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ORIGINAL ARTICLE

Examining the Sociodemographic and Clinical Characteristics and Addiction Profiles of Patients Admitted to Intensive and Low-/Medium-Intensity Outpatient Treatment Centers

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Main Points

- The patients in intensive outpatient treatment tend to have more severe addiction profiles, including older age, unemployment, and a history of psychiatric treatment.
- Intensive programs provide a more effective treatment plan for patients with more severe addictions, while low/medium intensity programs are suitable for those with less severe conditions.
- Matching patients to the appropriate intensity of treatment can improve long-term recovery, prevent relapse, and reduce overall health care costs by tailoring treatment to patient needs.

Abstract

The aim of this study was to examine the sociodemographic and clinical characteristics and addiction profiles of patients diagnosed with alcohol and substance use disorders admitted to intensive and low/medium intensity outpatient treatment centers. The study was designed as a cross-sectional follow-up study and was conducted at the outpatient rehabilitation center as an intensive outpatient treatment center and also at low/medium intensity treatment centers. Patients were given a demographic information form and the Addiction Profile Index. At the end of three months, whether the patients were still in treatment and whether they were able to complete the early remission process according to DSM-5 was assessed by telephone calls, patient data recorded in the hospital system, and control interviews. The main findings were that patients in intensive outpatient treatment were more likely to be older, unemployed, have a higher addiction severity, history of psychiatric treatment, and family history of addiction. In addition, at the end of three months, most patients in the intensive outpatient treatment center were in early remission. The results of this research show that intensive outpatient treatment programs are particularly effective for patients with more severe addiction profiles and highlight the critical role of appropriate patient referral in optimizing treatment outcomes, preventing relapse, and ultimately improving long-term recovery.

Keywords: Alcohol use disorder, addiction, intensive outpatient treatment, low/medium intensity outpatient treatment, substance use disorder

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Introduction

Alcohol and substance use disorders (ASUDs) are chronic conditions associated with morbidity, mortality, and high health care costs. Frequent relapse and repeated treatment interventions over the course of the disease affect individuals, society, and the health system (Mutschler et al., 2022;

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Trowbridge et al., 2017). Over the past 30 years, there have been a number of changes in the practice of addiction treatment, with intensive outpatient treatment replacing short-term inpatient services (Timko et al., 2003; Veach et al., 2000), and a focus on "continuity of care" ("Intensive Outpatient Treatment and the Continuum of Care," 2006; Mee-Lee & Shulman, 2003). Due to the diversity of the effects and consequences of the disease, ASUD should be treated with treatment options that differ in content, intensity, and goals (Nordfjaern et al., 2010).

Short-term and intensive inpatient treatment in a hospital setting is the costliest form of treatment for patients with high addiction severity (McLellan et al., 1997). In comparison to inpatient treatment, outpatient programs are less costly and more readily accessible (Haug & Schaub, 2016). The majority of outpatient programs are long-term in nature, yet they are less intensive in terms of weekly treatment hours, which may prove insufficient for the needs of patients (McNeese-Smith et al., 2014). Outpatient intensive treatment programs have been developed with the objective of ensuring continuity of care for patients with addiction-related mental health disorders, responding comprehensively to their needs, and reducing the cost of treatment (McLellan et al., 1997; Mee-Lee & Shulman, 2003). In accordance with the criteria set forth by the American Society of Addiction Medicine (ASAM), outpatient intensive treatment programs comprise a structured program of at least nine hours per week ("Intensive Outpatient Treatment and the Continuum of Care," 2006). Additionally, according to the ASAM treatment rating, these programs are more intensive than outpatient services and less intensive than inpatient treatment (McCarty et al., 2014). Outpatient rehabilitation programs are recommended for patients who require long-term intensive treatment. These programs offer a range of services, including biopsychosocial assessment, individual treatment planning, group treatments, family counseling, psychoeducation, substance use screening and monitoring, and psychotherapy services (Ünübol et al., 2021).

In cases where patients are unable to participate in a program of at least nine hours per week or present with a lower severity of addiction, less intensive treatments may be an appropriate option. McLellan et al. (1997) proposed that treatments with varying intensities should be differentiated according to the objectives set in the treatment plan, the planned duration of treatment, the number of weekly sessions, and the length and content of these sessions. In low-/medium-intensity outpatient programs, also defined as traditional outpatient treatment, a biopsychosocial assessment and psychotherapy are applied with a maximum of two hours per week.

A review of the literature reveals that patients who are followed up with intensive outpatient treatments tend to present with more serious medical, social, and psychiatric problems. Furthermore, there is evidence that patients' alcohol and substance use decreases after these treatment programs (McLellan et al., 1997). In studies evaluating the effectiveness of intensive outpatient treatment programs, decreases in addiction severity scores were observed. However, it was recommended that these scores be compared with those from other treatments (Campbell et al., 1997). In a study comparing the well-being, completion of treatment, and functionality level of patients followed up in a day hospital, which is one of the intensive outpatient treatment programs, with patients followed up in low-/medium-intensity treatment, no difference was found in terms of the effectiveness of treatment in the fourth and seventh months (Coviello et al., 2001). This indicates that the treatments are not inherently superior to one another when patients are directed to the most appropriate course of treatment. This highlights the importance of making appropriate referrals according to the specific needs of the patient.

