

**REPUBLIC OF TURKEY
MINISTRY OF INTERIOR
TURKISH NATIONAL POLICE
Anti-Smuggling and Organized Crime Department**



European Monitoring Centre
for Drugs and Drug Addiction



Turkish Monitoring Centre
for Drugs and Drug Addiction

**2014 NATIONAL REPORT (2013 data) TO THE
EMCDDA**

by the Reitox National Focal Point

TURKEY

**New Development, Trends and in-depth information
on selected issues**

**TURKISH MONITORING CENTRE FOR DRUGS AND
DRUG ADDICTION (TUBİM)**

REITOX

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Gendarmerie Criminal Department

Turkish Coast Guard Command

Intelligence Department

MINISTRY OF CUSTOMS AND TRADE

General Directorate of Customs
Enforcement

MINISTRY OF HEALTH

General Directorate of Health Services
Turkish Pharmaceuticals and Medical
Device Agency

Turkish Public Health Institution

Turkish Public Hospital Institution

MINISTRY OF JUSTICE

Council of Forensic Medicine
General Directorate of Prisons and
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MINISTRY OF NATIONAL EDUCATION

General Directorate of Special Education
and Guidance Services

**MINISTRY OF FOOD, AGRICULTURE
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Turkish Grain Board
General Directorate of Plant Production
Tobacco and Alcohol Market Regulatory
Authority

MINISTRY OF FINANCE

Financial Crimes Investigation Board

MINISTRY OF LABOUR AND SOCIAL SECURITY

Social Security Institution
General Directorate of Universal Health
Insurance
Turkish Employment Agency

MINISTRY OF FAMILY AND SOCIAL POLICIES

General Directorate of Family and
Community
General Directorate of Child Services

MINISTRY OF YOUTH AND SPORTS

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TUBİM

PREFACE

The Turkish Monitoring Center for Drugs and Drug Addiction (TUBIM), operating under the Anti-Smuggling and Organized Crime Department (KOM) of the Turkish National Police (EGM), collects data and reports on drugs and drug addiction at a national level, and shares Turkey's data with the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) as its Contact Point in Turkey.

The Turkish Drug Report, as one of the most significant outputs of TUBIM's national monitoring process, has been prepared and published since 2006, and is presented as a guide for the relevant institutions and organizations to foster effective policy development aimed at boosting the fight against drugs.

The 2014 Turkish Drug Report provides an overview of the current drug-related situation in Turkey with the relevant data and analyses. Thanks to the year-on-year progress made in the collection and diversification of data, the report is becoming a crucial scientific resource for the representatives of relevant public bodies and scientists working in the field of drugs and drug addiction.

The report on Turkey's drug profile presents the latest data on drug-related policies, studies on the prevalence of drug use, preventive action, high-risk drug use, drug addiction treatment, drug-related infectious diseases and deaths, post-treatment rehabilitation services, and efforts aimed at reducing drug supply. The report, which is prepared in line with the standards set by the EMCDDA, is published both in Turkish and English, and is shared regularly with the EMCDDA.

In the fight against drugs, it is vital to raise awareness among the general public, to define the current problems and to identify future steps to be taken to address the problem. To ensure an effective program it is required that all relevant institutions and organizations work in close cooperation with one another. In this regard, this report can be considered a good indicator of the sensitivity of all relevant institutions and organizations, as well as the inter-institutional coordination, and is a significant achievement that is attained through inter-institutional cooperation and collaboration.

The invaluable efforts of TUBIM's Institutional Contact Points, the writers of each section who provide vital data, and the TUBIM officials who ensure the required coordination for the writing of other sections and editing of the report are all highly appreciated. I would like to extend my sincere thanks to all the individuals and institutions that have contributed to this important

report, and hope that it will serve all relevant parties and shape the processes in the fight against drugs.

Orhan ÖZDEMİR
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ABBREVIATIONS

6-MAM	: 6-Monoacetylmorphine
AA	: Acetic Anhydride
AB	: European Union
ABD	: United States of America
AIDS	: Acquired Immune Deficiency Syndrome
AKB-48	: 1-pentyl-N-tricyclo[3.3.1.1 ^{3,7}]dec-1-yl-1H-indazole-3-carboxamide
AMATEM	: Research, Treatment and Training Centre for Alcohol and Substance Addiction
ASPB	: Ministry of Family and Social Policies
ATK	: Institution of Forensic Medicine
BSRM	: Care and Social Rehabilitation Centers
CEDIA	: Cloned Enzyme Donor Immune Assay
CTEGM	: General Directorate of Prisons and Detention Houses
EGM	: Turkish National Police
EMCDDA	: European Monitoring Centre for Drugs and Drug Addiction
EU	: Euro
EWS	: Early Warning System
GPS	: General Population Survey
GSS	: General Health Insurance
HBs	: Immunized against Hepatitis B
HBsAG	: Hepatitis B Virus Surface Antigen
HBV	: Hepatitis B Virus
HCV	: Hepatitis C Virus
HIV	: Human Immunodeficiency Virus
HRDU	: High Risk Drug Use
ICD	: International Statistical Classification of Diseases and Related Health Problems
INCB	: International Narcotics Control Board
İLTEM	: TÜBİM Provincial Contact Points
İŞKUR	: Turkish Employment Agency
JGK	: Gendarmerie General Command
JWH-018	: Naphthalen-1-yl-(1-pentylindol-3-yl)methanone
JWH-073	: Naphthalen-1-yl-(1-butylindol-3-yl)methanone
JWH-0122	: (4-methyl-1-naphthalenyl)(1-pentyl-1H-indol-3-yl)-methanone

KBRM	: Protection, Care, and Rehabilitation Centers
KOM	: Department of Anti-Smuggling and Organized Crime
MASAK	: Financial Crimes Investigation Board
MBÖ	: Drug Related Death
MDA	: 3,4-methylenedioxyamphetamine
MDEA	: Metil dietanolamine
MDMA	: 3,4 methylenedioxyamphetamine
MMDMG	: Metil3-[metilidindioxy]fenil 2-metil glycidate
NA	: Narcotic Anonymous
NGO	: Non-Governmental Organization
OST	: Opiate Substitution Program
PDU	: Problem Drug Use
PMK	: 3,4 Ethyllenedioxyphenylacetone
REITOX	: The European Information Network on Drugs and Drug Addiction
RNA	: Ribonucleic Acid
RTÜK	: Radio and Television Supreme Council
SAMBA	: Intervention Program for Tobacco, Alcohol and Drug Addiction
SGK	: Social Security Institution
SRO	: Safrole Olive Oil
ST	: Standard Table
SUT	: Health Application Communication
ŞİB	: Suspicious Transaction Notifications
TBMM	: Turkish Grand National Assembly
TCK	: Turkish Penal Code
THC	: Tetrahydrocannabinol
TİTCK	: Turkish Drug and Medical Device Institution
TL	: Turkish Lira
TMO	: Turkish Grain Board
TRT	: Turkish Radio and Television Corporation
TUBİM	: Turkish Monitoring Centre for Drugs and Drug Addiction
TÜİK	: Turkish Statistical Institute
UN	: United Nations
UNODC	: United Nations Office on Drugs and Crime
YPK	: Higher Planning Council

SUMMARY

Drug Policy: Laws, Strategies, and Economic Analyses

Even though the term “drugs” is thought to refer to only the substances with intoxicating properties, it is actually a term that has to be perceived in a wider sense, as most of society does, to include the substances that essentially stupefy, provoke, tranquilize, and stimulate the imagination and alertness. The target meaning of the term “drug” is not the effect it has on the central nervous system, but all of the types of substances with peculiar properties irrespective of these effects (National Policy and Strategy Document on Drugs, 2013-2018).

The concept of “the fight against drugs” is about presenting the current situation of the drug problem, and address the problem in a multidimensional model targeting supply reduction, demand reduction, international cooperation, data collection, research, assessment, and coordination.

The first section on drug policy covers the relevant legislative arrangements aimed at promoting the fight against drugs, and the legal amendments that were prepared/are followed by the institutions and organizations, which combat drugs and drug addiction, and that were introduced in 2013 and later, to the extent that they were reported to the Turkish Monitoring Center for Drugs and Drug Addiction (TUBIM).

As the terms of the first National Policy and Strategy Document on Drugs, which outlined Turkey’s policies against drugs as well as its strategies, and the second National Action Plan against Drugs ended as of 1 January 2013, a second National Policy and Strategy Document on Drugs (2013-2018), and a third National Action Plan against Drugs (2013-2015) were prepared with the contribution and agreement of the relevant institutions. The implementation of the recently prepared documents was deemed appropriate and approved by the Prime Ministry on 2 September 2013.

To ensure the effective implementation and coordination of practices relating to Children’s Rights, the “National Strategy Document on the Rights of the Child” encompassing the 2013-2017 period was approved by the Higher Planning Council (YPK) based on the decision number 2013/33 dated 14 December 2013, which was published in the relevant issue of the Official Gazette. This Strategy Document aims to improve the welfare and quality of life of

children, and to ensure that they can benefit to the fullest from their fundamental rights such as the right to live, development, protection, and participation. The “National Strategy Document on the Rights of the Child” encompassing the 2013-2017 period is one of the instruments used to define national policies, and establishes provisions on the necessary measures to be taken for the prevention of all children from addiction.

With respect to the activities for combatting drugs, the necessary coordination at a national level between the relevant institutions/organizations is ensured by TUBİM. The National Coordination Committee on Drugs of TUBİM holds meetings on two different subjects, one of which is “Combatting Supply,” while the other is “Reducing Demand, and Provision of Treatment and Rehabilitation.” The National Coordination Committee on Drugs has convened 18 times within 2013. The TUBİM Science Committee was formed according to the National Action Plan against Drugs (2007-2009) in order to provide scientific support to the activities being conducted in Turkey for combatting drugs and drug addiction. The committee provides scientific recommendations to the National Coordination Committee on Drugs. The Science Committee has convened 18 times as of the end of 2013.

The Early Warning System (EWS) Study Group is a significant element of the national coordination. As a result of the EWS Study Group’s meetings, 94 new psychoactive substances have been included between 2007 and 2013 into the scope of the Law on the Control of Drug Substances number 2313. With an additional 246 new psychoactive substances that have been included into the scope of this law in 2014, the number of new psychoactive substances to have been included into the scope of the law between 2007 and 2014 reached 340.

In Turkey, the expenses for combatting drugs were first documented and reported by TUBİM in 2010. To ensure that the necessary data would be collected more accurately and systematically, the “Form regarding Public Expenses for Combatting Illicit Addictive Substances” was developed in 2011. Data collected using this form began to be reported in 2012 (which reflected the data for 2011). While data for this report were initially collected from central institutions only, data also began to be collected from provincial municipalities starting in 2013 (which reflected the data for 2012) in order to increase data capacity.

In 2012, public expenses increased by 6.21% compared to the previous year to reach 395,792,281 TL. In 2013, public expenses increased considerably by 87.86% compared to the previous year to reach 743,546,907 TL. It was determined that this increase mainly stemmed

from a considerable rise compared to the previous year in the equipment and infrastructure-related expenses of one of the institutions that forwarded their data to TÜBİTAK.

Drug Use Prevalence

During the research on drug use in general population, carried out by TÜBİTAK in 2011, 8,145 households from 25 provinces were interviewed. The study revealed life-long drug use frequency to be 2.7%. According to the results of the study, being in the 15-24 age group, being male, having an income of 500 TL or lower (<200 Euro or <250 USD at the time of research), and using tobacco, alcohol, and medicines without the recommendation of a doctor increased drug use at significant level.

During the Schoolchildren Study, conducted by TÜBİTAK in 2011, 11,812 persons from 32 cities were interviewed, based on common and technical high school distribution. Forty-nine percent of these students were female (5,783 persons), while 51% of them were male (6,029 persons), and their average of age was 15.23 ± 0.69 , with a median of 15.00.

Life-long drug use frequency was determined to be 1.5% in the study of schoolchildren. One point one percent of those schoolchildren had a family member who used a substance apart from tobacco or alcohol, and for 87.4% of them, this person was either a parent or sibling. The average age for first time drug use was 13.88 ± 2.39 , with a median of 14.00.

Forty-two point one percent of those who are still on drugs use such substances once a week, while 36.8% of them uses drugs twice a week. Forty-nine point five percent of drug users shared the names of the substances they use. Even though only approximately half of the group revealed the names of the drugs, marijuana was in first place by a landslide, while the volatiles were the second most frequently mentioned. Despite the scarce number of answers, it was determined that one out of five users used more than one substance. The most common method to use such substances was respiration, while the second most common method was orally. Zero point seven percent of the female students had tried substances, while this number was 2.3% for the male students.

Among the drugs mentioned by the users, marijuana and derivatives are ranked first (84.1%), followed by volatiles (32.9%) and stimulants (22.7%). The percentage of the users indicating their first preference to be marijuana was 61.3%, while this substance was the second preference of 39.1% and the third preference for 25.0% of the users; results indicate that this substance ranks first.

It was concluded that the young people participated in this study intimately. It was also observed that not providing any substance choices was not a problem, and that it even led young people to share their knowledge by providing many names regarding marijuana and derivatives. The results indicated that the tobacco, alcohol, and substance use prevalence in Turkey remains at a certain level, that it cannot be avoided, that drug use should be addressed, and that Turkey should make unique steps for protection and prevention plans in this field.

Prevention

Preventive activities constitute an essential element in the fight against drug use and addiction. Prevention refers to all precautionary activities carried out to help individuals avoid developing bad habits and lead healthy lives.

The main objective of preventive actions is to ensure that an individual refuses to use drug when offered and minimize his/her addiction risk. The efforts by law enforcement officers to control the sale and trafficking (supply) of drugs can achieve success to the extent that they are supported by preventive activities.

Preventive activities in Turkey basically target youngsters between the ages of 15 and 24 (when most drug abuses start) as well as families, teachers, public officials, and non-governmental organizations.

Various institutions and organization conduct activities to prevent drug use and addiction. The Turkish Monitoring Center for Drugs and Drug Addiction (TUBIM) carries out preventive activities through the TUBIM Provincial Contact Point (ILTEM) staff employed in the Departments for Combatting Drug Use located in all 81 provinces.

The number of preventive activities carried out by 162 specialists employed in the Department for Combatting Drug Use aimed at different groups amounted to 3,848 in 2013. These specialists organized preventive activities such as conferences, seminars, and plays for 673,195 people in total in 2013 – 476,885 students, 62,244 families, 61,080 public officials, 18,756 teachers, and 54,230 individuals from various groups.

High-Risk Drug Use

In 2010 and 2011, Problem Drug Use (PDU) criterion was first defined in Turkey with the participation of TUBİM experts along with national and international experts. According to the study carried out in Ankara, Istanbul, and Izmir, the number of problem opium users was estimated to be 5,800 and 25,000 for Ankara and Istanbul, respectively, while the number of problem marijuana users was determined to be 28,500 and 33,400 for Ankara and Izmir, respectively.

According to the estimation made in 2013 with consultation of AMATEM (Alcohol and Substance Addiction Treatment Center) experts, the number of problem drug users (except for marijuana and ecstasy) in Turkey was estimated to be 59,895 (46,087-73,704).

Even though there are different methods in the estimation of high-risk drug use (HRDU), it is observed that more than one method is used in combination in a large number of European Union countries. The basic reason is to make the estimations as real as possible. Nonetheless, the multiplier method that uses only one data set (data on treatments, police data, or data on death) is a significant method that is generally accepted. The multiplier method that is built on the data on mortality has both weak (dependence on only one set of data) and strong aspects (determination of total problem use). Hence, the data on drug-related deaths may show the high risk of the substance and address the estimation more clearly.

For the multiplier method used in the reports issued by Turkey to be sent to the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) in previous years, the study of Bargagli et al. (2006) was adapted for Turkey. In this study, the estimation was based on the data on death pertaining to eight European cities. It was concluded that the estimation to be made by adapting the data of the same research to the data on death in Turkey would indicate the number of high-risk drug users in Turkey.

As a result of the above-mentioned study conducted by Bargagli et al., the death rate was determined to be between 3.09 and 7.37 for approximately each 1000 high-risk drug users (certain various values were not included). In the study of Bargagli et al. (2006), the average of these eight cities was determined to be approximately 6.44.

Accordingly, when direct (n=232) and indirect (n=416) data on death in Turkey are included in the calculation within the scope of the multiplier method, the approximate number of drug-related deaths in 2013 (direct and indirect) was 648 (232+416). As a result of such calculation,

if we assume that approximately 6.44 out of 1000 drug users die in Turkey, we can conclude that there are approximately 100,621 high-risk drug users in Turkey.

Drug Addiction Treatment

Public hospitals under the Ministry of Health, psychiatry wards of medical schools under universities, university hospitals in partnership with the Ministry of Health, and several private hospitals provide treatment for drug addiction in Turkey. In total, there are 26 treatment centers designed for drug addiction, where 706 beds are allocated to drug addicts. Four hundred seventy-nine of these beds are in hospitals under the Ministry of Health, and 277 are in the relevant units under university and public hospitals. These are the total number of beds that are allocated both to alcohol and substance addicts.

Two centers for drug addiction treatment opened in 2013. Twenty-five centers that offer inpatient drug addiction treatment throughout Turkey 2013 provided data for the study.

In order to provide improved drug addiction treatment services, higher-quality and standardized treatment in addition to more accessible treatment centers with increased capacity should be ensured. To this end, the Ministry of Health developed a standard training program for the personnel to be employed in these treatment centers. In 2013, 35 individuals received certificates at the end of this six-month training that includes both theoretical and applied modules.

Approximately 95.3% of the patients in Turkey receive treatment in the centers under the Ministry of Health, and their treatment costs are covered to a great extent by the Social Security Institution. According to the official data in 2012, the costs of 80.3% of the patients were covered by the Social Security Institute, 12.3% by universal health insurance, and 4.3% by the patients themselves (Turkish Statistical Institute Health Survey, 2012).

Probation has been implemented for drug-related crimes since 2006 in Turkey. The General Directorate of Prisons and Detention Houses reported 141,454 cases that were put on probation by the competent courts to be treated for drugs and stimulants as per Article 191 of the Turkish Penal Code between 2006 and 2013. Ninety-two percent (130,345) of these cases put on probation were adults, and 8% (11,109) were children.

The Law on Probation was amended in 2014. As per the amendments, drug use was also defined as a crime, and drug possession, which was previously subject to a one-to-two year prison sentence, was redesigned as drug possession/use with a two-to-five year prison sentence. An individual who benefited from probation previously cannot be put on probation for a second time within five years.

The Tobacco, Alcohol, and Drug Addiction (SAMBA) Treatment Program is a standardized, psychosocial program that is implemented in 17 sessions in most of the centers. There are different implementations of this program for adults, adolescents and families. In 2013, 65 individuals attended the training of implementers designed for this program in 25 centers.

Seven thousand eight hundred two forms were manually completed for 7,897 inpatients who sought treatment in these centers in 2013. The database consists of the forms that are manually completed in 24 treatment centers. The identifying details of the patients are kept confidential, as a coding system is used in completing these forms. All 24 centers that were functional in 2013 provided data.

The number of outpatients reached 218,574 in 2013. There is a rise in the number of the patients treated as part of the probation measure. The number of the patients that were on probation and treated increased to 91,486 in 2013. As for inpatients, the number amounted to 7,897 in 2013 with a 35% rise compared to 5,848 inpatients in 2012. This increase can be related to the more regularly collected data and higher reliability in institutional data.

While 51.5% (3738) of the patients placed under treatment in 2013 reported that it was their first treatment, 48.5% (3527) stated that they previously received treatment. There is no missing information related to this aspect among the data from 2013. The number of the patients who were placed under treatment for the first time recorded a 48.4% rise in 2013 compared to 2012, and the number of those who previously received treatment increased by 61.8%.

Classified according to age groups, 30.1% (2,190) of the patients were aged between 20 and 24 years; 26.8% (1,944) were aged between 25 and 29 years; 16.7% (1,233) were aged between 15 and 19 years; 17% (903) were aged between 30 and 34 years; and 7% (502) were aged between 35 and 39.

Out of the patients placed under treatment in 2013, 1.8% (132) never went to school; 25.7% (1,870) received 1-to-5 years of education; 43% (3,126) received 6-to-8 years of education; 25% (1,817) received 9-to-12 years of education; and 4.4% (320) attended university.

Health Correlates and Consequences

Two hundred thirty-two direct drug-related deaths (DRD) occurred in 2013 with a 43.2% rise compared to 162 direct DRDs in 2012. Out of all direct DRD cases in 2013, 97% (n: 225) were male and 3% (n: 7) were female.

Two hundred thirty-two DRDs were recorded in 2013. According to general mortality registries provided by the Turkish Statistical Institute, 0.006% of all the deaths (372,094) in 2013 were described as DRD.

The average age of direct DRDs was 31 among males (min: 14; max: 68), 33.3 (min: 16; max: 48) among females, and 31.1 in general. Regarding direct DRD cases classified by age groups, nearly 0.4% were under the age of 15; 11.2% were aged between 15 and 19 years; 19% were aged between 20 and 24 years; 23.3% were aged between 25 and 29 years; 10.8% were aged between 30 and 34 years; 11.6% were aged between 35 and 39 years; 11.2% were aged between 40 and 44 years; 3.4% were aged between 45 and 49 years; 2.6% were aged between 50 and 54 years; 2.2% were aged between 55 and 59 years; 1.3% were aged between 60 and 64 years; and 0.9% were aged 65 and over. Age ranges of 2.2% could not be identified.

In 2013, direct DRDs occurred most frequently in the group aged between 25 and 29 years. The distribution of age among male cases was very similar to the total of both genders. No further assessment could be made on the distribution of age among females due to the limited number of cases.

Direct DRDs occurred in 26 provinces in total. Istanbul recorded the highest rate of DRDs (n: 115, 49.6%), followed by Antalya (n:25, 10.8%), Adana (n: 17, 7.3%), Ankara (n: 13, 5.6%), İzmir (n: 11, 4.7%), Mersin (n: 7, 3%), Gaziantep (n: 7, 3%), Kocaeli (n: 5, 2.5%), and Hatay (n: 4, 1.7%), respectively. There were three cases (1.3%) each in Bursa, Konya, and Manisa (1,3%); two cases (0.86%) each in Diyarbakır, Hakkari, Kayseri, Osmaniye, and Şanlıurfa; and one case (0.43%) each in Aydın, Afyon, Muğla, Muş, Kastamonu, Sivas, Tekirdağ, Van, and Yalova.

Four hundred sixteen indirect drug-related deaths were identified in 2013 in Turkey. Ninety-seven point one percent (n: 404) of the cases were male, and 2.9% (n: 12) were female. The average age of male subjects was 32.8 (min: 13; max: 77), that of female subjects was 26.6 (min: 19; max: 35), and that of all the cases was 32.6 (min: 13; max: 77).

Indirect DRDs classified according to age groups were as follows: two cases were under the age of 15 years; 32 cases were aged between 15 and 19 years; 81 cases were aged between 20 and 24 years; 76 cases were aged between 25 and 29 years; 69 cases were aged between 30 and 34 years; 40 cases were aged between 35 and 39 years; 31 cases were aged between 40 and 44 years; 24 cases were aged between 45 and 49 years; 13 cases were aged between 50 and 54 years; 16 cases were aged between 55 and 59 years; eight cases were aged between 60 and 64 years; and six cases were aged over 65 years. The ages of 18 cases could not be identified. In 2013, indirect drug-related deaths occurred most frequently in the group aged between 20 and 24 years.

Unlike previous years, firearm injuries constituted the most frequent cause of death, followed by traffic accidents, cardiovascular diseases, sharp object injuries, hanging, unknown, falling from a height, drowning, blunt head traumas (of homicide origin), carbon monoxide intoxication, lung infection, and electrical injuries.

Indirect DRDs occurred in 50 provinces in total. Istanbul recorded the highest number of cases with 134 cases (32.2%), followed by 41 cases (10.7) in Izmir; 37 cases (8.9%) in Adana; 28 cases (6.7%) in Ankara; 22 cases (5.3%) in Antalya; 17 cases (4.1%) in Manisa; 12 cases (2.9%) in Mersin; 11 (2.6%) cases in Sakarya; nine cases (2.2%) in Samsun; eight cases (1.9%) in Aydın; eight cases (1.9%) in Muğla; seven cases (1.7%) in Tekirdağ; and five cases (1.2%) each in Düzce and Kayseri. There were four cases (1%) each in Bingöl, Elazığ, Rize, Trabzon, and Uşak; three cases (0.7%) each in Artvin, Kocaeli, Diyarbakır, Urfa, Malatya, Niğde, and Zonguldak; two cases (0.5%) each in Ağrı, Hatay, Kütahya, Osmaniye, Çorum, Gaziantep, and Van; and one case (0.2%) each in Afyonkarahisar, Aksaray, Amasya, Ardahan, Bayburt, Bolu, Bursa, Çanakkale, Çankırı, Hakkari, Iğdır, Karabük, Kırıkkale, Kırklareli, Sinop, Sivas, and Yalova.

Social Relations and Social Reintegration of Drug Addicts

Successful treatment for drug addiction is only possible through rehabilitation activities to be subsequently conducted. The societies where addicts have difficulty with reintegration into

social life present the lowest success rates in addiction treatment. Thus, not only medical treatment, but also the activities for social reintegration are essential for a healthy society.

In Turkey, as there is no established countrywide social rehabilitation structure for aftercare services, the rate of success in drug addiction treatment is low, because successful addiction treatment requires fully implemented social reintegration programs. Thus, in order to ensure relapse prevention, certain economic, social, and psychological factors should be redesigned in a way to make life easier for individuals who complete medical treatment programs.

Forty-eight point five percent of the patients that received inpatient treatment in 2013 stated that they were previously treated for addiction at least once. These rates indicate the inadequacy of rehabilitation services provided after medical treatment in Turkey.

Drug-Related Crimes, Prevention of Drug-Related Crimes, and Prisons

In 2013, 98,933 drug-related cases occurred throughout Turkey, and 148,121 suspects were arrested in relation to these cases. Compared to previous years, there was a clear increase in 2013 in terms of the number of cases and suspects. The increase in the number of cases was 19.01% compared to the previous year, while this figure was 13.90% for the number of suspects.

When all 98,933 drug-related cases in Turkey from 2013 are analyzed, it is clear that 81,363 cases (82.24%) were related to the purchase/acceptance/possession of drugs with the intent to use (Article 191 of the Turkish Penal Code - TPC); 13,840 (13.99%) cases were related to the production and trade of drugs (Article 188 of the TPC); four cases were related to facilitating drug use (Article 190 of the TPC); 3,706 cases (3.75%) were related to the violation of the Law on the Supervision of Drugs No.2313; and 20 cases (0.02%) were related to the violation of the Law on Drugs No.3298.

When the crime-related distribution of all 148,121 suspects arrested in Turkey in 2013 is analyzed, it is clear that 112,505 suspects (75.95%) were arrested for the purchase/acceptance/possession of drugs with the intent to use (article 191 of TPC); 31,183 suspects (21.05%) for the production and trade of drugs (Article 188 of the TPC); five suspects for facilitating the use of drugs (Article 190 of the TPC); 4,407 suspects (2.98%) for the violation of the Law on the Supervision of Drugs No.2313; and 21 suspects (0.01%) for violation of the Law on Drugs No.3298.

In 2013, 6,096 heroin-related cases were recorded in Turkey, and 9,849 suspects were arrested in these cases. There were 69,780 marijuana-related cases, and 106,390 suspects were arrested in these cases. In 2013, there were 863 cocaine-related cases in Turkey, and 1,288 suspects were arrested in these cases. There were 4,274 ecstasy-related cases, and 6,271 suspects were arrested in these cases. There were 227 captagon¹-related cases in Turkey, and 380 suspects were arrested in these cases. The number of methamphetamine-related cases, which have been observed in Turkey since 2009, increases constantly. In 2013, there were 119 methamphetamine-related cases in Turkey, and 197 suspects were arrested in these cases. Acetic anhydride substances are seized in a limited number of cases in Turkey. No increase or decrease was observed in terms of acetic anhydride-related cases in 2013, compared to 2011 and 2012; there were only three cases. A total of seven suspects were arrested in those cases.

Synthetic cannabinoids were first seen in Turkey in the middle of 2010 as “Bonsai” (JWH-018) and have been spreading rapidly in various forms. In early 2011, they were covered by the scope of the Law on the Supervision of Drugs No.2313, as a result of the Early Warning System (EWS) studies of National Working Group, conducted under the coordination of TUBİM. In 2013, there were 11,139 synthetic cannabinoid-related cases in Turkey, and 15,065 suspects were arrested in these cases.

According to the data collected through the User Profile Questionnaire for Addictive Substance Crimes (U-Form) that is implemented by TUBİM Provincial Contact Point personnel, the first two reasons to begin using drugs are friends (48.98%) and curiosity (23.71%).

According to the data from the U-Form, the average age for drug use was 26.33 years. Nevertheless, a large portion of the drug users who completed the questionnaire were observed to be within the age range of 18-29 years (75.61%).

It is observed that large portion of drug users (69.74%) were primary school/secondary school/elementary school graduates. However, this should not be interpreted as drug use being prevalent among people with low levels of education. According to the results of the TUBİM GPS Survey², no statistically significant relationship is present between education level and drug use.

¹ Tablets, which have the appearance and logo of captagon, and contain amphetamine as the active ingredient.

² Attitude and Behavior Survey on Tobacco, Alcohol and Drug Use in the General Population (Turkey) (TUBİM GPS Survey) was carried out by TUBİM in 2011 in 25 provinces determined by the Turkish

When the first substance (including cigarette and alcohol) used by drug users is taken into consideration, it can be concluded that a large portion of drug users (84.06%) began using substances with cigarettes. Hence, cigarettes are deemed to be a step leading to drug use.

According to the data gathered from the U-Form, a large portion of the drug users have never been married (66.49%). According to the data of TÜİK (Turkish Statistical Institute), 27.38% of the people above the age of 15 have never been married, while 63.92% are married. Five point forty-four percent were divorced, and 3.26% lost their partners. Based on these results, it can be claimed that a large portion of the population is married (63.92%), while the large portion of drug users have never been married; this indicates that drug use is more prevalent among single people, compared to those who are married. The TUBİM GPS survey also illustrates a statistically significant relationship between marital status and drug use.

Drug Supply (Drug Market)

Due to its strategic location, Turkey is a frequent location of legal and illegal trade flows of various products between Asia and Europe. In this context, Turkey was again heavily affected by the smuggling of opium and derivatives from Afghanistan in 2013.

Global potential opium production was estimated to be 6,883 tons in 2013, indicating a 40.3% increase compared to 2012. Potential opium production in Afghanistan was estimated to be 5,500 tons in 2013 with a 49% rise compared to 3,700 tons in 2012 (UNODC Afghanistan Opium Survey, 2013:10). Afghanistan accounts for 80% of the global opium production (UNODC World Drug Report, 2014:21)

Potential heroin production reached 560 tons globally in 2013 with a 45.5% increase compared to 2012 (UNODC World Drug Report, 2014:21). Two hundred ten kilograms of opium were confiscated in Turkey in 2013. There is scarcely any demand for opium in Turkey's domestic market. In 2012 and 2013, the majority of opium substances were seized while they were to be shipped by cargo to Canada, the USA, England, Australia, and Albania.

In 2013, 98.44% of the opium and derivatives that were confiscated in Turkey were in the form of heroin. Heroin illegally trafficked from Afghanistan and the Islamic Republic of Iran entered Turkey through Eastern provinces, mainly Hakkari, Van, and Ağrı; and recently, heroin from

Statistical Institute (TUIK) using face-to-face interview method. A total of 8,045 persons were interviewed during the survey.

Northern Iraq entered Turkey through the Habur border gate. Turkey reported the largest amount of heroin seized in the world in 2012 (UNODC World Drug Report, 2014), and each year since 2006, more heroin was seized in Turkey than in all EU countries combined (EMCDDA European Drug Report, 2014:21, 22). In 2013, 13,480 kg heroin was seized with a 1.35% increase compared to 13,301 kg in 2012.

Cannabis continues to be the most widely used and most frequently seized substance in Turkey, as is the case throughout the world. Cannabis produced in Turkey is placed on the domestic market by criminal organizations. It is mostly produced and consumed in the herb form in Turkey. Turkey became the second country that seized the largest amount of cannabis throughout Europe in 2012. In 2013, 274,380 kilograms of cannabis were confiscated in Turkey with an 80.41% increase compared to 152,086 kg in 2012.

Turkey is affected by cocaine trafficking both as a transit and destination country. The cocaine trafficking that is destined for Turkey departs from Argentina, Brazil, Ecuador, Paraguay, and Venezuela. In a large number of cases where Turkey is a country of destination, cocaine is first dispatched to West Africa, and then to Turkey. Cocaine is shipped from South America to Turkey either via sea or air cargo. Furthermore, it can be forwarded to inner regions via roads once it reaches Europe and the Middle East. Cocaine operations in Turkey mostly target drug mules at the airports. While West Africans constituted the majority of drug mules caught in previous years in Turkey, the number of European mules increased in 2013 (2013 Anti-Smuggling and Organized Crimes Report by the Turkish National Police, 2014). The amount of cocaine seized in Turkey in 2013 increased by 5.46% to 450 kg in 2013 compared to 476 kg in 2012.

Turkey is a country of destination for ecstasy as well. The majority of ecstasy seized in Turkey in 2013 originated from the Netherlands and Belgium. Ecstasy is dispatched from European countries to Turkey by sea, air, and land routes. High quality ecstasy has reappeared in the drug market in recent years. In 2013, 4,441,217 ecstasy tablets were seized in Turkey, with a 1.18% increase compared to 4,389,309 tablets in 2012.

Turkey is again both a country of destination and final market for captagon, as the brand name of an amphetamine type stimulant. The production of captagon is gradually growing in the Middle East in recent times (UNODC 2011). Analyses performed on captagon tablets seized in recent years in Turkey suggest that many of them contain amphetamine as the active substance. In 2013, 4,529,846 captagon tablets were seized in Turkey, with an increase equal to 23.68 times more than the amount seized the previous year.

Methamphetamine seized in Turkey generally originates from the Islamic Republic of Iran. Methamphetamine trafficked from the Islamic Republic of Iran mostly by land routes is transferred through Turkey to Asia-Pacific countries such as Malaysia, Thailand, Singapore, Japan, Indonesia, Vietnam, and Australia by means of drug mules and cargo. In 2013, 105 kilograms of methamphetamine were seized in Turkey. The steady upward trend in methamphetamine seizures between 2009 and 2012 was halted by a 79.08% decrease recorded in 2013 compared the previous year. Customs officials explain this sharp decline in methamphetamine seizures with the measures taken at Turkey's eastern border gates.

Turkey is a country of destination in the trafficking of synthetic cannabinoids, which illegally enter Turkey from European countries, the USA, and China. Active substances that are shipped to Turkey are mixed with or sprayed onto dried herb leaves such as sage and damiana, packed in two-to-three gram packages, and released to the market. In Turkey, synthetic cannabinoids are seized in liquid, powder, and tablet forms as well. In 2013, 780 kilograms of synthetic cannabinoids were seized in Turkey, with a 79.72% increase in seizures compared to the previous year (Graph 10-31). The amount of synthetic cannabinoids seized has increased 17 times since 2011 when they were first seized in Turkey.

PART A

NEW DEVELOPMENTS AND TRENDS

SECTION 1

DRUG POLICY: LAWS, STRATEGIES, AND ECONOMIC ANALYSES

Mustafa ERSOY³

Fikret DENİZ⁴

1.1. Introduction

Even though the term “drugs” is thought to refer to only the substances with intoxicating properties, it is actually a term that has to be perceived in a wider sense, as most of the society does, to include the substances that essentially stupefy, provoke, tranquilize, and stimulate the imagination and alertness. The target meaning of the term “drug” is not the effect it has on the central nervous system, but all of the types of substances with peculiar properties irrespective of these effects (National Policy and Strategy Document on Drugs, 2013-2018).

From these perspectives, drugs can be described as: *“the substances for which the use and possession are banned by law, and which disrupt the mental, physiological, and psychological balance of the individual by affecting the nervous system when taken in certain doses, and result in financial and social destruction for the individual and the society”* (National Policy and Strategy Document on Drugs, 2013-2018).

1.2. Legal Framework

1.2.1. Recent Legal Arrangements on the Fight against Drugs (Laws, Regulations, Directives and Other Practices)

Legislative arrangements of 2013 aimed at promoting the fight against drugs are analyzed under three titles: Laws, Regulations, and Directives.

1.2.1.1. Laws

The Turkish Penal Code number 5237:

³ TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction)

⁴ TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction)

- The Turkish Penal Code was amended in accordance with the Council of Ministers Decision number 2014/6545 dated 18 June 2014, which was published in the Official Gazette number 29044 dated 28 June 2014 (Annex1).

Law on the Control of Drug Substances number 2313:

- Pursuant to the Council of Ministers Decision number 2013/5742 dated 16 December 2013, published in the Official Gazette number 28893 dated 25 January 2014; 113 new psychoactive substances were included into the scope of the Control of Drug Substances number 2313 (Annex 2).
- Pursuant to the Council of Ministers Decision number 2014/5818 dated 03 January 2014, published in the Official Gazette number 28906 dated 7 February 2014; 26 new psychoactive substances were included into the scope of the Law on the Control of Drug Substances number 2313 (Annex 3).
- Pursuant to the Council of Ministers Decision number 2014/6330 dated 05 May 2014, published in the Official Gazette number 29008 (bis) dated 23 May 2014; 41 new psychoactive substances were included into the scope of the Law on the Control of Drug Substances number 2313 (Annex 4).
- Pursuant to the Council of Ministers Decision number 2014/6800 dated 15 September 2014, published in the Official Gazette number 29137 dated 2 October 2014; 66 new psychoactive substances were included into the scope of the Law on the Control of Drug Substances number 2313 (Annex 5).

Anti-Smuggling Law number 5607;

- In accordance with the Council of Ministers Decision dated 28 March 2013, published in the Official Gazette number 28615 dated 11 April 2013; Article 19 of the Anti-Smuggling Law number 5607 was amended as follows by Article 60 of the “Law regarding the Amendment of the Customs Law and of Certain Laws and Decree Laws” number 6455: *“The identity of those who report the offenses covered by Article 3 of this Law, as well as the identity of informants who are entitled to a reward in accordance with Article 23, shall not be revealed under any circumstances without their permission, or unless their act of reporting/informing has in itself constituted an offence. The provisions regarding the protection of witnesses shall apply for these individuals.”*
- In accordance with the Council of Ministers Decision dated 28 March 2013, published in the Official Gazette number 28615 dated 11 April 2013; Article 23, Subclause (b) of the Anti-Smuggling Law number 5607 was amended as follows by Article 61 of the

“Law regarding the Amendment of the Customs Law and of Certain Laws and Decree Laws” number 6455: *“In the seizure of drug substances and of plants cultivated for producing drug substances, the applicable premium will be calculated according to the quantity of all types of drug substances that were seized and/or the total surface area in which plants were cultivated for the production of drug substances. This shall be performed by multiplying values predetermined by the Council of Ministers with the salary coefficient of the civil servants. In seizures performed in accordance with the eighteenth and nineteenth subclauses of Article 3, the applicable premium will be calculated by multiplying a value predetermined by the Council of Ministers for packages, kilograms, or liters of materials seized with the salary coefficient of the civil servants. If the materials were seized together with their owners, half of the premium will be provided upon the initiation of the criminal case, while the other half will be provided within three months following the final verdict and decision of confiscation regarding the materials. If the materials were seized without their owners, all of the premium will be provided upon within three months following the final verdict and decision of confiscation regarding the materials.”*

Highway Traffic Law number 2918;

- In accordance with the Council of Ministers Decision dated 25 May 2013, published in the Official Gazette number 28674 dated 11 June 2013; Article 48 of the Highway Traffic Law number 2918 was amended as follows by Article 19 of the “Law regarding the Amendment of the Decree Law number 375 and Certain Laws” number 6455:
“It is prohibited for drivers to drive vehicles on highways when they have used drugs or stimulants, or are under the influence of alcohol.
In case a driver is involved in an accident that has resulted in injury or death, or has caused material damage as determined by law enforcement officers, it shall be mandatory for the driver to undergo the examinations described in the second clause. Drivers who object to the measurements performed by a breathalyzer device, or who refuse to perform measurements with a breathalyzer, will be taken to the nearest forensic medicine institution or forensic practitioner, or to the nearest healthcare institution affiliated with the Ministry of Health, in order to undergo tests that involve the collection and analysis of blood, saliva, or urine samples in order to detect drug or stimulant substances or alcohol. Throughout this process, the provisions of Article 75 of the Code of Criminal Procedure number 5271 dated 4 December 2004 shall apply, with the exception of this article's fifth clause.

In case the driver dies in the traffic accident, or becomes injured to the point where he/she is unable to exhale into a breathalyzer; blood, saliva, or urine samples will be collected from these persons in accordance with the provisions of the third clause.

In case the results of the analysis determines that the person was driving with a blood alcohol level above 0.50 promil, the person will, in addition to any other offence he/she might have committed, receive an administrative fine of 700 Turkish Liras, and have his/her driving license suspended for six months.

For all other vehicles other than private cars, the maximum level of blood alcohol that is permitted is 0.21. For persons whose driving licenses have been suspended once within the past five years for driving under the influence of alcohol, an administrative fine of 877 Turkish Liras will be applied on the second instance of driving under the influence of alcohol, with the driving license being suspended for two years; while an administrative fine of 1407 Turkish Liras will be applied on the third and following instances of driving under the influence of alcohol, with the driving license being suspended for five years in each one of these instances. In case the driving licenses are suspended for any reason, the abovementioned periods will begin at the end of the suspension period.

For drivers who are identified with a blood alcohol level above 1.00 promil based on the results of the analysis, the provisions of Article 179, Clause 3 of the Turkish Penal Code shall apply.

The relevant provisions of the Turkish Penal Code shall apply for drivers of private cars identified with blood alcohol levels above 0.50 and for drivers of other types of vehicles identified with blood alcohol levels above 0.20 in case their actions resulted in a traffic accident.

Drivers who are identified as having used drugs or stimulant substances will receive an administrative fine of 3600 Turkish Liras, and have their driving license suspended for a period of five years. The relevant provisions of the Turkish Penal Code shall also apply for these drivers.

Drivers who refuse to use the test devices presented by law enforcement officers to assess blood alcohol levels or to determine whether the driver used drug or stimulant substances will receive an administrative fine of 2000 Turkish Liras, and have their driving license suspended for a period of two years.

In case there is suspicion that the driver has used drug or stimulant substances, the provisions of Law number 5271 regarding the judicial police shall apply.

Drivers, whose driving licenses have been suspended twice within a period of five years for driving under the influence of alcohol, will be required to participate to training programs organized by the Ministry of Health for improving driving behavior, whose

procedures and practices shall be defined through directives issued by the Ministry of Interior, the Ministry of National Education, and the Ministry of Health. Drivers, whose driving licenses have been suspended three or more times within a period of five years for driving under the influence of alcohol, will be subject to psycho-technical evaluations as well as the examination of a psychiatry specialist.

The temporary suspension of driving licenses will be performed by officials listed in Article 6 of this law.

To receive driving licenses that have been suspended, according to the provisions of this article, drivers must fully pay the administrative fine(s) issued for the violation of traffic rules, which are described by the provisions of this article, while drivers whose licenses have been suspended for drug or stimulant substance use must also produce a medical board report provided by an official health institution which confirms there is no impediment for them to drive once again.

The minimum requirements for the technical devices to be used for the detection of alcohol, drugs and stimulants, as well as the other relevant procedures and principles regarding the examination of drivers, will be described in the relevant regulations.”

The Turkish Radio and Television Law number 2954

- The section regarding the Basic Principles and Broadcasting Guidelines of the Turkish Radio and Television Law number 2954 includes a provision which mentions the responsibility to “*prevent any broadcast that might harm the physical and mental health of society.*” In accordance with this provision, the Turkish Radio and Television Corporation (TRT) will conduct its broadcasting activities according to the requirements listed below, which are part of the TRT’s General Broadcasting Plan:
 - ✓ *To plan programs for youth. To focus on content that contributes positively to the physical and emotional developmental stages of the youth, that supports their mental development, that enables them to acquire positive new attitudes and behaviors, that allows them to further develop their personalities, and that allows them to participate to society as honest, healthy, happy, and productive individuals.*
 - ✓ *To prepare programs relating to health. The content of these programs shall focus on instilling social awareness regarding attitudes and behaviors associated with healthy living. These programs will also place emphasis on health services, diseases, and treatment capabilities; the institutions and organizations which provide health services, and the capabilities of these organizations; the opinions of scientists and specialists; and subjects relating to the preservation and*

improvement of health. Subjects relating to health should be covered in the news, discussed in various programs, and included into forums, panels and open sessions in a manner that reflects the views of ordinary citizens.

