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SUBSTANCE ADDICTION: A HANDBOOK ON DEFINITION, PERCEPTION, AND INTERVENTION

SUPPORTING FAMILIES OF PERSONS TRYING TO GET RID OF DRUG ADDICTION

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Substance Addiction: A Handbook on Definition, Perception, and Intervention

Purpose

To define substance addiction (substance use disorders) within a **biopsychosocial** framework; to make Türkiye and global epidemiology visible using up-to-date sources; to propose communication strategies that reduce stigma/perception problems; and to bring together diagnosis–assessment, treatment, rehabilitation, harm reduction, prevention, and policy components in a field-applicable **handbook** format.

Who is this text for?

Default target audience: **general healthcare workers, social workers, policymakers, and civil society organizations**.

The blunt reality

Globally, in 2023 (excluding alcohol and tobacco), **316 million** people used illicit drugs at least once; **64 million** people lived with a substance use disorder; and only **1 in 12** people with a substance use disorder received any treatment. This shows the gap between "intention" and "system capacity" is still massive.

Selected finding from Türkiye's official reports

In 2023, **349,393** outpatient applications to addiction treatment centers were reported (excluding alcohol/nicotine); **134,390** of these were referrals via probation. In the same year, there were **16,291** applications to inpatient centers and **13,168** unique individuals recorded; total treatment centers: **138**; bed capacity: **1,396**.

Drug-related death pattern (Türkiye, 2023)

The number of **direct drug-related deaths** was **300**; **61.6%** of deaths were associated with **polysubstance use**. This clearly says that a "single-substance" focus is insufficient clinically and politically.

Forward-looking direction

Türkiye's 2024–2028 strategy document acknowledges that surveys can be limited due to "hiding/stigma," and includes alternative measurement methods such as **wastewater epidemiology** in its target set. This approach has real potential for a leap in both epidemiological accuracy and policy accountability.

Priority institutional backbone sources

World Health Organization; United Nations Office on Drugs and Crime; in Türkiye the Republic of Türkiye Ministry of Health line (strategy/monitoring); TURKSTAT measurements; Presidency of Strategy and Budget policy monitoring framework; Cochrane for clinical evidence synthesis.

Implementations (summary table)

Implementation	Target audience	Sources	Time frame	Cost estimate
Common in-house language (stigma-reducing terminology) + "one-page" clinical pathway	Healthcare workers, social services, NGOs	UNODC/WHO Treatment Standards; YEDAM stigma materials	2–4 weeks	low
Unit-level screening–brief intervention–referral (SBIRT) flow	Family medicine, ED, non-psychiatric clinics	WHO mhGAP recommendations; SBIRT evidence summary	1–3 month pilot	medium

Local data dashboard: applications, treatment, quitting/relapse, deaths, HIV/HCV	Provincial health managers, policy	Türkiye 2024–2028 indicators; Türkiye Drug Report	3–6 months	uncertain
Multidisciplinary case management + family-inclusion protocol	AMATEM/addiction units, social services	System standards; Türkiye reports	3–6 months	medium

Key sources listed: UNODC World Drug Report 2025 “key figures”; WHO EB158/7 (2025) situation analysis; Türkiye Drug Report (2024; 2023 data); National Strategy Document and Action Plan 2024–2028; SBB Addiction-Fighting report (2025).

Definition of addiction and the biopsychosocial model

Purpose

To move “What is addiction?” beyond one-line slogans and define it clearly enough to guide clinical and policy decisions; to place biological, psychological, and social components in a single model; and to replace harmful misconceptions (moral weakness/lack of willpower) with a functional framework.

Key points

- In many authoritative frameworks, addiction is treated as a **chronic, recurrent medical condition** (with relapse), characterized by **continued use despite harm** and **loss of control/compulsive use**.
- Diagnostic systems (DSM and ICD) describe severity not only via withdrawal/tolerance, but via a combination of **loss of control, risky use, social/functional impairment, and pharmacological criteria**. This reduces both clinical error (focusing only on abstinence symptoms) and stigma risk (labeling the person as “weak-willed”).

Biological component

At the neurobiological level, addiction is shaped by interactions among **reward/learning, motivation, stress response, and executive function** circuits. So it's not "pure choice," but it's not "pure fate" either—treatment and environmental restructuring can retrain the system.