In the context of continuity of care in addiction treatment, it is crucial to determine the content and intensity of the optimal treatment program in order to keep patients in the treatment system and reduce health care costs (Mee-Lee & Shulman, 2003; Nordfjaern et al., 2010). As inpatient treatment is costly, less accessible, and of shorter duration, understanding the most appropriate outpatient treatment model for patients' needs can inform clinical decisions and practices that reduce relapse rates and healthcare costs. However, there are very few studies in the literature investigating different outpatient treatment models. In light of the aforementioned information, our aim in this study was to examine the sociodemographic and clinical characteristics and addiction profiles of patients admitted to intensive and low-/medium-intensity outpatient treatment centers and to present a descriptive study of patients who continued treatment in the centers and achieved early remission.

Methods

Study Setting

The study was conducted at the AMATEM Clinic of Erenköy Mental Health and Neurology Training and Research Hospital, a center providing consultancy, diagnosis, treatment, and follow-up services in addiction, as well as conducting scientific research. The center offers inpatient and outpatient treatment, psychotherapeutic interventions, and rehabilitation services. Specialized outpatient treatment centers within the hospital include low-/medium-intensity outpatient treatment centers and the Rehabilitation Center for Addicts as an intensive outpatient treatment center. Although the intensities of these outpatient centers vary, their treatment goals are to ensure mental, physical, and social recovery, prevent relapse, and develop coping strategies.

The rehabilitation center is an intensive outpatient facility. Patients who have completed detoxification treatment are engaged in a long-term psychosocial rehabilitation program, consisting of at least one full day per week (9 hours/week). The intensive outpatient program comprises individual psychotherapy, group psychotherapy, psychoeducation sessions, and workshops. The specialist physician is responsible for arranging pharmacological treatment for patients. In the event that a home visit is deemed necessary, it will be arranged. Patients who are under the care of the center undergo regular urine toxicology screening on a weekly basis. In the event of a recurrence, the patient is discontinued from the program and referred for detoxification treatment. Following detoxification treatment, patients may resume their treatment at the center.

The low-/medium-intensity outpatient treatment centers where the study was conducted are community-based treatment centers

located outside the main campus. In these centers, counseling, pharmacological treatment and follow-up, individual psychoeducation, and psychotherapy sessions are conducted. Patients are followed up with a program of 1 – 2 hours per week. These centers offer limited rehabilitation activities (Ünübol et al., 2021). Unlike intensive outpatient treatment centers, patients experiencing a relapse can continue their treatment in the same center without the need for inpatient care if detoxification treatment is sustainable within the center. Patients were allocated to these treatment centers on the basis of clinical recommendations, taking into account the severity of their addiction, their ability to participate, and their personal circumstances.

Sample Selection

The study was designed as a cross-sectional follow-up study. The first group of patients in our study were diagnosed with alcohol and/or substance use disorders at our hospital's AMATEM clinic and subsequently referred to the rehabilitation center for intensive outpatient treatment following detoxification. The second group comprises patients who have sought treatment at the low-/medium-intensity outpatient centers. The study population comprised all patients who applied to these treatment centers between 1 December 2022 and 28 February 2023 and agreed to participate on a voluntary basis. The study was approved by the Clinical Research Ethics Committee of the hospital with decision number and date 44/29.08.2022. The study was conducted in accordance with the ethical principles set forth in the Helsinki Declaration and the International Good Clinical Practice guidelines. The patients included in the study provided informed consent. The present study was designed as part of the Integrated Collaborative Platform Project, which is supported by the Development Agency.

Method

Following the detoxification treatment, the researchers employed the demographic information form and the Addiction Profile Index (API) (Ögel et al., 2012) to assess the patients included in the study. At the conclusion of the three-month period, the frequency of patient attendance at the treatment centers, the status of their ongoing treatment, and their ability to complete the early remission process (as defined by the DSM-5) within three months were evaluated through telephone interviews, the review of patient data within the hospital system, and control interviews. The sociodemographic and clinical characteristics and addiction profiles of patients admitted to intensive and low-/medium-intensity outpatient treatment centers were examined.

Data Collection Tools

Demographic Information Form

The form comprises sociodemographic and clinical characteristics, as developed by the researchers in consideration of the characteristics of the study. The form includes a number of variables, including age, gender, marital status, educational status, habitation, migration history, loss of a family member, separation of parents, employment status, own income, social security, past treatment history, forensic history, and history of alcohol-substance use in the family.

Addiction Profile Index

The scale is a self-report instrument comprising 37 items and five subscales. The subscales assess various aspects of substance use, including characteristics, diagnostic criteria for addiction, the impact of substance use on the individual's life, the strength of the desire for substance use, and the motivation to cease substance use. The Cronbach's α coefficient for the entire scale was 0.89, while the Cronbach's α coefficients for the subscales ranged from 0.63 to 0.86. The item – total score correlation coefficients ranged from 0.42 to 0.89. The scale was developed by Ögel et al. (2012).

Statistical Method

The statistical analysis was conducted using the SPSS v27.0 (IBM SPSS Corp.; Armonk, NY, USA) software package. The conformity of the data to a normal distribution was analyzed using the One-Sample Kolmogorov – Smirnov test. The independent samples *t*-test was employed to compare quantitative data that exhibited normal distribution between groups. The Mann – Whitney *U*-test was used to compare data that did not conform to normal distribution, while the chi-square test was utilized to compare categorical data. In all tests, a *p*-value of less than .05 was considered statistically significant.

Results

The research sample was divided into two groups for the purposes of analysis. The initial cohort comprised patients who were under the care of the rehabilitation center, an intensive outpatient treatment facility (n = 31), while the second cohort consisted of patients who were under the care of low-/medium-intensity treatment centers (n = 44).

