

## **Adolescent Substance Abuse Rehabilitation Program: Gaziantep, Turkey**

### **The Nature of the Problem**

Alcohol and drug abuse among adolescents remains a significant problem worldwide. Although data is sparse for many parts of the world, including Turkey, research compiled by the U.S. Center for Substance Abuse Treatment, the World Health Organization, the United Nations, universities and research centers, all point to a health care problem that plagues most countries.

Cannabis use is a significant issue in southern Turkey. Most cannabis is “home-grown” and is socially acceptable in many communities, including major cities such as Gaziantep, which has a population of 1.5 million residents.

In 2008, the Oya Bahadir Yuksel Rehabilitation Center, an adolescent substance abuse rehabilitation program in the suburbs of Gaziantep – about 30 minutes from the Syrian border, and two hours from Iraq – opened its doors. Istanbul native, Esra Cavusoglu, is the primary person in charge of this project, and under her leadership, the project will become a model for Turkey and perhaps Europe. I’ve had the privilege of playing a significant role in the development and operations of the Center.

A significant percentage of the Gaziantep population is Kurdish, displaced persons who fled their homes to escape the ongoing terrorist attacks along the Turkish-Syrian-Iraq-Iran borders. The Center serves boys, aged 15 to 19, many of whom have been living on the streets of Gaziantep for several years. Many of these boys have been separated from abusive families for years. The following represents the experience of the Gaziantep Adolescent Program.

Multiple problems associated with cannabis use are the norm, including: alcohol use; longtime histories of victimization; acts of physical violence and other illegal activity; and multiple social, emotional and medical problems. The movie *Slumdog Millionaire* aptly portrays the conditions from which the street boys of Gaziantep come. Many of the boys live off of whatever they can steal from homes, unsuspecting tourists and their families.

When there is evidence of substance dependence in Gaziantep among adolescent boys, many report health problems, acute mental distress, attention deficit hyperactivity disorders and conduct disorders. For boys who have run away from home and are living on the Gaziantep streets, solvents are the drug most often used, along with cannabis. Solvents (glue, thinner and even petroleum) are low cost. Most boys use solvents, cannabis, alcohol, Ecstasy, “roche” (nicknamed because of the “roche” name on the pill – benzodiazepine), and if they can afford it, any form of alcohol.

The costs to Turkey are difficult to calculate but can range from \$10,000 to over \$30,000 U.S. dollars per person per year. There is a high correlation between substance use severity and crime and violence. For adolescent boys at the Center between the ages of 12

and 17, half have had serious fights in school, most have sold drugs, and about a third have attacked another with the intent to harm. The vast majority have had a violent or illegal activity in the past year and committed acts of physical violence to another or property crimes and have had lifetime juvenile justice involvement. Many of the boys we treat at the Gaziantep Center have legal charges pending. If they were adults, many would be facing lengthy jail sentences for their crimes.

Substance use careers appear to be longer the younger the age of first drug use; and conversely, substance use careers are shorter the sooner boys receive treatment. The research data is clear: There are real and often lasting consequences of adolescent substance use on brain functioning and brain development, particularly with the use of solvents. Further, earlier intervention during adolescence and young adulthood can reduce the duration of an addiction career.

There are unique aspects about the population treated at the Gaziantep Center in Turkey: many of the boys are either illiterate or dropped out of primary school at an early age; and many have been living on the streets for years, with a primal instinct for survival. Despite coming from broken and violent homes, most of the boys still wish to return to their families. Their parents are living under very poor conditions. The world economic crisis has hit southern Turkey hard, where unemployment and under-employment is seriously felt. Finally, incest is common in many of the families. Fortunately, due to a low incidence of IV-drug use among the boys treated, HIV/AIDS has not become a significant issue for the Center, as yet.