Psychological component

Clinically, a common loop is "substance = emotion regulation tool": anxiety, post-traumatic symptoms, depressed mood, impulsivity, difficulty delaying gratification can function as **use triggers** and **relapse risks**. Therefore, treatment cannot be "detox only"; **psychosocial intervention must be the backbone**.

Social component

Unemployment, precarious work, educational disengagement, social exclusion, and contact with judicial processes are associated with both increased risk and decreased access/retention in treatment. In Türkiye's 2023 treatment data, a substantial portion of those treated had no "regular job," pointing to why **treatment + social reintegration** must be designed together.

Practical recommendations

The most common field error is framing addiction as a "willpower problem" and generating shame. Instead:
(i) **person-first language** ("person with a substance use disorder" instead of "addict"),
(ii) **short, measurable goals** (first 2 weeks: safety/withdrawal/sleep; first 3 months: use frequency and functioning),
(iii) design care like **chronic disease follow-up** (normalize episode–remission–relapse cycles from the start).

Epidemiology of substance addiction and disease burden

Purpose

To answer "How big is the problem?" without hiding measurement limitations; to present Türkiye and global data side by side.

Key findings (global)

In 2023 (excluding alcohol and tobacco), **316 million** people used drugs; within this:

- Cannabis: **244 million** (largest)
- Opioids: **61 million**
- Amphetamines: **30.7 million**
- Cocaine: **25 million**
- Ecstasy: **21 million**

The cost is not only individual: UNODC reports over **half a million** deaths and **28 million DALYs** (healthy life years lost) linked to substance use disorders (2021). WHO reports alcohol and psychoactive substance use correspond to **2.6 million** and **0.6 million** deaths, respectively.

Key findings (Türkiye)

- Türkiye's 2024 drug report states that by end-2023 there were **138** treatment centers (60 offering inpatient services) with total **1,396** beds.
- Outpatient treatment applications (excluding alcohol/nicotine): **349,393** (2023).
- Inpatient applications: **16,291** (unique **13,168**).
- In the substance distribution among those treated in 2023, **methamphetamine (37.1%)** and **heroin (28%)** stand out—suggesting field priorities should be planned as an **opioid + stimulant mix**.
- Direct drug-related deaths in 2023: **300**; **61.6%** linked to **polysubstance use**, with methamphetamine prominent in several headings.
- For "ever used illicit drugs at least once" in the general population, policy monitoring documents report **3.1%** for 2018 (within an indicator framework)—showing measurement exists, but also highlighting the need for updated/continuous measurement.

Measurement limitations

Due to the nature of illegal use, stigma, and legal risks, surveys produce underreporting. The national strategy document explicitly emphasizes methods like **wastewater analysis** as an "objective and frequently repeatable" alternative.

Note: The “substance type distribution in treatment” is not population prevalence. The treatment sample is a selected population due to access and referral mechanisms.

Implementations (epidemiology)

Implementation	Target audience	Sources	Time frame	Cost estimate
Provincial “addiction data dashboard” (applications, admissions, deaths, HIV/HCV, relapse)	Provincial health managers	Türkiye Drug Report; national plan indicators	3–6 months	uncertain
Wastewater epidemiology pilot (metropolitan)	Policy, universities	National plan; wastewater targets	6–12 months	high
Treatment capacity mapping (beds, outpatient units)	Health planning	Treatment center data	1–2 months	low
Risk communication tailored to polysubstance use	NGOs, media, field teams	Death pattern	1–3 months	low

Risk and protective factors

Purpose

To treat risk factors as “intervention points,” not labels; to convert protective factors into measurable design targets; to rationalize resource allocation by making the most vulnerable groups visible.

Key findings

Risk factors are multi-layered and interact:

- Individual (genetic vulnerability, early onset)
- Psychological (trauma, comorbid mental disorders)
- Social (poverty, exclusion, peer group, availability)
- Structural (treatment access, contact with the legal/penal system)

UNODC/WHO prevention standards emphasize that effective prevention is not a "single campaign," but a **system**.

Stigma produces secondary harm independent of risk itself: it delays help-seeking and makes treatment retention harder ("avoiding labels"). This mechanism is explicitly described in local stigma-focused sources in Türkiye.

Türkiye-specific risk windows: the high share of methamphetamine and heroin in treatment patterns increases the need for **high-intensity interventions** due to rapid tolerance–withdrawal cycles, psychosis risk, and transition likelihood into polysubstance use.