The mean age of patients undergoing intensive outpatient treatment was 40.16 ± 14.45 years. The majority of the group comprised male patients (n = 25, 80.6%). Sixteen individuals (51.6%) were single, while 13 (41.9%) were married. The majority of the group reported having completed secondary education (n = 14, 45.2%). A total of 13 individuals (41.9%) reside with their spouses and children, while 17 individuals (54.8%) live with other first-degree relatives. Of the subjects in the group, 21 (67.7%) were not employed, while six (19.4%) had regular employment. Thirteen individuals (41.9%) indicated that they were in possession of their own income. Approximately half of the group (n = 15, 48.4%) were not in receipt of social security benefits. The mean age of patients who were followed up at the low-/medium-intensity outpatient treatment center was found to be 33.77 ± 11.62 years, which was lower than that of patients in the intensive outpatient treatment group. The majority of the group comprised male patients (n = 39, 88.6%). Twenty-eight patients (63.6%) were single, while 14 (31.8%) were married. The majority of the group reported having completed secondary education (n = 19, 43.2%). A total of 14 individuals (31.8%) reside with their spouses and children, while 27 individuals (61.4%) live with other first-degree relatives. Of the individuals in the cohort, 22 (50%) were employed in regular positions. A total of 28 individuals (63.6%) indicated that they were in possession of their own income. A total of 75% (n = 33) of the group received social security benefits. The sociodemographic characteristics of the groups are presented in Table 1.

Table 1.
Sociodemographic Variables

	Intensive Outpatient Treatment	Low-/Middle-Intensity Outpatient Treatment
Age (mean ± SD)	40.16 ± 14.45	33.77 ± 11.62
Gender, *n* (%)		
Female	6 (19.4)	5 (11.4)
Male	25 (80.6)	39 (88.6)
Marital status, *n* (%)		
Single	16 (51.6)	28 (63.6)
Married	13 (41.9)	14 (31.8)
Divorced	2 (6.5)	2 (4.5)
Education, *n* (%)		
Literate	1 (3.2)	0 (0)
Primary school	4 (12.9)	3 (6.8)
Middle school	7 (22.6)	13 (29.5)
High school	14 (45.2)	19 (43.2)
University	5 (16.1)	9 (20.5)
Place of birth, *n* (%)		
Village	1 (3.2)	1 (2.3)
District	4 (12.9)	7 (15.9)
City	26 (83.9)	36 (81.8)
Current place of residence, *n* (%)		
District	1 (3.2)	7 (15.9)
City	30 (96.8)	37 (84.1)
Loss of family member, *n* (%)		
Yes	14 (45.2)	15 (34.1)
No	17 (54.8)	29 (65.9)
Parental seperation, *n* (%)		
Yes	4 (12.9)	5 (11.4)
No	27 (87.1)	39 (88.6)
Habitation, *n* (%)		
Alone	1 (3.2)	2 (4.5)
With spouse and children	13 (41.9)	14 (31.8)
With first-degree relatives	17 (54.8)	27 (61.4)
With second-degree relatives	0 (0)	1 (2.3)
Occupational Status, *n* (%)		
Unemployed	21 (67.7)	12 (27.3)
Irregular employment	4 (12.9)	10 (22.7)
Regular employment	6 (19.4)	22 (50)
Personal income, *n* (%)		
Yes	13 (41.9)	28 (63.6)
No	18 (58.1)	16 (36.4)
Social security, *n* (%)		
Yes	16 (51.6)	33 (75)
No	15 (48.4)	11 (25)

Note: *n*, number; SD, standard deviation.

Upon examination of the addiction and clinical profiles of the groups, it was found that 14 (45.1%) of the patients who had been followed up at the intensive outpatient treatment center had a history of alcohol or substance abuse in the family of the mother, father, or sibling. Six patients (19.4%) had a history of suicide, while 10 patients (32.3%) had a history of self-mutilation. Twenty individuals (64.5%) indicated that they had previously undergone psychiatric treatment. Of the total number of individuals in this group, 25 (80.6%) were referred to rehabilitation following inpatient treatment, while 6 (19.4%) were referred to rehabilitation following outpatient treatment. A total of 16 individuals (51.6%) met the criteria for an alcohol use disorder, 12 (38.7%) exhibited symptoms of polysubstance use, and three (9.6%) displayed indications of an opioid use disorder. Among the patients who were followed up in low-/medium-intensity outpatient treatment centers, eight (18.2%) had a family history of alcohol/substance abuse in a father or sibling. Six patients (13.6%) had a history of suicide, and seven patients (15.9%) had a history of self-mutilation. A total of 27 patients (61.4%) indicated that they had previously received psychiatric treatment. Of the total number of patients, 20 (45.5%) had directly applied to the centers,

Table 2.
Clinical Variables

	Intensive Outpatient Treatment	Low-/Middle-Intensity Outpatient Treatment
Family history of alcohol/substance use, *n* (%)		
None	14 (45.2)	30 (68.2)
Mother	2 (6.5)	0 (0)
Father	10 (32.3)	4 (9.1)
Sibling	2 (6.5)	4 (9.1)
Other relative	3 (9.7)	6 (13.6)
Criminal history, *n* (%)		
Yes	11 (35.5)	7 (15.9)
No	20 (64.5)	37 (84.1)
Suicide, *n* (%)		
Yes	6 (19.4)	6 (13.6)
No	25 (80.6)	38 (86.4)
Self-mutilation, *n* (%)		
Yes	10 (32.3)	7 (15.9)
No	21 (67.7)	37 (84.1)
Psychiatric treatment history, *n* (%)		
Yes	20 (64.5)	27 (61.4)
No	11 (35.5)	17 (38.6)
Referral to rehabilitation, *n* (%)		
Self	0 (0)	20 (45.5)
Inpatient service	25 (80.6)	7 (15.9)
Outpatient polyclinic	6 (19.4)	17 (38.6)

Note: *n*, number; SD, standard deviation.

seven (15.9%) had been referred after inpatient treatment, and 17 (38.6%) had been referred after outpatient treatment. A total of 16 patients (36.3%) were diagnosed with polysubstance use, 14 (31.8%) with alcohol use disorder, six (13.6%) with stimulant use, four (9%) with cannabinoid use, and four (9%) with opioid use disorder. The clinical characteristics of the groups are presented in Table 2.

