did not have any social activity, hobby, or leisure activity. Physical exercise is known to contribute to the emergence of positive results in the treatment of substance addiction as well as in the treatment of many psychiatric diseases (Brown et al., 2010; Stoutenberg 2016; Weinstock et al., 2017). Hobbies and leisure time activities have an important place in addiction treatment because they can provide physical and psychological satisfaction (Ertüzün et al., 2016). When the results of this study and the findings of other studies on this subject are evaluated together, it can be said that the implementation of rehabilitation programs in which addicted patients can improve their social skills, discover their own interests, and acquire physical exercise habits should be considered among the important needs for the success of addiction treatment.

Depression, anxiety, personality disorders, attention deficit, and hyperactivity disorder are among the psychiatric diseases that frequently accompany alcohol/substance addiction (Yildirim et al., 2016). Infection, liver and digestive system diseases, cancer, ischemic heart diseases, and bone resorption are physical diseases accompanying substance addiction (Habibi et al., 2016). It can be thought that including addiction together with other psychiatric and physical diseases in the treatment formulation, and meeting the needs of psychotherapy and rehabilitation in addition to medical treatment will have effective results in addiction treatment. (Mırsal et al., 2000). Any psychiatric or physical illness accompanied by SUD is important in respect of planning treatment for patients. In this study, 18.9% of the patients had physical diseases and 18.6% had psychiatric diseases. However, according to the report of EMCDDA (2018), these rates are higher and approximately 50% of substance addicts are reported to have another psychiatric disorder accompanied by SUD. In a UK study, 30% of alcohol dependents and 45% of substance addicts had another psychiatric disorder (Farrell et al., 2001). In addition, it has been reported that patients with a comorbid psychiatric disorder are more severe addicts, have lower social and occupational functioning, and have more frequent problems in family and interpersonal relationships (Kingston et al., 2017). In this study, mental or physical comorbidities accompanying SUD were not determined by a clinician during the examination but were based on subjective information given by the patients. This method reduced the value of the data in the study and can explain the low rate of physical and mental illness compared to other studies. Nevertheless, despite higher rates in other studies, one in five patients receiving addiction treatment in the current study was mentally ill and one in five patients had an additional biological disease. These results showed that there is a need to evaluate the patients who apply for addiction treatment in terms of other physical and psychiatric diseases and to add the treatments for these diseases to the SUD treatment.

The easy access of the dependent patients to the treatment centers, healthcare workers, and the social groups supporting addiction treatment is important for the continuity of the treatment and relapse prevention (Sacks et al., 2005). According to the results, 38.1% of the patients could not reach treatment centers easily when needed, more than half were not able to find a place in AMATEMs for inpatient treatment and two in five had difficulties in accessing support groups easily. It has been shown that easy access to treatment centers, health care workers, and social groups which support addiction treatment (AA, AN, etc.) is an important factor in preventing relapse while increasing the continuity of treatment (Sacks et al., 2005). A social and medical service that helps patients to access treatment centers and support groups easily was seen as an important need. Public or private healthcare institutions should carry out studies that will meet these needs of patients and it is thought that this would be beneficial for the continuation and success of SUD treatment.

In this study, the psychological, social, informational, and financial needs of patients with SUD were assessed and evaluation was made of the patients' knowledge about SUD, their attitudes toward addiction, their interpersonal relationships, financial status, social and cultural activities, daily functioning, and psychiatric and physical illnesses.

In conclusion, the results of this study showed that patients who apply for treatment of substance addiction were mostly supported by their families, but patients also need a job they can perform and a sufficient amount of income to provide a livelihood. In addition, these results suggested that patients with SUD need rehabilitation programs, which can develop their professional and social skills, allow them to discover their own areas of interest, and develop physical exercise habits.

Limitations and Directions/Suggestions for Future Research

In this study, the majority of the participants were inpatients using more than one substance and opiates. Although the most widely used substance in Turkey and throughout the world is cannabis (UNODC, 2018), users of this substance do not often present at treatment centers compared to opiate and other drug users. Therefore, this study included limited information about the outpatient treatment of cannabis and other substance users and their need for treatment. There is a clear need for more specific studies to evaluate substance addiction in outpatients and inpatients with a larger sample or separately.

Another limitation of this study was that the rates of male and female participants were significantly different, with a much lower number of females than males. Therefore, this study did not provide detailed and sufficient information in respect of female patients. Gender-specific treatment programs are being developed in countries such as the United States and Canada (Kutlu, 2011). In Turkey, the studies in this field are very limited (Ögel, 2004). Therefore, descriptive studies are needed to determine the separate needs of male and female addicts.

One of the important positive aspects of this study is that it is a multicenter study and the sample size is higher than similar studies. One of the important negative aspects of the study is the

absence of a control group. In this study, the social status and needs of people with substance addiction were specified, but these data were not compared with the control group of similar age and same sex, who were not diagnosed with addiction. This study was designed as a descriptive study, not a case-control study. However, the planning of studies comparing these two groups in future studies will reveal additional information in terms of addiction literature.

The questions used in this study were subjective and directed to the patients only. Thus the information given by the patients about themselves or their relatives was subjective, which partially reduces the value of some of the results presented in the study. It would be useful to conduct further studies using objective measurement methods in areas that can be measured more objectively, such as the level of knowledge of patients and their families about SUD.

Ethics Committee Approval: Ethics committee approval was obtained from the Clinical Research Ethics Committee of Erenköy Mental and Neurological Diseases Training and Research Hospital (Decision No: 14, dated: July 3, 2017).

Informed Consent: Informed consent was obtained from all participants prior to their inclusion in the study.

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