- ✓ *Advertisements should avoid themes that are exploitive towards the elderly, which negatively influence children and youth, and which encourage harmful habits.*
- ✓ *Health programs should mention and cover the activities of public institutions and non-governmental organizations that conduct studies regarding the use of cigarettes, alcohol, and drugs.*
- ✓ *Programs for the youth should provide information on problems that affect family, friends, social relations, and society; on social and psychological problems; on the problems encountered by young persons who abandon their families and are forced into a life of crime; on studies regarding juvenile courts and persons discharged from juvenile detention centers; on the problems experienced by the youth and their solutions; on the problems associated with adolescence; and on the effect of bad habits on youth such as frequenting coffeehouses, drinking alcohol, smoking, and using drugs.*
- ✓ *News programs should, in cooperation with radio and television agencies, provide information regarding efforts against illicit money and drug trafficking; describe – especially to children – the harms associated with harmful habits such as smoking, alcohol, and gambling; and cover the efforts conducted for limiting harmful habits.*

Decree Law on the Organization and Duties of the Ministry of Youth and Sports:

The provisions of the Decree Law number 638 dated 3 June 2011 regarding the “Organization and Duties of the Ministry of Youth and Sports” specifies the Ministry’s obligations to “*conduct studies and activities to protect youth from harmful habits*” in Article 7 subclause (e); to “*provide guidance and counselling services to the youth, and to conduct activities for the development of educational service and capabilities*” in Article 8/A subclause 1(e); and to “*prioritize support for projects towards the disadvantaged youth and for promoting the mobility of the youth*” in Article 8 subclause (b).

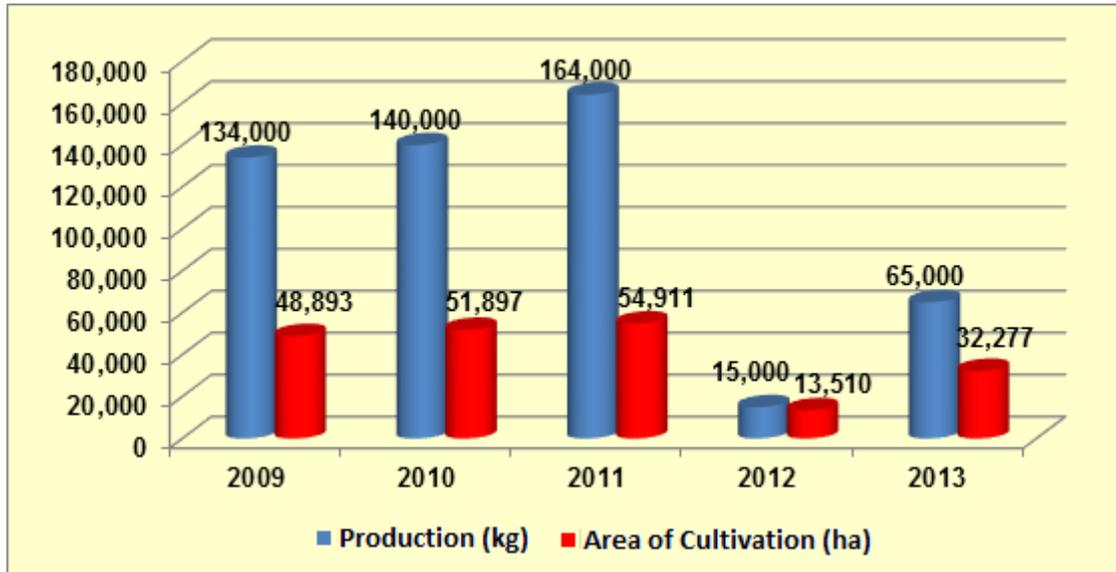
1.2.1.2. Regulations

- Turkey, India, Australia, France, Spain, Hungary, and Slovakia are countries where the cultivation of the opium poppy is legally permitted under the conventions of the United Nations. Turkey is considered as a traditional opium poppy producer, as well as a world supplier of opium alkaloids for medicinal purposes. The areas of opium cultivation in

Turkey are determined every year by decision of the Council of Ministers. Planting and cultivation of opium poppy outside of the areas designated by the Council of Ministers is strictly forbidden, regardless of the purpose of cultivation. The cultivation of opium is regulated according to the provisions of the “*Law on Drug Substances*” number 3298, and of the “*Regulation on the Plantation, Control, Harvest, Use, Disposal, Purchase, Export and Import of Opium*” (which is a regulation based on the abovementioned law). The monitoring of opium cultivation is performed by the Soil Products Office and law enforcement agencies.

- In accordance with the Council of Ministers Decision regarding “*The Purchase and Sale of Opium Poppy Capsules and Seeds*” number 2014/5876 dated 27 January 2014, published in the Official Gazette number 28921 dated 22 February 2014, as of the autumn of 2013, the plantation of opium poppies and the production of uncut opium poppy capsules are permitted in the following provinces and districts of Turkey, on the condition that the necessary licenses are obtained from the authorities: In all districts of the Afyonkarahisar, Amasya, Burdur, Çorum, Denizli, Isparta, Kütahya, Tokat, Uşak provinces; in the Balya, Bigadiç, Dursunbey, İvrindi, Kepsut, Savaştepe and Sındırgı districts of the Balıkesir province; in the Alpu, Beylikova, Çifteler, Günyüzü, Han, Mahmudiye, Mihaliççık, Seyitgazi and Sivrihisar districts of Eskişehir province; in the Ahırlı, Akören, Akşehir, Beyşehir, Derbent, Doğanhisar, Hüyük, Ilgın, Kadınhanı, Seydişehir, Tuzlukçu, Yalılıyük, and Yuna districts of the Konya province; and in the Merkez, Demirci, Gördes, Köprübaşı, Kula, Sarıgöl and Selendi Districts of the Manisa province.
 - The opium poppy capsules produced in legally-permitted cultivation areas are purchased by the Soil Products Office through its provincial offices, and then transferred to the Opium Alkaloids Factory for processing. The morphine and morphine derivatives produced at the Opium Alkaloids Factory are supplied as alkaloid substances to pharmaceutical factories both within Turkey and abroad.

Graph 1-1: Production of Morphine Equivalent Opiates and Total Area of Opium Poppy Cultivation in Turkey



Source: The Ministry of Food, Agriculture and Livestock, General Directorate of Soil Products Office, 2014

- The “Regulation on Substance Addiction and Treatment Centers” published in the Official Gazette number 28866 and dated 29 December 2013 is currently in effect.
- The “Regulation regarding the Implementation of Law number 6284 for the Protection of the Family and the Prevention of Violence Against Women,” which was published in the Official Gazette number 28532 and dated 18 January 2013, includes the following articles and clauses:
 - ✓ Article 17, Subclause (h): *“Persons under protection should not use alcohol or drugs and stimulant substances at the location in which they are sheltered, nor should these persons be in the proximity of other persons under protection and their shelter while under the influence of such substances. In case these persons have addictions, they should be provided with examination and treatment services, including hospitalization, if necessary.”*
 - ✓ Article 27, Clause 1: *“A judge may decide that the perpetrator of violence towards a person cannot use alcohol or drug and stimulant substances at the location in which this person is being sheltered, and that the perpetrator cannot be in proximity of the person under protection and his/her shelter while under the influence of substances. A judge may also decide for the perpetrator to receive treatment and examination services, including hospitalization, in case they have addictions.”*
 - ✓ Article 27, Clause 2: *“For a person subject to a preventive measure decision; examinations and treatments will be performed and the effect of these activities on the relevant person will be monitored by the Centre for Preventing and Monitoring Violence (ŞÖNİM) in coordination of the relevant institutions or organizations.”*

Depending on the characteristics of the activities that are necessary, ŞÖNİM may also request the support of law enforcement.”

- ✓ Article 27, Clause 3: *“In case a person subject to a preventive measure decision refuses to undergo treatment; the person’s refusal will be officially recorded and promptly reported to the Chief Public Prosecutor’s Office and ŞÖNİM”.*
- ✓ Article 27, Clause 4: *“Expenses relating to the implementation of this measure will be covered in accordance with the procedures and principles outline in Article 44, Clause 3.”*

The Regulation regarding the Project Support Programs of Ministry of Youth and Sports

- ✓ Article 4 Clause (1) of the *“Regulation on the Project Support Programs of Ministry of Youth and Sports”* number 28250 dated 31 March 2012 includes the following provision: *“By taking into account the objectives and priorities identified in development plans, government programs, policy documents, and strategic plans, the Ministry can, with the approval of the Minister, organize regional, national or international project support programs in the areas of education, culture, research, arts, science, entrepreneurship, sports, volunteerism, social activities, social participation, and social adaptation, as well as in other areas relating to the duties, tasks, and responsibilities of the Ministry.”* This provision also envisages support for projects regarding youth with substance addiction.

1.2.1.3. Circulars

TUBİM is responsible for activity number 28.1 concerning, “the conduct of the necessary activities for the establishment of Provincial Coordination Committees on Drugs in all 81 Provincial Governorships of Turkey,” and activity number 28.2 concerning, “the preparation of Provincial Action Plans Against Drugs,” listed in the Third National Plan Against Drugs, which has, per the decision of the Prime Ministry, entered into effect on the same date as the National Policy and Strategy Document on Drugs. In accordance with the activities and responsibilities mentioned above, TUBİM has prepared the *“Procedures and Principles regarding the Establishment, Tasks, and Functioning of Provincial Coordination Committees on Drugs”* and the *“Procedures and Principles Regarding the Preparation of Provincial Action Plans against Drugs,”* which have then been signed and put into effect on 4 November 2013 by the Ministry of Interior.

According to the Ministry Circular number 2013/51, Governorships were requested:

- To revise the structure of their Provincial Coordination Committee on Drugs in accordance with the procedures and principles outlined in the circular;
- To prepare Provincial Action Plans Against Drugs within three months at the latest in case these documents have not yet been prepared, or in case the current ones have expired; and
- To forward to TUBİM the Governor's approval relating to the revision of the Committee Structure, as well as a copy of their Action Plans within three months at the latest.
- The "*Regulation on Substance Addiction and Treatment Centers*," previously adopted following its publication in the Official Gazette number 25375 dated 16 February 2004, was subject to several revisions published in the Official Gazette number 28866 dated 29 November 2013. These revisions described that since institutions, organizations, and private hospitals providing outpatient and inpatient care have been granted permission to open Alcohol and Substance Addiction Treatment Centers (AMATEM), the Turkish Ministry of Health's Pharmaceuticals and Medical Devices Agency (TİTCK) has issued the Circular number 1165623 (2014/2) dated 20 January 2014 specifying that the medical reports necessary for the prescription of the medications Suboxone 2 mg/0.5 mg Sublingual Tablet and Suboxone 8 mg/2 mg Sublingual Tablet, used in replacement therapy for substance addiction, could also be given by centers that provide outpatient and inpatient substance addiction treatment within institutions, organizations and private hospitals. The intention of this revision was to facilitate and increase the accessibility of the said medications, and hence of substance addiction treatment.
- With Circular number 79687 (2013/7) dated 19 July 2013 of the Turkish Ministry of Health's Pharmaceuticals and Medical Devices Agency (TİTCK), combined medications containing ephedrine and pseudoephedrine salts were included into the list of controlled medications on the Medication Tracking System.

1.2.1.4. Other Practices

- RTÜK, which is responsible for the supervision of broadcasting services, has continued its supervision activities concerning the prevention of broadcasts that encourage and promote the use of drug substances. In this context, RTÜK has imposed sanctions on eight different occasions within 2013 for the violation of a provision of Law number 6112 which states that: "*Broadcasts should not encourage gambling or the use of addictive substances such as alcohol, tobacco products, and drugs*" (RTÜK 2014).

- The following additions were made to Article 4 of the Communiqué regarding Social Security Institution Health Practices, which was originally published in the Official Gazette number 28725 and dated 01 August 2013: “Treatment for alcohol and substance addiction will be invoiced on a ‘per service’ basis. As such, the sums listed in the Annex2/A of SUT will not be invoiced. In accordance with the per service payment method, the additional examinations and/or treatments that are considered necessary during or following a patient’s outpatient examination can be performed without the requirement of a new application to the relevant health institution.”

1.3. The Evaluation and Coordination of the National Policy and Strategy Document on Drugs and the National Action Plan against Drugs

Table 1-1: Timeline for the Implementation of the National Policy and Strategy Documents on Drugs and the National Action Plans against Drugs

I. ...													
First National Policy and Strategy Documents on Drugs	■	■	■	■	■	■	■						
First National Action Plan Against Drugs		■	■	■									
Second National Action Plan Against Drugs					■	■	■						
Second National Policy and Strategy Documents on Drugs								■	■	■	■	■	■
Third National Action Plan Against Drugs								■	■	■			

Source: Turkish Centre for Monitoring Drugs and Drug Addiction, 2014

1.3.1. The National Policy and Strategy Document on Drugs and the National Action Plan against Drugs

The first National Policy and Strategy Document on Drugs, which outlined Turkey’s policies against drugs as well as its aims and objectives, first entered into effect in 2006. In

continuation of this document, two separate Action Plans, each covering a period of three years, were prepared and implemented in order to define the necessary activities for achieving the objectives defined in the Policy and Strategy Document.

Following the end of this document's terms, as of 1 January 2013, a second National Policy and Strategy Document on Drugs, which encompasses the 2013-2018 period, and which defines Turkey's policies and strategies against drug trafficking and addiction, was prepared with the contribution and agreement of the relevant institutions.

This document was prepared based on current institutional experiences; the necessary assessments and analyses; the previous National Policy and Strategy Document of Drugs; the decisions taken during the meetings of the Science and Coordination Committee; the contribution of other strategy documents prepared by national institutions and EU member states, the Drug Reports on Turkey; the outcomes of the Turkish Conference on Drugs; and the Report of the "Parliamentary Investigation Committee Established to Research and Determine the Necessary Measures Against Problems Relating to Substance and Drug Addiction and Trafficking" (The National Policy and Strategy Document on Drugs 2013-2018).

In addition, to ensure the effective implementation of the strategic objectives described in the National Policy and Strategy Document on Drugs (2013-2018), the National Action Plan against Drugs (2013-2015) was prepared with the contribution and agreement of the relevant institutions.

Parallel to the National Policy and Strategy Document on Drugs (2013-2018), the Third National Action Plan against Drugs adopts, within the scope of the drug problem, a balanced approach for reducing supply and demand (National Action Plan against Drugs 2013-2015).

Every year, the EU Progress Report makes mention of the National Policy and Strategy Document on Drugs and National Action Plan against Drugs, and closely follows the developments in Turkey with regards to these documents (National Policy and Strategy Document on Drugs 2013-2018).

The implementation of the recently prepared National Policy and Strategy Document on Drugs (2013-2018) and of the National Action Plan against Drugs (2013-2015) was deemed appropriate and approved by the Prime Minister.

1.3.2. Evaluation of the Implementation of the National Policy and Strategy Document on Drugs and of the National Action Plan against Drugs

The National Policy and Strategy Document on Drugs 2006-2012, which represents the first strategy document in Turkey concerning the efforts against drugs, entered into effect in 2006. To achieve the objectives listed in this strategy document, two separate action plans were prepared and implemented, which were the National Action Plan against Drugs 2007-2009 and the National Action Plan against Drugs 2010-2012.

Following the end of term for the First and Second National Action Plans against Drugs, the necessary evaluations were performed according to the provisions listed below (which were integral to these two actions plans):

- The “Evaluation Methods” section in “Section Four” of the First National Action Plan against Drugs stated that: “... *Following the implementation of the Action Plan, an evaluation report assessing the results and effects of the Action Plan will be prepared within two months at the latest. This report will be prepared under the coordination of TUBİM by the institutional representatives who were assigned with this task by the Action Plan.*”
- The “Evaluation Methods” section in “Section Three” of the Second National Action Plan against Drugs stated that: “... *Following the completion of the Action Plan’s implementation, an evaluation report assessing the results and effects of the Action Plan will be prepared within three months at the latest, under the coordination of TUBİM, by the institutional representatives who were assigned with this task by the Action Plan.*”

The action plans were evaluated using the data and information collected from the relevant institutions with the “*Evaluation Form for the Action Plan Regarding the Implementation of the National Strategy Document for Combatting Addictive Substances and Addiction.*”

Table 1-2: Comparison of the First and Second National Action Plans against Drugs

	<i>First National Action Plan Against Drugs (2007-2009)</i>	<i>Second National Action Plan Against Drugs (2010-2012)</i>
<i>Number of Objectives</i>	73	33

<i>Number of Activities</i>	130	72
<i>Number of Institutions Responsible for Implementing the Activities</i>	34	27
<i>Number of Institutions Contributing to the Evaluation</i>	30 (87%)	27 (100%)
<i>Level of implementation for the Activities</i>	-33% (43) fully implemented, -51% (66) partially implemented, -15% (20) not implemented, -1% (1) unmeasurable/unanswered activities	-40% (29) fully implemented, -43% (31) partially implemented, -10% (7) not implemented, -7% (5) unmeasurable/unanswered activities

Sources: Turkish Centre for Monitoring Drugs and Drug Addiction, 2014.

1.3.3. Developments Concerning Other Policies against Drug Substances

National Strategy Document on the Rights of the Child (2013-2017):

To ensure the implementation and coordination of practices relating to Children’s Rights, the “National Strategy Document on the Rights of the Child” encompassing the 2013-2017 period was approved by the YPK² based on the decision number 2013/33 dated 14 December 2013, which was published in the relevant issue of the Official Gazette. This Strategy Document aims to improve the welfare and quality of life of children, and to ensure that they can benefit to the fullest from their fundamental rights such as the right to live, development, protection, and participation. This document also includes the following objectives and activities for the protection of children from addiction:

² The High Planning Council (*Yüksek Planlama Kurulu*, YPK) convenes under the presidency of the Prime Minister, and consists of Ministers designated by the Prime Minister and the Minister of Family and Social Policies. For meetings where the Prime Minister is not present, the council convenes under the presidency of another Ministry designated by the Prime Minister or the Minister of Family and Social Policies.

- Objective 6: The Development of Services for Supporting and Protecting the Family and Children.
 - Objective 6.2: The necessary measures should be taken to ensure the protection of all children from addictions.
 - ✓ Activity 6.2.1: To ensure that protective-preventive measures and support services for the protection of all children from substance abuse become more prevalent, the cooperation between institutions will be strengthened. To this end, the necessary coordination and cooperation will be ensured between institutions for the implementation of the National Policy and Strategy Document on Drugs (2013-2018) prepared by TUBİM.
 - ✓ Activity 6.2.2: Substance abuse treatment centers that provide treatment and rehabilitation services for children with substance addiction will be rendered more prevalent across the country, and the quality of the existing centers will be improved (The General Directorate of Child Services of the Ministry of Family and Social Policies, 2014).

Strategic Plan of the Ministry of Youth and Sports (2013-2017)

The purpose of this strategy document is to ensure that the youth become active citizens and make use of their leisure time productively; to enable the youth to acquire educational, social, cultural, athletic, and artistic skills; to contribute to the individual and social development of the youth; to ensure that the youth embrace ethical and humane values; to prevent youth from engaging in violence or acquiring harmful habits; to organize national and international events; to establish youth camps and youth centres; and to increase the effectiveness of these centres. The strategy document also envisages the following for preventing violence and harmful habits among the youth:

- ✓ To cooperate with our stakeholders in order to reach 250,000 young individuals by the end of the planned period through informative and preventive activities regarding violence and harmful habits.
- ✓ To conduct joint studies and activities with stakeholders in order to prevent violence and harmful habits among the youth.

The National Youth and Sports Policy Document (2013-2017)

By decision of the Council of Ministers, the “National Youth and Sports Policy Document” was prepared in accordance with Article 18 of the Decree Law number 638 dated 3 June 2011 on the

“Organization and Duties of the Ministry of Youth and Sports,” and was officially adopted following its publication in the Official Gazette number 28541 dated 27 January 2013. Within Section 5 of the National Youth and Sports Policy Document, several examples of the objectives defined in the relevant articles of the “Main Policy Objectives” section were as follows: *“To ensure safer social environments and educational institutions for the youth in order to protect them from substance addiction and violence,” “To take preventive measures in order to protect the youth from addictive substances, and to conduct activities for the treatment of young individuals with substance addiction,” “To ensure the social integration of young persons living in the streets,” “To ensure the social reintegration of young persons who have committed crimes, and to prevent criminal behaviour among the youth,” “To raise awareness among the youth and other segments of society towards disadvantaged individuals, and to ensure the active participation of youth in the social adaptation of these disadvantaged individuals,” and “To increase the prevalence of measures for the protection of youth from substance addiction and from habits that are detrimental for health as smoking and alcohol.”*

1.3.4. Regulations for Coordination

TUBİM National Coordination Committee on Drugs

With respect to the activities for combatting drugs, the necessary coordination at a national level between the relevant institutions/organizations is ensured by TUBİM. The National Coordination Committee on Drugs of TUBİM, which was established in 2006, holds meetings on two different subjects, one of which is “Combatting Supply,” while the other is “Reducing Demand, and Provision of Treatment and Rehabilitation.” The National Coordination Committee on Drugs has convened 18 times within 2013.

TUBİM Science Committee

The TUBİM Science Committee was formed according to the National Action Plan against Drugs (2007-2009). This committee was formed in order to provide scientific support to the activities being conducted in Turkey for combatting drugs and drug addiction. The committee provides scientific recommendations to the National Coordination Committee on Drugs. The Science Committee has convened 18 times within 2013.

The Early Warning System (EWS)

As is the case around the world, there are increasing numbers of psychoactive substances in Turkey, which, despite having effects similar to those of known narcotic and psychotropic substances regulated by existing laws, are not subject to any legal limitations or restrictions. Due to this lack of legal restrictions and their relative availability and accessibility, the supply of these substances to the market is gradually increasing.

Within the context of the activities for combatting drug substances and drug substance addictions, it is very important for these new psychoactive substances to be included as soon as possible into the scope of the current laws.

Institutions that are part of the EWS will report to TUBİM any new psychoactive substance they identify by using the “*Form for New Psychoactive Substances (drug, stimulant, hallucinogen, or similar substances)*.” In meetings regarding these substances, the following aspects will be evaluated:

1. The likelihood and severity of addiction with the relevant substance;
2. The social risks the substance represents for the user; and
3. The disturbances and violence the substance might engender within society.

As a result of the EWS Study Group’s meetings, 94 new psychoactive substances have been included between 2007 and 2013 into the scope of the Law on the Control of Drug Substances number 2313. With an additional 246 new psychoactive substances that have been included into the scope of this law in 2014, the number of new psychoactive substances to have been included into the scope of the law between 2007 and 2014 reached 340.⁵

1.4. Economic Analyses

1.4.1. Public Expenses

In Turkey, expenses relating to activities for combatting drugs are mainly covered from the general budget of the relevant institutions. However, it is difficult to determine the extent to which expenses from these general budgets have been made for combatting drugs. For this reason, the public expenses described in this section represent approximations based on the total expenses of the relevant institutions.

⁵ See Section 1.2.1.1. regarding the *Law on the Control of Drug Substances number 2313*

In Turkey, the expenses for combatting drugs were first documented and reported by TUBİM in 2010. To ensure that the necessary data would be collected more accurately and systematically, the “Form regarding Public Expenses for Combatting Illicit Addictive Substances” was developed in 2011. Data collected using this form began to be reported in 2012 (which reflected the data for 2011). While data for this report were initially collected from central institutions only, data also began to be collected from provincial municipalities starting in 2013 (which reflected the data for 2012) in order to increase data capacity.

Table 1-3: The Distribution According to the Years of the Public Expenses Performed for Combatting Drugs (TL)

Year	2010	2011	2012	2013
Public Expenses (TL)	563,835,266	372,638,683	395,792,281	743,546,907

Source: Turkish Centre for Monitoring Drugs and Drug Addiction, 2014.

In 2011, total public expenses were 372,638,683 TL. Although the figure for 2011 suggests a decreasing trend in public expenses when compared to the total expenses of 563,835,266 TL in 2010, it is important to note that figure for 2010 represents a miscalculation: one of the institutions that had provided data in that year had erroneously forwarded figures regarding the total expenses of their Ministry rather than the figures relating to the activities for combatting drugs, thus accidentally increasing the total value for 2010 (2012 Turkish Drug Report).

In 2012, public expenses increased by 6.21% compared to the previous year to reach 395,792,281 TL. In 2013, public expenses increased considerably by 87.86% compared to the previous year to reach 743,546,907 TL. It was determined that this increase mainly stemmed from a considerable rise compared to the previous year in the equipment and infrastructure-related expenses of one of the institutions that forwarded their data to TUBİM.

Table 1-4: Public Expenses Performed in 2013

Item No	Type of Expense	Institution (TL)	Institution (%)	Provinces (TL)	Provinces (%)	Total (TL)	Total (%)
1	Personnel Expenses	363.435.367,28	48.96	609.497,70	51.46	364.044.864,98	48.96

2	Equipment and Infrastructure Expenses	234.615.534,61	31.60	130.894,18	11.05	234.746.428,79	31.57
3	Training Expenses (Personnel)	1.633.512,00	0.22	2.770,00	0.23	1.636.282,00	0.22
4	Research and Development Expenses	3.000,00	0.00	0,00	0.00	3.000,00	0.00
5	Outpatient Treatment Expenses	25.855.939,65	3.48	0,00	0.00	25.855.939,65	3.48
6	Inpatient Treatment Expenses	33.926.045,99	4.57	0,00	0.00	33.926.045,99	4.56
7	Rehabilitation and Support Expenses	1.116.090,71	0.15	0,00	0.00	1.116.090,71	0.15
8	Medication Expenses	12.301.095,51	1.66	0,00	0.00	12.301.095,51	1.65
9	Preventive Activity Expenses	636.577,00	0.09	357.144,87	30.15	993.721,87	0.13
10	Court Expenses	0,00	0.00	0,00	0.00	0,00	0.00
11	Autopsy Expenses	17.000.000,00	2.29	0,00	0.00	17.000.000,00	2.29
12	Convict/Detainee Expenses	0,00	0.00	0,00	0.00	0,00	0.00
13	Probation Expenses	2.114.070,00	0.28	0,00	0.00	2.114.070,00	0.28
14	Operation Expenses	5.130.112,48	0.69	0,00	0.00	5.130.112,48	0.69
15	Analysis Expenses	14.076.559,61	1.90	0,00	0.00	14.076.559,61	1.89
16	Premium Expenses	29.113.289,54	3.92	0,00	0.00	29.113.289,54	3.92
17	Other Expenses	1.405.235,90	0.19	84.170,23	7.11	1.489.406,13	0.20
Total		742.362.430,28	100.00	1.184.476,98	100.00	743.546.907,26	100.00

Source: Turkish Centre for Monitoring Drugs and Drug Addiction, 2014.

In 2013, data regarding public expenses were collected from the Ministry of Justice; the Ministry of Family and Social Policies; the Ministry of Youth and Sports; the Ministry of Food, Agriculture, and Livestock; the Ministry of Customs and Trade; Ministry of Finance; the Ministry of National Education; the Ministry of Health; the General Directorate of Security; the Gendarmerie General Command; the Coast Guard Command; the Social Security Institution; the Turkish Radio and Television Corporation; and 45 Provincial Municipalities.

When public expenses for 2013 are considered separately for central institutions and provincial municipalities, it can be seen that:

- Central institutions conducted 742,362,430.28 TL in expenses; and
- Provincial municipalities conducted 1,184,476.98 TL in expenses.

An evaluation of the combined expenses of both central institutions and provincial municipalities for 2013 indicated that nearly half of the expenses (48.96%) consisted of personnel expenses. The areas/items which represented the leading expenses of central institutions and provincial municipalities are listed below:

- 48.96% (364,044,864.98 TL) of expenses were related to personnel expenses;
- 31.57% (234,746,428.79 TL) of expenses were related to equipment and infrastructure;
- 4.56% (33,926,045.99 TL) of expenses were related to inpatient treatment expenses; and
- 3.48% (25,855,939.65 TL) of expenses were related to outpatient treatment expenses.

Compared to the previous year's expenses, public expenses in 2013 saw significant increases in the areas of equipment and infrastructure expenses and personnel expenses. As such, from 2012 to 2013, equipment and infrastructure expenses increased 7.5 times (207,402,121.00 TL), while personnel expenses increased 57.56% (132,987,966.48 TL).

1.4.2. Budget

In Turkey, institutions do not have a specific budget to conduct activities against drugs. Institutions thus cover their expenses relating to the combat against drugs from their general budget.

1.4.3. Social Costs

Aside from the public expenses performed for combatting drugs, the harms caused by drugs and drug use also impose a significant cost on society. It is expected that this cost is far greater than the public expenses currently made against drugs. However, in 2013, no studies have been conducted in Turkey to assess the social costs associated with drugs and drug use.

SECTION 2

DRUG USE PREVALENCE

Prof. Dr. Mustafa N. İLHAN⁶

2.1. Introduction

Turkey works to reduce both the supply and demand of drugs. The entire Law Enforcement Agency, especially the Ministry of Interior, Turkish National Police, Department of Anti-Smuggling and Organized Crime, Gendarmerie, Ministry of National Education, Ministry of Justice, and Ministry of Health have embraced the fight against drugs, and defined the size of the problem in the process.

Several studies were conducted in Turkey to determine drug use in adults and youth, while the first two studies to represent the public and youth throughout the country were conducted by TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction) in 2011. The results on drug use frequency and concerned risk factors were used as one of the basic sources to determine the drug control policy and action plan in Turkey.

In this section of the report, the results obtained from the studies “drug use prevalence in general population of Turkey” and “drug use prevalence in schoolchildren in Turkey” will be discussed. However, for the August-September 2014 period, during which the report was issued, no new studies that represent the public in terms of the drug addiction rate were carried out. International and national scientific databases generally cover the studies devoted to inpatients and treatments.

Accordingly, drug use frequency and risk factors, details of which are discussed in the 2013 report, will be addressed briefly, and elaborative information on drug use in schoolchildren and risk factors will be given.

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2.2. Drug Use in the General Population

During the research on drug use in general population, carried out by TUBİM in 2011, 8,145 households from 25 provinces were interviewed. The study revealed life-long drug use frequency to be 2.7%. According to the results of the study, being in the 15-24 age group, being male, having an income of 500 TRY or lower (<200 Euro or <250 USD at the time of research), and using tobacco, alcohol, and medicines without the recommendation of a doctor increased drug use at significant.

2.3. Drug Use in Schools and the Youth Population

During the Schoolchildren Study, conducted by TUBİM in 2011, 11,812 persons from 32 cities were interviewed, based on common and technical high school distribution. 49% of these students were female (5,783 persons), while 51% of them were male (6,029 persons), and their average of age was 15.23 ± 0.69 , with a median of 15.00.

Life-long drug use frequency was determined to be 1.5% in the study of schoolchildren. 1.1% of those schoolchildren had a family member who used a substance apart from tobacco or alcohol, and for 87.4% of them, this person was either a parent or sibling. The average age for first time drug use was 13.88 ± 2.39 , with a median of 14.00.

Drug use prevalence values of the subjects (life-long, within the last 12 months, within the last 3 months, within the last month, and during the research) are given in Table 2.1.

Table 2.1: Drug use prevalence values of the schoolchildren (life-long, within the last 12 months, within the last 3 months, within the last month, and during the research)

	Drug Use Prevalence (%)
Life-long	1.5
Within the last 12 months	0.5
Within the last 3 months	0.5
Within the last month	0.5
Currently	0.5

Source: TUBİM School Population Survey, 2011

42.1% of those who are still on drugs use such substances once a week, while 36.8% of them uses drugs twice a week. 49.1% of drug users shared the names of the substances they use. Even though only approximately half of the group revealed the names of the drugs, marijuana

was in first place by a landslide, while the volatiles (gas, uhu, 404, bally)⁷ were the second most frequently mentioned. Despite the scarce number of answers, it was determined that one out of five users used more than one substance. The most common method to use such substances was respiration, while the second most common method was orally. Zero point seven percent of the female students had tried substances, while this number was 2.3% for the male students.

The substances used are divided into six groups, and the distribution of these groups is given below.

Table 2.2: Drug groups used by school children⁸

Code	Group	Drugs (Substances)
1	Cannabis and derivatives	Cannabis, gambling , ray, roj, roy, weed, sarı, siroit, sandoz, yeşilbaş, pro, pet, cigarette, shisha, cannabis, maraş otu, cannabis sativa, hubble-bubble
2	Volatiles	Gas, glue, adhesives, bally, thinner, cologne
3	Stimulants	Rolex, kuşgali, ecstasy, junk food, strawberries, energy drink
4	Heroin	Heroin, drug
5	Cocaine	Cocaine, crack
6	Hallucinogens	Bonsai

Source: *TUBIM School Population Survey, 2011.*

Among the drugs mentioned by the users, cannabis and derivatives are ranked first (84.1%), followed by volatiles (32.9%) and stimulants (22.7%). The percentage of the users indicating their first preference to be cannabis was 61.3%, while this substance was the second preference of 39.1% and the third preference for 25.0% of the users; and that results indicate that this substance takes place on the top.

The distribution of the substances based on preference is given below.

Table 2.3.: Distribution of the substances based on the preferences

Drug Groups	1 st Preference		2 nd Preference		3 rd Preference		Total	
	N	%*	N	%*	N	%*	N	%*
Cannabis and derivatives	54	61.4	18	39.1	2	25.0	74	84.1
Volatiles	16	18.2	10	21.8	3	37.5	29	32.9

⁷ These are glue trademarks that contain volatile chemicals, and used as narcotics.

⁸ The names appearing in this table are all slang and of highly changeable nature.

Stimulants	10	11.4	10	21.8	-	-	20	22.7
Heroin	4	4.6	6	13.0	2	25.0	12	13.6
Cocaine	2	2.2	2	4.3	-	-	4	4.5
Hallucinogens	2	2.2	-	-	1	12.5	3	3.4

* Column percentage (frequency among those who mentioned the substances they use)

Source: TUBIM School Population Survey, 2011.

One of the most striking results of this study is that drug use is statistically significant for lifetime tobacco, alcohol, and drug users, for those who have been using the same for the last 12 months, and those who are still using them, except for those who have used drugs in the last 12 months. This difference is especially clear in those who are still using substances.

Table 2.4: Lifetime substance use distribution of the subjects (lifetime tobacco, alcohol and drug use, and use of the same for the last 12 months and last 30 days)

		Life-Long Drug Use		
		Yes (%)	No (%)	
Lifetime				
Tobacco	Yes	5.1	94.9	
	No	0.2	99.8	p=0.001
Alcohol	Yes	5.7	94.3	
	No	0.5	99.5	p=0.001
Drug	Yes	16.7	83.3	
	No	1.2	98.8	p=0.001
Last 12 Months				
Tobacco	Yes	6.2	93.8	
	No	2.4	97.6	p=0.001
Alcohol	Yes	6.4	93.6	
	No	3.4	96.6	p=0.009
Drug	Yes	38.5	61.5	
	No	31.3	68.8	p=0.769
Still				
Tobacco	Yes	8.3	91.7	
	No	0.5	99.5	p=0.001
Alcohol	Yes	9.7	90.3	
	No	0.8	99.2	p=0.001
Drug	Yes	36.4	63.6	
	No	5.5	94.5	p=0.001

Source: TUBIM School Population Survey, 2011.

Most of the students who indicated that they used alcohol were male. Multiple drug use was mentioned by six females and 41 male students. In terms of lifetime ($p=0.0001$) and current ($p=0.001$) drug use, the values of male students were 3.9-fold greater than the female students.

Working in a job for money or compensation indicated no significant difference in terms of drug use in the last 12 months ($p=0.608$), in the last 3 months ($p=0.787$), in the last month ($p=0.396$), and current use of drugs ($p=0.142$). Those who did not have a job were the minority among those who revealed that they had a life-long drug use habit ($p=0.0001$). Having a job

was not determined to make any difference in multiple drug use.

Total monthly household income indicated no significant difference in terms of drug use in the last 12 months ($p=0.866$), in the last 3 months ($p=0.472$), and in the last month ($p=0.571$).

It was observed that, from the aspect of total monthly income of the household, at the lifetime ($p=0.0001$) and current ($p=0.031$) drug use phase, there was a tendency to greater drug abuse by the children of the families with no regular income or high income. Having a job was not determined to make any difference in the use of multiple drugs.

Owning a home indicated no significant difference in terms of lifetime drug use ($p=0.869$), drug use in the last 12 months ($p=0.365$), in the last 3 months ($p=0.265$), in the last month ($p=0.446$), and current drug use ($p=0.163$). Having a job was not determined to make any differences in the use of multiple drugs ($p=0.722$).

Having a room of one's own indicated no significant difference in terms of drug use in the last 12 months ($p=0.967$), in the last 3 months ($p=0.541$), in the last month ($p=0.142$), and current drug use ($p=0.234$). Young people with a lifetime drug abuse habit, who did not have a room of their own, indicated to have used more drugs ($p=0.003$). Having one's own room was not determined to make any difference in the use of multiple drugs ($p=0.349$).

The number of siblings indicated no significant difference in terms of drug use in the last 12 months ($p=0.300$), in the last 3 months ($p=0.174$), in the last month ($p=0.813$), and current drug use ($p=0.480$). Young people with a lifetime drug use habit, who had a lower number of siblings, stated to have used more drugs ($p=0.049$). The number of siblings was not determined to make any difference in the use of multiple drugs ($p=0.155$).

The location in which the subjects have spent a greater part of their life indicated no significant difference in terms of lifetime drug use ($p=0.654$), drug use in the last 12 months ($p=0.141$), last 3 months ($p=0.573$), in the last month ($p=0.058$), and current drug use ($p=0.779$). No significant difference was observed between the location in which the subjects had spent a greater part of their life and the use of multiple drugs ($p=0.795$).

The time spent in a location indicated no significant difference in terms of lifetime drug use ($p=0.574$), drug use in the last 12 months ($p=0.390$), in the last 3 months ($p=0.258$), in the last month ($p=0.513$), and current drug use ($p=0.761$). No significant difference was observed between the location in which the subjects have spent a greater part of their life and the use of

multiple drugs ($p=0.221$).

Having a mother indicates no significant difference in terms of drug use in the last 12 months ($p=0.924$), last 3 months ($p=0.881$), in the last month ($p=0.769$), and current drug use ($p=0.507$). Those who have a mother are the minority among those with lifetime drug use habit ($p=0.0001$). No significant difference was observed between having a mother or not in terms of the use of multiple drugs ($p=0.569$).

Having a father indicated no significant difference in terms of drug use in the last 12 months ($p=0.899$), in the last 3 months ($p=0.832$), in the last month ($p=0.701$), and current drug use ($p=0.953$). Those who had a father were the minority among those with a lifetime drug use habit ($p=0.001$). No significant difference was observed between having a father or not in terms of the use of multiple drugs ($p=0.750$).

Having a nuclear family indicated no significant difference in terms of drug use in the last 12 months ($p=0.530$), in the last 3 months ($p=0.410$), in the last month ($p=0.10$), and current drug use ($p=0.302$). The rate of those who have a nuclear family are the minority among those with a life-long drug use habit ($p=0.0001$). No significant difference was observed between having a nuclear family or not in terms of the use of multiple drugs ($p=0.905$).

The mother's job indicated no significant difference in terms of lifetime drug use ($p=0.123$), drug use in the last 12 months ($p=0.848$), in the last 3 months ($p=0.180$), in the last month ($p=0.830$), and current drug use ($p=0.250$). No significant difference was observed between the mother's having a job or not in terms of the use of multiple drugs ($p=0.666$).

The father's job indicated no significant difference in terms of drug use in the last 12 months ($p=0.798$), in the last 3 months ($p=0.706$), in the last month ($p=0.824$), and current drug use ($p=0.600$). Children of jobless fathers were observed to have the highest rate among those having a lifetime drug use habit ($p=0.041$). No significant difference was observed between the father's having a job or not in terms of the use of multiple drugs ($p=0.896$).

Having a housewife mother and jobless father indicated no significant difference in terms of drug use in the last 12 months ($p=0.565$), in the last 3 months ($p=0.450$), in the last month ($p=0.161$), and current drug use ($p=0.502$). This situation increased the rate of drug use among those with a lifetime drug use habit ($p=0.024$). This did not cause any difference in terms of the use of multiple drugs ($p=0.342$).

The mother's education level indicated no significant difference in terms of drug use in the last 12 months ($p=0.714$), in the last 3 months ($p=0.361$), in the last month ($p=0.679$), and current drug use ($p=0.475$). Young people with educated mothers were observed to be the majority among those who had a lifetime drug use habit. The education level of mother was not observed to make any difference in terms of the use of multiple drugs ($p=0.758$).

The father's education level indicated no significant difference in terms of drug use in the last 12 months ($p=0.499$), in the last 3 months ($p=0.666$), in the last month ($p=0.910$), and current drug use ($p=0.499$). The fathers of young people who had a lifetime drug use habit were observed to have not received formal education ($p=0.0001$). This was followed by the fathers with a high education level. The education level of fathers was not observed to make any difference in terms of the use of multiple drugs ($p=0.319$).

Having a disease for more than three months indicated no significant difference in terms of drug use in the last 12 months ($p=0.469$), in the last 3 months ($p=0.341$), in the last month ($p=0.769$), and current drug use ($p=0.723$). Having a disease for more than three months was very common among the young people with a life-long drug use habit ($p=0.0001$). Having a disease for more than three months or not was observed not to make any difference in the use of multiple drugs ($p=0.999$).

Result

It was observed that the young people participated in this study intimately. It was also observed that not providing any substance choices was not a problem, and that it even led young people to share their knowledge by providing many names regarding cannabis and derivatives.

The results indicated that the tobacco, alcohol, and substance use prevalence in Turkey remains at a certain level, it cannot be underestimated, drug use should be addressed, and that Turkey should take unique steps for protection and prevention plans in this field.

It would be appropriate to adopt a systematic approach that measures the frequencies in the community at certain intervals, in order to assess the effects of protection and prevention studies to be conducted, and that develops the methods to be used.

2.4. Drug Use between Target Groups / National and Local Regulations

No new data.

SECTION 3 PREVENTION

Mustafa ERSOY⁹

3.1. Introduction

Drug addiction is one of the major problems that has reached a critical level in Turkey, as is the case worldwide, and threatens both youngsters and future generations. Thoroughly combatting the drug problem, which has social, economic, health, and security-related dimensions, requires efforts to be made in cooperation with all the parties involved.

Preventive activities constitute an essential element in the fight against drug use and addiction. Prevention refers to all precautionary activities carried out to help individuals avoid developing bad habits and lead healthy lives. The main objective of preventive actions is to ensure that an individual refuses to use drugs when offered and minimize his/her addiction risk.

Drug use and addiction is a problem with a social dimension, which affects not only users but is likely to affect their social environments as well. Thus, target groups at risk should be given great attention in preventive activities, and these activities should be conducted at school, and with families and communities according to the risk potentials of these groups.

The drug problem as a multidimensional phenomenon is addressed by a number of different institutions and organizations in Turkey. Preventive actions are essentially based on Article 58 of the Constitution of the Republic of Turkey according to which: *“The State shall take the necessary measures to protect youth from addiction to alcohol and drugs, crime, gambling, and similar vices, and ignorance.”*; however since there is no single countrywide standard program for the prevention of drug use and addiction, the relevant institutions carry these activities out differently.

Various difficulties encountered during the treatment and rehabilitation processes, the extent of labor input and costs incurred, and the risk of failure at the end of these processes expose the importance and necessity of preventive activities.

Seminars, plays, posters and brochures, and programs presented through various media channels on the harmful effects and consequences of drug use constitute a major portion of preventive activities carried out in Turkey. These activities basically target youngsters between

9 TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction)

the ages of 15 and 24 (when most drug abuses start) as well as families, teachers, public officials, and non-governmental organizations.

The Turkish National Police is one of the major institutions that bear significant responsibilities regarding the reduction of both supply and demand. A multilateral struggle against drugs continues, where efforts by law enforcement officers to control the sale and trafficking (supply) of drugs are supported by preventive activities carried out by the Turkish Monitoring Center for Drugs and Drug Addiction (TUBİM) staff and TUBİM Provincial Contact Point (İLTEM) staff employed in the Departments for Combatting Drug Use located in all 81 provinces.

Preventive activities in Turkey are specifically conducted TUBİM, the Ministry of Justice, Ministry of Family and Social Policies, Ministry of National Education, Ministry of Health, Presidency of Religious Affairs, Radio and Television Supreme Council (RTÜK), municipalities, universities, and various non-governmental organizations.

This section is based on the data from preventive activities carried out by TUBİM in 2013 and by other institutions and reported to TUBİM.

3.2. Environmental Prevention

Environmental prevention, as a concept, refers to altering the immediate environments in which individuals make their choices about drug use, and environmental strategies involve regulations of substances such as tobacco and alcohol, which are considered gateway substances in transition to drug use (Beenstock and Rahav, 2002). The Tobacco and Alcohol Market Regulatory Authority, responsible for tobacco and alcohol-related regulations, takes necessary measures to control the production, release, and promotion of tobacco and alcohol.

Tobacco and alcohol use, similar to the risks related to drug use, does not pose a threat only to users, but also to passive users in their environments. Thus, Turkey has introduced various legal regulations in order to minimize the harmful effects of tobacco and alcohol on users, and to protect at-risk groups against these substances.