### **Treatment works**

Substance abuse treatment can result in risk reduction, enhanced community safety, and crime reduction (Hiller, Knight, Simpson, 1999). Reintegration back into the community can occur. To maximize effectiveness, the Gaziantep Center has sought to provide a structured environment, including: intense monitoring of the boys' behavior; strict boundaries and rules; and clearly stated and applied consequences for violations. Since programs that focus on privileges and consequences seem to have the highest rates of success, the Turkey program has developed a series of incentives for positive behavior. The boys treated are very accustomed to the punishments of living on the streets and being in and out of the juvenile justice system. Instead, the Center has focused on incentives for positive behavior.

Data clearly shows that the longer the length of stay/involvement in treatment, the better the outcome. Further, the pattern of substance abuse outcomes is directly related to the pattern of co-occurring psychiatric morbidity (Shane et al, 2003). Family involvement increases outcome rates, especially when there are sessions for adolescents and parents together, to enhance communication skills. When the Turkey program began, it was assumed that there would be little interest or involvement of the families with the boys who had run away from their homes years ago. Much to our surprise, almost all of the boys, after a one- to two-month period of rehabilitation, were interested in reconnecting with their families. The family unit is a critical factor in Middle Eastern culture. An

intensive program of family education and counseling was implemented to aid in this transition back to the family.

Other variables that positively affect outcome include: relapse prevention training; refusal skills; communication skills training; problem solving components; regular urine testing; weekly 12-step meetings; weekly family meetings, and weekly telephone contact after discharge from a residential facility; contact with the judicial/educational systems; and referrals to other social services. Also, since the boys have been living on the streets for extended periods of time, training and counseling in basic habilitation skills, impulse control, anger management and coping with cravings is vital to the program. The program draws heavily from the principles of Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), with three to four 12-step meetings held at the Center nightly, in addition to daily step work.

The program was initially designed for a six-month period. As the program evolved, we found this to be too long for an initial commitment, and broke the rehabilitation program into three phases: acute care (one month); intensive care (two to four months); and extended care (two months), with the boys enrolling at each phase of treatment. Vocational training and job skills training, along with daily classroom education, has become an essential part of the intensive phase of treatment. The Center has now begun a program of continuing care for “graduates” of the three phases, and those who have re-entered into the community. Out-patient counseling, medication management, and 12-step meetings are offered in downtown Gaziantep.

Research indicates that treatment needs to target the latter phases of treatment to impact the post-treatment recovery environment and/or social risk groups that are the main predictors of long-term relapse. Treatment is a long-term process, and emphasis on re-entry back into the community, to habilitation and rehabilitation, is critical to the success of treatment. We are involving the juvenile justice system and to harness its resources. This is especially the case for treatment services in cities such as Gaziantep where the emphasis has been on the care and treatment of socially disadvantaged and street children, arguably one of the most difficult populations to treat.

## **The Turkey Model**

Esra Cavusoglu was a key person in establishing the Turkey Model for adolescent substance abuse treatment. The model was developed based on the program at the Oya Bahadir Yuksel Rehabilitation Center in Gaziantep, Turkey and is a unique blend of behavioral science, evidence-based practices and 12-Step principles that forms an effective, humane approach to treating substance abuse. Our approach is model- and patient-driven, and starts with a few working assumptions that govern all that we do:

1. Addiction is a chronic, progressive, treatable, bio-psychosocial spiritual disease, with genetic, psychosocial, physical and environmental factors.
2. Initial motivation for treatment is unrelated to outcome.
3. In all we do, we seek to treat people with dignity, respect and compassion.

4. We treat the whole person – body, mind and spirit.
5. Spirituality is an integral part of recovery.
6. Substance abuse mirrors other chronic diseases and should be treated as such.
7. Substance abuse is an involuntary disease; the addict doesn't choose this disease.
8. The Model promotes abstinence for an individual with the disease of substance abuse dependence.
9. Personal responsibility is central to recovery.
10. The cost for not treating the disease outweighs the investment in recovery.
11. Relationships are key to recovery.
12. Changes in lifestyle become the focus of rehabilitation.
13. The longer someone remains in treatment, the better the outcome.
14. Rehabilitation is multi-disciplinary, and utilizes the natural resiliency, support systems of the individual, extended family and community.