Protective factors (use as measurable design goals):
(i) life skills and emotion regulation (especially children–adolescents),
(ii) family functioning (monitoring, boundaries, warm relationship),
(iii) school/work attachment and meaningful social roles. UNODC/WHO standards favor structured programs over fear/shock-style interventions without protective effect.

Practical recommendations

Link risk assessment not to "who is to blame?" but to "where do we start?" A simple field rule:

1. **Safety** (overdose, psychotic symptoms, severe withdrawal, suicide risk)
2. **Functioning** (school/work, family, housing)
3. **Support** (at least one trusted person + one institutional connection)

If any of these three is missing, case management should be intensified.

Addiction perception, stigma, and communication

Purpose

To expose stigma mechanisms (society–institution–individual) and convert them into measurable interventions; to correct media and in-service communication errors; to increase help-seeking behavior.

Key findings

- Studies in Türkiye examine stigmatizing attitudes toward addiction among both the public and health professionals; stigma directed at women who use substances and its impact on reducing treatment applications has been reported.
- Across university students and other groups, the level and determinants of stigmatization have been examined, showing this area is responsive to educational interventions.
- Institutional stigma is critical: expectations of "bad service experience" and "being labeled" delay applications and reduce retention—explicitly described in local stigma sources.

Practical consequences of stigma

Stigma is not just emotional harm; at scale, internalized stigma is linked to treatment motivation and social support. Research also examines how interventions like family involvement work via motivation and social support.

Media effect and communication policy

Türkiye's 2024–2028 action plan includes a communication component that targets not only public information campaigns but also news-making within a framework of "media ethics principles," plus impact analysis of communication activities—bringing the "there is news but also harm" problem into formal policy.

Practical recommendations

Three simple institutional changes can create dramatic differences:

1. **Language:** not "addict," but "person with a disorder" (state, not identity).
2. **Contact:** in the first meeting, not a "judgment interrogation," but a "safety and needs" assessment.

3. **Confidentiality:** unclear confidentiality rules close the door—especially for people with legal-system contact.

Short field script:
"Being here today is a step. I won't pressure you with 'why can't you quit?' What is the highest risk right now—insomnia, withdrawal, or a crisis? Let's secure safety first; then we'll build a plan together."

Diagnostic and assessment tools

Purpose

To standardize field decisions: who gets what screening, when to refer, how to diagnose; to translate DSM-5 and ICD-11 into practical tools; to embed screening scales (ASSIST, AUDIT, etc.) into institutional workflows.

Key findings

- DSM-5 evaluates SUD via 11 criteria; severity increases with the number of criteria met (mild 2–3, moderate 4–5, severe ≥6). This enables "talking about severity" and helps determine treatment intensity.
- ICD-11 classifies disorders under "disorders due to substance use and addictive behaviors," making public health framing and substance classes more visible.

Screening tools

- WHO's ASSIST was designed for primary care multi-substance screening and brief intervention/referral.
- AUDIT is widely used to detect risky/harmful alcohol use, with primary care guidelines.

Withdrawal and acute clinical assessment

- COWS for opioid withdrawal helps quantify clinical decisions (e.g., medication initiation timing); a Turkish validity–reliability study exists.

SBIRT

SBIRT aims to close the treatment gap through universal screening and early intervention. Meta-analyses on e-SBIRT suggest some short-term outcomes may improve, but results are context-sensitive—meaning it's not a "magic wand," it requires correct implementation and follow-up.

Implementations (assessment)

Implementation	Target audience	Sources	Time frame	Cost estimate
Standard screening package (ASSIST + AUDIT-C/AUDIT)	Primary care, ED, outpatient clinics	WHO ASSIST; WHO AUDIT	1–2 months	low
DSM-5 severity classification checklist	Clinical teams	APA DSM-5 SUD summary	2–4 weeks	low
COWS use for opioid withdrawal	ED/addiction units	COWS + TR validity	2–4 weeks training	low
SBIRT integration into workflow + audit	Health system managers	SBIRT evidence summaries; WHO recommendations	3–6 months	medium

Treatment approaches, rehabilitation, and harm reduction

Purpose

To move treatment beyond “detox + lecturing” into an evidence-based, modular, continuity-based system; to unify pharmacological, psychosocial, rehabilitation, and harm-reduction components on one line.