This part will cover recent regulations on both tobacco and alcohol that can be considered to be within the scope of environmental prevention.

3.2.1. Regulations regarding the Policies for Tobacco and Alcohol Control

A number of regulations aimed at controlling tobacco and alcohol are introduced under the coordination of the Turkish Public Health Agency under the Ministry of Health and Tobacco and Alcohol Market Regulatory Authority. These regulations include provisions ensuring that

non-users or individuals in at-risk groups lead healthy lives. Regulations since 2008 in particular have helped Turkey make progress in its efforts to control both tobacco and alcohol.

3.2.1.1. Preventive Regulations regarding the Policies for Tobacco Control

Provisions established in Law no. 4207 on November 7, 1996 on the Prevention and Control of Hazards of Tobacco Products provided a basis for the tobacco policies. Amendments passed into this law on January 3, 2008 in particular aimed to protect non-smokers from harmful effects of tobacco products. Within the scope of smoke-free zones, Article 2 of the relevant Law was amended as follows on January 19, 2008:

“Tobacco products shall not be consumed:

- In closed spaces of public utilities;
- In closed spaces, including corridors, of buildings that are used for the purposes of education, health, production, commerce, social, cultural, athletic, and recreation activities, are owned as private entities and that more than one person can have access to (excluding residential houses);
- In road, rail, sea and air transportation vehicles including taxicab services;
- In closed and open spaces of pre-schools, primary and secondary schools including private preparatory institutions and private educational establishments, and cultural and social service buildings; and
- In recreational establishments such as restaurants, coffeehouses, cafes, and pubs owned by private entities.”

Since July 19, 2009, smoking has been banned in public transportation vehicles and closed areas of all public and private buildings except for residential houses.

The success that was achieved in the reduction of tobacco use as part of the National Tobacco Control Program and Action Plan implemented between 2008 and 2012 are to be boosted by the National Tobacco Control Program and Action Plan to be effective between 2014 and 2018. The new action plan covers 133 activities under 10 titles, and 21 responsible institutions and organizations.

In line with the new action plan, entrances of establishments such as shopping malls, theaters and cinemas where people are concentrated, and certain parts of spaces such as playgrounds, restaurants and coffeehouses are planned to be designated as smoke-free zones. The action plan foresees increased supervision capacity to ensure absolute prevention of the use of tobacco products in areas defined as “closed spaces” in the relevant legislation,

and activities to be carried out to prevent tobacco use in all spaces such as public parks, from which children benefit.

3.2.1.2. Preventive Regulations regarding the Policies for Alcohol Control

Alcohol, besides tobacco, is also considered as a transition substance to starting drug use. Each and every step taken to regulate alcohol and its products, in addition to tobacco products, contribute to the prevention of drug use. To restrict individuals' access to tobacco and alcohol according to certain criteria will help them refrain from other addictive substances.

The Law no. 4250, enacted on June 12, 1942 on the Monopoly of Alcohol and Alcoholic Beverages, lays down the basic provisions related to alcohol control. Pursuant to the amendments passed in Article 6 of the law in 2013:

- Advertising activities and promotions aimed at consumers shall under no circumstances be conducted. No campaign, promotion or activity that encourages or promotes the use of such products shall be conducted.
- Producers, importers, and sellers of alcoholic beverages shall under no circumstances provide sponsorship to any event by using their trademarks, logos, or signs.
- No positive image of alcoholic beverages shall be presented in TV series, movies, and music videos.
- Producers, importers, and sellers shall under no circumstances distribute alcoholic beverages gratuitously, for promotion or incentive nor as samples.
- Alcoholic beverages cannot be sold and cannot be served to people under the age of 18.
- People under the age of 18 cannot be employed in the production, marketing, sale, or serving of alcoholic beverages. This provision does not apply to educational activities carried out as per the relevant legal arrangements.
- Alcoholic beverages cannot be sold by vending machines, and cannot be offered in any game or bet through slot machines or different methods. Alcoholic beverages cannot be sold to customers between 10 p.m. and 6 a.m.

Moreover the amended law stipulates increased penalties for breaching the aforementioned articles.

As per the amendments to Article 9 of the Law in 2013, enterprises selling retail or serving alcoholic beverages are required to be situated at least 100 meters away from educational institutions, student dormitories, and places of worship.

3.3. Universal Prevention

Universal prevention activities aim to inform individuals about drugs and their health hazards. Such activities are carried out at school, family, and community levels.

3.3.1. School-based Prevention

Educational institutions are suitable for drug use prevention activities, because it is easier to convey educational content in a school setting, and students are rather more open to taking in information they are provided. Thus educational institutions are significant players in the efforts to protect youngsters from addictive substances.

As part of school-based prevention, school counselors under the Ministry of National Education, and Counseling and Research Centers, and ILTEM officials carry out preventive activities at schools to protect youngsters against drugs.

The Ministry of National Education organizes seminars and conferences throughout the country in order to prepare students for life, help them cope with their problems and explain how they should respond to offers that will be detrimental to their lives such as drug use. Primary protection-and-prevention-based activities carried out by counseling services in schools, and Counseling and Research Centers in provinces and districts are as follows:

- To raise awareness among students, teachers, and school administrators about substance addiction and bad habit prevention;
- To implement training programs for refusal skills, communication skills, and conflict resolution skills; and
- To raise awareness among people/enterprises that are close to schools and students such as Internet cafés, kiosks, and gaming center personnel and bus drivers.

ILTEM officials employed in TUBIM's Department for Combatting Drug Use organize seminars, conferences, plays, movie screenings, and distribute posters and brochures at schools. ILTEM officials who receive the basic training on combatting drug use held by TUBIM inform youngsters about the harmful effects of drugs, how to avoid such substances, what to pay attention to, and the threats posed by drug use.

ILTEM officials reached 476,885 students in their preventive activities in 2013. In addition to activities such as seminars, conferences, and plays, more enduring project-based-activities including social and athletic activities are carried out.

3.3.2. Family-based Prevention

Families are certainly those to shoulder the most important responsibility in protecting children and youngsters from bad habits. Families guide their children in both their physical and psychological development paths starting from birth. One of the criteria of good parenting is related to how effectively parents can protect their children from drugs in particular and all bad habits in general.

Parents should take all necessary measures to remove existing risk factors associated with the initiation of drug use, get to know their children's close friends, and follow their children's school lives. In addition to providing appropriate education, parents are also responsible for creating necessary conditions to ensure their children's healthy developments. Preventive activities aimed at families to realize all these objectives are classified under family-based prevention activities.

The Ministry of National Education carries out the following activities as part of family-based prevention:

- To ensure increased numbers of implementers of the Parenting Training Program for the 0-18 years age group, and the Parenting Counseling Program for the 7-19 years age group throughout the country and thus provide training to parents;
- To ensure that school counseling services and Counseling and Research Centers raise awareness among families about drug addiction and bad habit prevention; and
- To ensure that teachers and school counselors inform parents during parent-teacher meetings about how to avoid bad habits and characteristics of adolescence.

Moreover, TUBIM Provincial Contact Personnel carry out informative activities for families on the prevention of drug use. As a result of these activities, 62,244 parents were provided awareness raising activities in 2013.

3.3.3. Community-based Prevention

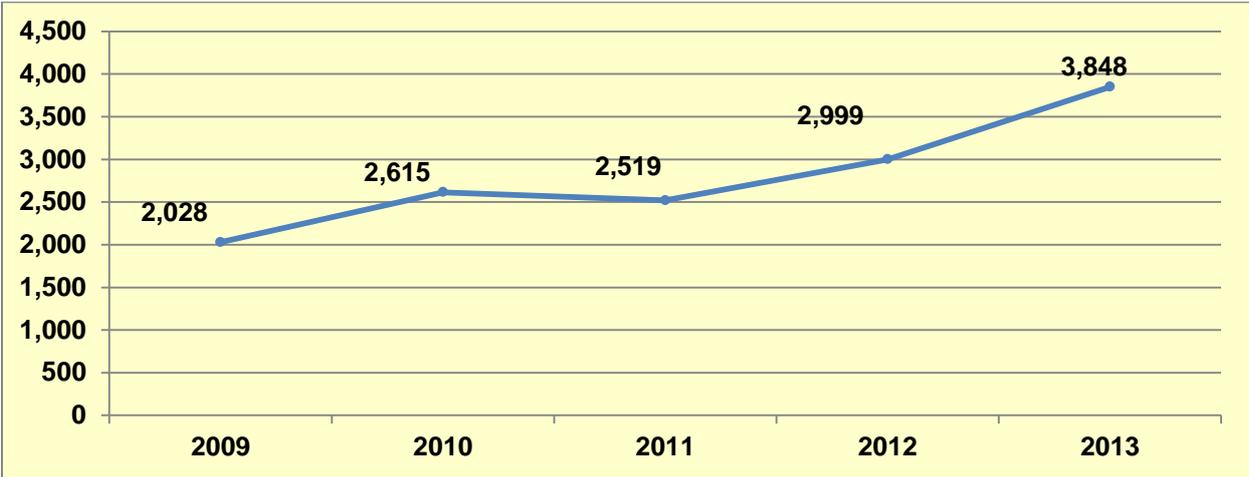
Community-based prevention activities do not target a specific group; but rather they aim to ensure increased awareness in general about drugs within the society. A society's perspective and perception of addiction influence drug use rates.

All activities aimed to ensure certain levels of awareness among all groups in a society fall under the scope of community-based prevention. There are a large number of institutions and organizations that target the whole community in their preventive activities.

The Presidency of Religious Affairs prepared 3349 sermons, 13 khutbahs, 5 TV programs and 1 radio program, organized 8 conferences, 3 seminars, and 4 meetings, and trained 300 religious officials concerning the reduction of demand to ensure the prevention of drug use in 2013.

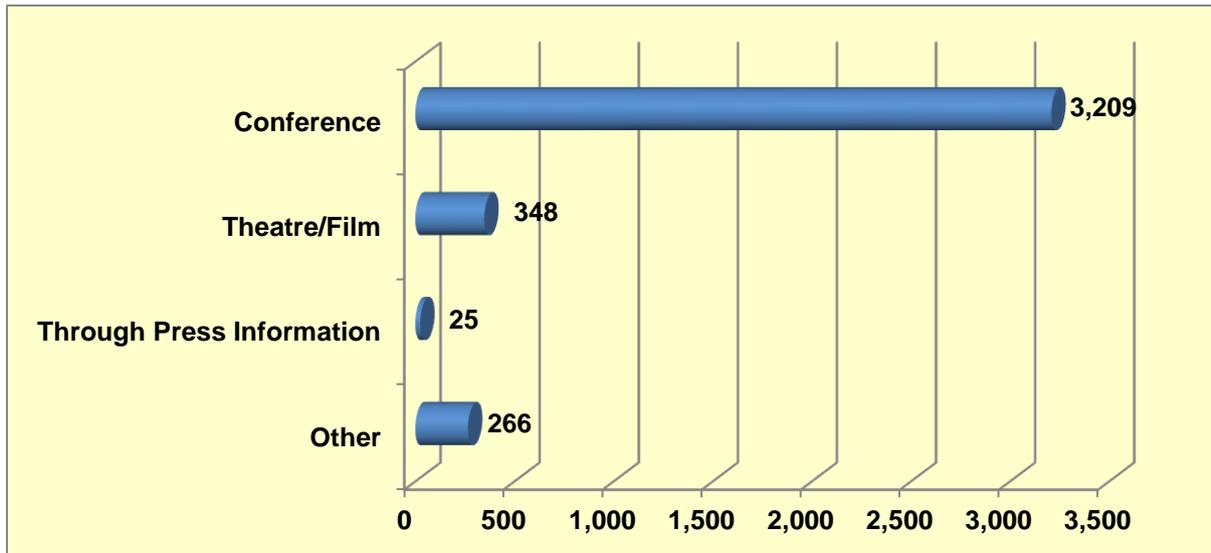
TUBIM targeted different groups including students and parents as part of their preventive activities. The number of preventive activities carried out by 162 specialists employed in the Department for Combatting Drug Use aimed at different groups amounted to 3,848 in 2013 with a 28.31% increase compared to 2,999 activities in 2012. These specialists carried out awareness raising activities in 2013 to 673,195 people with a 29.62% rise compared to 519,363 people in 2012.

Graph 3-1: Distribution of the Number of Activities carried out by the Department for Combatting Drug Use Personnel by Years



Source: Turkish Monitoring Centre for Drugs and Drug Addition, 2014.

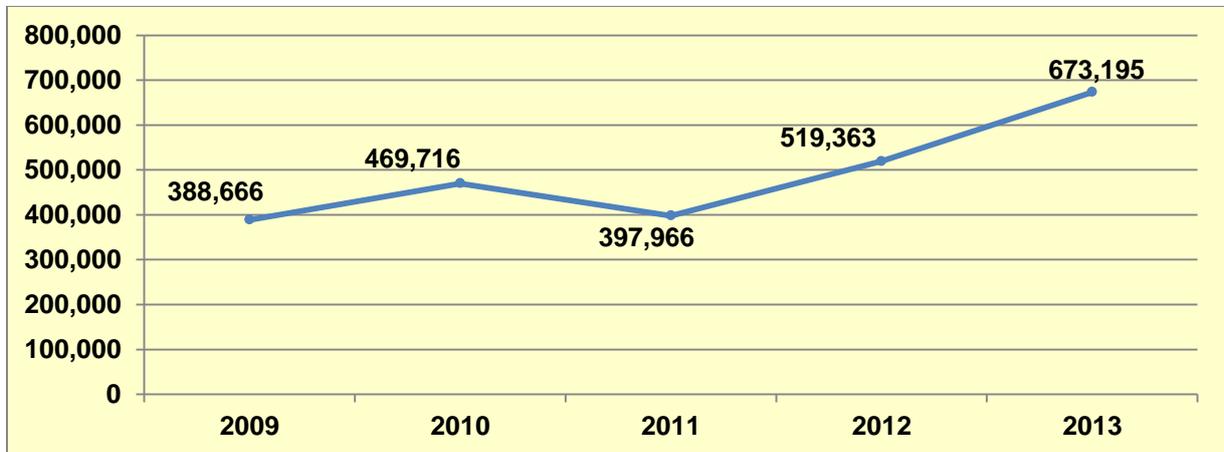
Graph 3-2: Distribution of the Numbers of Activities carried out by the Department for Combatting Drug Use Personnel in 2013 by Type



Source: Turkish Monitoring Centre for Drugs and Drug Addition, 2014.

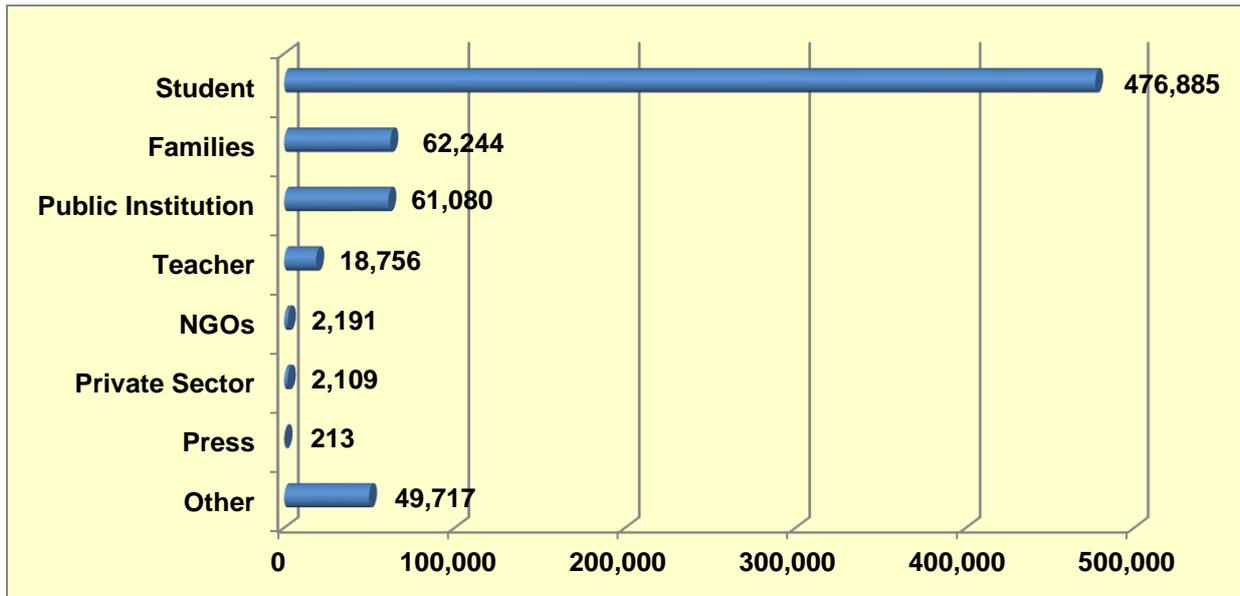
The number of individuals who participated in preventive activities conducted in 2013 reached 673,195 with a 29.62% increase compared to 2012.

Graph 3-3: Distribution of the Activities carried out by the Department for Combatting Drug Use Personnel by Number of Participants



Source: Turkish Monitoring Centre for Drugs and Drug Addition, 2014.

Graph 3- 4: Distribution of the Activities carried out by the Department for Combatting Drug Use Personnel in 2013 by Type of Participants



Source: Turkish Monitoring Centre for Drugs and Drug Addiction, 2014.

TUBİM held Basic Trainings on Combatting Drug Use three times during 2013 to train both the ILTEM personnel and representatives of other relevant institutions engaged in activities to ensure the prevention of drug use and addiction. TUBİM provided training of trainers to 211 officials in total: 55 from ILTEM, 43 from the General Staff of the Republic of Turkey, and 113 school counselors and representatives of the Provincial Coordination Committee on Drugs.

3.4. Prevention in At-Risk Groups

Drug use patterns observed throughout the world indicate that individuals start using drugs at early ages, leading to higher drug use rates among youngsters. Thus, high school and university years have been designated as particularly at-risk years, and these groups as groups at-risk, with research-based and preventive measures concentrated on these groups.

The Ministry of Family and Social Policies, Ministry of Youth and Sports, Ministry of Health, Turkish National Police, and municipalities lead the preventive activities for these at-risk groups.

Groups at-risk are addressed in three groups: children and youngsters, children living/working on the streets, and inmates.

3.4.1. Prevention for Children and Youngsters

Children and youngsters are among the groups at risk for the use of addictive substances. In addition to drugs, they should be protected from tobacco and alcohol as the gateway substances in the transition to drugs.

The United Nations Convention on the Rights of the Child established a provision to ensure the protection of children and youngsters from drugs and drug addiction. Article 33 of the Convention stipulates that: “State Parties shall take all appropriate measures, including legislative, administrative, social, and educational measures to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties and to prevent the use of children in the illicit production and trafficking of such substances.”

As a result of efforts by the Ministry of Family and Social Policies, the “National Strategy Document on the Rights of the Child,” which identifies the main objectives of the activities to be conducted to protect and expand the rights of the child throughout the country, was adopted by the Higher Planning Council’s decree no 2013/33 on December 10, 2013.

Led by the Ministry of Family and Social Policies, psycho-social support and awareness-raising activities are conducted for families as part of protective and preventive services, and the adaptation activities are carried out for cases where families and children can be reunited to facilitate their common lives. Furthermore, children are oriented towards social, athletic, artistic, and cultural activities and pastime habits as part of social support.

The Ministry of Youth and Sports also conducts various activities within this scope. The Ministry, with its mission to ensure that youngsters move healthily towards the future, published the National Youth and Sports Policy Document in 2013. The Ministry shapes its activities according to the points made in the Policy Document to protect youngsters from all addictive substances.

Five objectives were established in Article 4 from the policy-related section of the document. These objectives include efforts:

- To increase the number and enhance the accessibility of treatment and rehabilitation centers for adolescents addicted to drugs;
- To provide psychosocial services to adolescents addicted to drugs and to their families;
- To raise awareness among families by means of trainings to be held by specialists in drug addiction through youth centers; and

- To render more effective and expand treatment centers for drug addict youngsters,

3.4.2. Prevention for Children Living/Working on the Streets

Children living and/or working on the streets are at a greater risk of being introduced to addictive substances. Lack of families and closer contact with user groups render it easier for these children to start using drugs themselves. These factors suggest that children in this group require special attention and care, and necessitate specialized measures to be taken.

Based on the National Strategy Document on the Rights of the Child, the Ministry of Family and Social Policies aim, primarily, is to reinforce family ties of children living on the streets and ensure their reunification with families. Furthermore, the Ministry has agreed to provide improved care and social support services to these children in cooperation with all the relevant institutions and organizations, and lead an effective effort to prevent child labor.

In order to ensure that children working on the streets, that have been forced into beggary and are addicted to drugs are protected and rehabilitated within the society as part of the “Service Model for Children Living and/or Working on the Streets” put into effect by Circular no. 2005/5 issued by the Prime Minister’s Office, the Ministry and Social Services Centers carry out various activities. These activities aim to reintroduce these children into the education system and support them in the system, help them acquire professional skills, support their psychosocial developments, refer drug user children to treatment facilities and provide post-treatment social support.

Activities conducted by the Ministry of Family and Social Policies aim to integrate children working on the streets into formal or professional education systems, and help them conclude their rehabilitation processes as educated or employed adolescents. To this end, the Ministry works to ensure that children working on the streets, that are forced into beggary and addicted to drugs are removed from the streets and reintroduced into formal or vocational education systems, treated for drug addiction, have all their needs such as clothing and health needs satisfied, and reintegrated into the society.

Child and Youth Centers are responsible for providing all the relevant services aimed at removing from the streets children that are working on the streets and open to all forms of substance addiction, meeting their needs care, housing, health and education needs, ensuring their social rehabilitation and reintegrating them into the society.

Within the framework of the Regulation of February 9, 2013 on Social Services Centers, 29 day Child and Youth Centers, which offer counseling services to families, and protective and

preventive services to children that work on the streets, are forced to beg and are at-risk and, have been transformed into Social Services Centers or affiliated additional units. Social Services Centers, developed to provide easy access, have completed their organizational processes at provincial levels, but such efforts are still in progress at the district levels. One hundred thirty-six Social Services Centers are functional throughout the country. Nine boarding Child and Youth Centers serving children living on the streets and addicted to drugs continue with their social support services on a temporary basis.

3.4.3. Prevention for Inmates

Inmates form another group that is at greater risk of exposure to drugs due to their social settings. Though inmates who are likely to share the same environments with active or ex-users are not adequately included in preventive activities, there have been increased activities aimed at this group as a result of an improved perception of rehabilitation into the society.

The Ministry of Justice is responsible for activities for inmates in Turkey. Probation Directorates situated in provinces have initiated their activities as part of the Tobacco, Alcohol, and Drug Addiction Treatment Program (SAMBA). As part of the program, individuals under probation receive trainings on alcohol or drugs.

3.5. Individual-based Prevention

Individual-based prevention stipulates that each and every individual is addressed separately and that preventive activities are developed according to and tailored to his/her characteristics. There is a major lack of such prevention strategies in Turkey. There are small-scale activities undertaken by certain non-governmental organizations. Promising examples should be taken as models and expanded throughout the country.

3.6. National and Local Media Campaigns

Printed and visual media, as means of communication, ensure that messages are conveyed to the masses in the most effective and fastest manner. As such, they are inevitably used in communicating positive helpful messages to society. Individuals should be well-informed through public service announcements and messages included in programs, thus encouraged to abstain from addictive substance.

The Turkish Radio and Television (TRT) Corporation ensured that different topics such as combatting addiction, the harmful effects of tobacco, smoke-free zones, and the day against drug abuse are addressed in public service announcements and on various radio and TV

shows in different formats such as educational-cultural programs, sports programs, news, documentaries, on local radio channels (such as TRT Trabzon Radio, TRT GAP Diyarbakır Radio), and on TRT Okul (School), TRT Haber (News), TRT Turizm (Tourism), TRT Belgesel (Documentary), and TRT Arapça (Arabic) to raise awareness among society.

In 2013, TV and radio channels under the Turkish Radio and Television (TRT) Corporation broadcasted 75 activities and programs on drug addiction for different target groups

SECTION 4

HIGH-RISK DRUG USE

Prof. Dr. Mustafa N. ILHAN¹⁰

4.1. Introduction

Drug use is a serious public health problem. It is a criterion for “high-risk drug use” (HRDU), which is one of the five basic indicators of drug use and which has been defined as “problem drug abuse” until quite recently. The whole criterion and the scope thereof differ among countries; however, “drug injection, long term / regular heroin, cocaine and amphetamine use” is generally accepted as high-risk drug use. When it comes to Turkey, long-term cannabis use can also be considered in this group. Furthermore, bonsai (a chemical drug), which has recently become an issue in Turkey, can also be addressed within the same scope. However, an inter-country comparison is problematic due to the non-standard criteria.

The methods used in PDU studies and prevalence estimations vary according to the data resources and studies in the country concerned. While the methods to determine unknown masses vary, multiplier, multiple indicator, and capture-recapture methods are generally used. Furthermore, the network scale up method has lately began to be used to determine those hidden individuals. L

In Turkey, drug-related death data has been collected safely by the Council of Forensic Medicine since 2007. In this sense, the estimations are made through the multiplier method annually, using the data on drug-related deaths. Furthermore, in 2011, PDU estimation was prepared through the capture - recapture method using the data collected from various institutions.

4.2. Estimations on High-Risk Drug Use Prevalence and Frequency

In 2010 – 2011 periods, PDU criterion was first defined in Turkey with the participation of TUBİM experts and national and international experts. According to the study carried out in Ankara, Istanbul, and Izmir, the number of problem opium users was estimated to be 5,800 and 25,000 for Ankara and Istanbul, respectively, while the number of problem marijuana users was determined to be 28,500 and 33,400 for Ankara and Izmir, respectively.

¹⁰ Gazi University, Faculty of Medicine, Department of Public Health

Table 4-1: The number of Problem Opioid and Marijuana Users in Ankara, Istanbul, and Izmir, 2010

Province	Definition	
	Problem Opioid Users (≈)	Problem Marijuana Users (≈)
Ankara	5,800 (4,100 – 12,600)	28,500 (23600 - 33200)
Istanbul	25,000 (18,000 – 39,900)	-*
Izmir	-*	33,400 (29,500 – 38,200)

According to the estimation made in 2013 with consultation of AMATEM (Alcohol and Substance Addiction Treatment Center) experts, the number of problem drug users (except for marijuana and ecstasy) in Turkey was estimated to be 59,895 (46,087-73,704).

4.3. Characteristics of High-Risk Drug Users

Even though there are different methods in the estimation of high-risk drug use, we observed that more than one method is used together in several European Union countries. The basic purpose is to make the estimations as real as possible. Nonetheless, the multiplier method that uses only one data set (data on treatments, police data, or data on death) is a significant method that is generally accepted. In recent years, countries such as Italy, Spain, Czech Republic, Germany, and Portugal have been observed to carry out their problem (high-risk) drug use estimations through the multiplier method using treatment data. On the other hand, it was determined that Germany, Luxembourg, and Norway estimated high-risk drug use through the multiplier method using the data on death, and that they used other methods parallel to this.

The multiplier method that is built on the data on death (mortality) has both weak (dependence on only one set of data) and strong aspects (determination of total problem use). Hence, the data on drug-related deaths may show the high risk of the substance and address the estimation more clearly.

For the multiplier method used in the reports issued by Turkey to be sent to EMCDDA in previous years, the study of Bargagli et al. (2006) was adapted for Turkey. In this study, the estimation was based on the data on death pertaining to eight European cities. It was concluded that the estimation to be made by adapting the data of the same research to the data on death in Turkey would indicate the number of high-risk drug users in Turkey.

Rough death rates obtained by this research, which was carried out in Europe in 2005 and published in the European Journal of Public Health, were used for the estimations for Turkey in previous years (Bargagli et al., 2006; TUBİM Reports). The rough death rate obtained as a result of the study was adapted to Turkey.

As a result of the above-mentioned study carried out by Bargagli et al., the death rate was determined to be between 3.09 and 7.37 for approximately each 1000 high-risk drug users (certain various values were not included). In the study of Bargagli et al. (2006), the average of these eight cities was determined to be approximately 6.44.

Accordingly, when we included direct (n=232) and indirect (n=416) data on death in Turkey to the calculation within the scope of the multiplier method, the approximate number of drug-related deaths in 2013 (direct and indirect) was 648 (232+416) (See: Section 6).

As a result of such calculation, if we assume that approximately 6.44 out of 1000 drug users die in Turkey, we can conclude that there are approximately 100,621 high-risk drug users in Turkey.

This calculation, which indicates a figure slightly greater than 100,000, indicates only the number of high-risk drug users (high-risk drug use: HRDU). This figure does not reflect the entire scope of drug use in Turkey. Furthermore, the multiplier figure used in this calculation was related to the death rates in Europe in the 1990s. The up-to-date data and the risks in Turkey may indicate a significantly different situation in Turkey.

It is very clear that it would be very beneficial for the determination of policies against the fight against drugs if a national, regional, or local research was conducted to measure high-risk drug use in Turkey.

Conclusion

In the research initiated by EMCDDA in 2011, which was conducted to review the problem drug use indicator, detailing the definition of problem drug use and dividing it into two or more phases were brought to agenda. As a result of this research carried out between 2010 and 2011, certain estimations were made based on the new problem drug use definitions and methods, and the criterion was adopted to be used as a more comprehensive HRDU. Furthermore, it can be observed from the figures that the number of problem cannabis users is very high. Hence, tracking cannabis and chemical drug use in Turkey using HRDU methods would be very useful in creating the general frame of the country. The HRDU update, which

was completed by EMCDDA, is supported by Turkey, and it is deemed to be applicable in Turkey as well.

SECTION 5

DRUG ADDICTION TREATMENT

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Gamze Saçaklı¹³

5.1. Introduction

Public hospitals under the Ministry of Health, psychiatry wards of medical schools under universities, university hospitals in partnership with the Ministry of Health, and several private hospitals provide treatment for drug addiction in Turkey. In total, there are 26 treatment centers designed for drug addiction, where 706 beds are allocated to drug addicts. 469 of these beds are in hospitals under the Ministry of Health, and 227 are in the relevant units under university and public hospitals. These are the total number of beds that are allocated both to alcohol and substance addicts.

Due to the inadequate number of beds throughout Turkey, two centers for drug addiction treatment opened in 2013 in order to ensure an increased number of treatment centers and thus beds, and as a result render addiction treatment more accessible. According to the plans, the number of treatment centers will be multiplied in provinces that are populated and constantly receiving migrants. Meanwhile, a new understanding will guide the efforts to develop new treatment centers specific to children and adolescents addicted to drugs.

In addition to ensuring enhanced accessibility to treatment, it is essential to improve the quality of treatment as well. To identify the aspects that require improvement, patients' medical records should be kept regularly. Based on the analyses and assessments to be made from medical records, the existing problems and measures to be taken will be identified, and solutions will be formulated in order to achieve higher success in addiction treatment. The General Directorate of Health Services under the Ministry of Health collects and processes data of individuals addicted to drugs. In this section, data from all 25 centers that offer addiction treatment are included.

The objective is to ensure higher-quality and standardized treatment in addition to more accessible treatment centers with increased capacity. To this end, the Ministry of Health

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developed a standard training program for the personnel to be employed in these treatment centers. In 2013, 35 individuals received certificates at the end of this six-month training that includes both theoretical and applied modules.

The Tobacco, Alcohol and Drug Addiction (SAMBA) Treatment Program is a standardized, psychosocial program that is implemented in 17 sessions in most of the centers. There are different implementations of this program for adults, adolescents and families. In 2013, 65 individuals attended the training of implementers designed for this program in 23 centers.

5.2. Overview, Conformity and Quality Assurance

5.2.1. Strategy and Policy

Substance use constitutes a major problem all over the world, and requires a multi-disciplinary approach. In Turkey, the Ministry of Health conducts its activities related to addiction treatment, and the fight against drug addiction according to national action plans and policies, and in cooperation with the relevant institutions and organizations.

The National Policy and Strategy Document on Drugs (2013-2018), that establishes provisions on addiction treatment, has made as one of its objectives: “*effectively implementing and improving the treatment for drug addiction, thereby ensuring a measurable reduction in drug use, addiction, and drug related health and social risks.*” The National Action Plan against Drugs (2013-2015), which was put into force in line with the strategy document, establishes the following provisions on treatment in the section on demand reduction:

- *Improving treatment centers under public institutions in terms of physical capacity and the number of personnel;*
- *Opening new drug treatment centers under public institutions in the provinces to be identified as a result of needs assessment;*
- *Increasing the number of treatment centers under public institutions, that will serve only addicted children and adolescents, employ child and adolescent psychiatrists or medical staff specialized in addiction, and has physical facilities specific for children;*
- *Making arrangements to encourage medical staff, particularly psychiatrists, to work in addiction treatment;*
- *Addressing treatment for drug addiction with explanations under a separate section in the Communiqué on Healthcare Practices (SUT), and reviewing payment methods.*

The Ministry of Health prepared and published the National Mental Health Action Plan (2011-2023) in 2012. Regarding substance addiction, the action plan states that: *“Substance addiction does not concern only health-related issues. It has public, social, legal and administrative dimensions. As the rates of addiction vary according to regions, local approaches rather than a central one should be emphasized more in the fight against addiction. There are current local projects implemented by various municipalities, district governances, or private sector representatives. Since addiction requires a multidimensional approach, planning should not be made by a single institution or a center, but rather by a structure involving all the relevant local stakeholders. Drug addiction treatment should be long-term and permanent. In hospital-oriented treatment models, most cases cannot continue their treatments after they are discharged from hospital, thus significantly lowering the rates of success. There is an increasing transition to community-based intervention centers rather than hospital-based intervention centers throughout the world.*

The action plan emphasizes the importance of the transition to community-based intervention center model stating that it ensures:

- Easier access to treatment,
- Continuity in treatment,
- Cooperation and communication with local stakeholders and
- Easier intervention in environmental factors.

In order to achieve the objectives established in the National Policy and Strategy Document on Drugs, National Action Plan against Drugs, and National Mental Health Action Plan, all of which formulate strategies and policies for drug addiction treatment, 18 new treatment centers are planned to open in different regions according to their economic, cultural, socio-demographic characteristics, and populations.

5.2.2. Treatment Systems

A new regulation that promotes centers, which have limited numbers of beds and can provide better service through more flexible models, was issued in 2013 in order to increase the number of addiction treatment centers.

Following the amendments passed into the Regulation on Substance Addiction and Treatment Centers published in the Official Gazette no. 25375 on February 16, 2004, the new regulation

became effective after it was published in the Official Gazette no. 28866 on December 12, 2013. With the new regulation:

- Substance addiction, treatment, and rehabilitation are addressed in more detail. The concepts of outpatient treatment, inpatient treatment, psychosocial treatment, medical rehabilitation, outpatient treatment centers, and inpatient treatment centers are defined.
- The Scientific Committee for Methods of Drug Addiction Treatment was renamed as the “Scientific Committee for Substance Addiction,” with a decreased number of members to be selected from different areas of specialization.
- Provisions regarding the opening of substance addiction treatment centers were loosened.
- Provincial Healthcare Directorates were authorized to license and supervise substance addiction treatment centers instead of an institution from the central government.

These amendments aimed to increase the number of treatment centers and beds, thereby rendering addiction treatment more accessible. Based on this new regulation, while there will be higher number of inpatient treatment centers, outpatient treatment centers will be introduced into the system as well.

Approximately 95.3% of the patients in Turkey receive treatment in the centers under the Ministry of Health, and their treatment costs are covered to a great extent by the Social Security Institution. According to the official data in 2012, the costs of 80.3% of the patients were covered by the Social Security Institute, 12.3% by universal health insurance, and 4.3% by the patients themselves (Turkish Statistical Institute Health Survey, 2012).

Besides this, drug users are protected by relevant laws. The Ministry of Health covers the expenses of all services provided to the patients who are referred to treatment by judicial sanction, and who are not covered by any insurance program.

Probation has been implemented for drug-related crimes since 2006 in Turkey. The General Directorate of Prisons and Detention Houses reported 141,454 cases that were put on probation by the competent courts to be treated for drugs and stimulants as per Article 191 of the Turkish Penal Code between 2006 and 2013. % 92 (130,345) of these cases put on probation were adults, and 8% (11,109) were children (see Section 9).

The Law on Probation was amended in 2014. As per the amendments, drug use was also defined as a crime, and drug possession, which was previously subject to a one-to-two year

prison sentence, was redesigned as drug possession/use with a two-to-five year prison sentence. An individual who benefited from probation previously cannot be put on probation for a second time within five years.

Treatment Approach and Principles

Drug treatments are provided substantially by the centers under the Ministry of Health. These outpatient and inpatient treatment centers offer treatment for alcohol and drug addiction. Some of these centers have separate special units for addicted children and adolescents. Individuals on probation and those who are referred to treatment are also treated in these units.

Treatment centers essentially implement detoxification therapy programs as an inpatient option. Detoxification lasts three weeks on average.

However, inpatient therapies do not constitute the standard approach today. Motivational interviewing techniques and relapse preventive cognitive therapies are widely-used methods. The SAMBA Treatment program, which was introduced into the majority of addiction treatment centers in 2013, consists of 17 sessions, and is based on the Cognitive-Behavioral Theory. The program benefits from Mindfulness and Acceptance Therapy, and Dialectical Behavior Therapy. It includes Emotion Regulation practices (Ogel 2011). There are separate implementations for adults and adolescents.

SAMBA is a structured and standardized program, and as a result large numbers of members from treatment teams implement it, and centers with limited opportunities can employ it efficiently.

Rehabilitation programs are implemented in treatment centers to the extent of their available resources, and are not common.

New Treatments

A combination of buprenorphine and naloxone, as a partial opioid agonist introduced in 2010, marks significant progress in opioid addiction treatment. This medication is the first and only opioid (partial) agonist agent used in Turkey. Both withdrawal and maintenance techniques are used in opioid addiction. The number of opioid addicts who seek treatment in addiction treatment centers has increased since the release of the medication.

The buprenorphine/naloxone combination could initially be used only in Treatment and Training Centers for Alcohol and Substance Dependence (AMATEM) under the Ministry of Health; however, since 2014 all addiction centers licensed by the Ministry of Health can use it.

In opioid substitution therapy programs implemented countrywide in 2013, while the 2 mg buprenorphine/naloxone combination was administered in 868,952 tablets, the 8 mg buprenorphine/naloxone was administered in 617,764 tablets. However, these numbers duplicate. The exact numbers are not known since the Social Security Institute has not provided the number of persons that received treatment.

Harm Reduction

Harm reduction programs basically aim to minimize adverse social, economic, and health-related effects of drug use on individuals and the society. Rather than helping addicts overcome addiction, it seeks to minimize the relevant risks.

There is still no other structuring other than addiction treatment centers that perform opioid maintenance treatment. There are continuing legal arrangements for opening new centers to render opioid maintenance treatment more common.

There is no injection program for intravenous drug abusers and also no substitution medication other than the buprenorphine/naloxone combination.

Other Treatments

Apart from the Ministry of Health, a number of private clinics, universities, and non-governmental organizations also play role in the prevention and treatment of addiction. Self-help groups hold meetings to conduct their activities. Narcotics Anonymous (NA) is active in four provinces in Turkey. A few new non-governmental organizations have been founded, as well.

Chip treatment is another method to be considered under this title. In this treatment, a subcutaneous naltrexone chip is placed in order to help individuals not develop addiction to the effects of drugs used.

5.3. Access to Treatment¹⁴

In pursuant to Law no. 5510 on Social Insurance and Universal Health Insurance, citizens of the Republic of Turkey, who cannot afford to pay their premiums, have been included in the universal health insurance program as of January 1, 2012. As a result, healthcare benefits of the entire population in Turkey are covered by the Social Security Institution (SSI).

Individuals covered by the universal health insurance program can seek treatment in all contracted healthcare providers, and their medical benefits are provided by SSI.

The costs of outpatient and inpatient treatments for drug addiction, and costs of pharmaceutical drugs and medical equipment that are incurred for the patients covered by the universal insurance program in contracted healthcare providers are covered by SSI. In this scope, the expenses of the patients who are covered by the universal insurance program and treated in AMATEMs are met by the Social Security Institution. SSI also covers family therapies and rehabilitation services provided in psychiatric wards of all the contracted healthcare providers including AMATEM, and the services for mental health and disorders offered as part of outpatient treatments. Furthermore, medical examinations, psycho trainings for patients and their families, trainings for social skills, group psychotherapies, and occupational therapies, beds and other relevant services provided as psychiatry services as part of inpatient treatments in community mental health centers are also included in the SSI program.

5.3.1. Characteristics of Patients under Treatment

In this section, data on inpatients treated in addiction treatment centers in the year 2013 in Turkey are presented. Data on outpatients are not included. Data are gathered by the General Directorate of Health Services under the Ministry of Health through the forms designed for the “Treatment Notification System for Drug Users in Turkey”. 7,897 outpatients were recorded in 2013. The database consists of the forms that are manually completed in 25 treatment centers. The identifying details of the patients are kept confidential, as a coding system is used in completing these forms. All 25 centres that were functional in 2013 provided data.

Table 5-1: Distribution of the inpatients treated in the centers in 2013 by type of drug

¹⁴ Information under this tile was gathered from the Social Insurance Directorate-General Directorate of Universal Health Insurance.

ICD Codes	January 1, 2013- December 31, 2013 Number of polyclinics (Between ICD F10- F19)	January 1, 2013- December 31, 2013 Number of Inpatients (Between ICD F10-F19)
F11 (Opioid Addiction)	65,462	5,287
F12 (Cannabinoid Addiction)	125,680	789
F13 (Sedative and Hypnotic Substance Addiction)	527	50
F14 (Cocaine Addiction)	878	59
F15 (Addiction to Caffeine and Other Stimulants)	678	5
F16 (Hallucinogen Addiction)	215	16
F18 (Inhalant (Volatile and Solvent) Addiction)	2,401	168
F19 (Addiction to more than one Medication and other Psychoactive Agents)	22,733	1,523
Total	218,574	7,897

*Probation data are included.

Source: General Directorate of Health Services under the Ministry of Health, 2014.

7,802 forms were manually completed for 7,897 inpatients who sought treatment in these centers in 2013.

There was a 1.2% data loss. After deducting the duplicate cases from 7,802 patients, 7,265 net data cases resulted. The percentage of duplicate cases among inpatients was 6.88%. Analyses were performed on these net data. As the forms designed for the "Treatment Notification System for Drug Users in Turkey" are manually completed with information collected from the patients addicted to drugs, F10 and F17 codes were excluded from the table above. Detailed statistics cannot be kept for outpatients.

The number of outpatients reached 218,578 with a 16.68% increase in 2013 compared to 187,329 in 2012. There is also a similar rise in the number of the patients treated as part of the probation measure.

The number of the patients that were on probation and treated increased to 91,486 with a 1.51% rise in 2013 compared to 90,121 in 2012.

Table 5-2: Distribution of the inpatients treated in 2013 by province

Provinces	Number	Percentage
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Istanbul	2,395	32.97
Adana	938	12.91
Antalya	556	7.65
Mersin	513	7.06
Konya	396	5.45
Ankara	383	5.27
Gaziantep	380	5.23
Şanlıurfa	160	2.20
İzmir	159	2.19
Bursa	152	2.09
Hatay	109	1.50
Other Provinces	1.088	14.98
Abroad	36	0.50
Total	7.265	100.00

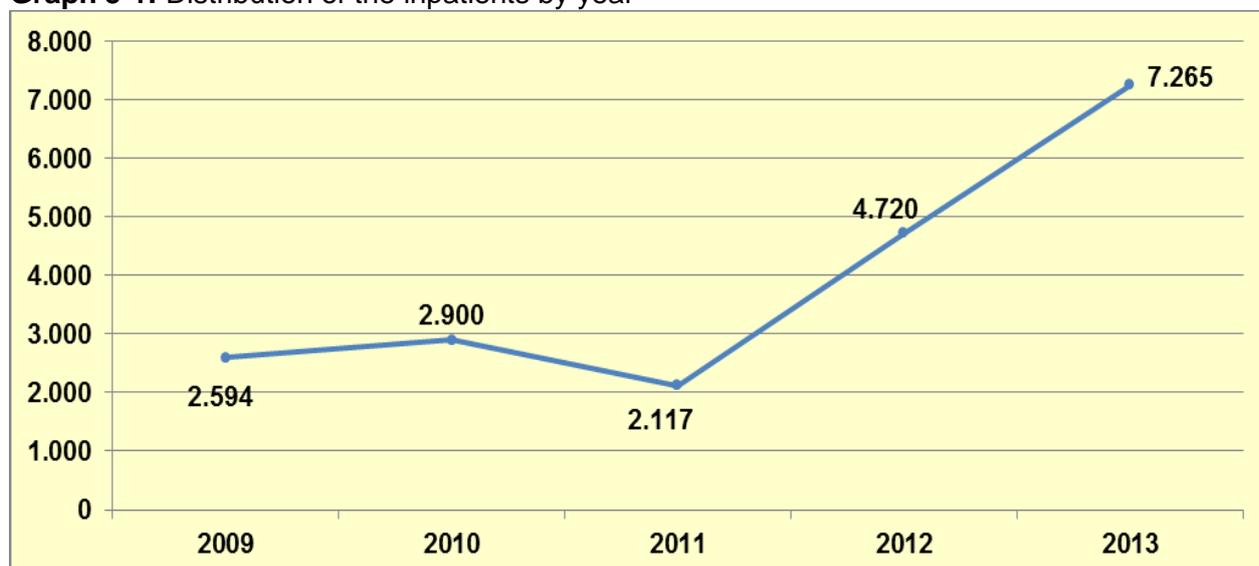
Source: General Directorate of Health Services under the Ministry of Health, 2014.