The components of rehabilitation in the Turkey Model include detoxification, counseling, psycho-education, classroom education, behavior modification, contingency management, life skills training and habilitation and vocational training. The Turkey Model is part of a continuum of care that begins and ends in the community, and includes residential care, extended care, transitional residential services, outpatient care, 12-Step programs, family education and counseling and community reintegration services.

The reader may think this all sounds like “motherhood and apple pie,” reminiscent of typical adolescent programs in America. Well, that's half right. The model draws heavily from American models of treatment. However, to fully appreciate the significance of the Gaziantep Center, one has to see the context in which the program operates: a predominantly Middle Eastern, Muslim country, within a population greatly affected by issues of poverty, terrorism, war and displaced persons.

To address these issues, the Turkey Model was designed to be flexible, dynamic and pragmatic, drawing upon the best that science-based medicine has to offer (with an emphasis on Motivational Interviewing and Contingency Management); and the life experiences of those who have worked in the addictions field for considerable time, adapted to a unique culture and population. The onset of addiction in the adolescents we treat has resulted in arrested physical, cognitive and social development. Treatment must address both substance-related issues and the healthy integration of coping and living strategies appropriate to the adolescent's stage of development. Recovery involves abstinence from mood-altering substances.

Esra Cavusoglu believes the best single mechanism for ensuring long-term recovery is active participation in mutual-help groups. The reintegration of the adolescent into sobriety is critical, involving a safe transition from residential to the community; safe housing/living arrangements; vocational and job training; and connections, when appropriate, back to the family. Therefore, we introduced Al-Anon to the families as a self-help means for the family members. In Gaziantep the extended family is typically involved, including parents, grandparents, aunts, uncles, siblings and often, neighbors.

We also believe the boys need positive male role models in their lives, as many of them come from violent, abusive homes, with substance-abusing fathers and friends.

The goals of treatment for the Turkey program are:

- to provide treatment maximizing long-term recovery for all boys;
- to provide a healthy, safe, supportive and caring environment by both adults and peers throughout the process;
- recovery potential is enhanced when the family, social, educational, vocational and living environments are supportive of their recovery goals; and
- it is essential that the adolescents develop positive, structured support systems.

### **Our treatment approach**

There are several evidence-based practices (EBPs) with good indicators for success. There are four that the Turkey Model has incorporated (12-Step, Behavioral, Family-Based and Therapeutic Community):

- **12-Step approach.** As is the case with most rehabilitation programs, the main feature of our approach is step work, a series of treatment and lifestyle goals that are works in groups and individually. The first three steps are covered in the acute and intensive phase of treatment, while steps four and five are addressed in extended care. Other components of our approach includes group counseling (the primary mode of treatment delivery); individual counseling; lectures and psycho-education; family programming (see below); written assignments (including step work); recreational activities; participation in Level 3 planning; and attendance at NA meetings and Al-Anon meetings for family members.
- **Cognitive Behavioral Therapy (CBT).** Behavioral approaches focus on the underlying cognitive processes, beliefs and environmental cues associated with the teens' use of substances and teaching them coping skills to help them remain drug-free. The goal of our behavioral approach is to teach adolescents to "unlearn" their use of substances and to learn alternative, pro-social ways to cope with their lives. Coping with the craving for substances is a critical phase in our treatment. In particular, given behavior is mediated by thoughts and beliefs, so the focus is on altering thinking as a way to change behavior. We emphasize aggression replacement training, reasoning, change thinking, interpersonal social problem solving, multi-systemic therapy, multidimensional family counseling, adolescent community reinforcement and assertive continuing care.