The API was evaluated at the time of admission to the center for each group. The mean addiction severity of patients undergoing intensive outpatient treatment was found to be 13.37 ± 2.6. Of the patients in the group, eight (24.8%), 10 (32.2 %), and 13 (41.9%) had low, moderate, and high addiction severity, respectively. The mean addiction severity of patients who were followed up in low-/medium-intensity outpatient treatment centers was found to be 11.13 ± 3.35. Of these patients, 24 (54.5%) exhibited low addiction severity, 13 (29.5%) exhibited moderate addiction severity, and seven (15.9%) exhibited high addiction severity. The results obtained from the API of the groups are presented in Table 3.

At the conclusion of the 3-month treatment period, 24 (77.4%) of the patients who were followed up at the intensive outpatient treatment center had achieved early remission and were still undergoing treatment. Among the patients followed up in the low-/medium-intensity outpatient treatment center, 16 (36.4%) completed the early remission period, and 30 (68.2%) discontinued treatment. The parameters related to the 3-month treatment outcome of the groups are presented in Table 4. The analysis revealed significant differences in addiction severity and treatment outcomes between patients undergoing intensive and low-/medium-intensity outpatient treatment, particularly in remission rates and addiction profiles.

Table 3.
Addiction Profile Index (API/BAPI) of Groups

	Intensive Outpatient Treatment Mean ± SD	Low-/Middle-Intensity Outpatient Treatment Mean ± SD
BAPI SUC	3.14 ± 1.66	2.39 ± 1.48
BAPI diagnosis	17.34 ± 4.44	13.9 ± 5.7
BAPI impact on life	29.58 ± 6.65	21.7 ± 10.13
BAPI craving	8.61 ± 4.1	8 ± 3.48
BAPI motivation	11.39 ± 1.2	10.34 ± 2.17
BAPI toplam	13.37 ± 2.6	11.13 ± 3.35

Note: BAPI, Bağımlılık Profil Indeksi; SD, standard deviation; SUC, substance use characteristics.

Table 4.
Parameters Related to 3-Month Treatment Outcomes of Groups

3-Month Remission Status, *n* (%)	Intensive Outpatient Treatment	Low-/Middle-Intensity Outpatient Treatment
No	7 (22.6)	20 (45.5)
Yes	24 (77.4)	16 (36.4)
Unknown	0	8 (18.2)
Continuation of Treatment, *n* (%)		
Drop out	7 (22.6)	30 (68.2)
Continuing	24 (77.4)	14 (31.8)

Note: *n*, number; SD, standard deviation.

Discussion

This study examined the sociodemographic and clinical characteristics, as well as the addiction profiles, of patients admitted to intensive and low-/medium-intensity outpatient treatment centers. The findings underscore the efficacy of varying levels of treatment intensity in outpatient follow-up for patients with diverse profiles, in alignment with the tenet of continuity of care in addiction treatment. All patients who sought treatment at these facilities were referred by a medical practitioner or initiated the treatment process independently. Referrals were made in accordance with the severity of the addiction, the patient's desire for treatment, and the intensity of the program that might be appropriate due to the patient's employment status or other personal circumstances. These findings highlight the importance of matching the intensity of treatment with patient needs, as demonstrated by the higher remission rates in the intensive group.

In our study, an analysis of the sociodemographic data revealed that the mean age, gender distribution, education, and marital status of the patients in both groups were consistent with the findings reported in the literature (De Sousa, 2023; Haug & Schaub, 2016; López-Goñi et al., 2012; McLellan et al., 1997; McNeese-Smith et al., 2014). It is notable that there is a discrepancy in the participation of women and men in both groups, with women being less likely to engage in treatment. A review of the literature reveals that studies worldwide have identified several factors that contribute to women's lower rates of participation in treatment compared to men. These include fear of stigmatization, pregnancy, the lack of gender-sensitive treatment approaches, and the presence of other lifestyle-related barriers (Dayal et al., 2017; De Sousa, 2023).

Unlike previous studies, we observed lower employment rates in the intensive treatment group (McLellan et al., 1997; Rychtarik et al., 2000; Veach et al., 2000). This may be due to regional economic conditions, suggesting that local socio-economic factors need to be taken into account when recommending intensive treatment. However, in our study, despite the majority of patients in this group being unemployed, it was observed that half of the group had their own income and social security. Given the age of the patients followed up at this center, it was hypothesized that retired individuals might be included in the group, and that they might have opted for an intensified treatment program due to their lack of employment at the time. The low employment rates of the patients in this group make it understandable that work-related issues are included in the recovery goals of intensive outpatient treatment programs (Timko et al., 2003). In the low-/medium-intensity outpatient treatment center, 50% of patients

were in regular employment, 63.6% had their own income, and 75% had social security. These results were found to be consistent with the literature (López-Goñi et al., 2012; Rychtarik et al., 2000). Given the relatively lower severity of addiction in this group, it can be posited that the impact of addiction on occupational functioning is also relatively lower. Furthermore, it is possible that patients in this cohort may have sought treatment with reduced weekly hours due to their engagement in regular employment.