As can be concluded from the table above, Istanbul has the highest number of inpatients under treatment. Continuous migration and high population density certainly contribute to the high number of cases.

The direct relation between population density and the number of individuals who seek treatment can also be observed in the populous southern provinces where there is considerably high demand for inpatient treatment.

5.3.2. Trends in Patients

Graph 5-1: Distribution of the inpatients by year



Source: General Directorate of Health Services under the Ministry of Health, 2014.

In 2013, 7,265 patients received inpatient treatment and the relevant forms were completed for them.

Graph 5-2: Distribution of the first-time treatment seekers and previously treated patients by year



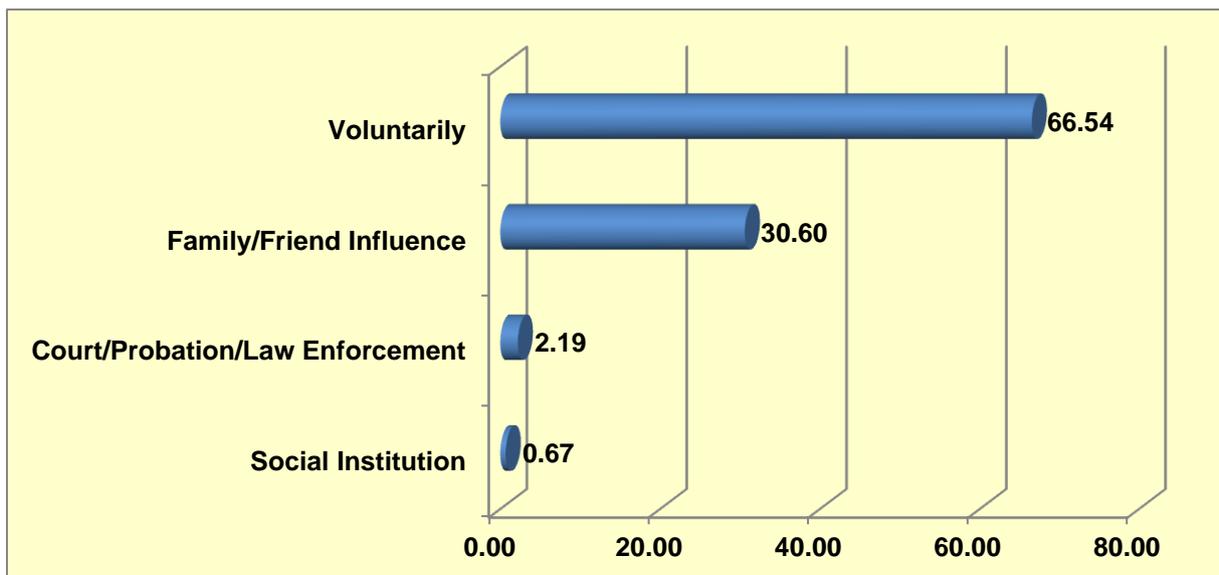
Source: General Directorate of Health Services under the Ministry of Health, 2014.

While 51.5% (3738) of the patients placed under treatment in 2013 reported that it was their first treatment, 48.5% (3527) stated that they previously received treatment. There is no missing information related to this aspect among the data from 2013.

The number of the patients who were placed under treatment for the first time recorded a 48.4% rise in 2013 compared to 2012, and the number of those who previously received treatment increased by 60.2%.

45.92% of the patients who sought treatment in the last five years had previously received treatment.

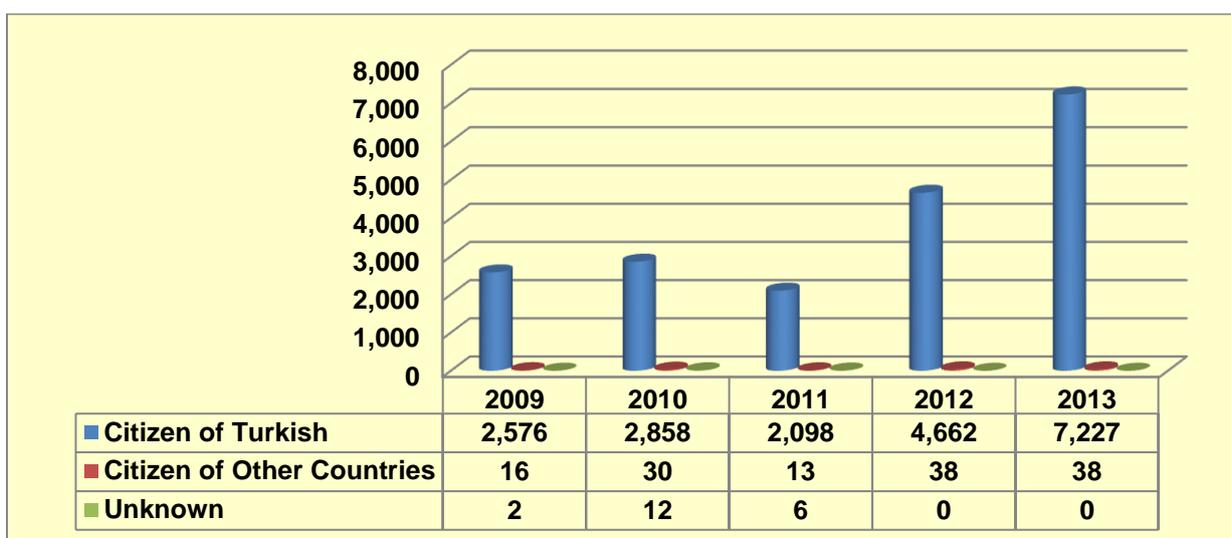
Graph 5-3: Distribution of patients according to the ways of referral to treatment



Source: General Directorate of Health Services under the Ministry of Health, 2014.

Based on the available data, it is also possible to determine the statistics of the means through which addicts were referred to treatment. Among 7,265 inpatients from 2013, 4,843 (66.54%) sought treatment at their own request, while 2,223 (30.60%) were under the influence of families/friends. Despite high rates of patients on probation referred to outpatient treatment, only 159 (2.19%) received inpatient treatment.

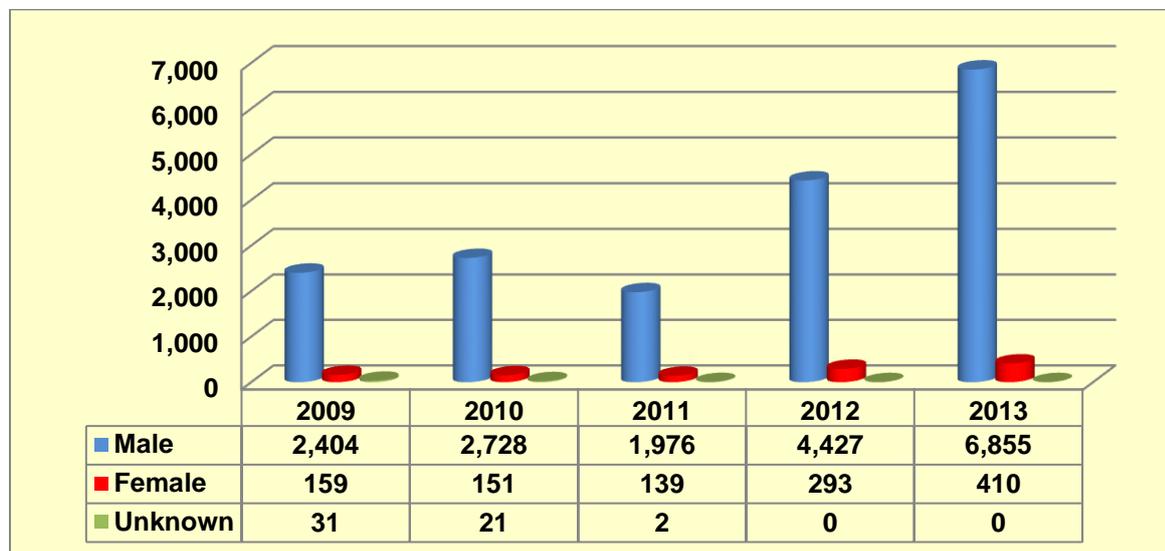
Graph 5-4: Distribution of patients by nationality



Source: General Directorate of Health Services under the Ministry of Health, 2014.

99.5% (7227) of the patients from 2013 were citizens of the Republic of Turkey, and 0.5% (38) was citizens of other countries. There was no patient with unknown nationality.

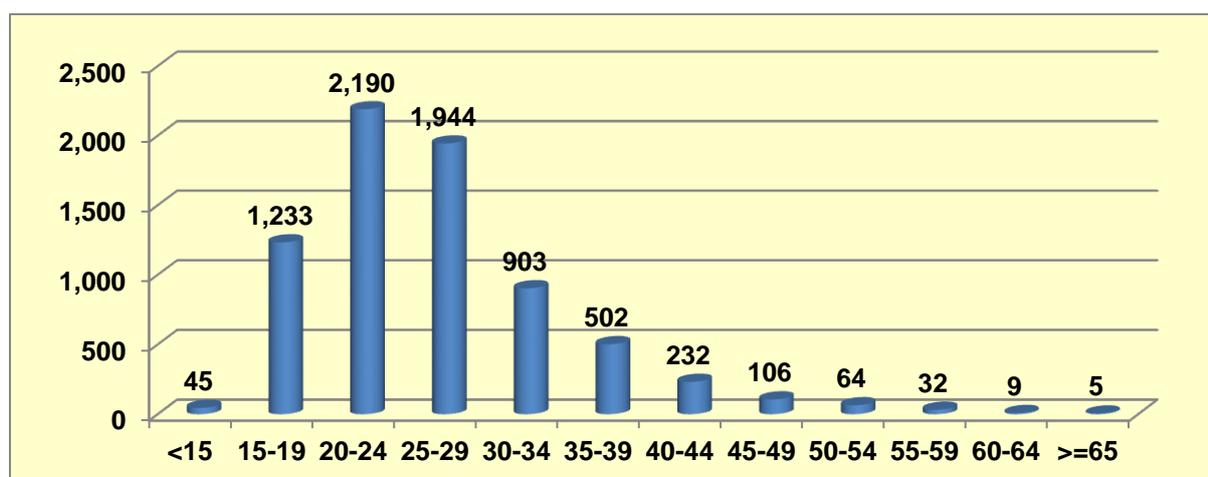
Graph 5-5: Distribution of patients by gender and year



Source: General Directorate of Health Services under the Ministry of Health, 2014.

While 94.4% (6,855) of the inpatients from 2013 were male, 5.6% (410) were female. The reason for low rates among women is rather controversial, because it is not certain whether the drug abuse problem is not common among women, or women seek treatment less frequently (Ögel 2011).

Graph 5-6: Distribution of patients by age



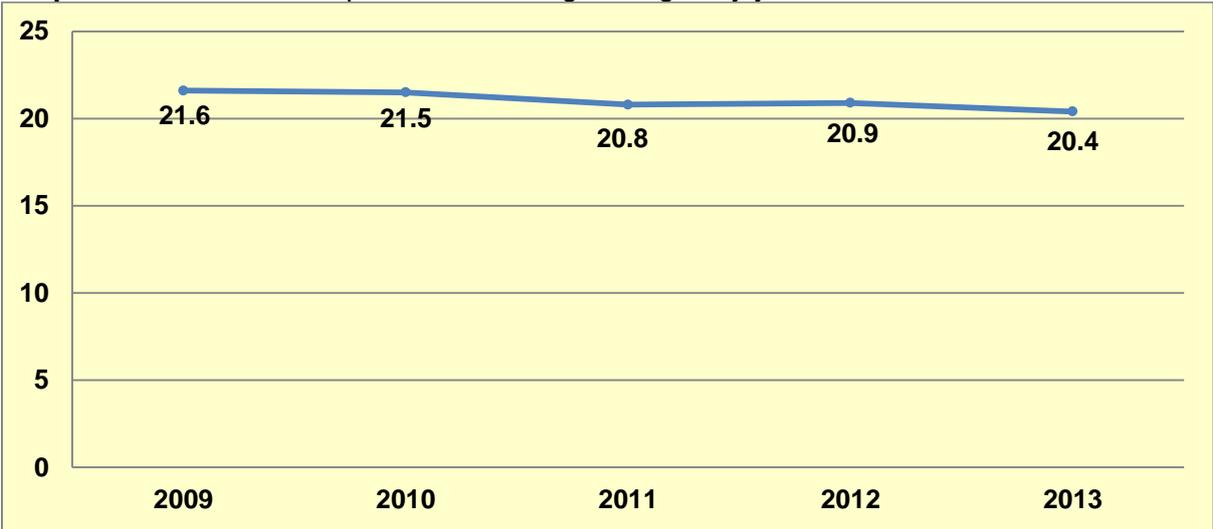
Source: General Directorate of Health Services under the Ministry of Health, 2014.

As the graph above suggests, the patient population is concentrated between the ages of 20 and 29 years. The ratio of the patients in this age group to all the patients in total was 56.9% (4,134). While the youngest patient was 11 years old, the oldest patient was 69 years old. The average age was 26.28 (sd: 7.61).

Classified according to age groups:

- 30.1% (2,190) of the patients were aged between 20 and 24 years;
- 26.8% (1,944) were aged between 25 and 29 years;
- 16.9% (1,233) were aged between 15 and 19 years;
- 12.4% (903) were aged between 30 and 34 years; and
- 7% (502) were aged between 35 and 39.

Graph 5-7: Distribution of patients' first drug use ages by year

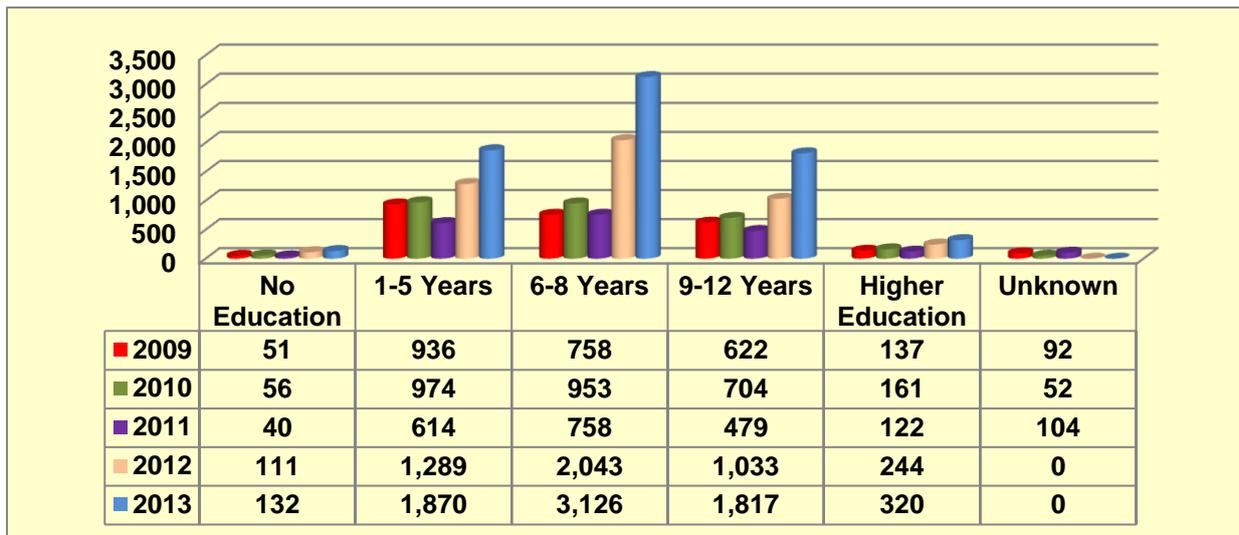


Source: General Directorate of Health Services under the Ministry of Health, 2014.

The average age when the patients first started using drugs was 20.4 years. While the age range varied between 21 and 22 in 2009 and 2010, it dropped to 20 and 21 years of age in 2011 and 2012.

Out of the 7,265 inpatients from 2013, 10.9% (788) started using drugs before the age of 15, 39.2% (2846) started using drugs between the ages of 15 and 19, 30.1% (2189) started between the ages of 20 and 24, and 11.6% (845) started between the ages of 25 and 29.

Graph 5-8: Distribution of patients by education level



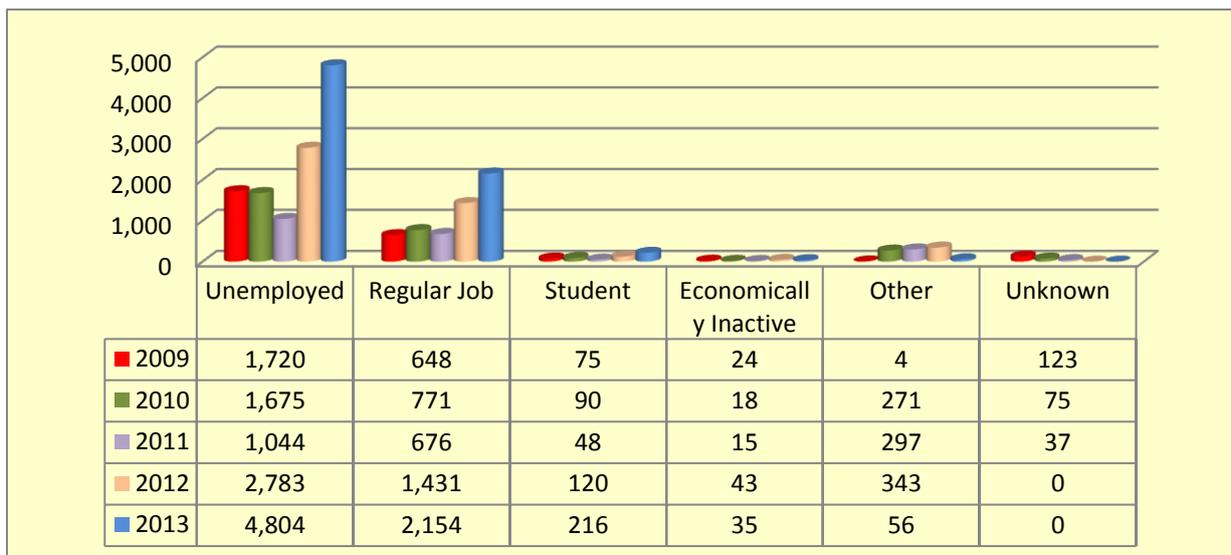
Source: General Directorate of Health Services under the Ministry of Health, 2014.

Out of the patients placed under treatment in 2013:

- 1.8% (132) never went to school;
- 25.7% (1,870) received 1-to-5 years of education;
- 43% (3,126) received 6-to-8 years of education;
- 25% (1,817) received 9-to-12 years of education; and
- 4.4% (320) attended university.

The patients who are secondary school or high school graduates had a greater increase in their referral to treatment when compared to those who never went to school and those who are primary school or university graduates.

Graph 5-9: Distribution of patients by employment



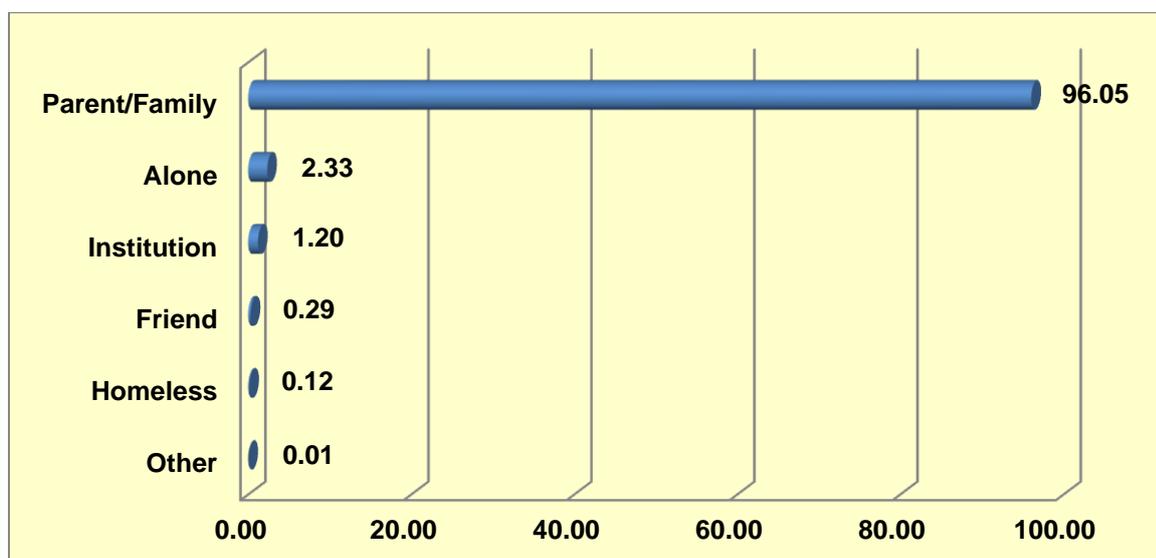
Source: General Directorate of Health Services under the Ministry of Health, 2014.

Out of the patients placed under treatment in 2013:

- 66.1% (4804) were unemployed and
- 29.7% (2154) were regular employees.

These data from 2013 are similar to those from previous years in terms of patients' employment statuses, and suggest that addicted patients function poorly. Only one-third of the patients had regular jobs.

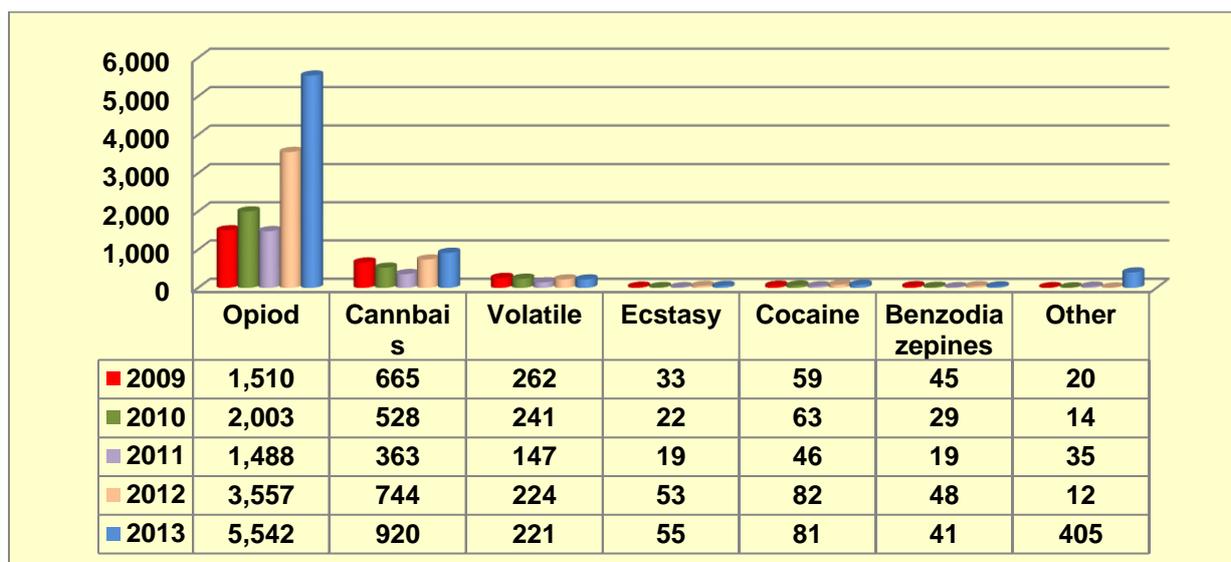
Graph 5-10: Distribution of patients by lifestyle



Source: General Directorate of Health Services under the Ministry of Health, 2014.

As the graph above indicates, 96.05% (6,978) of the patients lived with their parents/families, 2.33% (169) lived alone, and 1.2% (87) lived in an institution. 0.29% (21) of the patients lived with a friend, and 0.1% (9) were homeless/living on the streets. This distribution is similar to the distribution within the community in general (Turkish Statistical Institution, 2006, Family Structure Survey).

Graph 5-11: Distribution of the main substances that patients used by year



Source: General Directorate of Health Services under the Ministry of Health, 2014.

According to the distribution of main substances used by the inpatients from 2013:

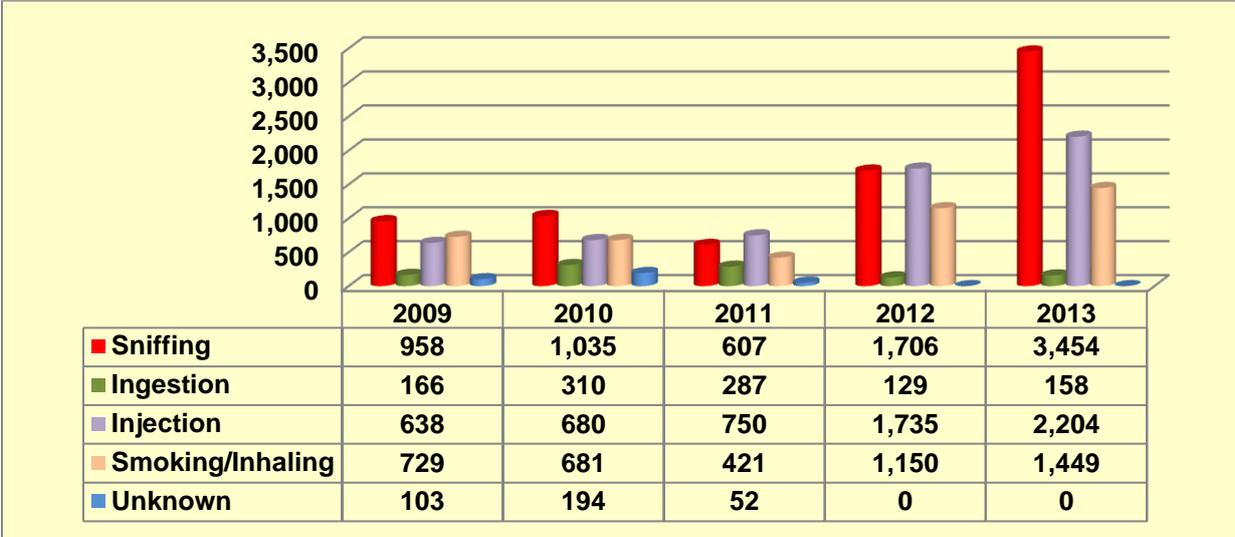
- 76.3% (5,542) used opiates;
- 12.7% (920) used marijuana;
- 3% (221) used volatile substances;
- 1.1% (81) used cocaine;
- 0.8% (55) used ecstasy;
- 0.6% (41) used benzodiazepine; and
- 5.6% (405) used other substances.

There is an increased use of opiates and “other substances” among the inpatients treated in 2013 compared to previous years. Out of 405 users defined as addicted to other substances, 391 used “synthetic cannabinoids,” which was 96.5% of this group (n: 391). These statistics

show that increasing numbers of synthetic cannabinoid users sought treatment compared to previous years.

After the buprenorphine/naloxone combination was introduced in 2010, opiate users began to seek treatment in addiction centers in growing numbers. Synthetic cannabinoids have become increasingly more widespread in Turkey’s substance market and more popular among users. The relevant statistics regarding the referrals to treatment support this observation in trend.

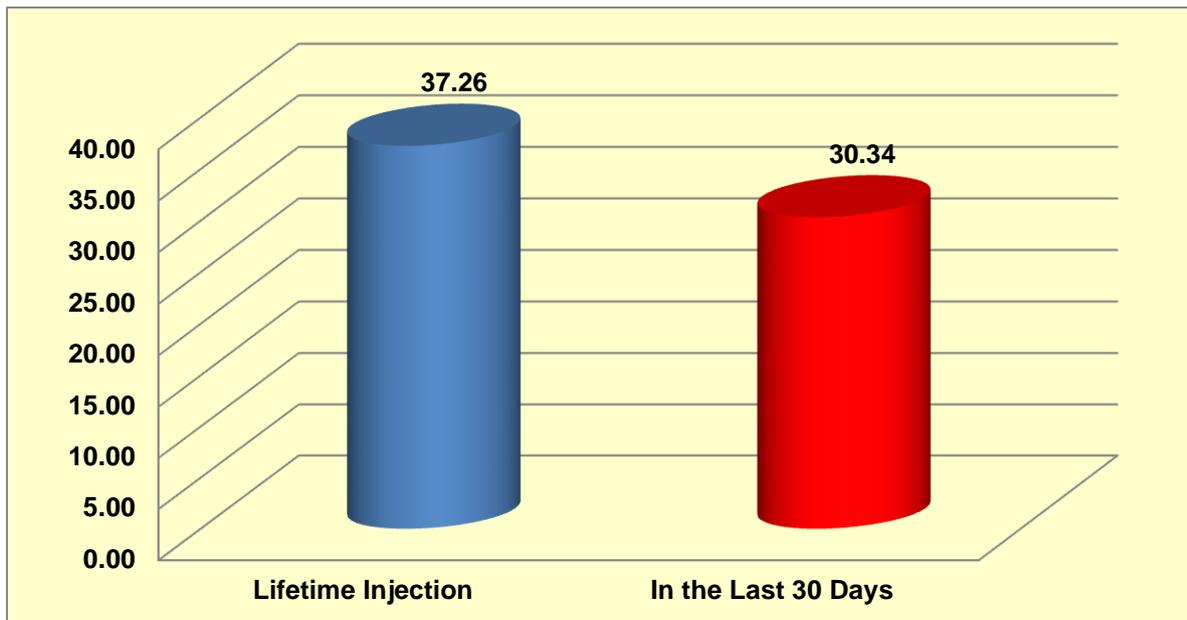
Graph 5-12: Distribution of patients by route of administration and year



Source: General Directorate of Health Services under the Ministry of Health, 2014.

Out of the inpatients from 2013, 30.3% (2,204) used their primary substances by means of injection, 47.5% (3,454) by snorting, 19.9% (1,449) by huffing/sniffing, and 2.2% (158) by eating/drinking.

Graph 5-13: Distribution of patients by injecting use



Source: General Directorate of Health Services under the Ministry of Health, 2014.

Out of 7,265 patients, 37.26% (2707) reported that they used drugs by means of injection at least once in their lives, and 62.74% (4558) did not report any injection experience. 30.34% (2,204) stated that they injected drugs within the last 30 days.

SECTION 6

HEALTH CORRELATES AND CONSEQUENCES

Elif Mutlu, MD¹⁵
Mustafa Kemal Çetin, MD¹⁶

6.1. Introduction

Data on individuals that were placed under treatment for substance use were collected through the General Directorate of Health Services under the Ministry of Health. Socio-demographic data, medical histories of the patients' substance use, and screening test results were gathered for inpatients through the standard forms designed for the "Treatment Notification System for Drug Users in Turkey". 25 centers that offered inpatient treatment for drug addiction across Turkey in 2013 provided data for this study. Data were from addicted adolescents and adults.

A standard form was used for data collection. These forms were completed by data entry officers at the treatment centers according to the patients' medical records. Duplicate cases were removed, and 7,265 patients were recorded in 2013.

Out of 7,265 patients, 2,707 individuals (37.26%) reported that they used drugs by means of injection at least once in their lives. 2,204 people (30.34%) stated that they injected drugs within the last 30 days. Nearly all those who reported intravenous drug use within the last 30 days (2,201 people) preferred opiates. One person with benzodiazepine use reported injection within the last 30 days before the treatment. The most prevalent substance among opiates was heroin (2,155 people). 46 (2.04%) noted they injected other opiate substances. These data suggest that heroin is the primary substance used intravenously among addicts placed under treatment in Turkey; other opiates are rather rare.

These forms used for data collection on infectious diseases included details about the patients such as gender, age, previous treatment history, method of using drugs, and length of intravenous drug use, as well as serological details such as Hepatitis C antibody, HIV antibody, HBs antigen, and HBV antibody.

6.2. Drug Use-Related Infectious Diseases

6.2.1. HIV/AIDS Incidence

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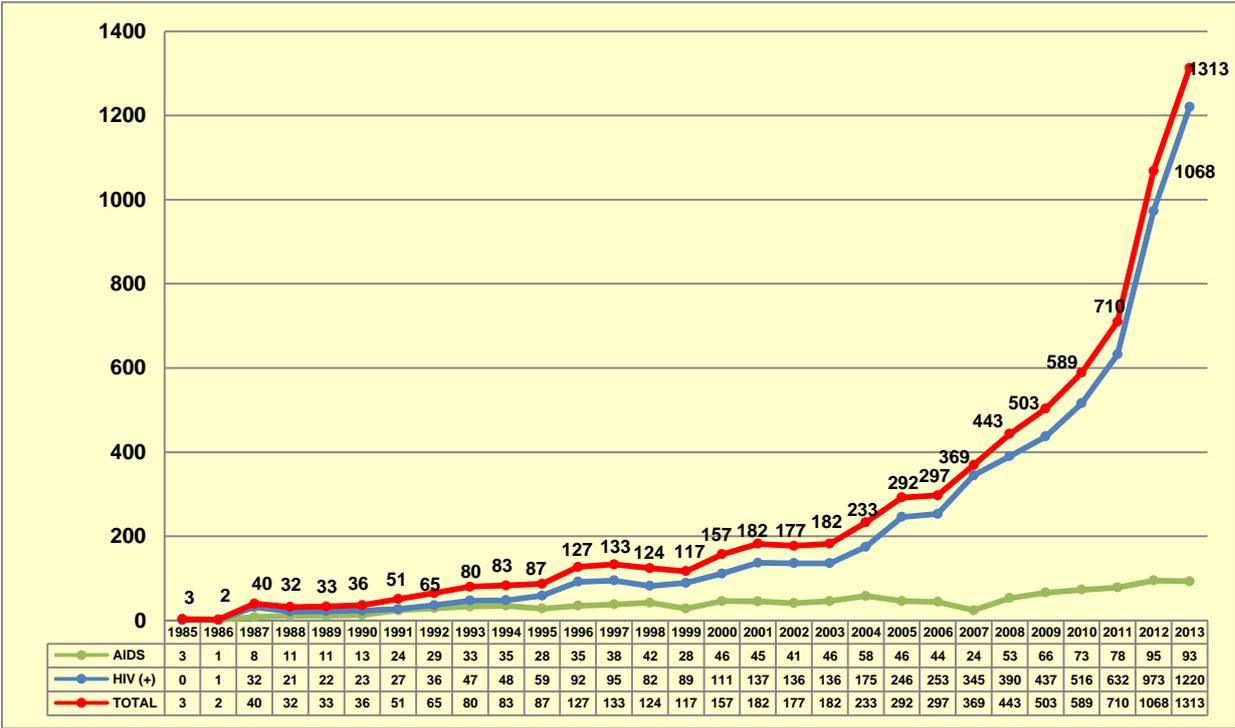
¹⁶General Directorate of Health Services under the Ministry of Health.

Data presented in this section were gathered from two separate units that collect data on infectious diseases. The Turkish Public Health Agency gathers the medical records of the patients who have tested positive for HIV from treatment centers throughout the country. The General Directorate of Health Services collects data on intravenous drug users who receive inpatient treatment through the “Drug Addiction Notification System.”

All 2,707 individuals with medical histories of intravenous drug use, who received inpatient treatment in 2013, were screened for HIV and viral hepatitis. The number of valid results for all serological tests was 2,676.

In Turkey, HIV infection was first detected in 1985. Three people were reported to have HIV/AIDS in 1985, and that number reached 1,313 in December 2013. Out of 1,313 individuals, 1,220 are HIV-positive, and 93 have AIDS.

Graph 6.1. Distribution of HIV/AIDS cases in Turkey by year



Source: Turkish Public Health Agency under the Ministry of Health, 2013.

According to the data provided by the Turkish Public Health Agency, out of 7,528 reported cases from 1985 to the end of 2013 in Turkey, 174 cases were found to be related to injecting drug use.

Out of 1,313 new cases diagnosed in 2013, four cases reportedly contracted the disease by injecting drug use. The number of HIV-positive cases among the inpatients with previous histories of injecting drug use was five (Table 6-1).

Table 6-1: Distribution of HIV screening test results of the inpatients with histories of injecting drug use under treatment in addiction treatment centers by year

HIV	2009	2010	2011	2012	2013
Patients tested (n)	696	644	716	1,821	2,676
Negative result (n)	694	641	714	1,809	2,671
Positive result (n)	2	3	2	12	5
Positive result (%)	0.29	0.47	0.28	0.66	0.19

Source: General Directorate of Health Services under the Ministry of Health, 2013.

Out of 2,707 injecting drug users that were placed under treatment in 2013, 2,676 were tested for HIV, and 5 tested positive.

A positivity rate of 0.19% was observed among the injecting drug users that received inpatient treatment.

6.2.2. Viral Hepatitis Incidence

Out of 2,707 injecting drug users that were placed under treatment in 2013, 2,676 were screened for hepatitis markers. Serum samples were used for both markers. HBsAg (Hepatitis B surface antigen) and Anti-HCV (Hepatitis C total antibody) were analyzed for Hepatitis B and Hepatitis C, respectively. As HCV-RNA and the genotype were not determined systematically, they were not included among the data.

According to the results:

- Out of 2,676 individuals tested for Hepatitis C, 1,206 (45.07%) tested positive (Table 6-7).
- Out of 2,676 individuals tested for Hepatitis B, 121 (4.52%) tested positive (Table 6-2).

6.2.2.1. Hepatitis B Incidence

Table 6-2: Distribution of HBV test results of the inpatients with histories of injecting drug use under treatment in addiction treatment centers by year

HBV	2009	2010	2011	2012	2013
Patients tested (n)	687	618	707	1,821	2,676
Negative result (n)	651	596	654	1,665	2,555

Positive result (n)	36	22	53	156	121
Positive result (%)	5.24	3.56	7.50	8.57	4.52

Source: General Directorate of Health Services under the Ministry of Health, 2014.

Hepatitis B screening results show that the disease was less prevalent among injecting drug users after 2006. A lower incidence of HBV was observed among the general population as well. While the number of HBV-positive injecting drug users was 8,593 in 2006, it decreased to 3,099 in 2010. A slight increase in HBV positivity rates in 2012 may be related to the size of sample. The downtrend continued in 2013.

Since Anti-HBs (Hepatitis antibody) values of the sample could not be reached, vaccination coverage could not be identified. In consideration of these data, the lower prevalence of HBV infection could be linked to wider vaccination coverage (Demirören et al., 2007). Turkey is classified among the mid-high endemic countries in terms of HBsAg prevalence among the general population.

Based on different studies on HBsAg incidence rates among the general population, HBsAg positivity varies between 2.5% and 9.1% according to the region and structure of the study. The most prevalent genotype within the population was reported to be genotype B, as is the case in other Mediterranean countries (Leblebicioglu et al., 2004).

Table 6-3: Distribution of HBV test results among injecting drug users under inpatient treatment in addiction treatment centers in 2012 by gender

HBV	Male	Female
Patients tested (n)	2,551	125
Negative result (n)	2,440	115
Positive result (n)	111	10
Positive result (%)	4.35	8.00

Source: EMCDDA Standard Table 9/2, 2014.

Hepatitis B incidence among injecting drug users that were placed under inpatient treatment in addiction treatment centers was 8.00% among females and 4.35% among males (Table 6-3). On the contrary, among the general population, HBV positivity was higher among males (Akcem et al., 2009; Yildirim et al., 2009). The difference between drug users and the general population in Hepatitis B rates could be explained by higher comorbid disease incidence among female drug users, socioeconomic status, and poorer living conditions.

Table 6-4: Distribution of HBV test results among injecting drug users that were under inpatient treatment in addiction treatment centers by year and age

HBV	<25			25-34			>34		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Patients tested (n)	305	729	1,101	306	822	1,219	96	270	356
Positive result (n)	19	72	53	24	57	48	10	27	20
Positive result (%)	6.23	9.88	4.81	7.84	6.93	3.94	10.42	10.0	5.62

Source: EMCDDA Standard Table 9/2, 2014.

Higher HBV positivity rates (5.62%) were observed among injecting drug users over the age of 34 that were placed under inpatient treatment. Hepatitis prevalence is considered to be correlated with age among the general population, as well. Compared to previous years, lower HBV prevalence was found in all age groups among the drug users that were placed under inpatient treatment in 2013.

Table 6-5: Distribution of HBV test results among injecting drug users that were under inpatient treatment in addiction treatment centers by length of time after the first injection

HBV	<2 years	2-5 years	5-10 years	>10 years
Patients tested (n)	187	923	1,148	418
Positive result (n)	9	40	43	29
Positive result (%)	4.81	4.33	3.75	6.94

Source: EMCDDA Standard Table 9/2, 2014.

Hepatitis B prevalence among the injecting drug users with more than 10 years of injection experience that were placed under treatment in 2013 was 6.94%. The longer the injection period, the higher the risk of contracting infectious diseases.

Table 6-6: History of treatment and HBV results among the injecting drug users that were placed under inpatient treatment in addiction treatment centers in 2012

HBV	First-time treatment	Previous history treatment
Patients tested (n)	924	1,752
Positive result (n)	42	79
Positive result (%)	4.55	4.51

Source: EMCDDA Standard Table 9/2, 2014.

According to history of treatment, 4.55% of 924 injecting drug users, who sought treatment for the first time, tested positive for HBV. Among those with previous treatment history, 4.51% were HBV positive (Table 6-6).

6.2.2.2. Hepatitis C Incidence

Table 6-7: Distribution of HCV test results of the inpatients with histories of injecting drug use under treatment in addiction treatment centers by year

HCV	2009	2010	2011	2012	2013
Patients tested (n)	709	666	722	1,821	2,676
Negative result (n)	504	447	371	909	1,470
Positive result (n)	205	219	351	912	1,206
Positive result (%)	28.91	32.88	48.61	50.1	45.07

Source: General Directorate of Health Services under the Ministry of Health, 2014.

Out of 2,676 injecting drug users that were placed under inpatient treatment in 2013, 1,206 (45.07%) tested positive for HCV. HCV prevalence among the general population varies between 0.17% and 2.8% (Kurt et al., 2003), which is similar to the rates in other East Mediterranean countries. Though HCV RNA was not tested among the injecting drug users, the relevant studies suggest HCV RNA positivity in more than 50% of all the registered HCV cases in Turkey. As per the studies, genotype-1 is the most prevalent genotype throughout the country is (genotype-1b: ~80%, genotype-1a: ~ 9-20%); genotype 2, 3, and 4 are very rare (1-2%) (Bozdayi et al., 2004).

According to the data from 2013, out of 1,206 HCV-positive injecting drug users that were placed under inpatient treatment, 1,162 were male and 44 were female. While the positivity rate among males was 45.55%, it was 35.10% among females (Table 6-8). The relevant statistics show lower numbers of female patients seeking treatment compared to male patients. The reason for low rates among women is rather controversial because it is not certain whether the drug abuse problem is not common among women, or women seek treatment less frequently (Ögel, 2011). Nonetheless, epidemiological studies conducted on the general population did not report any difference between genders in HCV positivity (Badur and Emiroğlu, 2010). The studies conducted on addicts in Turkey reported that sharing drug injection equipment was more common among female injecting drug users, and was thus accompanied more frequently by comorbid diseases (Evren et al., 2003; Ögel, 2005). The data by the Ministry of Health from 2013 reveal that fewer female patients received inpatient treatment.

Table 6-8: Distribution of HCV test results among injecting drug users under inpatient treatment in addiction treatment centers by gender

HCV	Male	Female
Patients tested (n)	2,551	125
Negative result (n)	1,389	81
Positive result (n)	1,162	44
Positive result (%)	45.55	35.20

Source: EMCDDA Standard Table 9/2, 2014.

Table 6-9: Distribution of HCV test results among injecting drug users that were under inpatient treatment in addiction treatment centers by year and age

HCV	<25			25-34			>34		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Patients tested (n)	309	729	1,101	308	822	1,219	105	270	356
Positive result (n)	147	319	456	141	424	536	63	169	214
Positive result (%)	47.57	43.76	41.42	45.78	51.58	43.97	60.00	62.59	60.11

Source: EMCDDA Standard Table 9/2, 2014.

Based on the HCV results according to age range among the injecting drug users, infection rates were considerably higher (60.11%) among the group over the age of 34 (Table 6-9). Increasing rates parallel to age may be related to the length of injecting drug use. When patients are grouped according to the length of time since their first injection, the HCV positivity rate was 63.16% among those who injecting drugs for more than 10 years (Table 6-10).

It is a known fact that the length of injecting drug use increases the risk of contracting infectious diseases. Higher HCV rates among the group with a history of injecting drug use for more than 10 years, and those over the age of 34 are indeed expected (Chang et al., 1999; Garfein et al., 1996; Garfein et al., 1998). It is reported that HCV positivity is most prevalent among individuals over the age of 35 among the general population (Kurt et al., 2003).