Key findings

- UNODC/WHO international treatment standards emphasize that effective treatment should improve physical–psychological–social functioning in addition to symptom reduction; warn that practices inconsistent with scientific evidence may be ineffective/harmful; and include explicit warnings against human-rights violations.
- In opioid use disorder, agonist treatment (methadone/buprenorphine) reduces mortality risk; death risk rises sharply especially after leaving treatment—so initiation–maintenance–discontinuation phases require risk management.
- In stimulant use disorder, psychosocial interventions—especially contingency management and CBT—stand out; this is one of the areas where “medication will solve it” most clearly fails.
- MI can be useful in some contexts for reducing use, but because effects are heterogeneous, it should be positioned within a package rather than presented as a miracle on its own.

Pharmacological approaches

- Opioids: options such as methadone/buprenorphine, naltrexone; withdrawal management and long-term maintenance are planned separately; WHO recommends medication together with psychosocial support.
- Alcohol: options such as naltrexone/acamprosate/disulfiram (per country protocols); guidelines integrate screening + brief intervention + specialist treatment when needed.
- Nicotine: combining pharmacotherapy and behavioral support; even if the handbook focuses on “drugs,” excluding nicotine treatment is a clinical mistake given the reality of multiple addictions.

Psychosocial treatments

CBT, relapse prevention, MI, group therapies, family-based interventions; the goal is not “feel perfect,” but “restore functioning + make relapse manageable + reduce harms.”

Rehabilitation and social reintegration

Türkiye's report directly emphasizes the need for long-term rehabilitation and social reintegration after treatment; relapse risk is high if cases are left with medical detox only.

Harm reduction

- WHO recommends community access to naloxone and training of people likely to witness overdose—this is not "approving use," it's "preventing death."
- WHO's 2026 operational guide defines planning and scaling steps for needle–syringe programs (NSP) for people who inject drugs, recommending a human-rights and public-health package approach.

Examples of service access in Türkiye (referral logic)

Addiction treatment runs through inpatient/outpatient centers (network and capacity are included in the report). In addition, NGO-based psychosocial counseling services (e.g., Turkish Green Crescent-linked counseling network and the Yeşilay Counseling Center model; Liman Sober Living Association model) provide free psychosocial support and lower the "first contact" barrier. Hospital-based adult treatment unit pages (e.g., AMATEM descriptions on specific hospital sites) provide practical references for the field question "where do we refer?"

Implementations (treatment)

Implementation	Target audience	Sources	Time frame	Cost estimate
Opioid agonist therapy + psychosocial support	Addiction units, psychiatry	WHO opioid guideline; BMJ mortality meta-analysis	6–24 months (chronic)	uncertain

CM/CBT for stimulant disorders	Addiction clinics	Cochrane stimulant psychosocial	3–6 month program	medium
Naloxone access + training	ED, community teams, NGOs	WHO overdose guideline	3–12 months scaling	uncertain
NSP planning and scaling	Public health, municipalities	WHO NSP guide 2026	6–18 months	high
Rehabilitation & social reintegration (work/housing/family roles)	Social services, employment partnerships	Türkiye reports; system standards	6–24 months	uncertain

Prevention, policy, ethics–human rights, family guide, case examples, and monitoring–evaluation

Purpose

To build an integrated final section showing addiction response is not “one institution’s job”; proposing implementable policy packages across school–community–health system–law; clearly setting human-rights boundaries; giving concrete steps for families/caregivers; and providing a case-based implementation guide and metrics set.

Key findings

- UNODC/WHO prevention standards stress the need for an evidence-based intervention portfolio plus a national system; instead of short fear campaigns, components like life skills, family programs, school climate, and community protective networks matter.

- Türkiye's 2024–2028 strategy document defines final indicators (chronic use; last month/last year/lifetime use; youth/university indicators; wastewater analysis; HIV/HCV; deaths), institutionalizing "you can't manage what you don't measure."
- Ethics and human rights: involuntary "treatment" detention/closed centers have been criticized in joint UN statements due to human-rights violation risk and lack of evidence for effectiveness, with calls to close them and shift to voluntary, community-based services.
- UNODC/WHO published a handbook recommending structuring treatment for justice-involved people as an "alternative to conviction/punishment," aiming to improve health outcomes and reduce reoffending/rearrest cycles.