Upon examination of the addiction and clinical profiles of the groups, it was found that approximately half of the patients who were followed up at the intensive outpatient treatment center had a family history of addiction. In this cohort, 64.5% of patients reported a history of psychiatric treatment. A family history of addiction was identified in 18.2% of patients undergoing low-/medium-intensity outpatient treatment. A total of 61.4% of the group had a history of psychiatric treatment. In other studies conducted in this field, it has been demonstrated that the comorbidity of ASUDs with other mental disorders is a prevalent phenomenon. This comorbidity also serves to illustrate the gravity of the clinical picture (Fernández et al., 2023). The family history of addiction and past psychiatric treatments in patients in both centers corroborates the conclusion that children whose parents use alcohol or substances are at an elevated risk of developing mental disorders and addiction in the future (Dyba et al., 2019).

In the intensive outpatient treatment group, 80.6% of patients were referred to the center after short-term inpatient detoxification treatment, a figure that is considerably lower in low-/medium-intensity treatment centers. Approximately half of this group had been referred directly to the center. It was hypothesized that the working status and addiction severity of the patients may have been effective in determining the intensity of the treatment to which they were referred.

In the intensive outpatient treatment center, 50% of patients were diagnosed with an alcohol use disorder, while 38.7% were found to use more than one substance. In the low-/medium-intensity treatment center, 36.3% of the group exhibited polysubstance use, 31.8% displayed alcohol use disorder, and 13.6% demonstrated a substance use disorder involving stimulants. In a study conducted by McNeese et al., all patients who continued outpatient treatment with similar intensities to those observed in our study were evaluated. The results demonstrated that alcohol was the primary and secondary substance of choice for more than half and approximately one-third of the patients, respectively (McNeese-Smith et al., 2014). In a further study in which patients undergoing outpatient intensive treatment were examined, alcohol was identified as the most commonly used substance, followed by cocaine and polysubstance use. These findings are consistent with the results presented here (Veach et al., 2000). In patients followed up in a low-/medium-intensity treatment center with weekly sessions, it was demonstrated that alcohol was the most frequently used substance, followed by cocaine and other substances (López-Goñi et al., 2012). Upon evaluation of the groups in terms of the API at the time of admission to the center, it was determined that the mean addiction severity of the patients followed up in an intensive outpatient treatment center was 13.37 ± 2.6, while the mean addiction severity of the patients followed up in a low-/medium-intensity outpatient treatment center was 11.13 ± 3.35. It was observed that 41.9% of patients followed up in the intensive outpatient treatment center exhibited a high severity of addiction, while this rate was 15.9% in the low-/medium-intensity treatment center. In our study, we observed that patients who were followed up in the intensive outpatient treatment center were older, unemployed, predominantly diagnosed with alcohol use disorder, required inpatient detoxification prior to commencing treatment at the center, and exhibited a greater family history of addiction. This result is consistent with the existing literature, indicating that intensive treatment programs are designed for patients with more pronounced addiction-related issues. These patients require more comprehensive support, targeted intervention for problematic areas, and access to resources (Campbell et al., 1997; McLellan et al., 1997). This points to the need for tailored social interventions alongside medical treatment.

At the conclusion of the 3-month treatment period, 77.4% of patients enrolled in the intensive outpatient treatment center had achieved early remission and were continuing with their treatment regimen. Among the patients who were followed at the low-/medium-intensity outpatient treatment center, 36.4% completed the early remission period, with 68.2% subsequently leaving the treatment program. The available evidence indicates that treatment at both intensities is associated with a reduction in alcohol and substance use, and an improvement in health problems and functionality (McCarty et al., 2014; McLellan et al., 1997). As observed in our own findings, patients of advanced age and with more severe addiction issues were found to have higher rates of treatment continuation (Myers et al., 2018). The fact that the patients followed up in the intensive outpatient treatment center completed the 3-month early remission period and continued treatment despite the high severity of addiction is also an important indicator of the efficacy of this treatment in this patient group. Furthermore, the decision to continue treatment is influenced by personal factors and motivation for treatment. While not evaluated in the present study, previous research has indicated that treatment motivation is typically lower in younger patients (Myers et al., 2018). Given that patients who were followed up in low-/medium-intensity outpatient treatment centers were younger, had lower addiction severity, and had better occupational functioning, it can be concluded that their awareness of the long-term risks and possible life impacts of addiction may be lower.

This study has some limitations. One limitation of the study is the relatively small sample size, which may limit the generalizability of the findings. Additionally, the use of self-report data in assessing addiction profiles introduces the potential for reporting bias, as patients may underreport substance use. The study also assessed the early remission period of the patients. Nevertheless, it would be beneficial to assess the long-term outcomes of the therapeutic interventions. It would be beneficial to assess the addiction profile indices at the outset and conclusion of the study in order to ascertain the extent of recovery. Further studies with a larger number of patients and longer follow-ups are required in this field.

In conclusion, the extant research demonstrates that there are a variety of treatment modalities with varying intensities for patients with disparate sociodemographic and clinical characteristics in the treatment of ASUDs. These options are relatively novel, having been developed in recent years and continuing to evolve. Outpatient treatment provides a system whereby patients can receive support while continuing to reside in their own living environment. The continuity of care provided by these treatment centers allows for the prevention of recurrent hospitalizations and facilitates the patient's adaptation to the gradual transition from intensive to less intensive care. In terms of continuity and effectiveness of treatment, it will be important to evaluate the severity of addiction, living conditions, and the effects of addiction on life in order to direct the patient to a treatment with an intensity appropriate to their needs.

Availability of Data and Materials: The data that support the findings of this study are available on request from the corresponding author.