Table 6-10: Distribution of HCV test results among injecting drug users that were under inpatient treatment in addiction treatment centers by length of time after the first injection

HCV	<2 years	2-5 years	5-10 years	>10 years
Patients tested (n)	187	923	1,148	418
Positive result (n)	52	348	542	264
Positive result (%)	27.81	37.70	47.21	63.16

Source: EMCDDA Standard Table 9/2, 2014.

Table 6-11: History of treatment and HCV results among injecting drug users that were placed under inpatient treatment in addiction treatment centers

HCV	First-time treatment	Previous treatment history
Patients tested (n)	924	1,752
Positive result (n)	311	895
Positive result (%)	33.66	51.08

Source: EMCDDA Standard Table 9/2, 2014.

According to history of treatment, out of 2,606 patients that were tested for HCV, 924 reported that it was their first treatment, and 33.66% (311) tested positive. Among 1,752 patients with previous treatment history, 51.08% (895) were HCV positive (Table 6-11).

6.3. Other Drug-related Health Problems and Consequences

No new data is available.

6.4. Drug-related Deaths and Mortality among Drug Addicts

Bülent ŞAM, Assoc. Prof^{17,18}

Data on drug-related deaths (DRD) were collected and reported by the Council of Forensic Medicine (CFM) under the Ministry of Justice through special death certificates (CFM's autopsy records). CFM is organized across Turkey and archives autopsy records.

The 2014 Drug Report of Turkey observes the “Selection D” definition recommended by the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) for deaths related directly to drugs. It covers deaths that occur shortly after the consumption of one or more than one illegal substance (opium and derivatives, cocaine, cannabis, amphetamine and derivatives, hallucinogens, and new substances that can be analyzed), in some cases in combination with alcohol and/or psychoactive medicines, and deaths that occur in hospitals after a state of coma resulting from the consumption of one or more of these substances. The report excludes deaths occurring as a result of taking psychoactive medicine to commit suicide.

Investigation records kept by law enforcement officers, crime scene investigation reports, and autopsy findings were considered while assessing all direct DRDs included in the report, and these cases were interpreted as drug-related deaths by accident. Intoxication cases of homicide origin were not included.

Indirect DRDs refer to all cases where one or more of the aforementioned substances are detected in blood, urine, intraocular fluid, bile, nasal swab, skin, or internal organ samples; however, the cause of death is not substance intoxication. All DRD data were gathered through complete autopsies.

Toxicological analyses were performed in the laboratories of the Council of Forensic Medicine located in İstanbul, Ankara, İzmir, Adana, Bursa, Malatya, Diyarbakır, Trabzon, Antalya, and Erzurum. Only cannabinoid analyses varied among the laboratories. As of 2013, while only JWH-018 and JWH-073 could be analyzed in İstanbul, Trabzon, and İzmir, JWH-018, JWH-073, and JWH-0122, along with their metabolites, could be analyzed in Ankara. In 2013, synthetic cannabinoid analyses could not be performed in the laboratories of Adana, Bursa, Malatya, Antalya, Diyarbakır, and Erzurum.

¹⁷ The Council of Forensic Medicine under the Ministry of Justice

¹⁸ National Expert on Drug-Related Deaths and Mortality

Screening tests (CEDIA) were conducted in the toxicological analyses, and verification tests (GC/MS and LC/MS/ MS) were performed in all the cases that tested negative or positive in the screening tests.

6.4.1. Direct Drug-Related Deaths (DRD)

Two hundred thirty-two DRDs occurred in 2013. According to general mortality registries provided by the Turkish Statistical Institute, 0.06% of all the deaths (372,094) in 2013 were described as DRD.

Compared to 162 DRDs in 2012, the number of DRD cases reached 232 with a 43.2% increase in 2013.

Table 6-12: Distribution of average ages of direct DRD cases between 2007 and 2013 by gender and year

Years	Gender	Average Age	Min. Max. Age
2007	Male (n:128)	34.3	18-70
	Female (n: 8)	32.7	23-44
	Total (n:136)	34.2	18-70
2008	Male (n:140)	34.5	15-70
	Female (n:7)	34.8	17-60
	Total (n:147)	34.5	15-70
2009	Male (n:133)	34.8	15-71
	Female (n:20)	33.2	15-66
	Total (n:153)	34.6	15-71
2010	Male (n:119)	34.4	16-65
	Female (n:7)	31.3	23-42
	Total (n:126)	34.2	16-65
2011	Male (n:100)	33.5	13-79
	Female (n:5)	43.2	22-75
	Total (n:105)	34	13-79
2012	Male (n:156)	30.1	12-66
	Female (n:6)	32	18-48
	Total (n:162)	30.2	12-66
2013	Male (n:225)	31	14-68
	Female (n:7)	33.3	16-48
	Total (n:232)	31.1	14-68

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014; EMCDDA Standard Table 6, 2014.

Data on fetuses that were stillborn due to substance intoxication, with heroine detected in the samples by toxicological analyses were not included in this report.

Out of all direct DRD cases in 2013, 97% (n: 225) were male and 3% (n: 7) were female (Table 6-12).

The average age of direct DRDs was 31 among males (min: 14; max: 68), 33.3 (min: 16; max: 48) among females, and 31.1 in general (Table 6-12).

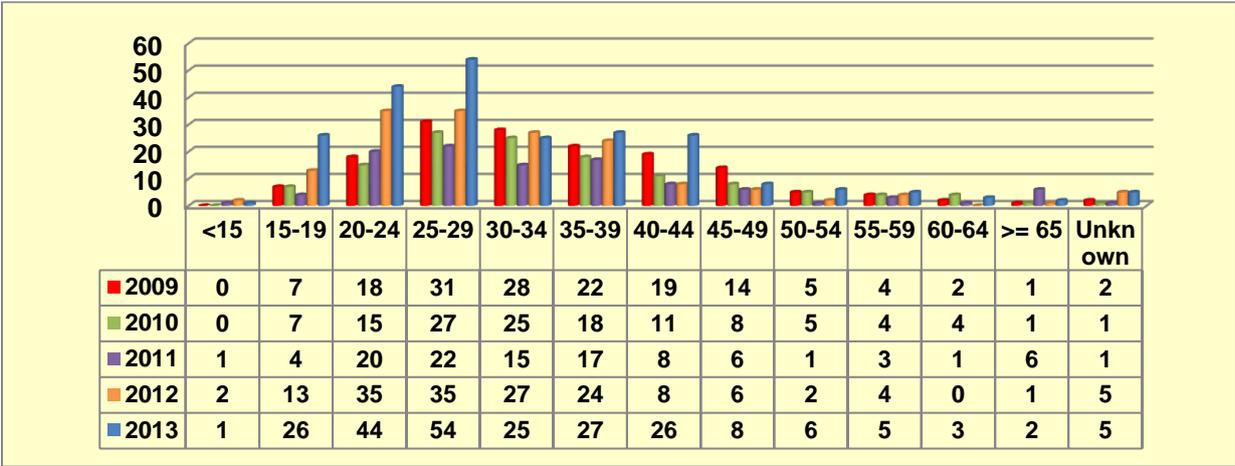
Table 6-13: Distribution of age ranges of direct DRD cases in by gender

Age range	Male	Female	Total
<15	1	0	1
15-19	24	2	26
20-24	43	1	44
25-29	54	0	54
30-34	25	0	25
35-39	27	0	27
40-44	23	3	26
45-49	7	1	8
50-54	6	0	6
55-59	5	0	5
60-64	3	0	3
>=65	2	0	2
Unknown	5	0	5
Total	225	7	232

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014; EMCDDA Standard Table 5, 2014.

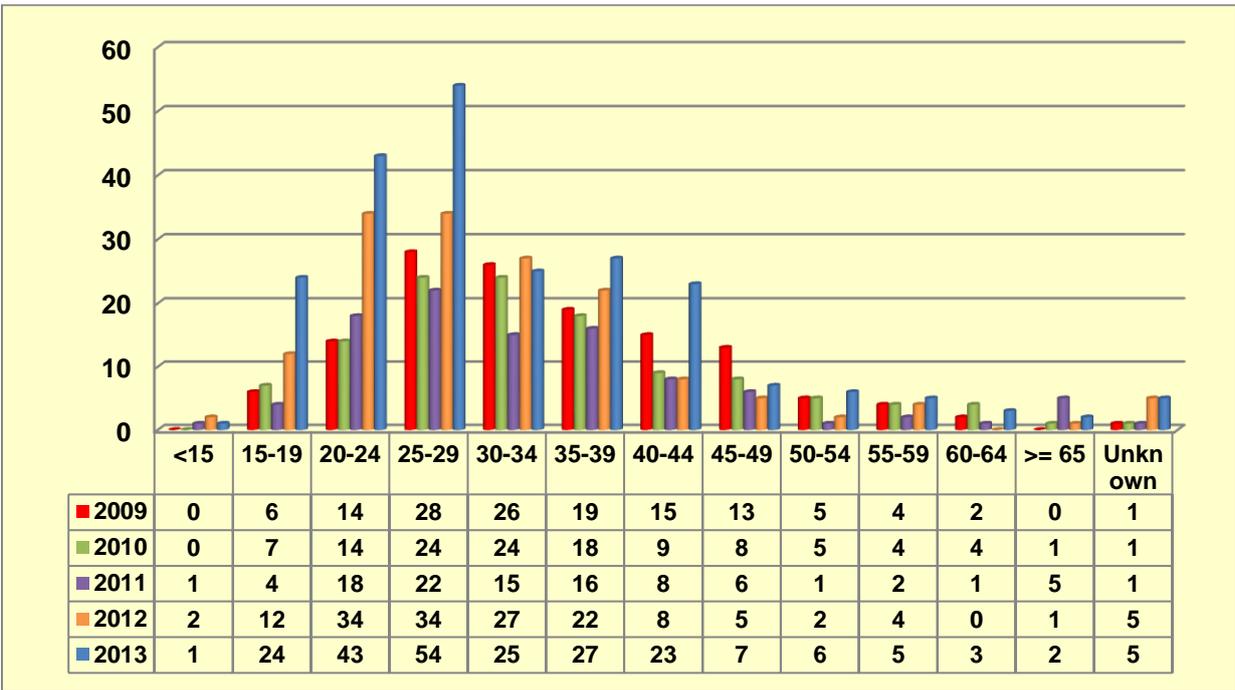
Regarding direct DRD cases classified by age groups, nearly 0.4% were under the age of 15; 11.2% were aged between 15 and 19 years; 19% were aged between 20 and 24 years; 23.3% were aged between 25 and 29 years; 10.8% were aged between 30 and 34 years; 11.6% were aged between 35 and 39 years; 11.2% were aged between 40 and 44 years; 3.4% were aged between 45 and 49 years; 2.6% were aged between 50 and 54 years; 2.2% were aged between 55 and 59 years; 1.3% were aged between 60 and 64 years; and 0.9% were aged 65 and over. Age ranges of 2.2% could not be identified (Table 6-13).

Graph 6-2: Distribution of age ranges of direct DRD cases between 2009 and 2013 by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014; EMCDDA Standard Table 5, 2014.*

Graph 6-3: Distribution of age ranges of males among direct DRD cases between 2009 and 2013 by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014; EMCDDA Standard Table 5, 2014.*

In 2013, direct DRDs occurred most frequently in the group aged between 25 and 29 years, followed by the groups aged between 20 and 24 years, 35 and 39 years, 30 and 34 years, 15 and 19 years, and 40 and 44 years (Graph 6-2), respectively. The distribution of age among

male cases was very similar to the total of both genders (Graph 6-3). No further assessment could be made on the distribution of age among females due to the limited number of cases.

Table 6-14: Top 10 provinces with the most frequent DRD cases between 2007 and 2013

	2007	2008	2009	2010	2011	2012	2013
ISTANBUL	86	93	77	57	45	70	115
ANTALYA	8	6	18	15	5	25	25
ADANA	4	8	8	14	9	15	17
ANKARA	3	2	1	4	5	7	13
İZMİR	1	0	0	1	2	3	11
MERSİN	0	1	3	3	6	9	7
GAZİANTEP	10	10	9	9	4	9	7
KOCAELİ	1	0	5	1	1	4	5
HATAY	1	1	3	2	2	1	4
BURSA	0	2	0	3	2	1	3

Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

DRDs occurred in 26 provinces in total. Istanbul recorded the highest rate of DRDs (n: 115, 49.6%), followed by Antalya (n:25, 10.8%), Adana (n: 17, 7.3%), Ankara (n: 13, 5.6%), İzmir (n: 11, 4.7%), Mersin (n: 7, 3%), Gaziantep (n: 7, 3%), Kocaeli (n: 5, 2.5%), and Hatay (n: 4, 1.7%), respectively. There were three cases (1.3%) each in Bursa, Konya, and Manisa (1,3%); two cases (0.86%) each in Diyarbakır, Hakkari, Kayseri, Osmaniye, and Şanlıurfa; and one case (0.43%) each in Aydın, Afyon, Muğla, Muş, Kastamonu, Sivas, Tekirdağ, Van, and Yalova (Table 6-14).

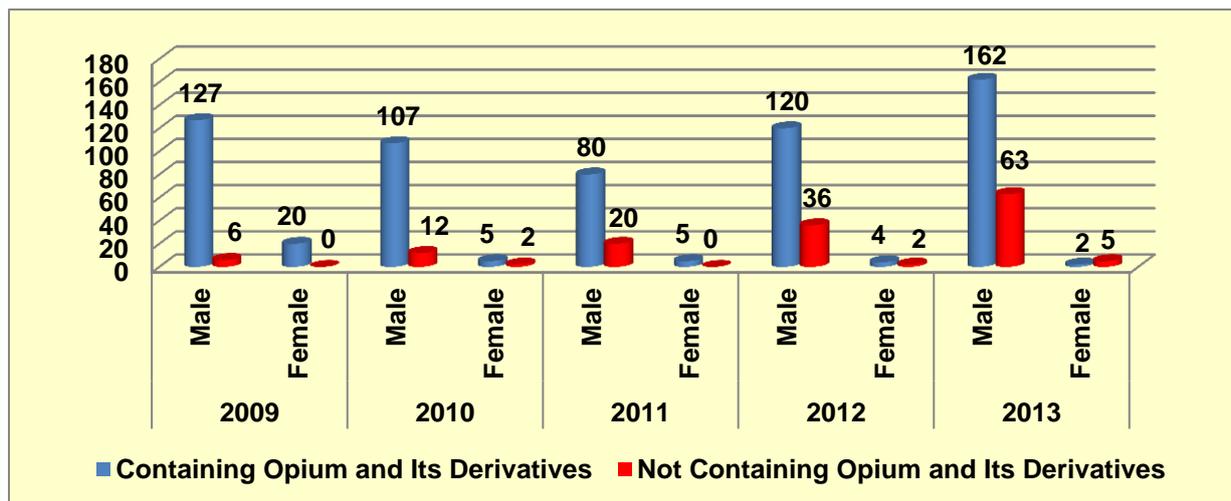
Table 6-15: Distribution of direct DRDs on the basis of opiates in 2013 by gender

Poisoning	Male	Female	Total
Opiates only (excluding methadone only)	90	2	92
Methadone only	2	0	2
Poly-substances including opiates	70	0	70
Poly-substances excluding opiates	63	5	68
Total	225	7	232

Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

At least one substance containing opiates (in combination with another substance or other substances in some cases) was detected in 70.7% (n: 164) of the cases, and substances not containing opiates were detected in 29.3% (n: 68) of the cases (Table 6-15, Graph 6-4).

Graph 6-4: Distribution of DRDs on the basis of opiates in between 2009 and 2013 by gender



Source: The Council of Forensic Medicine under the Ministry of Justice, 2014; EMCDDA Standard Table 5, 2014.

Table 6-16: Substances that were detected in direct DRDs between 2008 and 2013

	2008 (n)	2008 (%)	2009 (n)	2009 (%)	2010 (n)	2010 (%)	2011 (n)	2011 (%)	2012 (n)	2012 (%)	2013 (n)	2013 (%)
6-MAM*	82	55.8	93	60.8	76	60.3	42	40	67	41.4	115	49.6
Morphine	45	30.6	38	24.8	34	27	42	40	56	34.6	45	19.4
Codeine	78	53.1	101	66	75	59.5	64	61	97	59.9	143	61.6
Other opioids	5	3.4	3	2	5	4	4	3.8	1	0.6	5	2.2
Cocaine	15	10.2	5	3.3	15	12	10	9.5	19	11.7	29	12.5
Benzodiazepine	14	9.5	16	10.5	23	18.3	17	16.2	23	14.2	47	20.3
Methamphetamine	0	0	0	0	6	4.8	2	1.9	1	0.6	11	4.7
Amphetamine	0	0	0	0	0	0	4	3.8	3	1.9	13	5.6
MDMA/MDA/MDEA	10	6.8	0	0	1	0.8	19	18	29	17.9	58	25
Antidepressants	18	12.2	13	8.5	7	5.6	3	2.9	11	6.8	26	11.2
Neuroleptics	1	0.7	3	2	3	2.4	3	2.9	2	1.2	19	8.2
Other psychotropic medicine	3	2	4	2.6	2	1.6	6	5.7	18	11.1	20	8.6
Volatile substances (Butane gas/Solvents)	7	4.8	6	3.9	7	5.6	5	4.8	12	7.4	10	4.3
Cannabis	20	13.6	20	13.1	21	6.3	20	19	37	22.8	62	26.7
JWH-018/073/122 and Metabolites	-	-	-	-	-	-	-	-	7	4.3	35	15.1

* 6-MAM is a metabolite of heroin.

**Synthetic cannabinoids.

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

Table 6-16 presents a detailed breakdown of the substances detected by toxicological analyses in the samples of the direct DRD cases that occurred in the last six years. The table

includes only 6-MAM in the cases in which 6-MAM was detected in combination with morphine.

Alcohol analysis was performed in only 90.5% (210) of the direct DRD cases. Out of 201 cases, alcohol was detected in 28 (13.3%) cases. Out of these 28 cases, only heroin was detected in six cases; heroin in combination with other substances was detected in 14 cases (cannabis in seven cases, ecstasy in four cases, methamphetamine in two cases, JWH-018 in two cases, cocaine in two cases, and psychotropic medicines in 11 cases); JWH-018 was detected in two cases; cocaine was detected in two cases; only a volatile substance (toluene) was detected in one case; ecstasy was detected in one case; and ecstasy in combination with other substances was detected in two samples (with amphetamine, methamphetamine and benzodiazepine in one case, and with cocaine in one case) (EMCDDA Standard Table 5, 2014).

The use of synthetic cannabinoids was identified in 15.1% (n: 35) of the direct DRD cases in 2013 (only JWH-018 and metabolites in 31 cases; JWH-018, JWH-073, and metabolites in four cases). Out of these cases, only JWH-018 was detected in one case, and JWH-018 in combination with alcohol was detected in two cases. The use of synthetic cannabinoids in combination with cannabis was detected in six cases; with ecstasy was detected in six cases; with cocaine was detected in one case; with amphetamine was detected in one case; with amphetamine and methamphetamine was detected in one case; with heroin in three cases; with heroin and other substances was detected in ten cases (cannabis in eight cases, ecstasy in four cases, methamphetamine in two cases, amphetamine in one case, cocaine in two cases, alcohol in two cases, and psychotropic medicines in eight cases); and with ecstasy and other substances was detected in four cases (cannabis in two cases, methamphetamine in one case, cocaine in one case, and psychotropic medicines in one case). It was established that three (1.3%) out of these deaths occurred due to the use of synthetic cannabinoids only (EMCDDA Standard Table 5, 2014).

The use of opiates was found in 70.1% (n: 164) of the direct DRDs. Only heroin was detected in 46 cases; heroin and alcohol were detected in six cases; only methadone was detected in two cases; and heroin and methadone were detected in one case. In terms of prevalence, benzodiazepines (n: 44), cannabis (n: 43), cocaine (n: 19), ecstasy (n: 19), dextromethorphan (n: 19), neuroleptics (n: 17), antidepressants (n: 16), synthetic cannabinoids (n: 13), amphetamine/methamphetamine (n: 11), and barbiturates (n: 1) were used in combination with opiates (EMCDDA Standard Table 5, 2014).

The use of ecstasy (MDMA/MDA/MDEA) was identified in 25% (n: 58) of the direct DRDs. Only ecstasy was detected in 12 cases; and ecstasy and alcohol were detected in one case. In terms of prevalence, cannabis (n: 19), heroin (n: 18), synthetic cannabinoids (n: 14), amphetamine/methamphetamine (n: 11), benzodiazepines (n: 6), cocaine (n: 6), antidepressants (n: 3), dextromethorphan (n: 2), and neuroleptics (n: 2) were used in combination with ecstasy (EMCDDA Standard Table 5, 2014).

The use of cocaine was detected in 12.5% (n: 29) of the direct DRDs. Only cocaine was found in two cases; and cocaine and alcohol were detected in two cases. In terms of prevalence, heroin (n: 19), ecstasy (n: 7), benzodiazepines (n: 7), dextromethorphan (n: 6), neuroleptics (n: 6), cannabis (n: 4), antidepressants (n: 4), synthetic cannabinoids (n: 3), amphetamine/methamphetamine (n: 2), and barbiturates (n: 1) were used in combination with cocaine (EMCDDA Standard Table 5, 2014).

The use of amphetamine/methamphetamine was identified in 8.6% (n: 20) of the DRD cases (amphetamine in nine cases, methamphetamine in seven cases, and amphetamine in combination with methamphetamine in four cases). Out of these cases, one death occurred due to the use of only amphetamine. In terms of prevalence, heroin (n: 11), ecstasy (n: 11), synthetic cannabinoids (n: 6), cannabis (n: 4), benzodiazepines (n: 3), antidepressants (n: 3), cocaine (n: 2), dextromethorphan (n: 2), and neuroleptics (n: 1) were used in combination with amphetamine/methamphetamines (EMCDDA Standard Table 5, 2014).

Out of ten deaths related to volatile substance use, five deaths occurred due to toluene intoxication (in combination with acetone in two cases, with isopropanol in one case, and with 3-methyl-1-butanol and 2-methyl-1-propanol in one case), and five deaths were due to n-butane intoxication (due to the inhalation of butane gas). Heroin was detected in one case, and alcohol was detected in one case (EMCDDA Standard Table 5, 2014).

By nationality, 13.8% (n: 32) of the direct DRD cases in 2013 were foreign nationals. Out of these foreign nationals, 22 were from Georgia; three were from Turkmenistan; two were from Armenia; one was from Azerbaijan; one was from Kosovo; one was from Nigeria; one was from China; and one was from India.

6.4.2. Indirect Drug-Related Deaths

416 indirect drug-related deaths were identified in 2013 in Turkey.

Table 6-17: Distribution of average ages of indirect DRDs by gender and year

Years	Gender	Average Age	Min. Max. Age
2008	Male (n:126)	34.5	15-70
	Female (n:9)	34.8	17-60
	Total (n:135)	34.5	15-70
2009	Male (n:141)	32.3	13-72
	Female (n:4)	40	19-69
	Total (n:145)	32.4	13-72
2010	Male (n:139)	33.6	13-84
	Female (n:5)	43	26-90
	Total (n:144)	33.9	13-90
2011	Male (n:248)	33.9	14-79
	Female (n:12)	33.7	21-61
	Total (n:260)	33.9	14-79
2012	Male (n:158)	35.5	16-72
	Female (n:5)	27.8	22-39
	Total (n:163)	35.3	16-72
2013	Male (n:404)	32.8	13-77
	Female (n:12)	26.6	19-35
	Total (n:416)	32.6	13-77

Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Ninety-seven point one percent (n: 404) of the cases were male, and 2.9% (n: 12) were female. The average age of male subjects was 32.8 (min: 13; max: 77), that of female subjects was 26.6 (min: 19; max: 35), and that of all the cases was 32.6 (min: 13; max: 77) (Table 6-17).

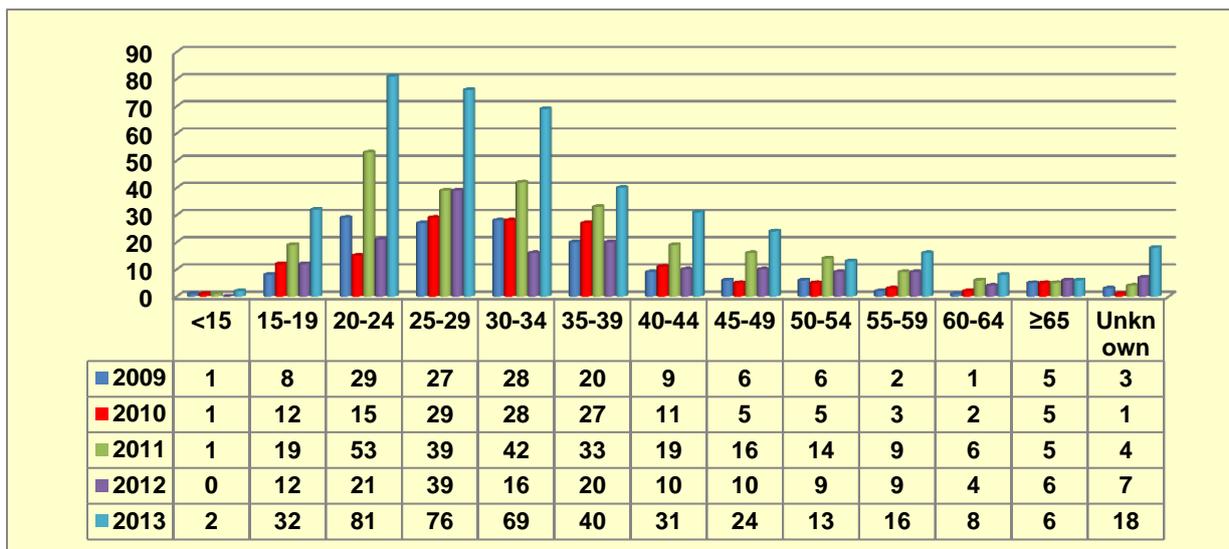
Table 6-18: Distribution of age ranges by gender

Age	Male	Female	Total
<15	2	0	2
15-19	31	1	32
20-24	77	4	81
25-29	74	2	76
30-34	66	3	69
35-39	39	1	40
40-44	31	0	31
45-49	24	0	24
50-54	13	0	13
55-59	16	0	16
60-64	8	0	8
≥65	6	0	6
Unknown	17	1	18
Total	404	12	416

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

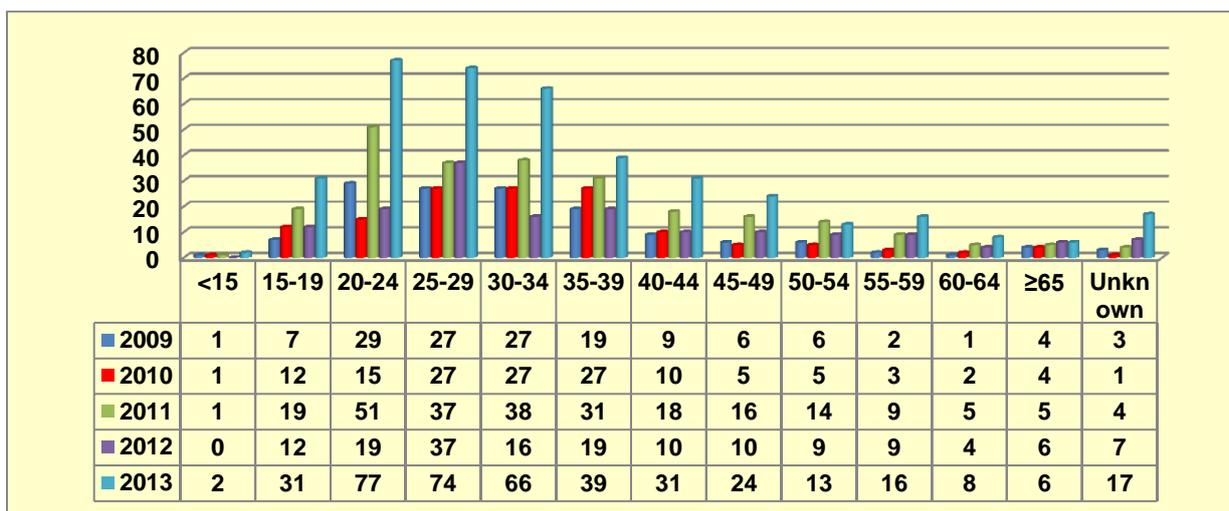
Indirect DRDs classified according to age groups were as follows: two cases were under the age of 15 years; 32 cases were aged between 15 and 19 years; 81 cases were aged between 20 and 24 years; 76 cases were aged between 25 and 29 years; 69 cases were aged between 30 and 34 years; 40 cases were aged between 35 and 39 years; 31 cases were aged between 40 and 44 years; 24 cases were aged between 45 and 49 years; 13 cases were aged between 50 and 54 years; 16 cases were aged between 55 and 59 years; eight cases were aged between 60 and 64 years; and six cases were aged over 65 years. The ages of 18 cases could not be identified (Table 6-18).

Graph 6-5: Distribution of age ranges of indirect DRDs in 2013 by year



Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

Graph 6-6: Distribution of age ranges of males among indirect DRD cases in 2013 by year



Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

In 2013, indirect drug-related deaths occurred most frequently in the group aged between 20 and 24 years, followed by the groups aged between 25 and 29 years, between 30 and 34 years, between 35 and 39 years, between 15 and 19 years, between 40 and 44 years, between 45 and 49 years, between 55 and 59 years, and between 50 and 54 years (Graph 6-5), respectively. The distribution of age among male cases was very similar to the total of both genders (Graph 6-6). No further assessment could be made on the distribution of age among females due to the limited number of cases.

Table 6-19: Distribution of indirect DRD cases in 2013 by gender on the basis of cause of death and opiates

CAUSE OF DEATH	MALE		FEMALE		TOTAL	
	OPIATE (+)	OPIATE (-)	OPIATE (+)	OPIATE (-)	N	%
Firearm injuries	19	98	0	4	121	29.1
Traffic accidents	8	46	0	1	55	13.2
Cardiovascular diseases	4	47	0	0	51	12.3
Sharp object injuries	3	36	0	0	39	9.4
Hanging	6	30	0	3	39	9.4
Unknown	3	24	0	1	28	6.7
Falling from a height	2	20	0	1	23	5.5
Drowning	1	18	0	0	19	4.6
Blunt head trauma (homicide)	2	6	0	1	9	2.2
Carbon monoxide intoxication	0	6	0	0	6	1.4
Lung infection	3	2	0	0	5	1.2
Electrical injuries	0	3	1	0	4	1
Non-traumatic cerebral hemorrhage	1	3	0	0	4	1
Cancer	1	3	0	0	4	1
Burn	0	2	0	0	2	0.5
Intoxication by medicines	0	1	0	0	1	0.2
Strangulation	0	1	0	0	1	0.2
Alcohol intoxication	0	1	0	0	1	0.2
Occupational accident	1	0	0	0	1	0.2
Gastrointestinal bleeding	0	1	0	0	1	0.2
Insecticide poisoning	0	1	0	0	1	0.2
Chronic lung disease	0	1	0	0	1	0.2
Total	54	350	1	11	416	

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

Unlike previous years, firearm injuries constituted the most frequent cause of death, followed by traffic accidents, cardiovascular diseases, sharp object injuries, hanging, unknown, falling from a height, drowning, blunt head traumas (of homicide origin), carbon monoxide intoxication, lung infection, and electrical injuries (Table 6-19).

Table 6-20: Substance detected in the samples of the indirect DRDs between 2008 and 2013

	2008 (n)	2008 (%)	2009 (n)	2009 (%)	2010 (n)	2010 (%)	2011 (n)	2011 (%)	2012 (n)	2012 (%)	2013 (n)	2013 (%)
6-MAM*	3	2.2	8	5.5	17	11.8	8	3	2	1.2	20	4.8

Morphine	15	11.1	17	11.7	13	9	30	11.5	19	11.7	35	8.4
Codeine	12	8.9	10	6.9	15	10.4	29	11.2	10	6.1	38	9.1
Other opioids	0	0	2	1.4	1	0.7	0	0	0	0	1	0.2
Cocaine	12	8.9	12	8.3	9	6.3	19	7.3	9	5.5	24	5.8
Benzodiazepines	2	1.5	0	0	4	2.8	0	0	11	6.7	24	5.8
Methamphetamine	3	2.2	2	1.4	4	2.8	5	1.9	2	1.2	15	3.6
Amphetamine	0	0	0	0	0	0	20	7.7	5	3.1	13	3.1
MDMA/MDA/MDEA	10	7.4	0	0	9	6.3	35	13.5	31	19	94	22.6
Antidepressants	2	1.5	0	0	2	1.4	0	0	2	1.2	11	2.6
Neuroleptics	0	0	1	0.7	0	0	0	0	0	0	7	1.7
Other psychotropic medicines	1	0.7	4	2.8	1	0.7	5	1.9	0	0	3	0.7
Volatile substances (Butane Solvents) gas/	1	0.7	3	2.1	0	0	0	0	2	1.2	3	0.7
Cannabis	87	64.4	107	73.8	108	75	197	75.8	111	68.1	291	70
JWH-018/073/122 and metabolites**	-	-	-	-	-	-	-	-	8	4.9	61	14.7

* 6-MAM is a metabolite of heroin. **Synthetic cannabinoids.

Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Ethyl alcohol analysis could be performed in only 297 cases (71.4%) of the all indirect DRDs. Out of these 297 cases, alcohol was identified in 65 cases (21.9%).

An opiate substance was detected in 13.2% (n: 55) of the indirect DRDs (in combination with other substances in 31 cases). Heroin was found in all cases (n: 55). Methadone was detected in one case. Out of these cases, the use of only heroin was identified in 18 cases, and heroin in combination with alcohol was detected in six cases. In terms of prevalence, cannabis (n: 11), cocaine (n: 10), ecstasy (n: 6), benzodiazepines (n: 6), neuroleptics (n: 4), amphetamine/methamphetamine (n: 4), synthetic cannabinoids (n: 3), antidepressants (n: 2), and dextromethorphan (n: 2) were used in combination with opiates (Table 6-20).

The use of only non-opiate substances was identified in 86.8% (n: 361) of the indirect DRD cases. Cannabis (n: 280), ecstasy (n: 88), synthetic cannabinoids (n: 58), benzodiazepines (n: 18), amphetamine/methamphetamine (n: 16), cocaine (n: 14), antidepressants (n: 7), neuroleptics (n: 3), volatile substance (n: 3), and barbiturates (n: 1) were used as non-opiate substances (Table 6-20).

Out of three indirect deaths related to volatile substance use, two deaths occurred due to toluene intoxication (in combination with JWH-018 in two cases, and with alcohol in one case), and one death was due to n-butane intoxication (in combination with JWH-018) (Table 6-20).

Table 6-21: Distribution of indirect DRDs on the basis of their origins by gender

Origin of death	Male	Female	Total
Natural/internal causes	66	0	66
Accidents not related to poisoning	90	3	93
Suicide not related to poisoning	46	4	50
Homicide not related to poisoning	84	2	86
Undetermined causes not related to poisoning	118	3	121
Total	404	12	416

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

Out of 295 indirect drug-related deaths with known origins, 31.5% (n: 93) of the deaths occurred due to accidents, 29.2% (n: 86) were due to homicide, 22.4% (n: 66) were natural deaths, and 16.9% (n: 50) were due to suicide (Table 6-21).

There were nine (2.3%) indirect DRD cases involving foreign nationals, out of which two were from Turkmenistan, two were from the Islamic Republic of Iran, one was from Georgia, one was from Azerbaijan, one was from the USA, one was from Germany, and one was from Syria.

Indirect DRDs occurred in 50 provinces in total. Istanbul recorded the highest number of cases with 134 cases (32.2%), followed by 41 cases (10.7) in Izmir; 37 cases (8.9%) in Adana; 28 cases (6.7%) in Ankara; 22 cases (5.3%) in Antalya; 17 cases (4.1%) in Manisa; 12 cases (2.9%) in Mersin; 11 (2.6%) cases in Sakarya; nine cases (2.2%) in Samsun; eight cases (1.9%) in Aydın; eight cases (1.9%) in Muğla; seven cases (1.7%) in Tekirdağ; and five cases (1.2%) each in Düzce and Kayseri. There were four cases (1%) each in Bingöl, Elazığ, Rize, Trabzon, and Uşak; three cases (0.7%) each in Artvin, Kocaeli, Diyarbakır, Urfa, Malatya, Niğde, and Zonguldak; two cases (0.5%) each in Ağrı, Hatay, Kütahya, Osmaniye, Çorum, Gaziantep, and Van; and one case (0.2%) each in Afyonkarahisar, Aksaray, Amasya, Ardahan, Bayburt, Bolu, Bursa, Çanakkale, Çankırı, Hakkari, Iğdır, Karabük, Kırıkkale, Kırklareli, Sinop, Sivas, and Yalova.

Table 6-22: Top ten provinces with the most frequent indirect DRD cases between 2009 and 2013

	2009	2010	2011	2012	2013
ISTANBUL	57	66	98	51	134

İZMİR	13	12	15	20	41
ADANA	9	2	10	10	37
ANKARA	12	4	14	10	28
ANTALYA	13	13	13	9	22
MANİSA	2	1	6	6	17
MERSİN	1	1	4	6	12
SAKARYA	1	5	8	1	11
SAMSUN	3	2	7	1	9
AYDIN	0	2	6	4	8

Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

6.4.3. Comparison and Trend Analysis

Compared to 162 direct DRD cases that were recorded in 2012, the number reached 232 with a 43.2% rise in 2013. A steady upward trend was observed in direct DRDs between 2007 and 2009 (2007: 136, 2008: 147, 2009: 153); however, the number of cases decreased to 126 in 2010 and to 105 in 2011. This decrease was considered to be parallel to the diminished opium production in Afghanistan. Again, the increase in the number of deaths in 2012 resulted from a growing heroin supply in Afghanistan, and it continued its upward trend in 2013 (EMCDDA 2013 National Report, p.102).

However, the rise in the number of deaths in 2013 did not result exclusively from the increased heroin supply. In 2013, a considerable increase was recorded in the number of intoxications by other substances as well. While 31 direct DRDs occurred due to amphetamine derivatives (amphetamine, methamphetamine, and ecstasy), in 2012, this number reached 82 with a 165% rise in 2013. Compared to the previous year, there were 68% and 53% increases in cannabis and cocaine, respectively (Table-6-23, Graph 6-7).

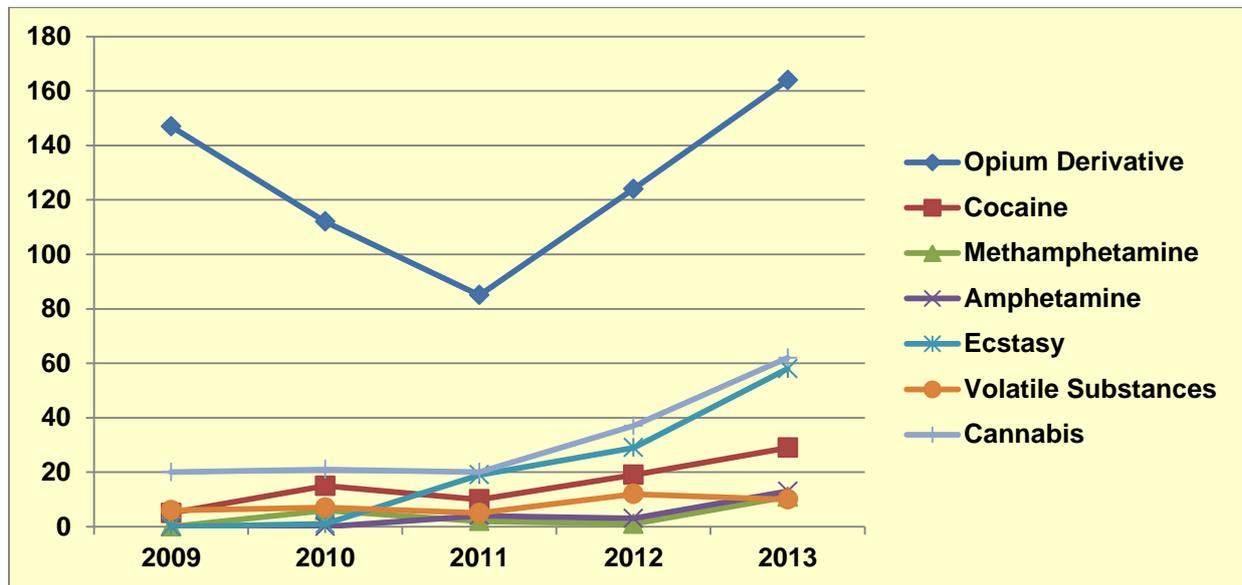
Unlike previous years, as more laboratories were involved in synthetic cannabinoids, the number of DRDs increased. Another parameter to explain the rise in deaths is the ratios of purity in substances. The lowest purity ratio/amount of the substances seized in 2013 was the same as or higher than that of the substances of the previous year (See Section 10).

Table-6-23: Distribution of the substances detected in the direct DRDs by year

	2009	2010	2011	2012	2013
Opiate	147	112	85	124	164
Cocaine	5	15	10	19	29
Methamphetamine	0	6	2	1	11
Amphetamine	0	0	4	3	13
Ecstasy	0	1	19	29	58

Volatile substances	6	7	5	12	10
Cannabis	20	21	20	37	62

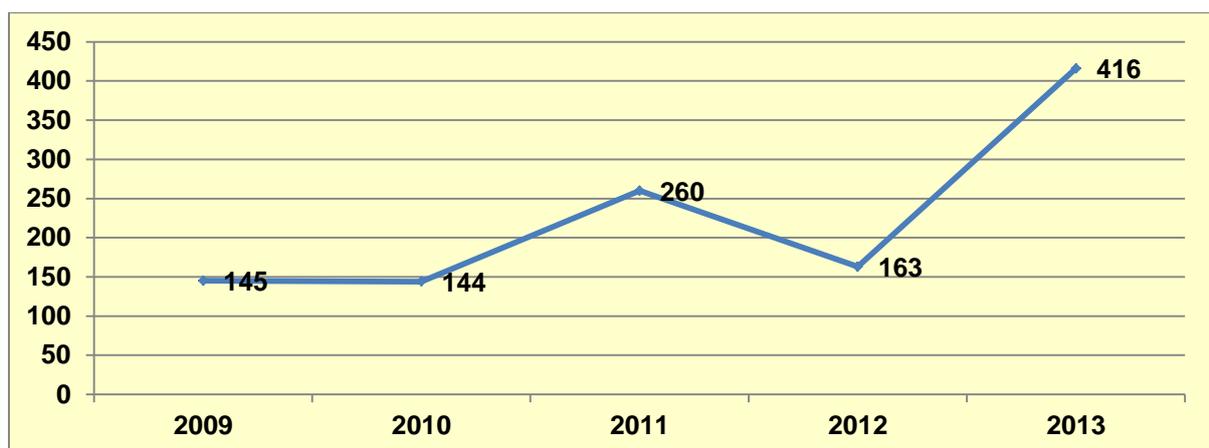
Graph 6-7: Distribution of the substances detected in the direct DRDs by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

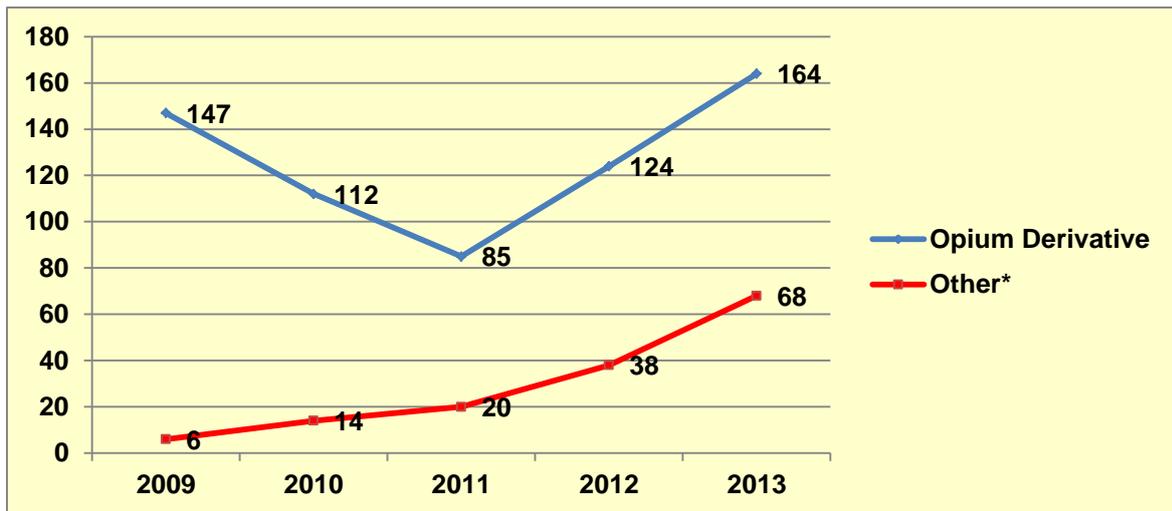
The number of indirect DRD cases in 2012 decreased by 37.3% compared to 2011. However, this number reached 416 in 2013 with a 155% increase compared to 2012, and a 60% increase compared to 2011 (Graph 6-8).