Family and caregiver guide

The reality for families: "trying very hard" is not always "helping correctly." Effective support carries boundaries, consistency, and safety together. Local counseling models (like YEDAM) define the family as part of the service and emphasize confidentiality—practically breaking the "we're alone" feeling. Research in Türkiye samples has examined family involvement in relation to stigma, social support, and treatment motivation—showing excluding the family can be a clinical error.

Ten-item rapid guide for families

1. Crisis safety: if violence/psychosis/overdose is suspected, it's not a "discussion," it's emergency help.
2. Home boundaries: money/debt/home rules in writing and consistent.
3. Replace "evidence debate" with "emotion and need": not "again?" but "what's the risk today?"
4. Accompany treatment: appointment, transport, follow-up plan—without taking over responsibility.
5. Trigger map: sleep, stress, loneliness, peer group, money flow.
6. Relapse plan: not "relapse = finished," but "relapse = plan activated."
7. Family communication: blaming language feeds addiction; boundary language manages it.
8. Children: age-appropriate openness; don't load them with "secrets."
9. Caregiver burnout: support group/psychological support plan.

10. Law-judicial process: aim is not punishment, but expanding treatment and social reintegration options.

Case examples and practical guide

Case A: Methamphetamine + insomnia + paranoid thoughts (acute risk window)

- Situation: 28-year-old male; minimal sleep for 5 days; "I'm being followed" belief; intermittent alcohol; brought by family.
- Assessment: psychotic symptoms → safety first; high likelihood of polysubstance use. Methamphetamine has a high share in Türkiye's treatment data and can co-occur with polysubstance patterns.
- Practical steps:
    - Brief screening + risk: suicide/violence, severe agitation, withdrawal.
    - Medical assessment: vitals; manage sleep/agitation; admit if needed.
    - Psychosocial: train family: "don't argue, protect safety"; follow-up within 48–72 hours.
- Follow-up metric: 7 days "sleep + number of use days"; 1 month "functioning"; 3 months "relapse/follow-up."

Case B: Opioid use disorder + withdrawal + ambivalence toward treatment

- Situation: 34 years; daily opioids; "I want to quit but I can't stand it."
- Assessment: score opioid withdrawal severity with COWS (Turkish validity exists).
- Practical steps:
    - Explain options: agonist treatment + psychosocial support; accurate info on early-phase and post-dropout death risk (risk management, not scare tactics).
    - Naloxone training: home/peers may witness overdose; WHO recommends community naloxone strategies.
- Follow-up metric: retention, non-opioid use, emergency visits.

Case C: Probation referral + low motivation

- Situation: 22 years; in the program saying "I have to."

- Assessment: even with coercion, the target is not “punishment,” but “connecting to treatment.” In Türkiye, a large portion of outpatient applications are probation referrals.
- Practical steps:
    - Use MI to discuss “goal conflict”: short goals + relationship building.
    - Structured psychoeducation programs (e.g., SAMBA-type) are used in institutions; implementation should follow local protocol.
- Follow-up metric: program continuation/completion; 6-month repeat judicial case rate (aligned with national plan indicators).

Implementations (policy + system)

Implementation	Target audience	Sources	Time frame	Cost estimate
Evidence-based national prevention system (school–family–community)	Policy, MoNE, local government	UNODC/WHO Prevention Standards	2–5 years	uncertain
Human-rights safeguards (voluntariness, confidentiality, against forced detention)	Health, justice, NGOs	OHCHR/UN joint statements; UNODC/WHO standards	ongoing	low–medium
Alternative sanctions: referral to treatment (instead of punishment)	Justice system, health	UNODC/WHO “Alternatives…”	1–3 years	uncertain
Family support protocol + caregiver training	Clinics, YEDAM-like services	Family–stigma studies; counseling model	6–12 months	low–medium

Monitoring–evaluation dashboard + wastewater pilot	Provincial coordination	Türkiye 2024–2028 indicators	1–2 years	uncertain–high

Key sources listed: UNODC/WHO International Standards on Drug Use Prevention (2018); Türkiye 2024–2028 indicators (use, wastewater, HIV/HCV, deaths); OHCHR/UN joint statement (forced detention centers); UNODC/WHO “Alternatives to Conviction or Punishment” (2018); Türkiye Drug Report (treatment and death patterns); SBB performance indicator framework.