Ethics Committee Approval: This study was approved by the Ethics Committee of Erenköy Mental Health and Neurology Training and Research Hospital University (Approval no.: 44, Date: 29.08.2022).

Informed Consent: Written informed consent was obtained from the patients/patient who agreed to take part in the study.

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References

Campbell, J., Gabrielli, W., Laster, L. J., & Liskow, B. I. (1997). Efficacy of outpatient intensive treatment for drug abuse. *Journal of Addictive Diseases*, *16*(2), 15 – 25. [CrossRef]

Coviello, D. M., Alterman, A. I., Rutherford, M. J., Cacciola, J. S., Mckay, J. R., & Zanis, D. A. (2001). The effectiveness of two intensities of psychosocial treatment for cocaine dependence. In *Drug and Alcohol Dependence*, *61*(2), 145 – 154. [CrossRef]

Dayal, P., Sarkar, S., & Balhara, Y. P. S. (2017). Predictors of inpatient treatment completion among females with opioid use disorder: Findings from a tertiary care drug dependence treatment centre of India. *Indian Journal of Psychological Medicine*, *39*(4), 464 – 468. [CrossRef]

De Sousa, A. (2023). Substance Abuse in Women: Critical clinical issues. In *Indian Journal of Mental Health*, *10*(2).

Dyba, J., Moesgen, D., Klein, M., & Leyendecker, B. (2019). Methamphetamine use in German families: Parental substance use, parent – child interaction and risks for children involved. *Substance Use and Misuse*, *54*(4), 583 – 591. [CrossRef]

Fernández, S. D., Miranda, J. J. F., Pastor, F. P., & Muñoz, F. L. (2023). Gender and addiction and other mental disorders comorbidity: Sociodemographic, clinical, and treatment differences. *Archives of Women's Mental Health*, *26*(5), 639 – 650. [CrossRef]

Haug, S., & Schaub, M. P. (2016). Treatment outcome, treatment retention, and their predictors among clients of five outpatient alcohol treatment centres in Switzerland. *BMC Public Health*, *16*(1), 581. [CrossRef]

López-Goñi, J. J., Fernández-Montalvo, J., & Arteaga, A. (2012). Addiction treatment dropout: Exploring patients' characteristics. *American Journal on Addictions*, *21*(1), 78 – 85. [CrossRef]

McCarty, D., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Substance abuse intensive outpatient programs: Assessing the evidence. *Psychiatric Services*, *65*(6), 718 – 726. [CrossRef]

McLellan, A. T., Hagan, T. A., Meyers, K., Randall, M., & Durell, J. (1997). "Intensive" outpatient substance abuse treatment: Comparisons with "traditional" outpatient treatment. *Journal of Addictive Diseases*, *16*(2), 57 – 84. [CrossRef]

McNeese-Smith, D. K., Faivre, C. L., Grauvogl, C., Warda, N. U. S., & Kurzbard, M. A. (2014). Substance abuse treatment processes and outcomes in day/outpatient health maintenance organization setting. *Journal of Addictions Nursing*, *25*(3), 130 – 6; quiz 137. [CrossRef]

Mee-Lee, D., & Shulman, G. (2003). Principles of addiction medicine, 453-465. In *ASAM Placement Criteria and Matching Patients to Treatment*, (453 – 465).

Mutschler, C., Junaid, S., Tellez, C., Franco, G., Gryspeerdt, C., & Bushe, J. (2022). Community-based residential treatment for alcohol and substance use problems: A realist review. In *Health and Social Care in the Community*, Chichester, UK: John Wiley and Sons Inc., *30*(2), e287 – e304. [CrossRef]

Myers, B., Williams, P. P., Govender, R., Manderscheid, R., & Koch, J. R. (2018). Substance abuse treatment engagement, completion and short-term outcomes in the Western Cape Province, South Africa: Findings from the Service Quality Measures Initiative. *Drug and Alcohol Dependence*, *185*, 278 – 284. [CrossRef]

Nordfjaern, T., Rundmo, T., & Hole, R. (2010). Treatment and recovery as perceived by patients with substance addiction. *Journal of Psychiatric and Mental Health Nursing*, *17*(1), 46 – 64. [CrossRef]

Ögel, K., Evren, C., Karadağ, F., & Gürol, D. (2012). Bağımlılık profil İndeksi'nin (BAPİ) Geliştirilmesi, Geçerlik ve Güvenilirliği. *Türk Psikiyatri Dergisi*, *23*(4), 264 – 273.

Rychtarik, R. G., Connors, G. J., Whitney, R. B., Mcgillicuddy, N. B., Fitterling, J. M., & Wirtz, P. W. (2000). Treatment settings for persons with alcoholism: Evidence for matching clients to inpatient versus outpatient care. In *Journal of Consulting and Clinical Psychology*, *68*(2), 277 – 289. [CrossRef]

Timko, C., Sempel, J. M., & Moos, R. H. (2003). Models of standard and intensive outpatient care in substance abuse and psychiatric treatment. In *Administration and Policy in Mental Health*, *30*(5), 417 – 436. [CrossRef]

Intensive outpatient treatment and the continuum of care (2006). In *Treatment Improvement Protocol (TIP) series*, *47*. Rockville (MD): Substance Abuse and Mental Health Services Administration. US.