Graph 6-8: Number of indirect DRDs by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Graph 6-9: Distribution of male subjects among direct DRDs on the basis of opiates by year

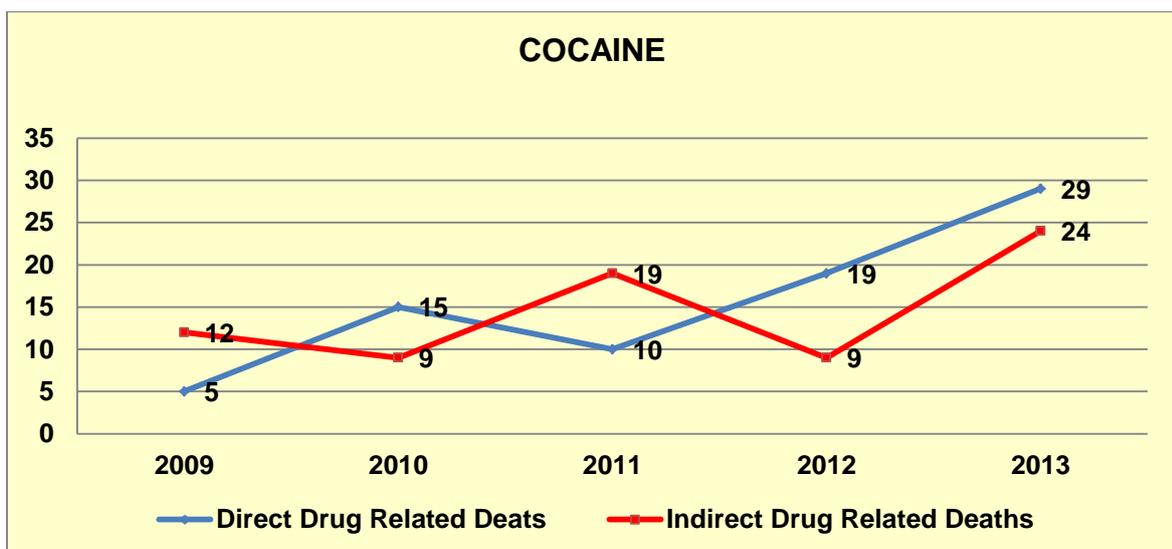


*Cocaine, Amphetamine Derivatives, Cannabis, Synthetic Cannabinoids, Volatile substances

Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Graph 6-9 shows a high decrease in the number of deaths related to opiate substance intoxication between 2009 and 2011, and a higher increase in the subsequent years. However, despite a rise in the number compared to the previous year, there was a 5.8% decrease in deaths related to opiate substance intoxication, and an increase in the same rate in deaths related to intoxication by other substances. While the rate of opiate use among the direct DRDs was 76.5% in 2012, it was 70.7% in 2013. However, deaths that occurred due to the use of non-opiate substances increased.

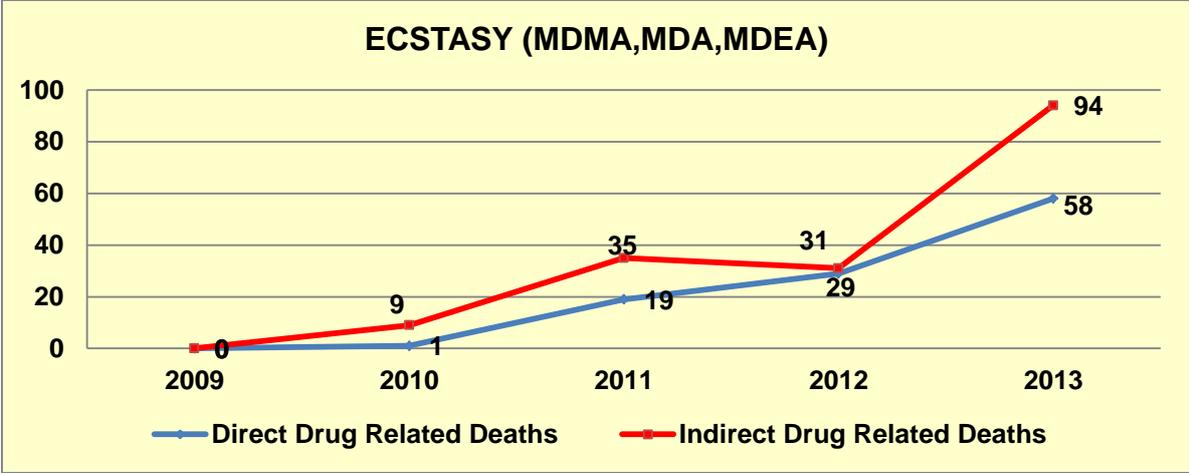
Graph 6-10: Distribution of the cases that involved cocaine use among direct and indirect DRDs by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Graph 6-10 presents a considerable increase, compared to the previous year, in the number of cases that involved cocaine use among both direct and indirect DRDs. The rate of increase is very high; thus, it is envisaged that the upward trend in deaths due to cocaine will continue in the coming years as well. The average level of purity of the cocaine that was seized in 2013 was higher compared to previous years. The lowest ratio of purity that was recorded as 10% in 2012 increased to 19% in 2013. While the upper limit purity was 92% in 2012, it reached 95% in 2013 (See Section 10).

Graph 6-11: Distribution of the cases that involved ecstasy use (MDMA, MDA, MDEA) among direct and indirect DRDs by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

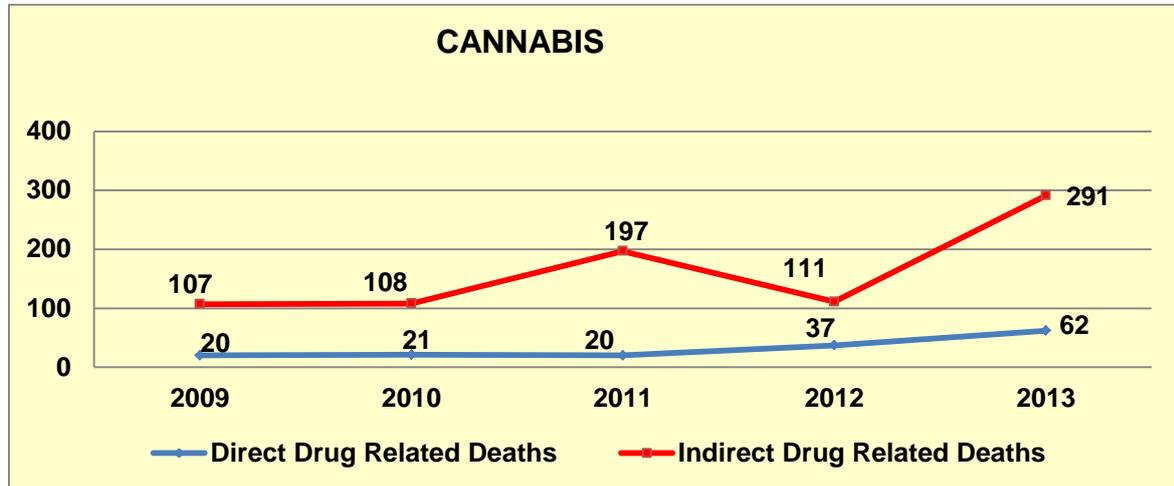
Graph 6-1 shows a significant increase in the number of the cases that involved the use of ecstasy among both direct and indirect DRDs compared to the previous year. While no ecstasy was detected in any of the deaths in 2009, ecstasy was found in 58 direct and 94 indirect DRD cases in 2013 following the upward trend that started in 2010.

Compared to the previous year, the number of the direct DRDs related to ecstasy use doubled, and that of the indirect DRDs tripled. In addition to the rise in the number of cases, its prevalence among all cases increased over the years (Table 6-18 and 6-22). While 0.8% of the direct DRD cases were related to ecstasy use in 2010, the rate increased to 25% in 2013. As per the estimations, this upward trend will continue in the coming years.

The ratios of purity in ecstasy constitute another parameter to account for the rise in deaths. The average amount of purity in ecstasy tablets was higher in 2013 compared to the previous year. The lowest amount of purity for one tablet was 8 mg in 2012, and it increased to 26 mg in 2013. While the upper limit of purity was 240 mg in 2012, it reached 258 mg in 2013 (see

Section 10). The 2014 European Drug Report prepared by EMCDDA draws attention to the increased purity in ecstasy, and suggests that it may affect next year's data.

Graph 6-12: Distribution of the cases that involved cannabis use among direct and indirect DRDs by year

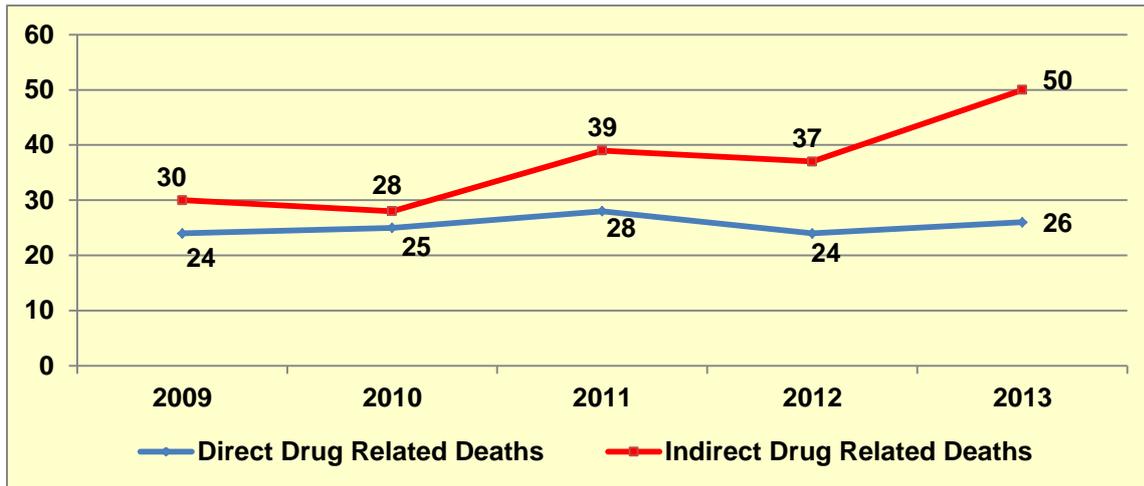


Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Graph 6-12 demonstrates a significant increase in the number of the cases that involved the use of cannabis among both direct and indirect DRDs compared to the previous year. There was a 67.6% rise in the number of the direct DRD cases that used cannabis, and a 162.2% increase in the indirect DRDs. In addition to the rise in the number of cases, its prevalence among direct DRDs increased over the years; however, its prevalence rate remained nearly at indirect DRD levels (Table 6-16 and 6-20).

While the number of the provinces where direct DRDs occurred remained at nearly the same level in the last five years, the number of the provinces with indirect DRD cases increased significantly (Graph 6-9). Compared to 30 provinces where indirect DRD cases were recorded in 2009, the number of these provinces reached 50 in 2013 with a 66.7% increase in the last five years. The number of the provinces involved did not vary significantly in direct DRDs because opiates are the most prevalent substances in direct DRDs, opiate users generally live on the route, and it is more difficult to have access to opiates. The rise in the number of provinces where indirect DRDs occurred suggests that substance use has expanded over a wider geographic area.

Graph 6-13: Number of the provinces where direct and indirect DRD cases occurred in the last five years



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

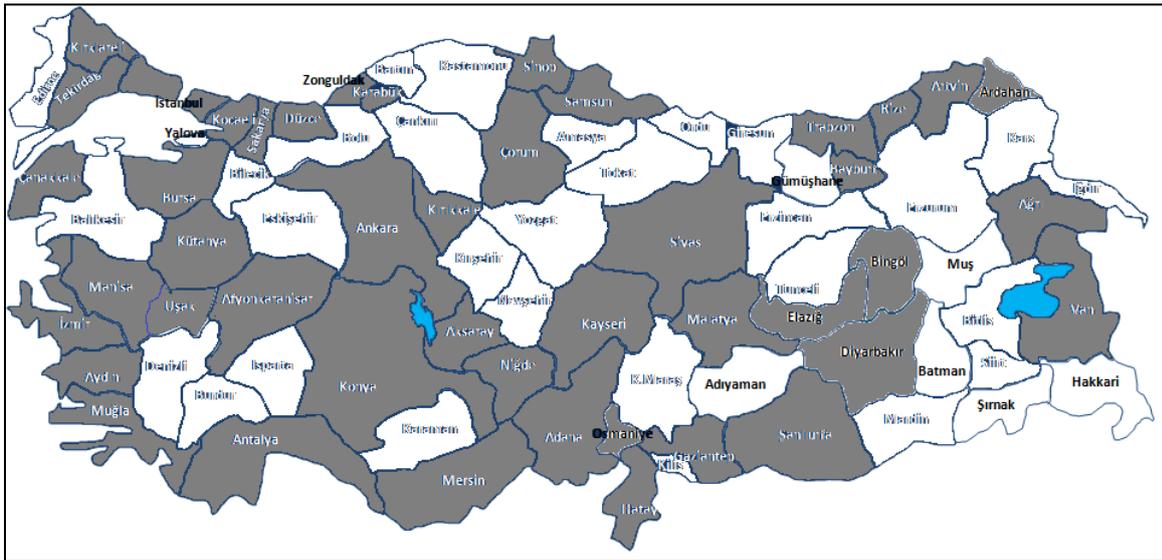
The top five provinces (Istanbul, Ankara, Izmir, Adana, and Antalya) with the highest rates of both direct and indirect DRDs remained the same. 78% of the direct DRDs, and 63% of the indirect DRDs were recorded in these five provinces. Both direct and indirect DRDs increased substantially in Ankara and Izmir over the years.

Among all DRDs, opiates were used in 29 provinces; cannabis was used in 45 provinces; amphetamines were used in 30 provinces; cocaine was used in 11 provinces; and volatile substances were used in five provinces. Cannabis is the most widespread substance in terms of both the number of related cases and geographic extent (Diagram 6-1, 2, 3, 4).

When all DRDs (both direct and indirect) are considered together, deaths occurred in 52 provinces in total. When the prevalence of substances in all DRDs (both direct and indirect) is distributed by province, all the substances involved were most prevalent in Istanbul. Apart from Istanbul, opiates were most frequent in Şanlıurfa, Gaziantep, Adana, Osmaniye, Hatay, Mersin, and Antalya, with 32.9% of the opiate users living in these provinces. They are the neighboring provinces situated on the southern route, which is one of the routes for heroin trafficking in Turkey (Table 6-24). Deaths related to opiates occur mainly in the provinces located on the route of illicit heroin trade in the country. The use of opiate substances is decreasing in the provinces that are not on the heroin route.

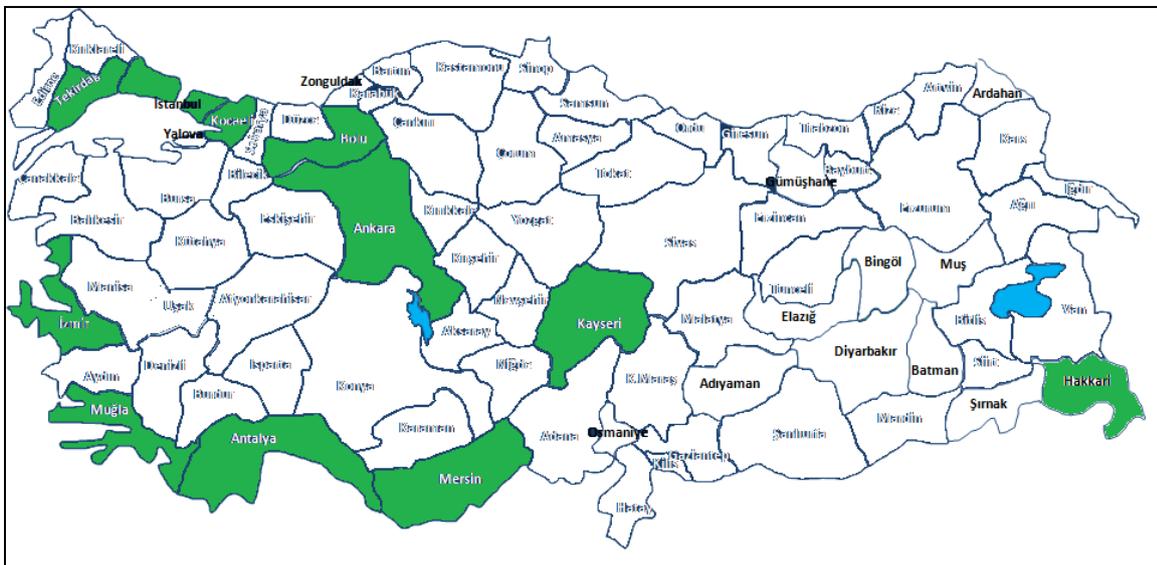
The use of opiates was identified in only four provinces of the Aegean Region and in seven cases in total (3.2% (n: 219) of the cases involving opiates, and 1.1% (n: 648) of all the cases). Instead, compared to other regions, non-opiate substances are used at higher rates. Across the Aegean Region, cannabis and amphetamine derivatives are the most prevalent substances in all DRDs, with 66 and 39 cases, respectively (Table 6-24).

Figure 6-3: Provinces involving the use of cannabis in all DRDs



Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

Figure 6-4: Provinces involving the use of cocaine in all DRDs



Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

The use of all substances was detected only in Istanbul, Tekirdağ, Izmir, Muğla, Antalya, Mersin, Ankara, and Kayseri (Tables 6-24, Diagrams 6-1, 2, 3, 4).

There was a significant rise in the use of cannabis and amphetamine derivatives in Aydın, Muğla, and Kayseri (Table 6-24).

DRDs occur in all regions, but mainly in more densely populated provinces. Though they do not have high numbers of permanent residents, the provinces that attract large numbers of tourists in summer season (such as Aydın and Muğla) present increased DRD cases as well.

Table-6-24: Distribution of the substances detected in all direct and indirect DRDs by province

	OPIATES	CANNABIS	AMPHETAMINES	COCAINE	VOLATILE SUBSTANCES
ADANA	24	30	12		
AFYON	1	1			
AĞRI	1	1			
AKSARAY		1	1		
AMASYA	1				
ANKARA	14	32	13	8	
ANTALYA	24	21	6	6	5
ARDAHAN		1			
ARTVİN	1	1	1		
AYDIN		8	3		
BAYBURT		1			
BİNGÖL		4			
BOLU	1			1	
BURSA		1	2		1
ÇANAKKALE		1			
ÇANKIRI			1		
ÇORUM		2	2		
DİYARBAKIR	1	2			2
DÜZCE		4			
ELAZIĞ		4			
GAZİANTEP	8	4			
HAKKARİ	2		1	1	
HATAY	4	2			
İĞDIR			1		
İSTANBUL	102	106	86	29	9
İZMİR	4	35	22	2	
KARABÜK		1			
KASTAMONU	1				
KAYSERİ	2	5	5	1	
KIRIKKALE		1			
KIRKLARELİ		1			
KOCAELİ	4	4	4	1	
KONYA	2	1	1		
KÜTAHYA		1	1		
MALATYA		3			
MANİSA		13	10		
MERSİN	6	13	4	1	
MUĞLA	1	6	2	1	
MUS			1		
NİĞDE		1	2		
OSMANIYE	4	2			
RİZE		4			
SAKARYA		10	1		
SAMSUN	2	6	1		
SİNOP		1			
SİVAS	1	1	1		
TEKİRDAĞ	2	5	1	1	
TRABZON		3	1		
Ş.URFA	2	3	3		
UŞAK	1	2	1		
VAN	1	2			
YALOVA	1		2		
ZONGULDAK	1	2			1

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

The cause of death in the majority (63.8%) of direct DRDs was poly-substance (substances in combination) use. The use of only one substance (opiate, cocaine, amphetamines, synthetic cannabinoids, or volatile substances) was identified in only 84 cases (36.2%). 14.3% (n: 12) of these 84 cases involved the use of a single substance in combination with alcohol. Poly-substance use further increases the risk of death (Tables 6-15, 16, 20).

Nearly all of the direct DRDs and nearly half of the indirect DRDs are problem drug users.

Due to poly-substance use in most of the direct DRDs, it is difficult to identify the extent of the impact the substances had on death.

Synthetic cannabinoids were detected in 35 direct and 61 indirect DRDs. Since the analyses of synthetic cannabinoids could not be performed in the laboratories in Adana, Bursa, Malatya, Antalya, Diyarbakır, and Erzurum in 2013, the relevant data do not reveal the frequency of synthetic cannabinoid use. In other laboratories, only two (JWH-018/073) or three (JWH-018/073/122) synthetic cannabinoids could be analyzed. Thus the 2013 data or DRDs do not show the prevalence of synthetic cannabinoid use. The rise in and frequency of operations conducted to seize synthetic cannabinoids reveals the extent of use in the best manner. In 2013, synthetic cannabinoids were seized in 70 provinces out of 80 in Turkey, with a 62.8% increase compared to the previous year (see Sections 9 and 10). Most of the provinces where synthetic cannabinoids are not seized are the provinces where cannabis is produced the most frequently. It is likely that due to high availability of cannabis, the use of synthetic cannabinoids remains very limited in these provinces with the highest rates of cannabis cultivation.

The number of the cases (n: 35) involving the use of synthetic cannabinoids among direct DRDs is restricted due to problems in analyzing. However, direct DRD due to the use of synthetic cannabinoids was identified in only three cases (in combination with alcohol in two cases). Other 32 deaths occurred due to the use of synthetic cannabinoids and other substances in combination. The main cause of these deaths was poly-substance use in combination with synthetic cannabinoids. In other words, synthetic cannabinoids, like opiates or ecstasy, are frequently used in combination with other substances, and the majority of the deaths occur due to poly-substance use. Among the samples sent for analysis to the FCM's Narcotics Department, there are drug cocktails mixed (a cocktail of AKB-48, AM-2201, and JWH-18, or of JWH-018 and MDMA) (Source: İsmail Ateş, Symposium entitled "Bonsai in All Aspects", August 21, 2014).

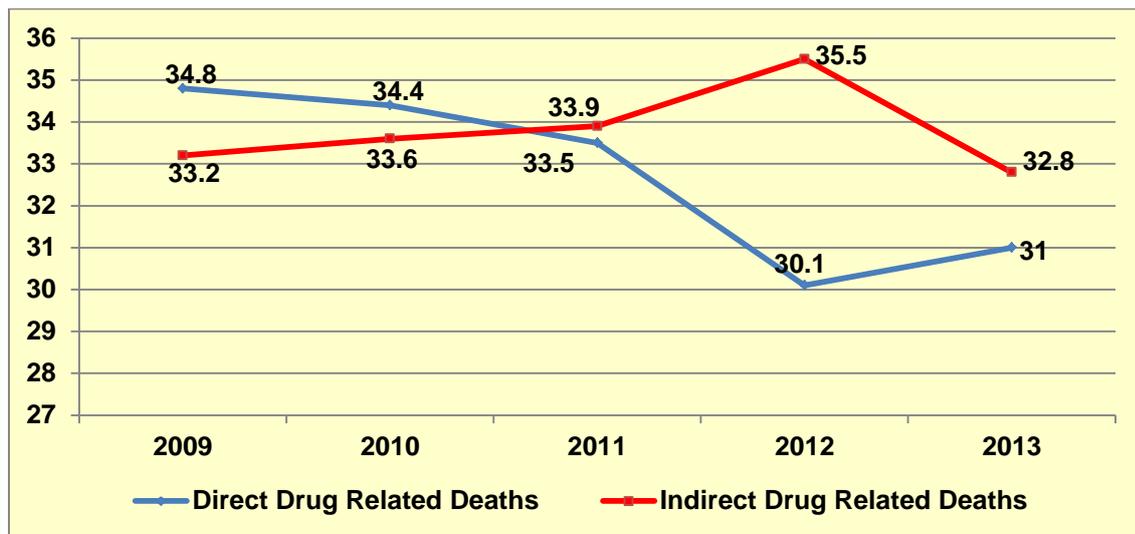
It is not possible for illegal laboratories to fix the doses of the compounds in synthetic cannabinoids. Videos available on social media show that the amounts of compounds are adjusted by a rule of thumb, which explains a part of deaths.

A portion of synthetic cannabinoids that are seized very frequently cannot be analyzed. Thus, some unidentified substances may be present in some of the drug-related deaths, and as a result, poly-substance use may have caused some of them.

The use of volatile substances (solvent and butane gas inhalation) was identified in 13 DRDs in 2013 in only Istanbul, Bursa, Diyarbakır, Antalya, and Zonguldak. As per the estimates, the use of volatile substances will not subside next year.

The classification of the direct and indirect DRDs in 2013 by gender shows that substance use was more prevalent among males compared to females, as was the case in previous years (Table 6-12, Table 6-17).

Graph 6-14: Distribution of average ages of males among direct and indirect DRDs by year



Source: *The Council of Forensic Medicine under the Ministry of Justice, 2014.*

Despite a slight rise in the average age of male subjects among direct DRDs compared to the previous year, this number still remained lower compared to previous years. Decreased average age can be explained by the increase in the number of cases under the age of 19. Compared to 9.3% (n: 15) in 2012 and 5% (n: 5) in 2011, the rate of the male subjects under the age of 19 among direct DRDs reached 11.1% (n: 25) in 2013 (Graph 6-3, Graph 6-14).

The average age of male subjects among indirect DRDs decreased significantly compared to the previous year (Graph 6-14). Based on the data provided by the General Directorate of Health Services under the Ministry of Health, and parallel to the decrease in the average ages

recorded in both direct and indirect DRD cases, while average age of the patients that were placed under treatment was 27.13 years in 2012, the patients were, on average, 26.28 years old in 2013 (see Section 5).

In 2013, direct DRDs occurred most frequently in the group aged between 25 and 29 years; followed by the groups aged between 20 and 24 years; between 35 and 39 years; between 30 and 34 years; between 15 and 19 years; and between 40 and 44 years, respectively. Indirect DRDs were observed most frequently in the group aged between 20 and 24 years; followed by the groups aged between 25 and 29 years; between 30 and 34 years; between 35 and 39 years; between 15 and 19 years; between 40 and 44 years; between 45 and 49 years; between 55 and 59 years; and between 50 and 54 years, respectively (Graph 6-2 and Graph 6-5). Deaths are most prevalent in the group aged between 20 and 29 years. The data by the Social Security Institute support these findings. Patients who were placed under treatment for substance use in 2013 were mostly between the ages of 20 and 29 (See Section 5).

Table 6-25: Distribution of the substances detected in the direct DRDs by age groups

	10-19	20-29	30-39	40-49	50-59	>=60	TOTAL
OPIATES	10	71	41	23	10	4	159
CANNABIS	5	25	20	6	4	0	60
ECSTASY	14	25	13	5	0	1	58
COCAINE	0	13	6	10	0	0	29
AMPHETAMINE/ METHAPHETAMINE	2	8	6	2	1	0	19
VOLATILE SUBSTANCES	6	2	1	1	0	0	10
JWH_018/073/122	5	18	8	2	2	0	35
TOTAL	42	162	95	49	17	5	

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

In direct DRDs, ecstasy was the most prevalent substance among the cases aged between 10 and 19 years, followed by opiates, volatile substances, cannabis, and synthetic cannabinoids, respectively. Opiates were the most frequent in other age groups. In the group aged between 20 and 39 years, opiates were followed by cannabis, ecstasy, synthetic cannabinoids, cocaine, and amphetamine/methamphetamine, respectively. Cocaine was the second most prevalent substance in the group aged between 40 and 49 years.

Sixty percent of the volatile substance related cases were under the age of 18. Volatile substances were detected mostly in the cases under the age of 20, as was the case in previous years.

Table 6-26: Distribution of the substances detected in the indirect DRDs by age groups

	10-19	20-29	30-39	40-49	50-59	>=60	TOTAL
OPIATES	1	20	16	12	4	2	55
CANNABIS	24	110	75	33	22	12	276
ECSTASY	10	35	29	9	5	1	89
COAINE	1	13	4	4	1	0	23
AMPHETAMINE/ METHAMPHETAMINE	2	8	3	4	1	0	18
VOLATILE SUBSTANCES	0	2	1	0	0	0	3
JWH_018/073/122	8	33	10	7	1	1	60
TOTAL	46	221	138	69	34	16	

Source: The Council of Forensic Medicine under the Ministry of Justice, 2014.

In indirect DRDs, cannabis was the most prevalent substance among the cases aged between 10 and 19 years; this was followed by ecstasy, synthetic cannabinoids, and amphetamine/methamphetamine, respectively. Cannabis was most frequent in other age groups. In the group aged between 20 and 39 years, cannabis was followed by ecstasy, opiates, synthetic cannabinoids, cocaine, and amphetamine/methamphetamine respectively. In the group aged between 40 and 49 years, cannabis was followed by opiates, ecstasy, synthetic cannabinoids, cocaine, and amphetamine/methamphetamine, respectively. Ecstasy and synthetic cannabinoids, like cannabis and opiates, were used by all age groups.

Unlike previous years, accident and homicide-related deaths ranked first and second, respectively, in terms of origins of indirect drug-related deaths. This change in the causes of deaths reveals the threat posed by the increased substance use to the social life (Table 6-21). The number of suicides was also high. Cannabis was the most prevalent substance among the cases of suicide, followed by ecstasy. It is a known fact that individuals who take ecstasy are at a greater risk of suicide. There will be a rise in the number of suicides in parallel to increased ecstasy use.

Of the foreign nationals involved in the direct DRDs in the last seven years, those from Georgia and Turkmenistan, which are located on the Northern Black Sea Route, ranked first and second, respectively. The numbers of the cases involving foreign nationals were 13 in 2007, 32 in 2008, 22 in 2009, 20 in 2010, 17 in 2011, 21 in 2012, and 32 in 2013.

SECTION 7

RESPONSES FOR HEALTH CORRELATES AND CONSEQUENCES

7.1. The Prevention of Drug-related Emergencies and Deaths

No new data.

7.2. Prevention and Treatment of Drug-related Infectious Diseases

No new data.

7.3. Responses to Other Health Correlates Among Drug Users

No new data.

SECTION 8

SOCIAL RELATIONS AND SOCIAL REINTEGRATION OF DRUG ADDICTS

Bülent ÖZCAN¹⁹

8.1. Introduction

Successful treatment for drug addiction is only possible through rehabilitation activities to be subsequently conducted. The societies where addicts have difficulty with reintegration into social life present the lowest success rates in addiction treatment. Thus, not only medical treatment, but also the activities for social reintegration are essential for a healthy society.

Though rehabilitation is an all-inclusive term that covers the entire process, a review of the literature presents other terms such as social rehabilitation, reintegration into society, or re-adaptation to social life. The concept of social reintegration, which is defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as “any social intervention designed to help individuals become new full members of their societies by means of education, employment, housing, and social relations,” covers the things to do following addiction treatment. Based on this definition, various institutions and organizations have responsibilities for ensuring full reintegration of individuals into society after medical treatment for addiction.

Pursuant to Article 38 of Single Convention on Narcotic Drugs adapted in by the United Nations in 1961: “*The Parties shall take all necessary measures for the treatment and social reintegration of drug addicts.*” The same provision is also established in the 1971 Convention on Psychotropic Substances. Article 3 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in 1988 stipulates that offenders of drug-related crimes shall also undergo measures such as treatment, aftercare, and social rehabilitation.

The European Union Drugs Strategy of 2013-2020 sets the following priority for aftercare: “*Develop and expand integrated models of care, covering the needs related to mental and/or physical health-related problems, rehabilitation, and social support in order to improve and increase the health and social situation, social reintegration, and recovery of problem and dependent drug users, including those affected by co-morbidity.*”

The European Union Action Plan on Drugs covering the period 2013-2016 establishes the following objectives and actions regarding aftercare:

¹⁹ TUBİM (Turkish Monitoring Centre for Drugs and Drug Addiction)

- Enhance the effectiveness of drug treatment and rehabilitation, including services for people with co-morbidity, to reduce the use of illicit drugs; problem drug use; the incidence of drug dependency, and drug- related health and social risks and harms and to support the recovery and social re/integration of problematic and dependent drug users;
- Focus on supporting the social re/integration including the employability of problem and dependent drug users.

Turkey's National Strategy Document on Drugs, 2013-2018 establishes following strategic objective: "develop and implement rehabilitation and social reintegration programs." The document identifies the following actions in its section on demand reduction:

- Provide rehabilitation services/programs for the rehabilitation and social reintegration of drug addicts after medical treatment;
- Introduce drug addicts to Active Labor Force Services provided by the Turkish Employment Agency (İŞKUR) for their social reintegration after medical treatment; and
- Give priority to social integration projects involving youngsters addicted to drugs as part of the Youth Projects Support Program.

As there is no established countrywide social rehabilitation structure for aftercare services in Turkey, the rate of success in drug addiction treatment is low. Because successful addiction treatment is a process that requires fully implemented social reintegration programs. Thus, in order to ensure relapse prevention, certain economic, social, and psychological factors should be redesigned in a way to make life easier for individuals who complete medical treatment programs.

45.9% of the patients whom were provided inpatient treatment in addiction treatment centers in the last five years reported that they had previous treatment experiences. 48.5% of the patients that received inpatient treatment in 2013 stated that they were previously treated for addiction at least once (See Section 5). These rates indicate the inadequacy of rehabilitation services provided after medical treatment in Turkey.

The individuals that are treated for drug addiction should undergo certain changes in their lives to prevent relapse. After completing their medical treatments for drug addiction, those who return to their previous settings where they were introduced to drugs inevitably experience relapse. Thus, either these settings should be abandoned, or the characteristics of these settings should change. As it is not always possible to leave these settings, certain changes to

be introduced into these settings and individuals themselves will help individuals permanently give up the idea of drugs.

In terms of economic status, individuals that are not regularly employed or have a low income develop addiction habits more frequently. According to the relevant data, specifically unemployed individuals with primary-school-level education constitute the group that seeks treatment at the highest rates at Research, Treatment, and Training Centers for Alcohol and Substance Addiction (AMATEMs) (See Section 5).

Regular employment plays a very important role in individuals' efforts to readapt themselves to their societies. The same applies to the school-aged youth. Risk of addiction is higher among youngsters who drop out of school or do not regularly go to school are at higher risk of addiction.

Another point that should be noted in this regard: Are these individuals unemployed (or out of school) because they use drugs, or do they use drugs because they are unemployed (or out of school)? There is no concrete study to establish the exact causal relationship between these two statuses.

All the activities covered by the term rehabilitation should be implemented not only for those who complete their medical treatments, but also for inmates or ex-inmates that are released from prison after serving their sentences. According to the results of the Survey on User Profile in Crimes Related to Addictive Substances²⁰ conducted by the Turkish Monitoring Centre for Drugs and Drug Addiction (TUBİM), out of 2,948 respondents, 44.62% (1,021) stated that they were ex-convicts, and 69.83% (713) of these ex-convicts noted that they were convicted for drug-related crimes. Nearly 45% of the offenders had previous criminal records. This rate reveals the importance of post-prison rehabilitation programs for the prevention of recidivism.

Different institutions and organizations have duties and responsibilities in the rehabilitation of drug addicts. Major activities are conducted as part of probation, which requires the imposition of compulsory measures on individuals. However, due to the high number of probationers, the program implemented as part of probation does not prove fully efficient. The Ministry of Family and Social Policies and Turkish Employment Agency (İŞKUR) conducts certain

²⁰ The Survey conducted by TUBİM's Provincial Contact Point personnel with volunteers over the age of 18. Legal actions were taken against them by law enforcement officers in line with Article 191 of the Turkish Penal Code.

activities for the reintegration of individuals into society, and their activities are reported to TUBIM and presented in this section.

8.2. Social Exclusion and Drug Use

One of the consequences inherent to drug use is social exclusion. However, when assessed in terms of a cause-and-effect relationship, there are cases where social exclusion leads to drug use.

While social exclusion is related to the codes of a society, there are subcultures in a society where drug use is already a part of life. In such a subculture, it is probable that a non-user, as opposed to a user, is isolated from the community.

The studies addressing the drug users and cultural sanctions imposed by the society on users in Turkey are not adequate. There is no relevant study reported to TUBIM.

8.3. Social Reintegration of Drug Addicts

The activities aimed at the reintegration of drug addicts into society can be conducted while the medical treatment continues, or after the treatment is completed. The main objective of social reintegration is to reestablish an individual's relationship with society as it was before addiction.

Social reintegration services address the main characteristics of drug users' social exclusion experiences, thus support treatment and prevent relapse. Nearly half (47%) of the addicts who received treatment in 2012 in Europe were unemployed, and nearly one-tenth (9%) of them lacked stable accommodation. These statistics show the significance of such services (The European Drug Report by EMCDDA, 2014:61).

In addition to psycho-social and economic support provided to individuals, society should embrace to this integration at the same rate. In such situations, individuals are frequently stigmatized as addicts, and exposed to various social and cultural exclusions.

Despite the lack of an integrated program aimed at the social reintegration of the addicts in Turkey, there are activities conducted in the areas of housing, education, and employment to ensure reintegration.

8.3.1. Housing

The majority of the drug addicts in Turkey are from low-income groups with low education backgrounds. As a natural consequence, the individuals who live on the streets or under worse conditions are at greater risk of addiction. Thus, housing is one of the fundamental problems that require a solution not only in the development of addiction but also during or after the treatment process. Yet dire economic conditions or poor prospects of finding a job due to stigmatization render the problem of housing even more complicated.

Article 40 of the Directive on the Organization and Duties of the General Directorate of Child Services under the Ministry of Family and Social Policies formulates the activities of the Social Rehabilitation Department as follows: “opening child and youth centers, monitoring and following centers for children, and protection, care, and social rehabilitation centers to ensure that children who are forced into crime/victims of crime, children living at risk on the streets and/or forced to labor on the streets, and children who need rehabilitation as a result of substance use are cared for, protected, treated, and reintegrated into society; monitoring, assessing and improving the existing centers; and preparing plans, programs and projects for providing more effective and efficient services.”

In line with this provision, the Ministry of Family and Social Services opened eight Care and Social Rehabilitation Centers²¹ in Burdur, Isparta, Erzurum, Istanbul Anatolian side, Samsun İlkadım, Ordu, and Antalya, and four Protection, Care and Rehabilitation Centers²² in Konya, Tekirdağ, İzmir, and Afyonkarahisar in 2013 for the social reintegration of drug addicts. By the end of 2013, 39 care and social rehabilitation centers, 14 protection, care, and rehabilitation centers and nine child and youth centers were operational (2013 Activity Report of the Ministry of Family and Social Services).

These centers provide various rehabilitative services such as:

- Assessing children and their families psychosocially and supporting them;

²¹ A social service organization which provides separate boarding for the male and female children between the ages of 7- 18 who have been emotionally, sexually and/or physically abused; and attempts to help the victims recover from the trauma and/or behavioral disorders caused by the adverse and unfavorable experiences. It also provides temporary support and protection until the rehabilitation process, in which measures are taken to treat their relationship with the family, immediate environment, and society, is completed.

²² A social service organization which provides separate boarding for the male and female children between the ages of 7- 18 whose tendency towards the crimes have been proved. This organization attempts to provide temporary support and protection with the purpose of helping these young people recover the behavioral disorders, until the rehabilitation process, in which measures are taken to treat their relationship with the family, immediate environment, and society, is completed.

- Supporting the psychosocial development of children and families, fulfilling housing, care, clothing, and food needs;
- Raising awareness about the significance of education, ensuring the reintegration of children into school system, conducting supportive activities for education, and satisfying education-related needs; and
- Conducting activities for the acquisition of professional skills, and social, cultural, athletic, and pastime activities.

In 2013, 495 children benefited from 14 Protection, Care and Rehabilitation Centers and 1168 children benefited from and 39 Care and Social Rehabilitation Centers.

Furthermore, 95 children addicted to drugs received care, protection, treatment, and familial and social reintegration services provided by the institutions under the Ministry of Family and Social Policies (2013 Activity Report of the Ministry of Family and Social Services).

The Ministry of Family and Social Services takes certain actions to improve the services offered by the Protection, Care, and Rehabilitation Centers, and Care and Social Rehabilitation Centers.

Ms. Ayşenur ISLAM, Minister of Family and Social Services, stated that 17 protection, care, and rehabilitation centers will be turned into “*specialized units in the fight against drugs*,”²³ which suggests that the social rehabilitation services for children will be improved.

Under the current circumstances, children of different problem groups are provided rehabilitation services in the same environment, which causes adverse interactions among children, and thus impairs the rehabilitation processes. The Protection, Care, and Rehabilitation Centers, and Care and Social Rehabilitation Centers should be specialized according to the root causes of children’s referral to institutional care, and the problems and needs of different children that are classified under different groups such as children addicted to drugs, children that are victims of sexual and commercial exploitation, and children that are victims of incest and sexual abuse. After these institutions are specialized, their personnel will have the opportunity to specialize in their own fields, as well, thus ensuring greater success in social rehabilitation.

²³ <http://www.aile.gov.tr/haberler/bakan-islam-yasam-hakini-elinden-alan-butun-girisimleri-tum-kalbimle-ianetliyorum>

8.3.2. Education

One of the most important problems encountered in the drug addiction process is the discontinuity in formal and informal education. Offering education opportunities is a significant part of the social reintegration process. Reintroducing school-aged children into the education system and organizing vocational trainings for individuals of working age will help them reach a socially satisfying level, set goals for their future, and readapt themselves into society more easily.

The Turkish Employment Agency organizes courses to train the labor force in order to help convicts/ex-convicts, which form a disadvantaged group in the labor market, and obtain employment in the professions that are demanded by the labor market. The agency opened 119 courses for convicts/ex-convicts in 2013, attended by 1,626 individuals—1,515 males and 111 females (2013 Annual Report of the Turkish Employment Agency). However, there is no data on the number of courses intended for individuals convicted for drug-related crimes.

8.3.3. Employment

Employment-related activities constitute another part of the rehabilitation processes of the individuals who completed their medical treatment for drug addiction. Employment is the most important element of a regular life that is required to prevent the relapse of a treated individual into drug habits. However, there is no integrated and systematic employment program implemented throughout Turkey.

As one of the institutions carrying out activities in this regard, The Turkish Employment Agency (İŞKUR) provides work or professional consultancy, participation to active workforce (vocational, on – the – job and entrepreneurship training programs) and work placement services to those in drug addiction treatment or in rehabilitation along with the other target groups within the context of combatting unemployment and keeping employment levels steady. However, since the individuals are not asked during the provision of these services whether they have addiction or not, the number addicts benefiting from the activities is not accurately known. But the efforts to carry out special projects and programs for this purpose, have intensified.

SECTION 9

DRUG-RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND, PRISON

Bülent DEMİRCİ²⁴

9.1. Introduction

Data from the Turkish National Police, General Command of the Gendarmerie, General Directorate of Customs Enforcement, and Coast Guard Command, which are the law enforcement units of Turkey, the relevant standard tables of EMCDDA, and data collected through the “User Profile Questionnaire for Addictive Substance Crimes: U-Form” applied at İLTEM centers (which are the contact points of TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction)) were used in preparation of this section.

9.2. Drug-Related Crimes

Several drug-related crimes are included within the scope of the drug problem. Drug-related crime, which is generally observed to be only a single crime, is actually addressed within certain sub-groups such as drug seeding/planting, production, transfer, possession, purchase, selling, and use. It also encompasses several other subjects such as chemical substances, which are used in the production of drugs and controlled by international agreements, and the laundering of drug-related illicit money. When drug-related crimes of violence, homicides, forgery, robbery, border violations, arms trafficking, and terrorism are considered, it is very clear that drug-related crimes are not simple; on the contrary they are highly complicated, international, and organized crimes.