Other behavioral approaches focus on the development of coping skills, introduced and modeled by staff. Such skills training include: substance refusal skills; resisting peer pressure to use substances; communication skills (non-verbal communication, assertiveness training, negotiation and conflict resolution skills, anger management skills); problem-solving skills; relaxation training; social network development; and leisure-time management. New behaviors are tried out in low-risk situations (during group counseling role play sessions or individually

with a counselor) and eventually applied in more difficult, “real life” situations. Homework assignments are used to try out new behaviors or for collecting problem situations to discuss during counseling. Staff and senior patients provide positive reinforcement for the use of new, healthier behaviors.

Behavioral contracting is used to address behaviors to be changed. Weekly or daily incremental goals are mutually agreed upon. As each goal is reached, the adolescent is highly praised and reinforced through privileging. Behaviors are explicitly defined on the contract with criteria and time limitations noted.

- **Family-based approaches.** Despite the history of abuse within the home, the family plays a critical role in the development and maintenance of substance abuse problems. In Turkey, the family is a collection of sub-systems (e.g. parents, grandparents, step-parents, siblings, relatives, neighbors and community), each with a variety of roles. Our family program is multi-dimensional and progressive, depending on the stage of development, familial relationships, severity of the illness and impaired relationships. Our approach includes: observing the family’s interactional patterns; identifying problems in interactions; family education about the disease of addiction and how the family is involved; and steps the family can take to address the adolescent’s issues.
- **A Positive Peer Culture, as found in a modified therapeutic community.** Our philosophy seeks to address all aspects of the adolescent, body, mind and spirit, integrating these elements through a positive peer culture. Since Turkey is 99 percent Muslim, theological education has been an essential part of our rehabilitation program for many of the boys.

It is imperative that the adolescent learn how to integrate healthy behaviors into his maladaptive drug-based lifestyle. The therapeutic community is a surrogate family for the adolescent, providing a therapeutic and supportive environment for the person to mature and grow. Many of the boys have known each other on the streets. In some cases, they protected each other in dangerous situations or fought with each other.

Our program is highly structured, with days scheduled from early morning through the evening and weekends. Idle time is the worst enemy for the adolescent’s recovery. Days are filled with school classes and tutoring, peer groups, group counseling, individual therapy, recreation, vocational and skills training and occupational training. Management of the community rests, in part, on the resident/adolescent himself, and all are assigned tasks and jobs. Through progress and productivity, they rise through the hierarchy to positions of coordination and leadership. Rewards are an integral part of the program.

## **The Facility**

The Gaziantep Program is a unique blending of public (the Municipality of Gaziantep) and private (philanthropic) cooperation, under the vision of Esra Cavusoglu. The facility was constructed with private gifts, and land was donated by the Municipality. Staffing is provided by the Municipality through a private contracting firm. Structure, program design and implementation and clinical oversight are provided through funding from a private donor. This unique combination of public/private management is a model for the European Union.

The main facility has the capability of housing up to 120 boys. However, the current plan is to admit from 60 to 80 boys, at which point the capacity will be reviewed. A staff of 50 offers the full range of services from medical/nursing care, counseling, psychological and psychiatric services, counselor assistants/aides, classroom education, job skills training, housekeeping, physical therapy and recreation, drama, folk dancing and music, theological education, handicrafts, security and food services. There is a small but growing community of recovering persons in southern Turkey. The Center has recruited people in recovery from throughout Turkey. Training of personnel has been a primary goal for the first year of operation. As services expand, additional facilities will be needed for extended care, aftercare, job skills training and reintegration back into the community.

## **Conclusion**

The Turkey Model for Adolescent Substance Abuse Rehabilitation is a model that, although new, could become an outstanding approach for substance abuse treatment for Turkey and Europe. As outcome data is accumulated, we are optimistic that we will be successful at returning valuable youth to their community and to society. For further information, contact Esra Cavusoglu at [esra.cavusoglu@yahoo.com](mailto:esra.cavusoglu@yahoo.com) or David Powell at [www.ichc-us.org](http://www.ichc-us.org), [djpowell2@yahoo.com](mailto:djpowell2@yahoo.com).

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