Trowbridge, P., Weinstein, Z. M., Kerensky, T., Roy, P., Regan, D., Samet, J. H., & Walley, A. Y. (2017). Addiction consultation services – Linking hospitalized patients to outpatient addiction treatment. *Journal of Substance Abuse Treatment*, *79*, 1 – 5. [CrossRef]

Ünübol, B., Çinka, E., Mayi, M., Şamar, B., Yılmaz, M., Urcan, M. F., Demircan, S., & Bilici, R. (2021). Bağımlı Hastalar için Rehabilitasyon: Erenköy BAHAR Modeli. *Psikiyatride Güncel Yaklaşımlar*, *13*(3), 412 – 427. [CrossRef]

Veach, L. J., Remley, T. P., Kippers, S. M., & Sorg, J. D. (2000). Retention predictors related to intensive outpatient programs for substance use disorders. In *American Journal of Drug and Alcohol Abuse*, *26*(3), 417 – 428. [CrossRef]

Genişletilmiş Özet

Ayakta Tedavi Merkezlerine Başvuran Hastaların Sosyodemografik ve Klinik Özellikleri ile Bağımlılık Profillerinin İncelenmesi

Giriş

Alkol ve madde kullanım bozuklukları (AMKB) morbidite, mortalite ve yüksek sağlık bakım maliyetleri ile ilişkili, kronik seyirli hastalıklardır. Hastalığın seyrinde sık nüksler ve yineleyen tedavi girişimleri hem bireyi hem de toplumu ve sağlık sistemini etkilemektedir. Son yıllarda bağımlılık tedavilerinde "bakımın sürekliliği" ilkesi çerçevesinde kısa süreli yataklı bakımlar yerine uzun süreli ayakta tedaviler ön plana çıkmıştır. "Bakımın sürekliliği", hastaların ihtiyaçlarına uygun seviyede tedaviye başladıkları ve takipte kalarak ihtiyaç halinde daha çok veya az yoğun tedaviye yönlendirildikleri bir tedavi sistemini ifade eder. Bu yaklaşım, hastaların ihtiyaçlarına uygun yoğunlukta tedavi ile başlamalarını ve gerektiğinde farklı yoğunluklardaki tedavilere yönlendirilerek sürekli bakım almalarını sağlar.

Yoğunlaştırılmış ayakta tedaviler, yüksek maliyetli yataklı tedavilere alternatif olarak geliştirilmiş, daha düşük maliyetli, poliklinik hizmetlerinden daha yoğun, yataklı tedaviden daha az yoğun bir tedavi biçimidir. Haftalık en az 9 saat yapılandırılmış bir program ile biyopsikososyal değerlendirme, bireysel tedavi planlaması, grup tedavileri, aile danışmanlığı, psikoeğitimler, madde kullanımı tarama ve izlemi ve psikoterapi hizmetleri sunulur. Haftalık en az dokuz saatlik programa katılım sağlayamayan hastalar içinse düşük/orta yoğunluklu ayakta tedavi programları önerilmektedir. Bu tedavide ise haftada en fazla iki saatlik bir program ile biyopsikososyal değerlendirme ve psikoterapi uygulanır.

Tedavi etkinliklerini karşılaştıran çalışmalar, hastaların uygun tedaviye yönlendirildiğinde tedavilerin birbirine üstünlüğü olmadığını ve hastaların ihtiyaçlarına uygun yönlendirmeler yapmanın önemini göstermektedir. Bu bilgiler ışığında, bu çalışmada amacımız yoğunlaştırılmış ve düşük/orta yoğunluklu ayakta tedavi merkezlerine başvuran hastaların sosyodemografik ve klinik özellikleri ile bağımlılık profillerini incelemek ve merkezlerde tedaviye devam eden ve erken remisyon dönemlerini tamamlayan hastalarla ilgili tanımlayıcı bir araştırma sunmaktır.

Yöntem

Bu çalışma, bağımlılık tedavisi sunan bir eğitim ve araştırma hastanesi AMATEM Kliniği'nde yürütülmüştür. Araştırmamız kesitsel izlemi çalışması olarak tasarlanmış olup, araştırmaya 01.12.2022-28.02.2023 tarihleri arasında başvuran tüm hastalardan gönüllü olanlar dahil edilmiştir. Çalışma için etik kurul onayı ve tüm hastalardan bilgilendirilmiş onam alınmıştır. Hastalara başvuru sırasında demografik bilgi formu ve Bağımlılık Profil İndeksi (BAPİ) uygulanmış, üç ay sonunda hastaların hala tedavide olup olmadığı ve DSM-5'e göre erken remisyon (3 ay) süresini tamamlayabilme durumu telefon aramaları, hastane sisteminde kayıtlı hasta verileri ve kontrol görüşmeleri ile değerlendirilmiştir.

Bulgular

Araştırma örneklemi iki grup olarak ele alınmıştır. Birinci grup, yoğunlaştırılmış ayakta tedavi merkezi olan rehabilitasyon merkezinde takip edilen hastalardan oluşurken (n=31), ikinci grup, düşük/orta yoğunluklu tedavi merkezlerinde takip edilen hastalardan oluşmaktadır (n=44). Sosyodemografik veriler incelendiğinde yoğunlaştırılmış ayakta tedavi grubundaki hastaların yaş ortalaması 40,16±14,45 iken, düşük/orta yoğunluklu tedavi grubundaki hastaların yaş ortalaması 33,77±11,62'dir. Yoğunlaştırılmış gruptaki hastaların çoğunluğu (%80,6) erkek olup, büyük çoğunluğu lise mezunudur (n=14, %45,2). Düşük/orta yoğunluklu ayakta tedavi merkezlerinde de aynı şekilde grubun çoğunluğunu erkek hastalar (n=39, %88,6) oluşturmaktadır. Yoğunlaştırılmış ayakta tedavi merkezinde takip edilen hastaların çoğunluğu (n=21, %67,7) çalışmamaktadır, yaklaşık yarısının (n=15, %48,4) sosyal güvencesi yoktur. Düşük/orta yoğunluklu tedavi grubunda ise hastaların yarısı düzenli işe sahip ve %75'inin sosyal güvencesi vardır.

Yoğunlaştırılmış ayakta tedavi grubunda alkol kullanım bozukluğu (%51,6) ve karışık madde kullanımı (%38,7) yaygındır. Düşük/orta yoğunluklu grupta ise karışık madde kullanımı (%36,3) ve alkol kullanım bozukluğu (%31,8) daha yaygındır. Gruplar merkeze başvuru sırasındaki bağımlılık profil indeksi açısından değerlendirildiğinde, yoğunlaştırılmış ayakta tedavi merkezinde takibe alınan hastaların bağımlılık şiddeti ortalama 13,37±2,6 bulunmuş olup, grupta 8 (%24,8) kişi düşük, 10 (%32,2) kişi orta, 13 (%41,9) kişi yüksek bağımlılık şiddetine sahiptir. Düşük/orta yoğunluklu ayakta tedavi merkezinde takibe alınan hastaların bağımlılık şiddeti ise ortalama 11,13±3,35 bulunmuş olup, grupta 24 (%54,5) kişinin düşük, 13 (%29,5) kişinin orta, 7 (%15,9) kişinin de yüksek bağımlılık şiddetine sahip olduğu görülmüştür. Grupların üç aylık tedavi sonundaki durumlarına bakıldığında yoğunlaştırılmış ayakta tedavi merkezinde takip edilen hastalardan 24 (%77,4) kişi erken remisyon süresini tamamlamış olup tedaviye devam etmektedir. Düşük/orta yoğunluklu ayakta tedavi merkezinde takip edilen hastalardan 16 (%36,4) kişi erken remisyon süresini tamamlamış, 30 (%68,2) kişi tedaviden ayrılmıştır.

Tartışma

Bu çalışmada, farklı yoğunluktaki ayakta tedavi merkezlerine başvuran hastaların sosyodemografik ve klinik özellikleri ile bağımlılık profilleri karşılaştırılmıştır. Çalışmamızda, sosyodemografik veriler incelendiğinde her iki gruptaki hastaların yaş ortalamaları,

cinsiyet dağılımı, eğitim ve medeni durumları literatürle uyumludur. Hastaların istihdam durumlarına bakıldığında yoğunlaştırılmış ayakta tedavi merkezindeki hastaların çoğunluğunun çalışmadığı görülmüştür. Ancak bu gruptaki hastaların çoğunluğunun çalışmıyor olmasına rağmen, grubun yarısının kendine ait gelirinin ve sosyal güvencesinin olması, gruptakilerin daha ileri yaşta oldukları da düşünüldüğünde emekli olabileceğini ve şu anda düzenli bir iş sahibi olmamaları nedeniyle de yoğunlaştırılmış tedaviye yönlendirilmiş olabileceğini düşündürmüştür. Bu gruptaki hastaların çalışma oranlarının düşük olması, yoğunlaştırılmış ayakta tedavi programlarında iyileşme hedefleri içinde yer alan iş-istihdam sorunlarını da anlaşılır kılmaktadır. Düşük/orta yoğunluklu grupta ise hastaların yarısından fazlasının düzenli işi, kendine ait geliri ve sosyal güvencesi vardır ve sonuçlarımız literatürle uyumlu bulunmuştur. Bu gruptaki hastaların bağımlılık şiddetinin de görece daha düşük olduğu düşünülürse, bağımlılığın bu grupta mesleki işlevsellik üzerindeki etkilerinin daha az olduğu düşünülebilir. Bununla beraber, bu gruptaki hastalar düzenli işleri olması nedeniyle de haftalık saati daha az olan tedaviye başvurmuş olabilirler.

Gruplar merkeze başvuru sırasında bağımlılık profil indeksi açısından değerlendirildiğinde, yoğunlaştırılmış ayakta tedavi merkezindeki hastaların bağımlılık şiddeti, düşük/orta yoğunluklu ayakta tedavi merkezindeki hastalardan daha yüksektir. Araştırmamızda yoğunlaştırılmış ayakta tedavi merkezindeki hastaların daha ileri yaşta olduğu, çalışmadığı, merkeze başlamadan önce arındırma için yataklı tedavi ihtiyacı duyduğu ve ailede bağımlılık öyküsünün daha fazla olduğu düşünüldüğünde, literatürle uyumlu olarak yoğunlaştırılmış tedavi programlarına bağımlılık şiddeti ve bağımlılıkla ilişkili sorunları daha fazla olan hastaların yönlendirildiğini ve bu hastaların tedavisinin daha fazla destek, sorun alanlarına yönelik hedef belirleme ve kaynak gerektirdiğini göstermektedir. Yoğunlaştırılmış ayakta tedavi merkezindeki hastaların yüksek bağımlılık şiddetine rağmen diğer gruba göre daha fazla oranda üç aylık erken remisyon süresini tamamlamaları ve tedaviye devam etmeleri de bu tedavinin bu hastalarda etkin olduğuna dair önemli bir veridir.

Sonuç olarak elde edilen bulgular, bağımlılık tedavisinde bakımın sürekliliği ilkesi gereği farklı profillerdeki hastaların ayaktan takiplerinde, farklı yoğunluklardaki tedavi yaklaşımlarının etkinliğini vurgulamaktadır. Tedavinin devamlılığı ve etkinliği açısından hastaların bağımlılık şiddeti, yaşam koşulları ve bağımlılığın yaşam üzerine etkilerinin değerlendirilip, hastanın ihtiyaçlarına uygun yoğunlukta bir tedaviye yönlendirilmesi önemli olacaktır.