9.3. Violation of Drug Laws

The types of crimes that fall under this section are addressed by the Turkish Law Enforcement Units within the scope of drug-related crimes and include:

- Crimes covered by the following clauses of Turkish Penal Code No.5237, dated September 26, 2004:
 - Production and trade of drugs or stimulants (Article 188 of the TPC),
 - Facilitating the use of drugs or stimulant use (Article 190 of the TPC),
 - Purchase, acceptance, or possession drugs or stimulants for use or use drugs or psychotropic substances (Article 191 of the TPC),

²⁴ TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction)

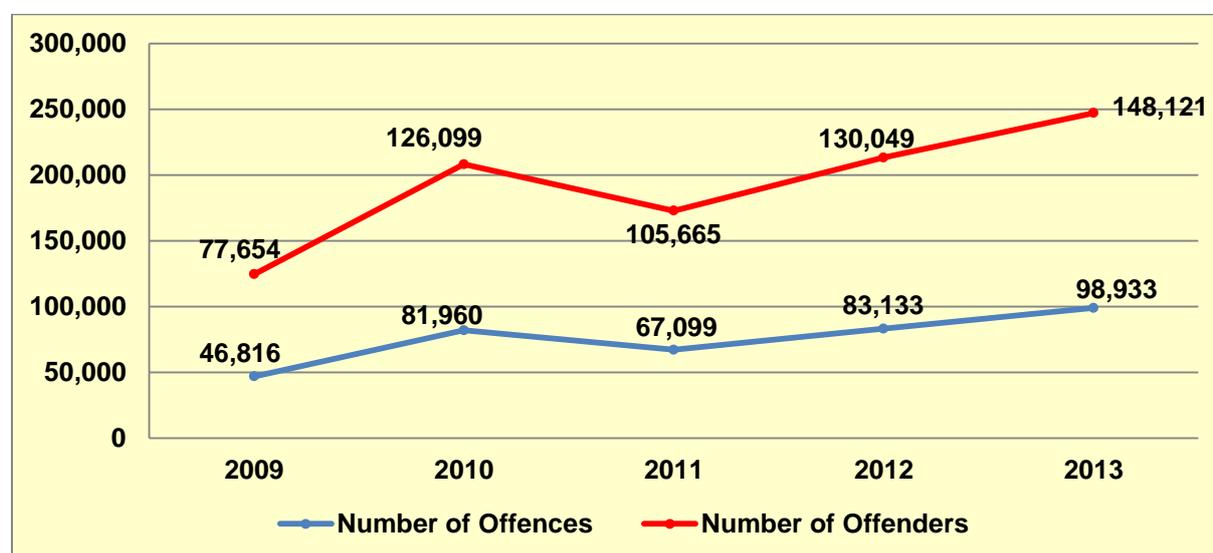
- Violation of the Law No.2313 on the Supervision of Drugs, dated June 12, 1933,
- Violation of the Law on Drugs No.3298, dated June 03, 1986.

9.3.1. Drug-Related Cases and Number of Suspects

9.3.1.1. Total Number of Cases and Suspects

In 2013, 98,933 drug-related cases occurred throughout Turkey, and 148,121 suspects were arrested in relation to these cases (EMCDDA Standard Table 11, 2014) (Graphic 9-1).

Graph 9-1: Total Number of Cases and Suspects by Year

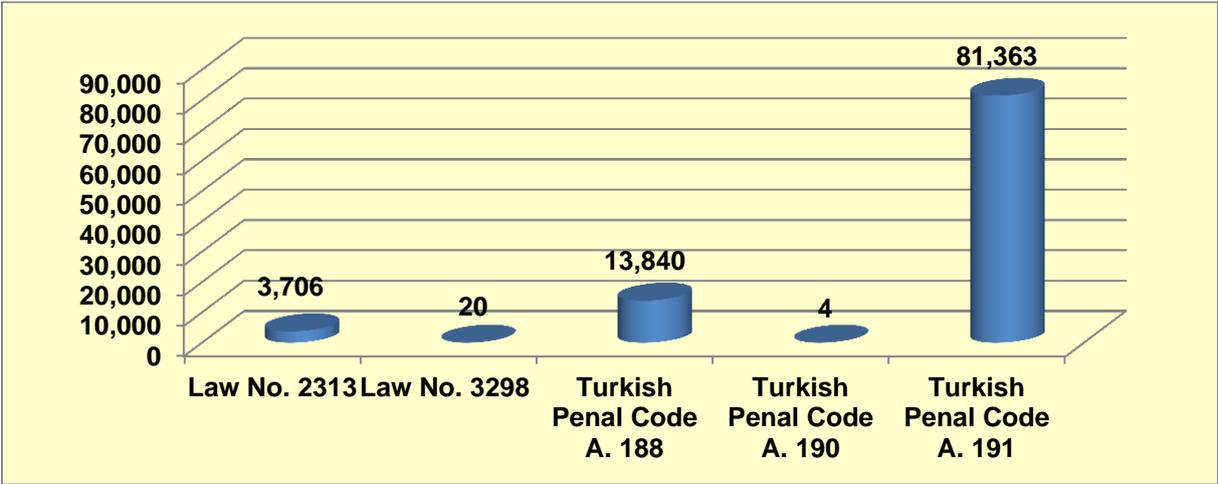


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Compared to the previous years, there was a clear increase in 2013 in terms of the number of cases and suspects. The increase in the number of cases was 19.01% compared to the previous year, while this figure was 13.90% for the number of suspects (Graphic 9-1).

A large portion of drug-related crimes in most of the European countries is related to drug use and possession with the intent to use. In a general sense, more than one million cases were estimated to be reported in Europe in 2012, and this indicates a 17% increase compared to 2006. More than two-thirds of these crimes were related to cannabis. Drug-supply crimes have increased by 28% since 2006 in Europe, and reached a figure greater than 230,000 in 2012. Cannabis, again, took the lead, as it did in possession crimes (EMCDDA European Drug Report, 2014:68, 69).

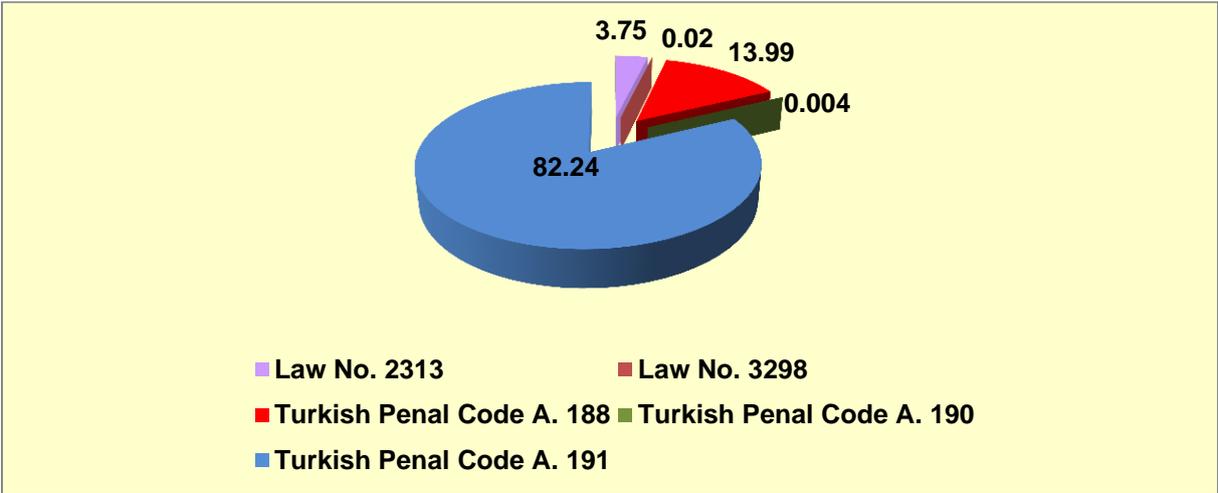
Graph 9-2: Distribution of the Number of Drug-Related Crimes according to Type of Crime



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

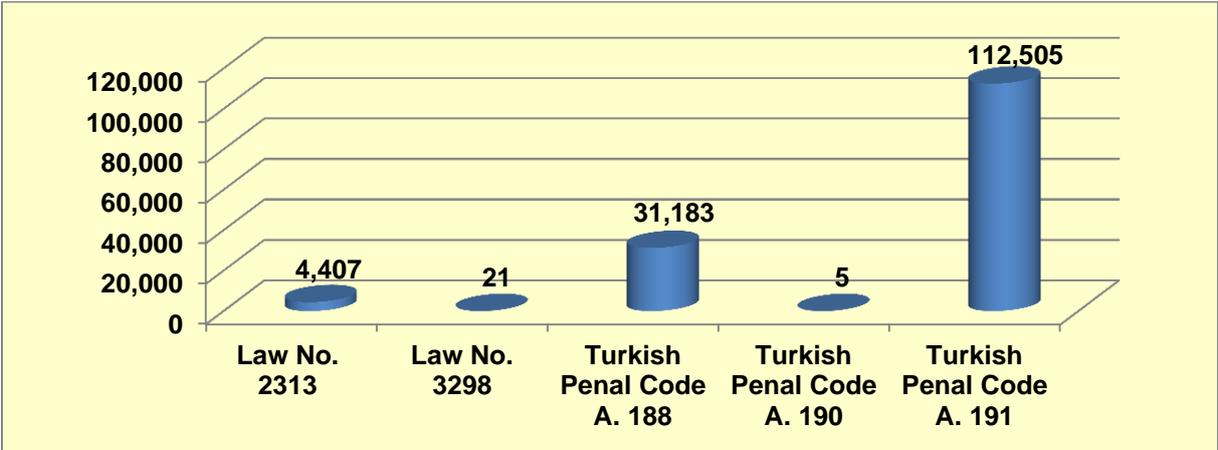
When all 98,933 drug-related cases in Turkey from 2013 are analyzed, it is clear that 81,363 cases (82.24%) were related to the purchase/acceptance/possession of drugs with the intent to use (Article 191 of the TPC); 13,840 (13.99%) cases were related to the production and trade of drugs (Article 188 of the TPC); four cases were related to facilitating drug use (Article 190 of the TPC); 3,706 cases (3.75%) were related to the violation of the Law on the Supervision of Drugs No.2313; and 20 cases (0.02%) were related to the violation of the Law on Drugs No.3298 (EMCDDA Standard Table 11, 2014) (Graphic 9-2, Graphic 9-3).

Graph 9-3: Distribution of the Number of Drug-Related Cases according to Type of Crime (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

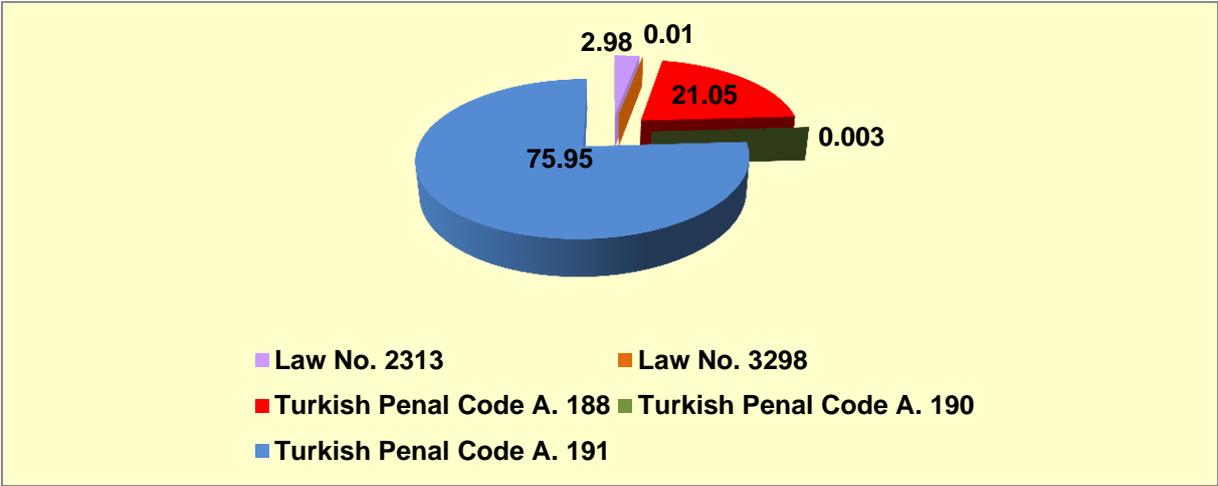
Graph 9-4: Distribution of the Number of Drug-Related Suspects according to Type of Crime (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the crime-related distribution of all 148,121 suspects arrested in Turkey in 2013 is analyzed, it is clear that 112,505 suspects (75.95%) were arrested for the purchase/acceptance/possession of drugs with the intent to use (article 191 of TPC); 31,183 suspects (21.05%) for the production and trade of drugs (Article 188 of the TPC); five suspects (0.01%) for facilitating the use of drugs (Article 190 of the TPC); 4,407 suspects (2.98%) for the violation of the Law on the Supervision of Drugs No.2313; and 21 suspects (0.01%) for violation of the Law on Drugs No.3298 (EMCDDA Standard Table 11, 2014) (Graphic 9-4, Graphic 9-5).

Graph 9-5: Distribution of the Number of Drug-Related Suspects according to Type of Crime (%)

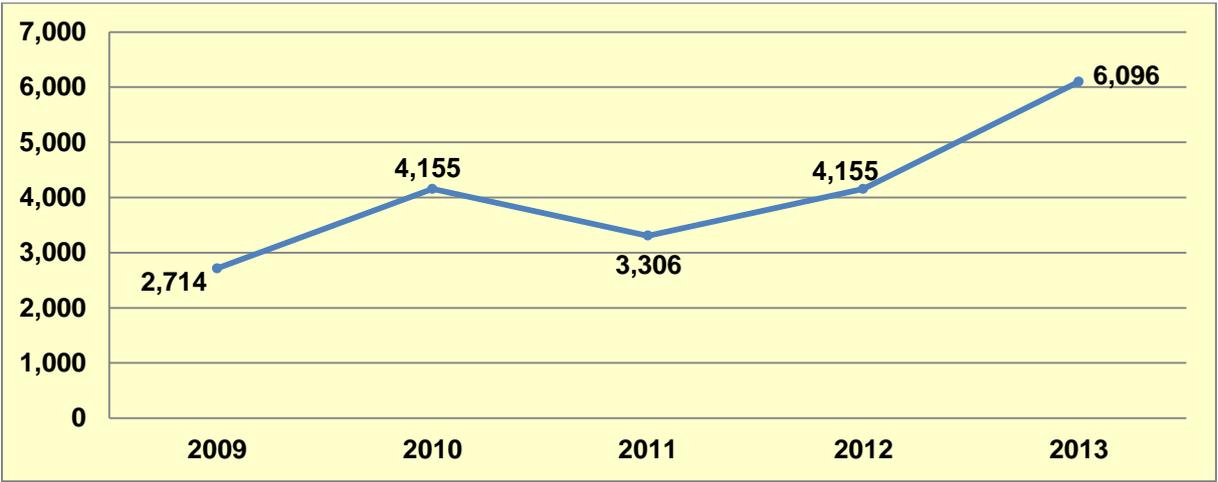


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

9.3.1.2. Heroin

In 2013, 6,096 heroin-related cases were recorded in Turkey, and 9849 suspects were arrested in these cases.

Graph 9-6: Total Number of Heroin-Related Cases by Year

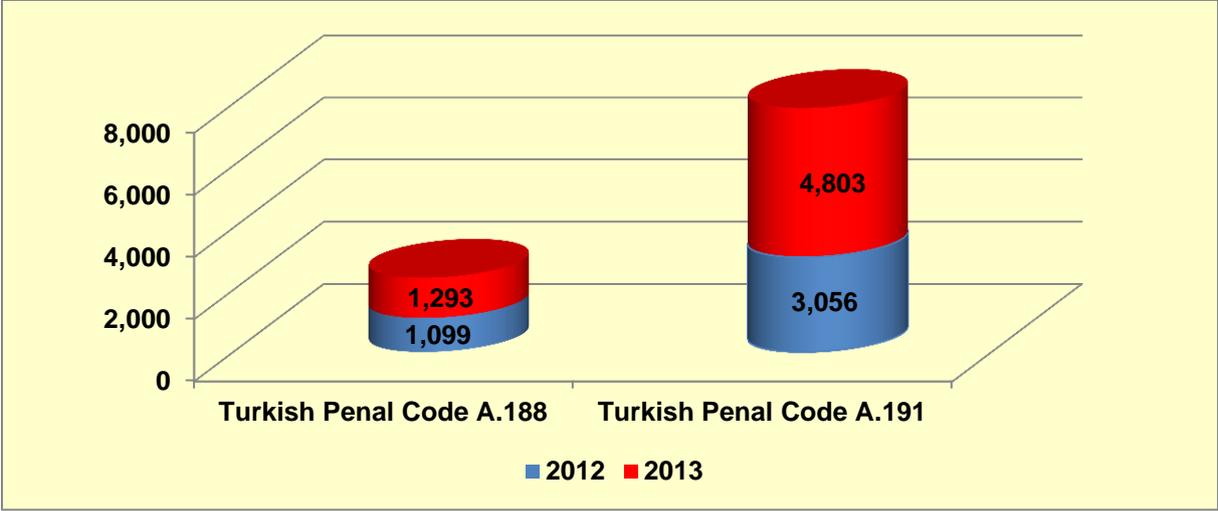


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

A constant increase has been observed in the number of heroin-related crimes since 2011. The number of heroin-related cases increased by 46.71% in 2013, compared to 2012, which is a serious rate of increase (Graph 9-6). With this increase in the number of heroin-related

cases in 2013, the number of heroin-related suspects also increased by 34.02% compared to the previous year.

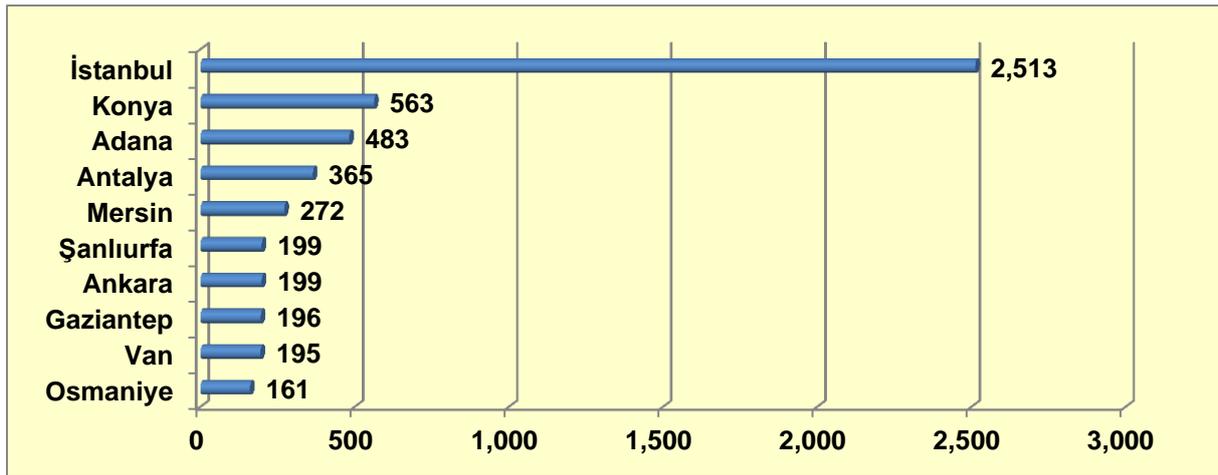
Graph 9-7: Distribution of the Number of Heroin-Related Cases according to the Type of Crime



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It was observed that 78.79% of the heroin-related cases (4803) in 2013 were related to the purchase/acceptance/possession of drugs with the intent to use (Article 191 of the TPC), while 21.21% (1293) were related to the production and trade of drugs (Article 188 of the TPC) (Graphic 9-7). An approximately 5% increase was observed in 2013 related to the purchase/acceptance/possession of drugs with the intent to use (Article 191 of the TPC) compared to the previous year.

Graph 9-8: Distribution of the Number of Cases According to Ten Cities with the Highest Number of Heroin Cases in 2013



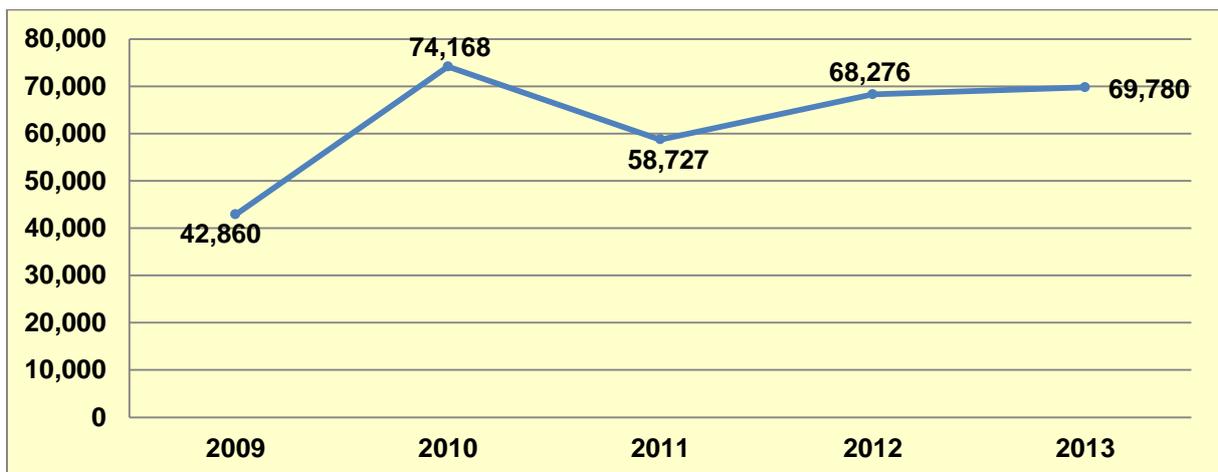
Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the distribution pattern of heroin-related cases in 2013 according to city in Turkey is analyzed, it is clear that the cases were very dense in Istanbul, the population of which is greater than the other cities, and that 41.22% of the cases (2,513) occurred in this city (Graphic 9-8).

9.3.1.3. Cannabis

In 2013, there were 69,780 cannabis-related cases in Turkey, and 106,390 suspects were arrested in these cases.

Graph 9-9: Total Number of Cannabis-Related Cases by Year



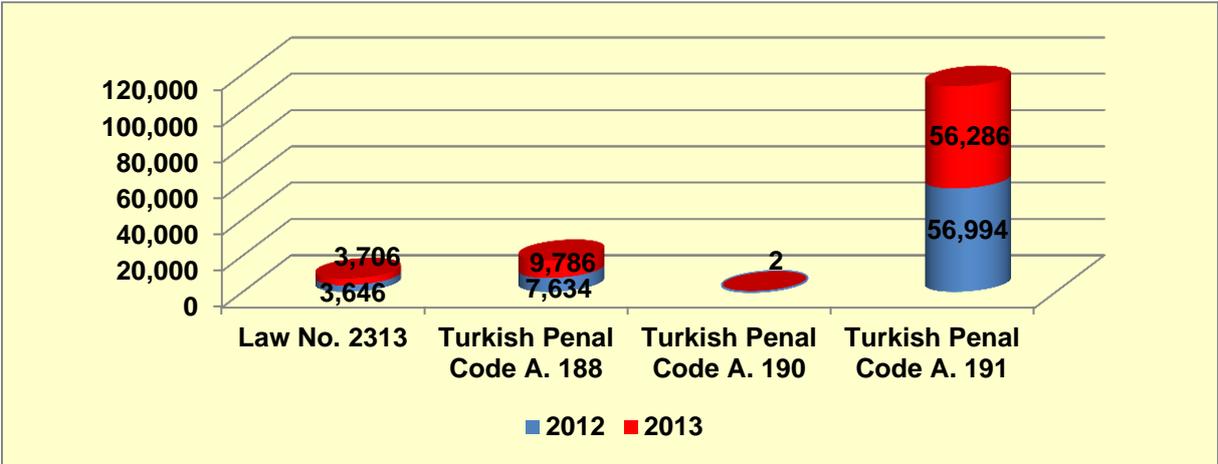
Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the number of cannabis-related cases is considered by year, it is clear that recent years have witnessed a constant increase until 2011, in which a decrease was observed compared to 2010. In 2013, the number of cannabis-related cases increased by 2.20% compared to the previous year (Graphic 9-9).

Even though an increase was observed in the number of cannabis-related cases in 2013, there was a 1.02% decrease in the number of suspects.

Cannabis-related crimes constitute a majority of the drug-use crimes throughout the world (UNODC World Drug Report, 2014). Most of the cannabis-related cases in Turkey were related to the purchase/acceptance/possession with the intent to use the drug. The reason behind that is deemed to be the fact that cannabis produced in Turkey is consumed in Turkey. There is no evidence to prove that the cannabis produced in Turkey is exported.

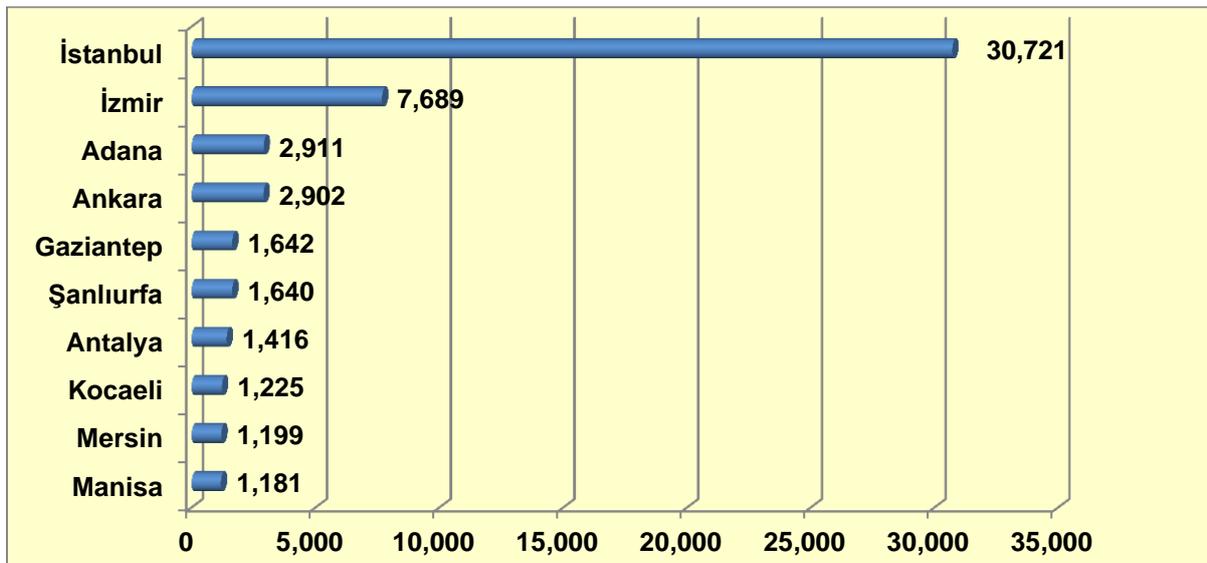
Graph 9-10: Distribution of the Number of Cannabis-Related Cases according to the Type of Crime



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It was observed that 80.66% of cannabis-related cases (56,286) in 2013 were related to the purchase/acceptance/possession of the drug with the intent to use; 14.02% (9786) were related to the production and trade of drugs; two cases were related to facilitating use; and 5.31% (3,706) were related to the violation of the Law on Supervision of Drugs No.2313 (Graphic 9-10).

Graph 9-11: Distribution of the Number of Cases According to the Ten Cities with the Highest Number of Cannabis Cases in 2013



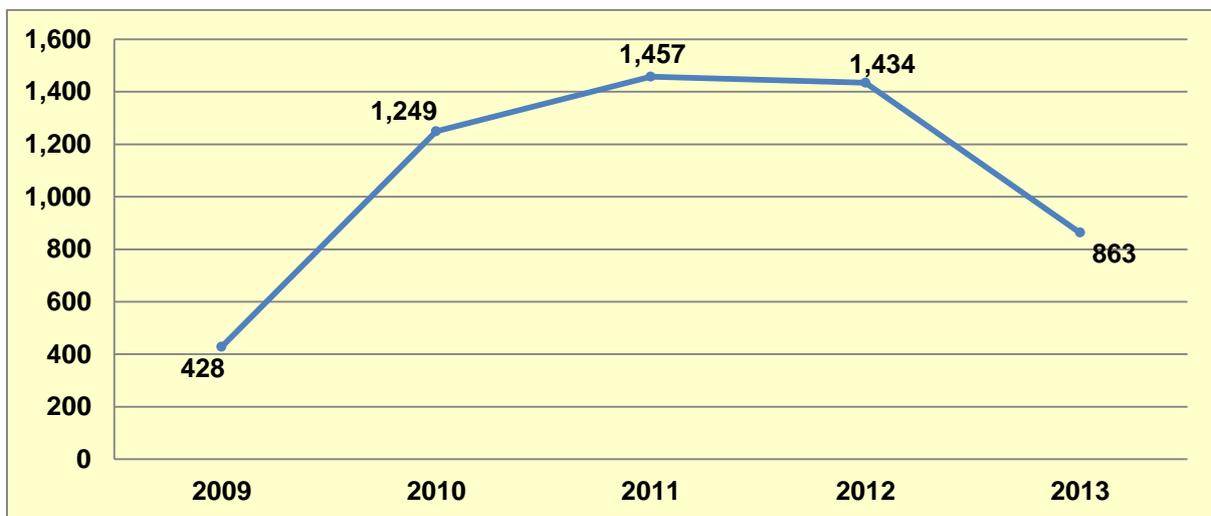
Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It is observed that cannabis-related cases in Turkey in 2013 generally occurred in Istanbul and Izmir, at rates of 44.03% (30,721) and 11.02% (7,689), respectively (Graphic 9-11).

9.3.1.4. Cocaine

In 2013, there were 863 cocaine-related cases in Turkey, and 1288 suspects were arrested in these cases.

Graph 9-12: Total Number of Cocaine-Related Cases by Year

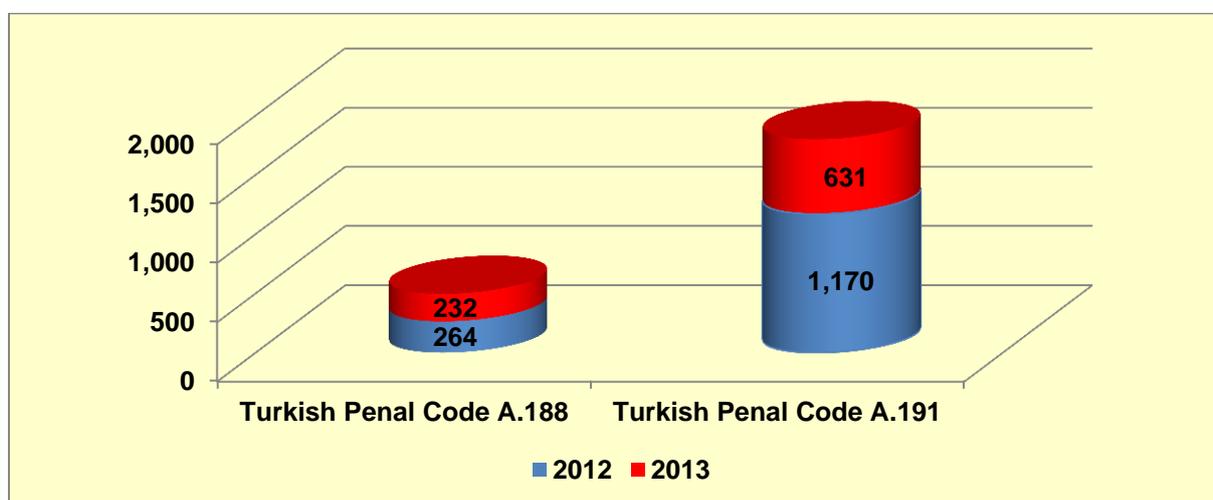


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Even though Turkey experienced a constant increase in the number of cocaine-related cases, in 2012 and 2013, a decrease was observed. This decrease in 2013 was 39.82% compared to the previous year, and it is deemed to be a significant figure (Graphic 9-12). Cocaine seizure rates are decreasing in EU countries as well (EMCDDA European Drug Report, 2014:22).

In accordance with this decrease in the number of cases in 2013, a 35.24% decrease was also observed in the number of suspects, compared to the previous year.

Graph 9-13: Distribution of the Number of Cocaine-Related Cases according to the Type of Crime

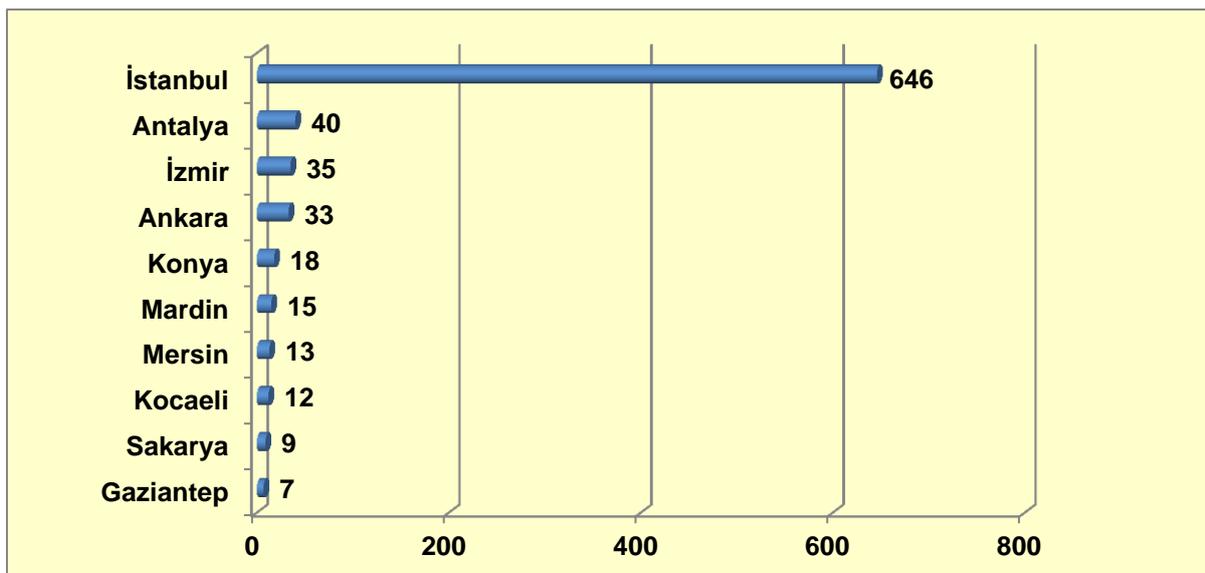


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It was observed that 73.12% of the cocaine cases (631) in 2013 were related to the purchase/acceptance/possession of drugs with the intent to use, while 26.88% (232) were related to the production and trade of drugs (Graphic 9-13).

It is clear that a great portion of cocaine-related cases in Turkey were related to the purchase/acceptance/possession of drugs with the intent to use, as was the case with cannabis.

Graph 9-14: Distribution of the Number of Cases According to the Ten Cities with the Highest Number of Cocaine Cases in 2013



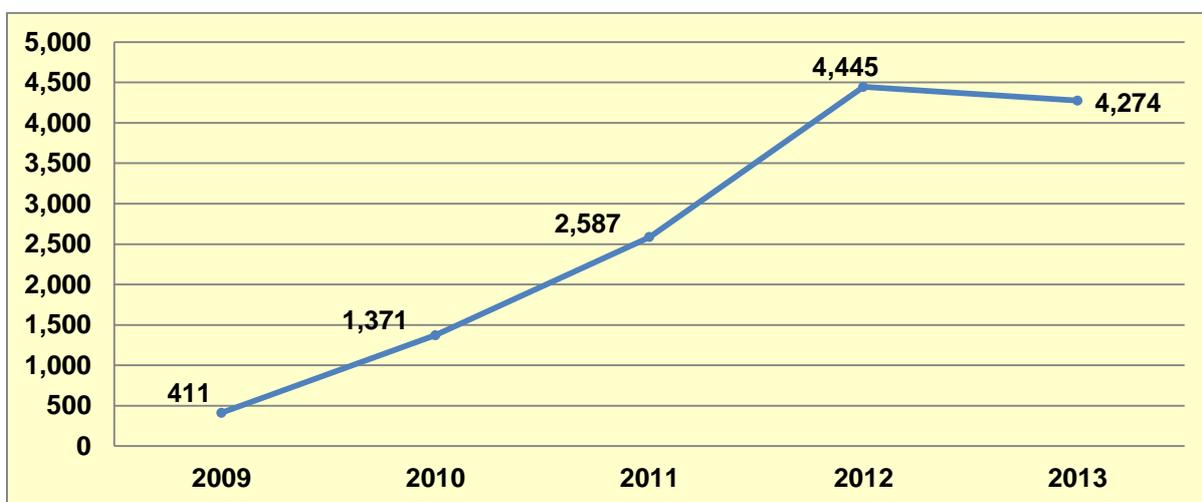
Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the cocaine-related cases are addressed at a provincial level, it is observed that the number of cases grew in Istanbul, and 74.86% of the cases (646) occurred in this city (Graphic 9-14).

9.3.1.5. Ecstasy

In 2013, there were 4,274 ecstasy-related cases in Turkey, and 6,271 suspects were arrested in these cases.

Graph 9-15: Total Number of Ecstasy-Related Cases by Year

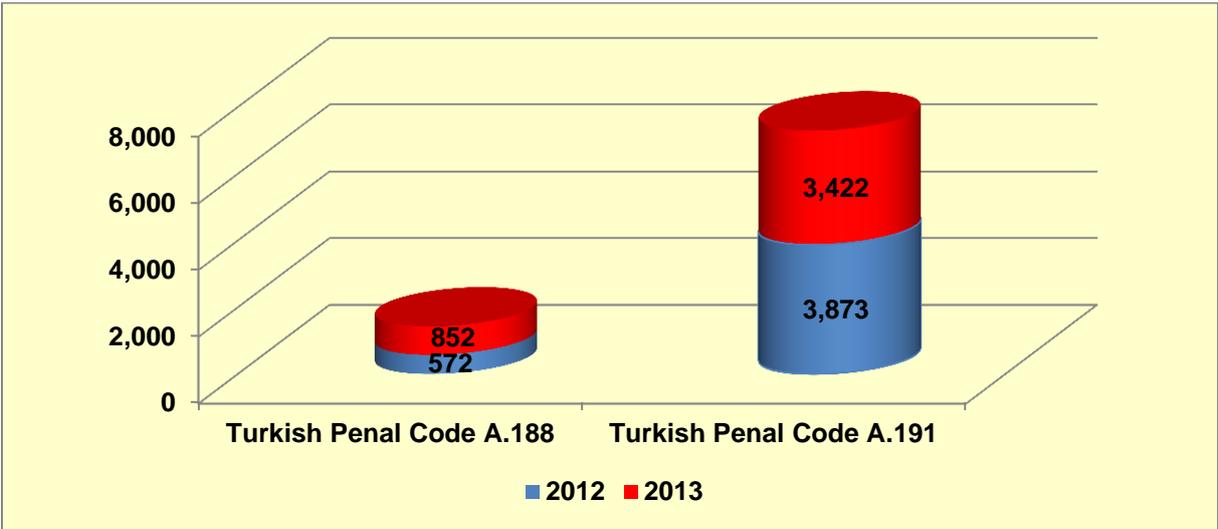


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The number of ecstasy-related cases in 2013 slightly decreased (3.85%) in 2013 compared to the previous year (Graphic 9-15).

Parallel to this decrease in the number of ecstasy-related cases, the number of suspects decreased by 0.89%, as well.

Graph 9-16: Distribution of the Number of Ecstasy-Related Cases according to the Type of Crime

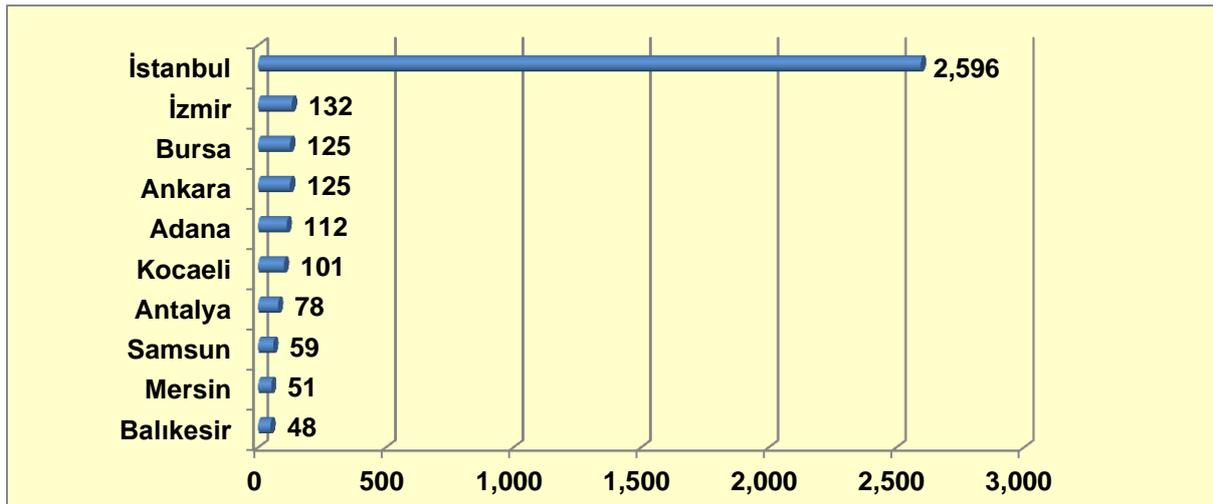


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It was observed that 80.07% of ecstasy-related cases (3422) in 2013 were related to the purchase/acceptance/possession of drugs with the intent to use, while 19.93% (852) were related to the production and trade of drugs (Graphic 9-16).

It is clear that a large portion of ecstasy-related cases in Turkey were related to the purchase/acceptance/possession of drugs with the intent to use, as was the case with cannabis and cocaine. The reason behind this result is deemed to be the fact that Turkey is a target country for ecstasy trafficking, and that most of the cases are directed at the domestic market.

Graph 9-17: Distribution of the Number of Cases According to the Ten Cities with the Highest Number of Ecstasy-Related Cases in 2013



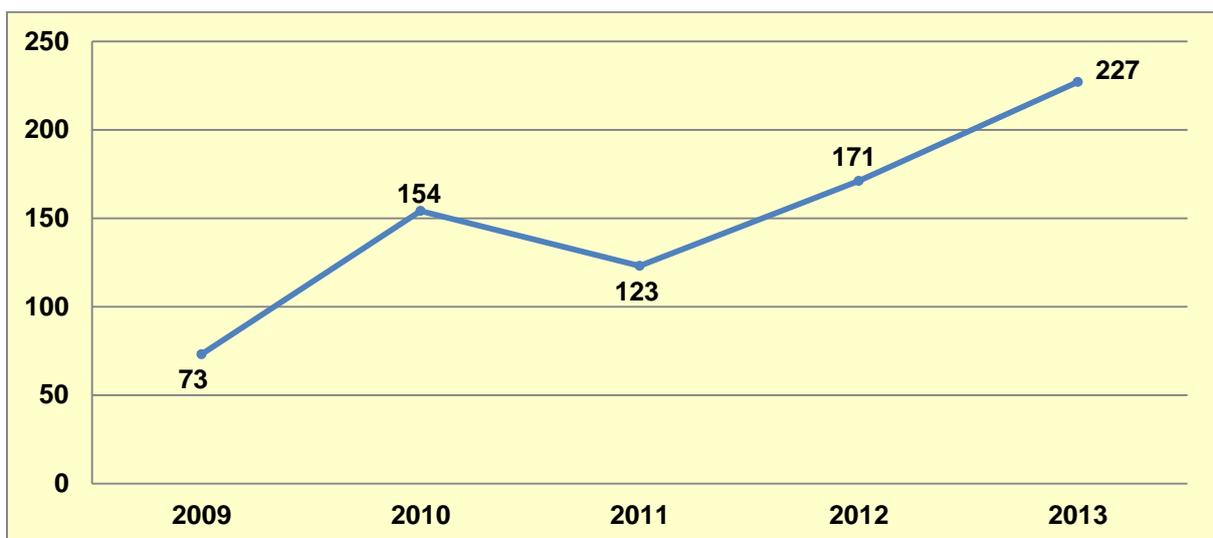
Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When we consider the distribution of ecstasy-related cases in 2013 according to city, it is observed that a large portion of the cases (60.74%; 2,596) occurred in Istanbul (Graphic 9-17). It is clear that ecstasy-related cases are generally seen in metropolitan areas.

9.3.1.6. Captagon

In 2013, there were 227 captagon²⁵-related cases in Turkey, and 380 suspects were arrested in these cases.

Graph 9-18: Number of Captagon-Related Cases by Year



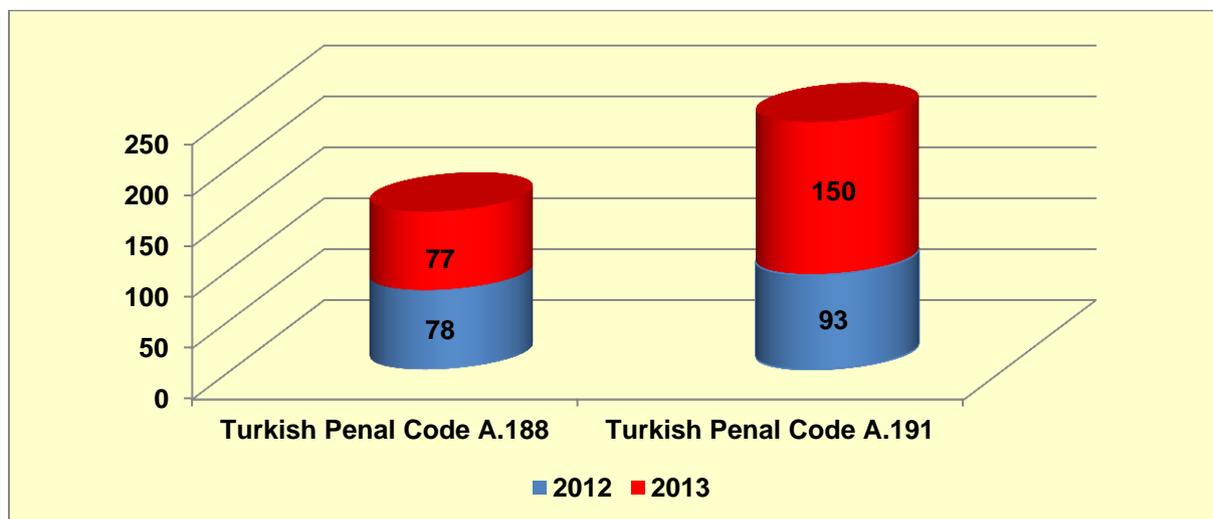
²⁵ Tablets, which have the appearance and logo of captagon, and contain amphetamine as the active ingredient.

Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Despite the constant increase in the number of captagon-related cases in the recent years, a 20.13% decrease was observed in 2011 compared to the previous year. However, in 2013, a 32.75% increase was observed in the number of captagon-related cases, similar to the increase in 2012 (Graphic 9-18).

Parallel to this increase in the number of cases in 2013, number of suspects increased by 36.69%, as well.

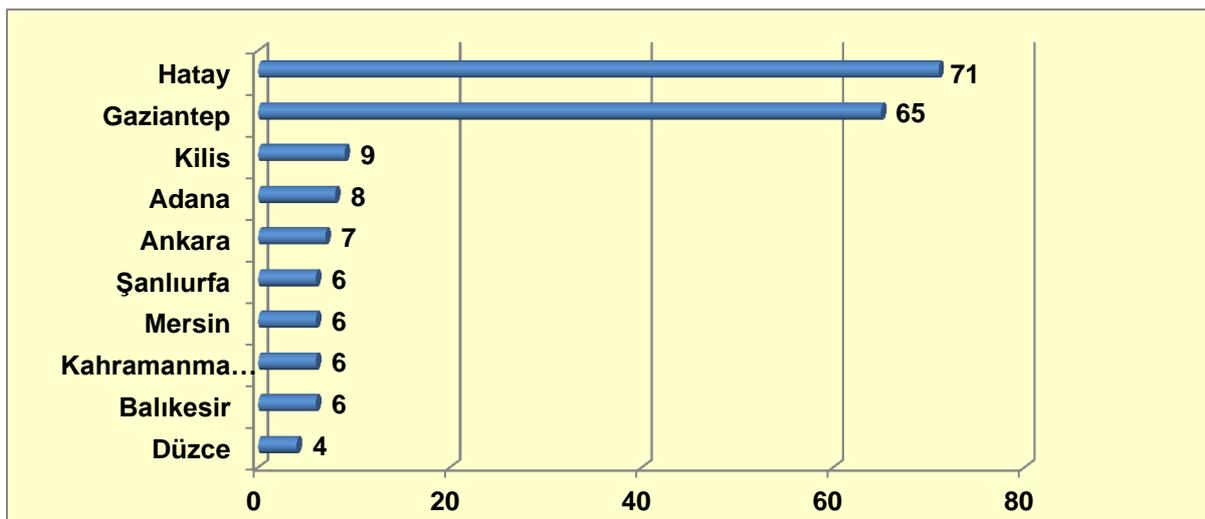
Graph 9-19: Distribution of the Number of Captagon-Related Cases according to the Type of Crime



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It is observed that 66.08% of captagon-related cases (150) in 2013 were related to the purchase/acceptance/possession of drugs with the intent to use, while 33.92% (77) were related to the production and trade of drugs (Graphic 9-19).

Graph 9-20: Distribution of the Number of Cases According to the Ten Cities with the Highest Number of Captagon-Related Cases in 2013



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

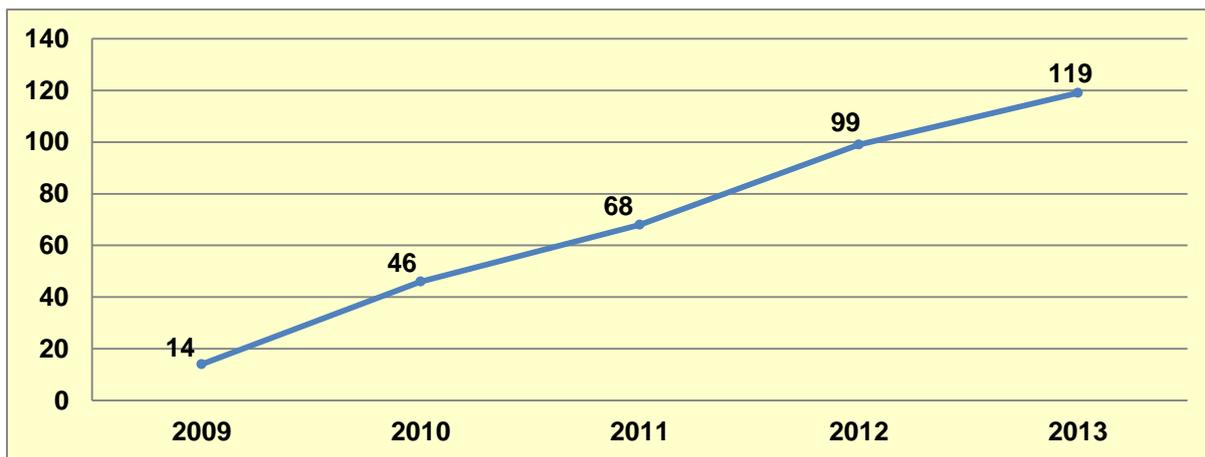
When the captagon-related cases in 2013 are considered at a provincial level, it is clear that the number of cases in Hatay and Gaziantep were greater compared to the other cities, and that 31.28% (71 cases) of captagon-related cases occurred in Hatay and 28.63% (65 cases) in Gaziantep (Graphic 9-20).

According to the results, 66.52% of captagon-related cases (151) in Turkey in 2013 occurred in the cities sharing borders with Syria, due to the fact that the target region of this substance is generally Middle Eastern countries (Graphic 9-20).

9.3.1.7. Methamphetamine

The number of methamphetamine-related cases, which have been observed in Turkey since 2009, increases constantly. In 2013, there were 119 methamphetamine-related cases in Turkey, and 197 suspects were arrested in these cases.

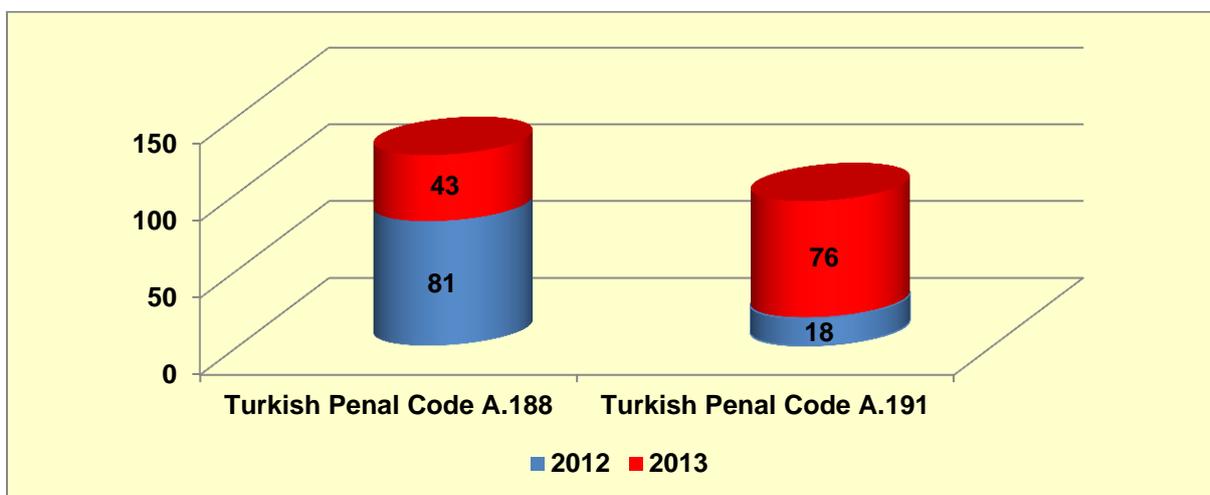
Graph 9-21: Number of Methamphetamine-Related Cases by Year



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

In 2013, the number of methamphetamine-related cases increased by 20.20% compared to the previous year (Graphic 9-21). Additionally, the number of suspects increased by 2.07% compared to 2012.

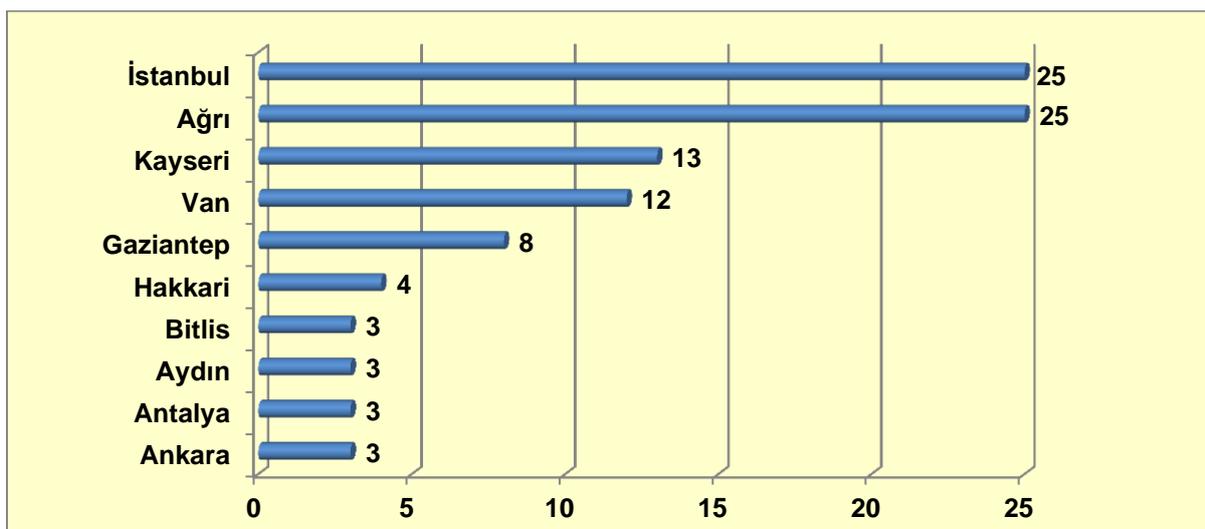
Graph 9-22: Distribution of the Number of Methamphetamine-Related Cases according to the Type of Crime



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It was observed that 63.87% of methamphetamine-related cases (76) in 2013 were related to the purchase/acceptance/possession of drugs with the intent to use, while 36.13% (43) were related to the production and trade of drugs (Graphic 9-22).

Graph 9-23: Distribution of the Number of Cases According to the Ten Cities with the Highest Number of Methamphetamine-Related Cases in 2013



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When we analyze the distribution of the methamphetamine-related cases in 2013 by city, we can see that the largest portion of the cases occurred in İstanbul, Ağrı, Kayseri, and Van, at rates of 21.01% (25), 21.01% (25), 10.92% (13), and 10.08% (12), respectively (Graphic 9-23).

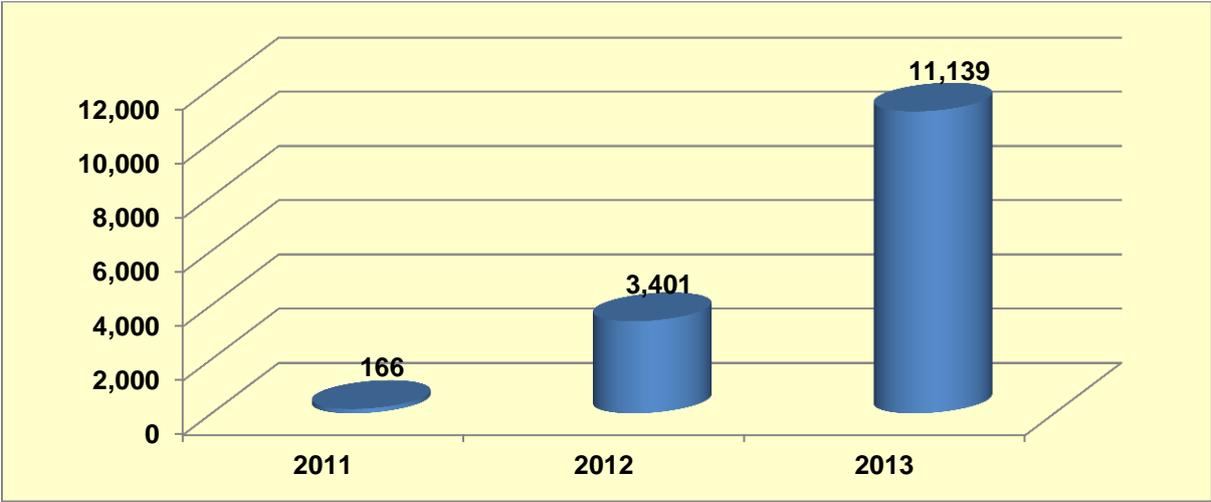
Due to the prevalence of methamphetamine seizures that also performed in the provinces other than Van in Turkey; when the methamphetamine-related cases in Turkey are considered, it is clear that the methamphetamine produced in the Islamic Republic of Iran enters Turkey through eastern borders and is shipped from İstanbul to Far East countries via airline.

9.3.1.8. Synthetic Cannabinoids (Bonsai, etc...)

Synthetic cannabinoids were first seen in Turkey in the middle of 2010 as “Bonsai” (JWH-018) and have been spreading rapidly in various forms. In early 2011, they were covered by the scope of the Law on the Supervision of Drugs No.2313, dated June 12, 1933, as a result of the Early Warning System (EWS) studies of National Working Group, conducted under the coordination of TUBİM. Between 2011 and October 2014, a total of 125 synthetic cannabinoid types were seized within the scope of Law No.2313.

In 2013, there were 11,139 synthetic cannabinoid-related cases in Turkey, and 15,065 suspects were arrested in these cases.

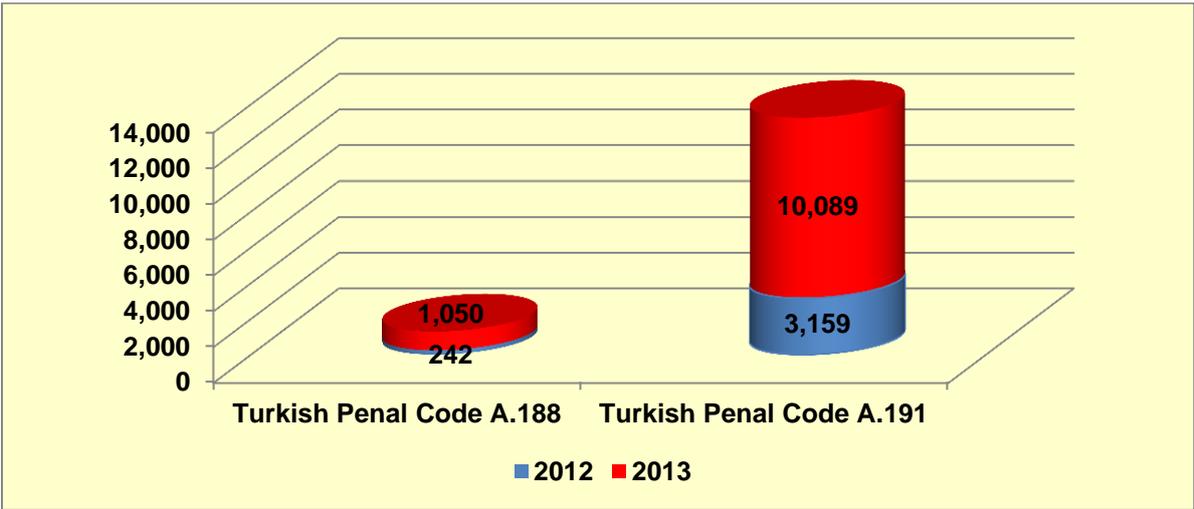
Graph 9-24: Number of Synthetic Cannabinoid-Related Cases by Year



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

In 2013, the number of synthetic cannabinoid-related cases increased by 66-fold compared to 2011, the first year of seizure in Turkey, while the number of suspects increased by 182-fold. This significant increase in both the number of cases and suspects indicates that synthetic cannabinoids are rapidly becoming popular in Turkey.

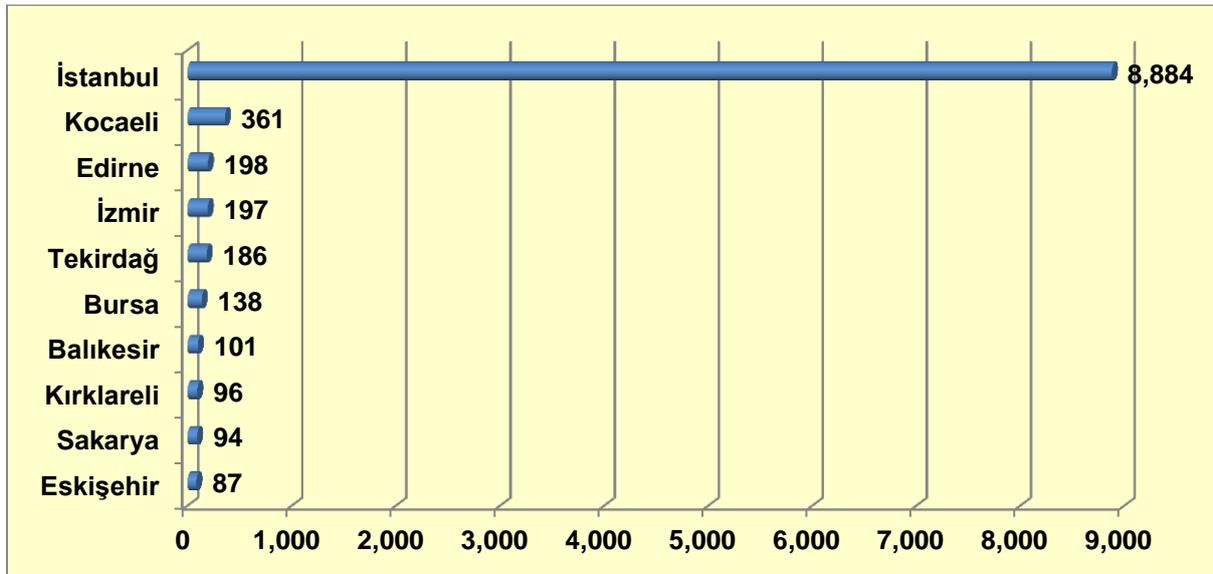
Graph 9-25: Distribution of the Number of Synthetic Cannabinoid-Related Cases according to the Type of Crime



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It is observed that 90.57% of synthetic cannabinoid-related cases (10089) in 2013 were related to the purchase/acceptance/possession of drugs with the intent to use, while 9.43% (1050) were related to production and trade of drugs (Graphic 9-25).

Graph 9-26: Distribution of the Number of Cases According to the Ten Cities with the Highest Number of Synthetic Cannabinoid-Related Cases in 2013

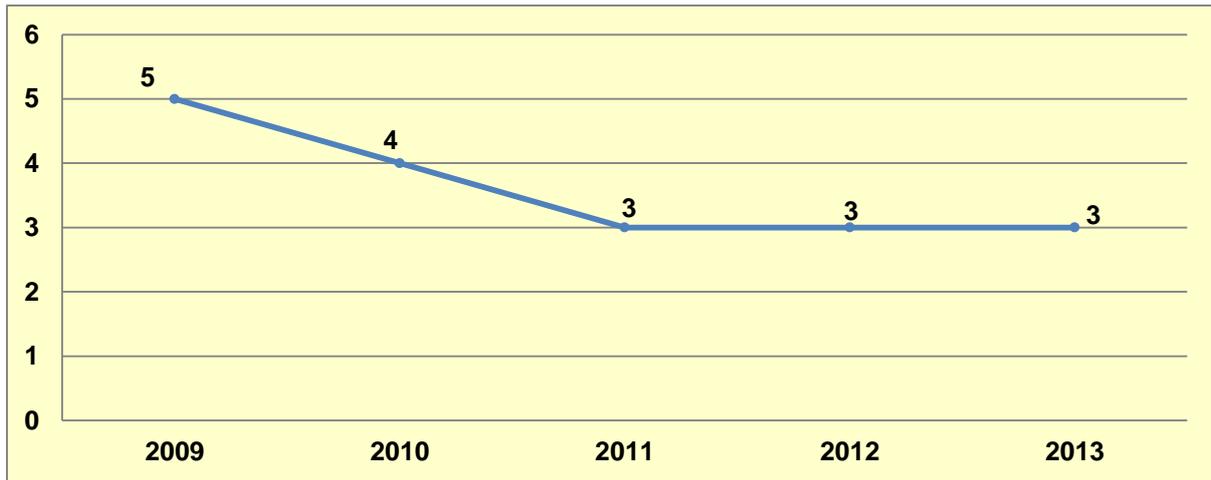


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

In 2013, 79.76% of synthetic cannabinoid-related cases (8,884) in Turkey occurred in Istanbul. Furthermore, it is clear that 90.30% of synthetic cannabinoid-related cases (10,058) were observed in the cities of the Marmara Region, which is a point of entry between Europe and Turkey (Graphic 9-26).

9.3.1.9. Acetic Anhydride

Graph 9-27: Number of Acetic Anhydride-Related Cases by Year



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

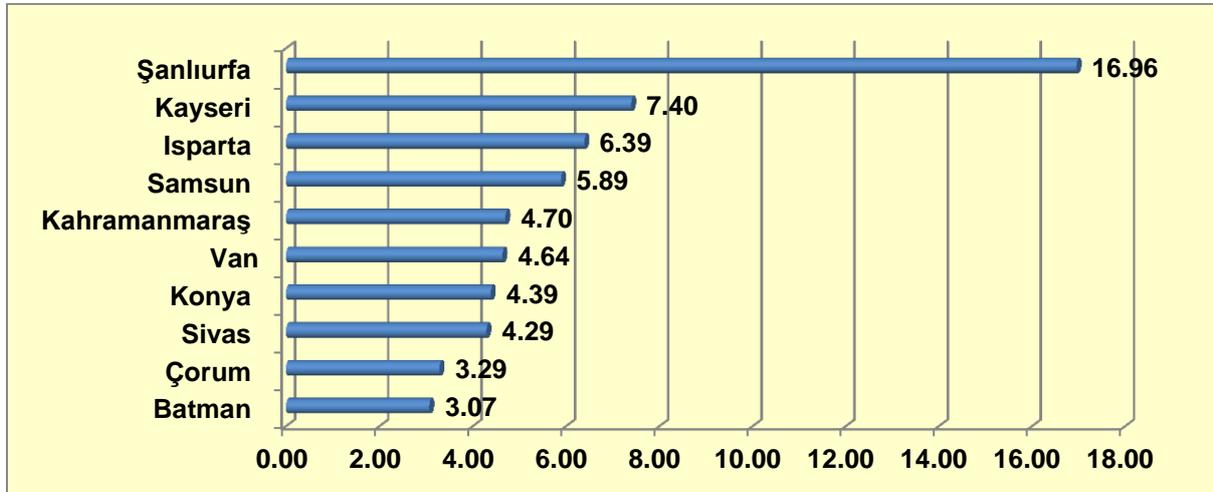
Acetic anhydride substances are seized in a limited number of cases in Turkey. No increase or decrease was observed in terms of acetic anhydride-related cases in 2013, compared to 2011 and 2012; there were only three cases in 2011, 2012, and 2013 (Graphic 9-27). A total of 7 suspects were arrested in those cases in Edirne, Istanbul, and Hakkari.

9.3.2. User Profile Questionnaire for Addictive Substance Crimes (U-Form)

A questionnaire study that covers volunteers older than 18 years of age, who have been charged with the purchase, acceptance, or possession of drugs (Article 191 of the TPC) within the same year, was conducted by TUBİM personnel, who are also the contact points in cities.

The face-to-face interview technique was used in this study, which is called the User Profile Questionnaire for Addictive Substance Crimes (U-Form). The objective of this study is to create a general profile of drug users in Turkey. This study is deemed to be a very important tool in the determination of the reasons for drug use in scientific terms. The results obtained through this questionnaire are used to develop strategies for fighting drug use, and especially in the field of prevention.

Graph 9-28: Number of Questionnaires according to the Ten Cities that Completed the Highest Number of U-Forms in 2013 (%)

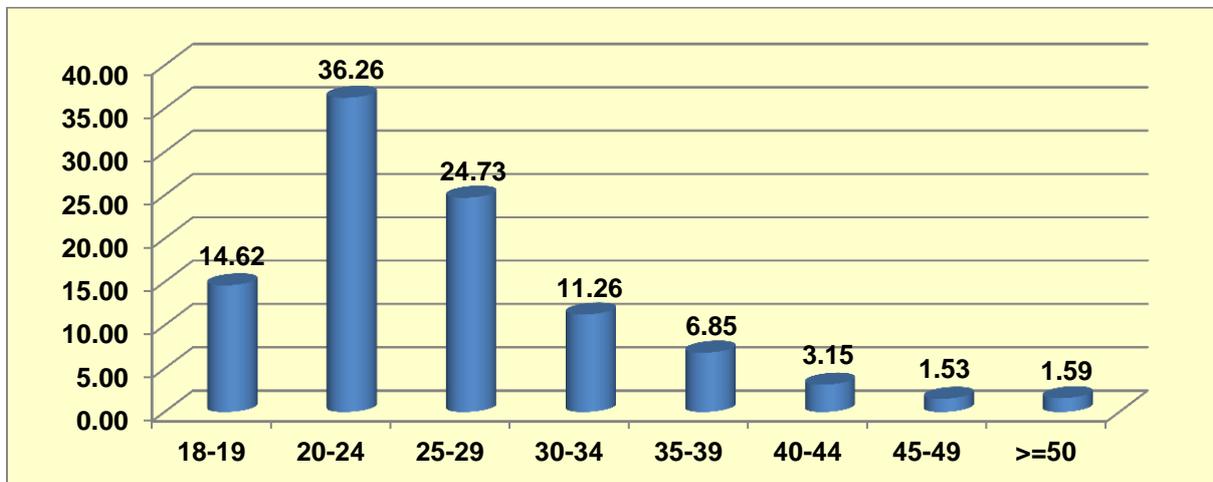


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The ten cities that completed the most number of U-Forms in 2013 are illustrated in Graphic 9-28. However, the high number of forms does not necessarily indicate a high number of drug addicts in these cities. The above-mentioned form is not used on each user charged within the scope of Article 191 of the TPC due to several reasons, including the workload and inadequate number of personnel as two of the top reasons.

The data obtained from the “User Profile Questionnaire for Addictive Substance Crimes (U-Form)” gathered from 2,948 persons in 2013 were as follows:

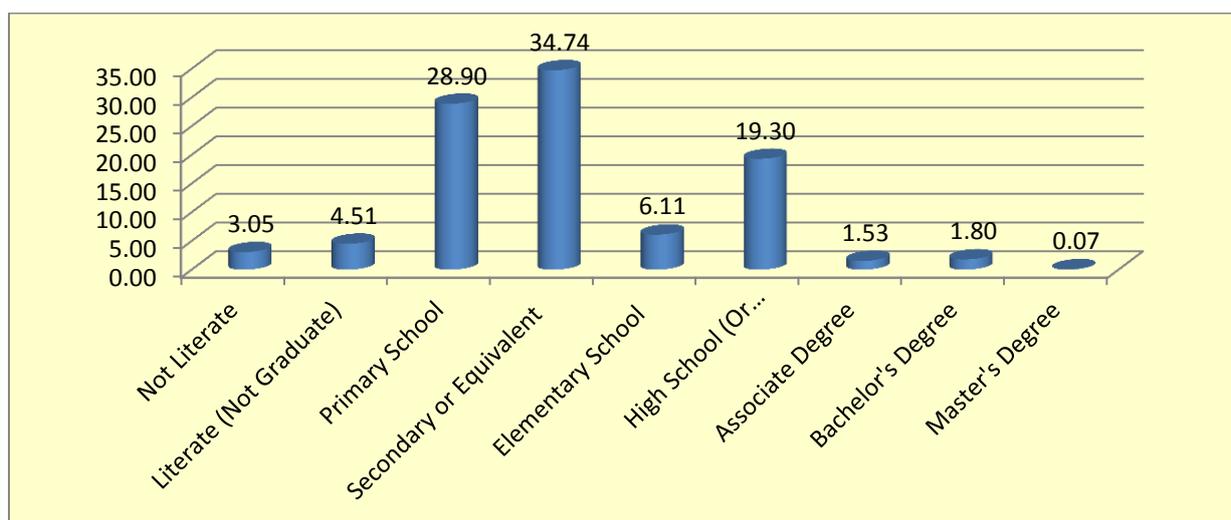
Graph 9-29: Distribution of Drug Users According to Age Range (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the data from the U-Form, the average age of drug users was 26.33 years. Nevertheless, a large portion of the drug users who completed the questionnaire were observed to be within the age range of 18-29 years (75.61%) (Graphic 9-29).

Graph 9-30: Distribution of Drug Users According to Education Level (%)

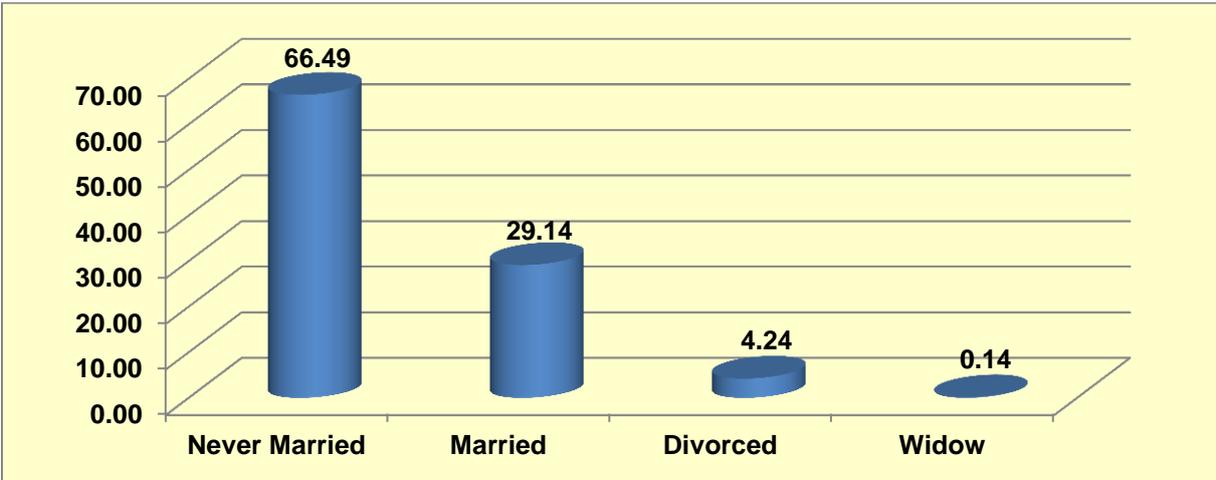


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It is observed that large portion of drug users (69.76%) were primary school / secondary school / elementary school graduates (Graphic 9-30). However, this should not be interpreted as drug use being prevalent among people with low levels of education. According to the results of the TUBİM GPS Survey²⁶, no statistically significant relationship is present between education level and drug use.

²⁶ Attitude and Behavior Survey on Tobacco, Alcohol and Drug Use in the General Population (Turkey) (TUBİM GPS Survey) was carried out by TUBİM in 2011 in 25 provinces determined by the Turkish Statistical Institute (TUIK) using face-to-face interview method. A total of 8,045 persons were interviewed during the survey.

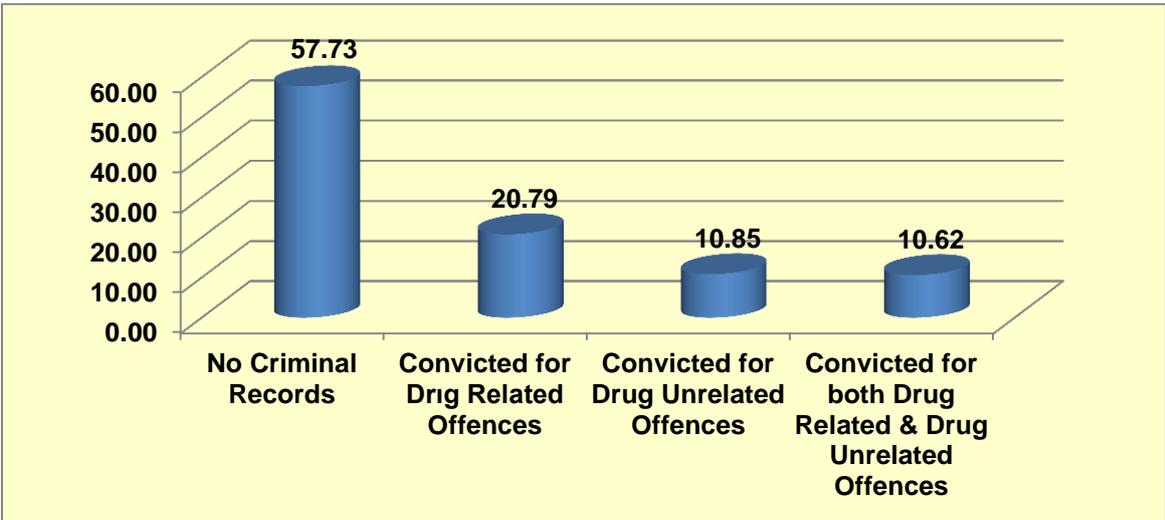
Graph 9-31: Distribution of Drug Users According to Marital Status (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the data gathered from the U-Form, a large portion of the drug users have never been married (66.49%) (Graphic 9-31). According to the data of TÜİK (Turkish Statistical Institute), 27.38% of the people above the age of 15 have never been married, while 63.92% are married. Based in these results, we can claim that a large portion of the population is married (63.92%) while the large portion of drug users have never been married; this indicates that drug use is more prevalent among single people, compared to those who are married. The TUBİM GPS survey also illustrates a statistically significant relationship between marital status and drug use.

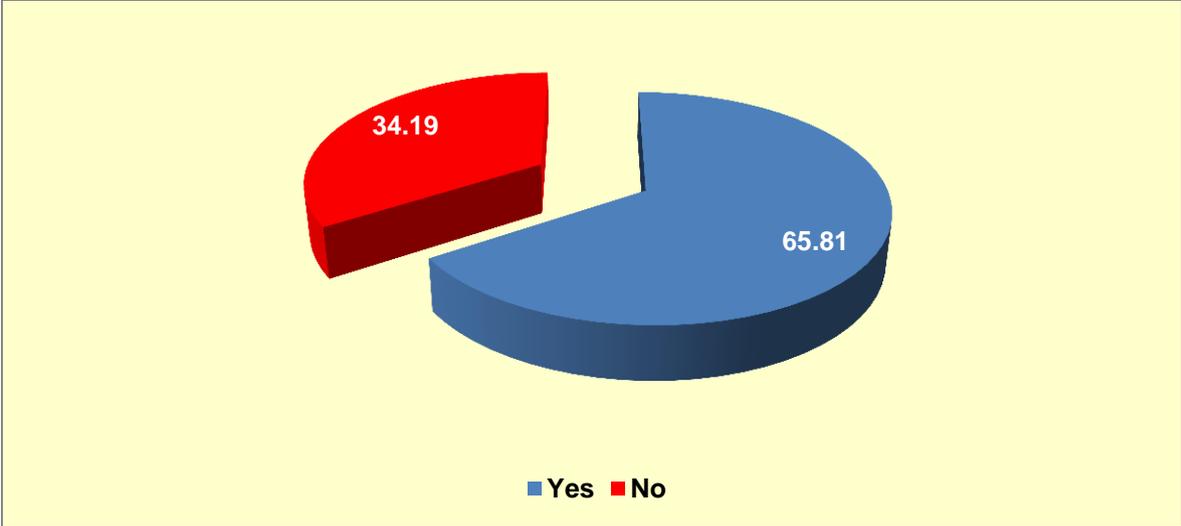
Graph 9-32: Distribution of Drug Users According to Criminal Records (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It is observed that 57.73% of drug users had no criminal records, while 42.27% had criminal records. This result indicates the invalidity of the approach that suggests higher drug use prevalence among people with previous criminal records (Graphic 9-32).

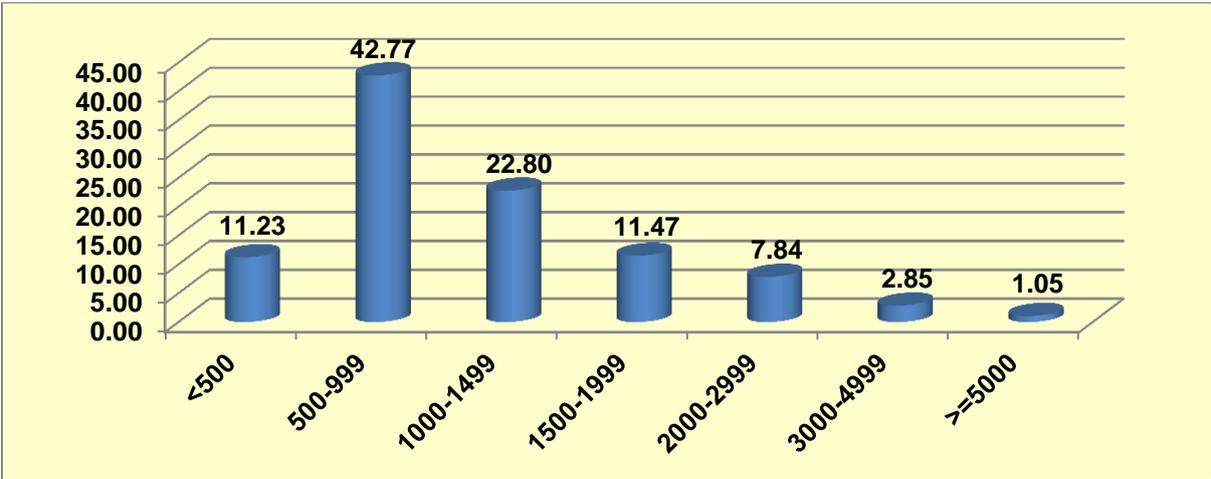
Graph 9-33: Distribution of Drug Users According to Job Status (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It can be observed from the job status (being employed or unemployed) of drug users that 65.81% of the users had an income-generating job while 34.19% had no job (Graphic 9-33).

Graph 9-34: Distribution of Drug Users According to Income Levels (%)

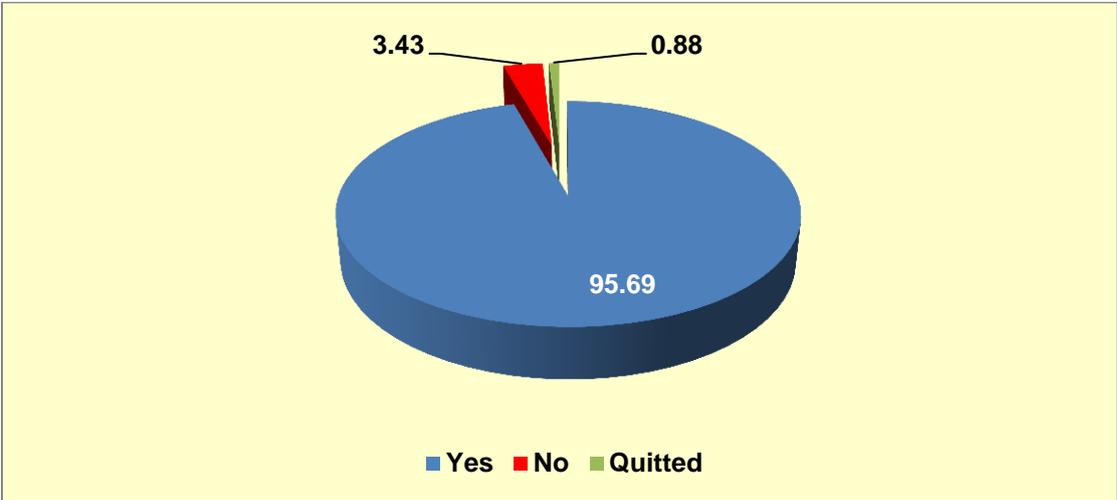


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It can be observed from the graphic that 54% of drug users had monthly income less than 1,000 TRY, while 34.26% of them had a monthly income of 1000 – 2,000 TRY, and 11.74% had a monthly income of more than 2,000 TRY (Graphic 9-34).

When we consider the income levels of drug users according to the drugs they use, it can be concluded that the income levels of cannabis users are lower than heroin, cocaine, and ecstasy users, while the income levels of cocaine users are considerably high compared to the income levels of the users of other drugs. This is deemed to have a connection with the availability of drugs and their prices in the streets; and cannabis is deemed to be used by people with low income levels due to its affordable prices compared to other drugs.

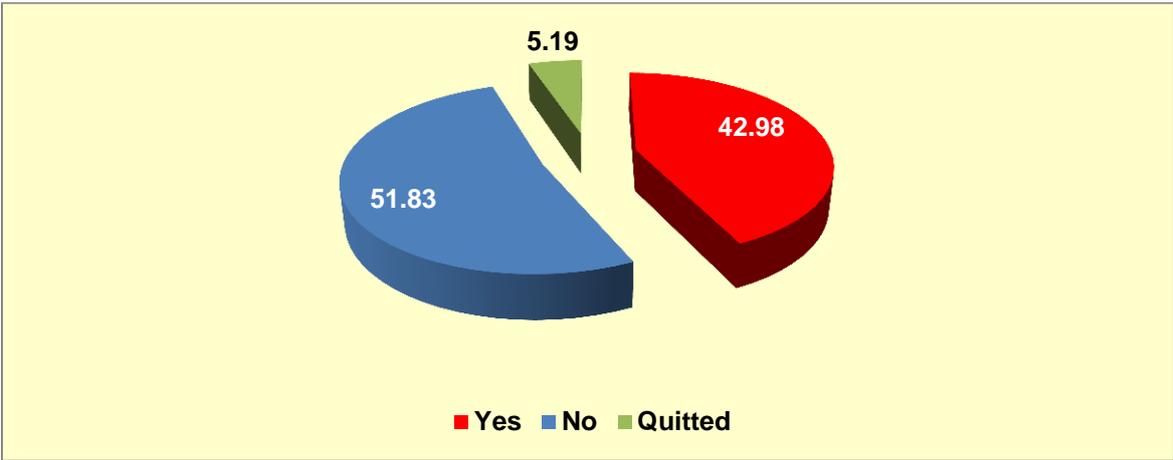
Graph 9-35: Smoking (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the smoking habits of drug users are considered, it is observed that 95.69% of drug users were smokers, while 3.43% of them were non-smokers, and 0.88% of them had quit smoking (Graphic 9-35).

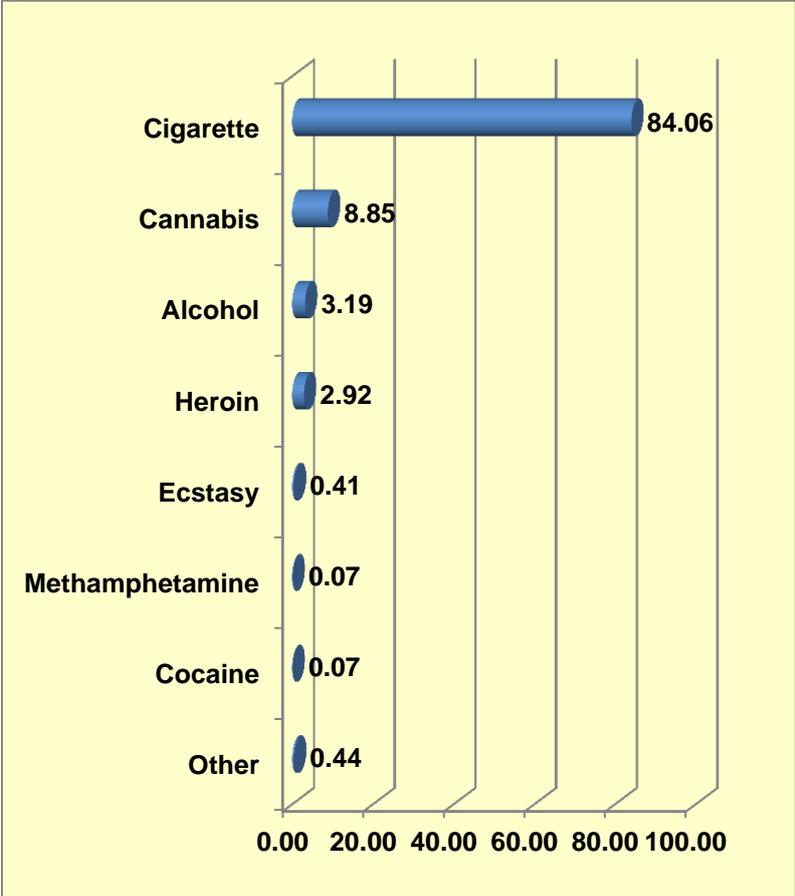
Graph 9-36: Alcohol Use (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

It can be observed from the graphic that 42.98% of drug users also used alcohol, while 51.83% of them did not use alcohol, and 5.19% of them had quit using alcohol (Graphic 9-36). Furthermore, a significant portion of drug users (41.42%) both smoked and used alcohol.

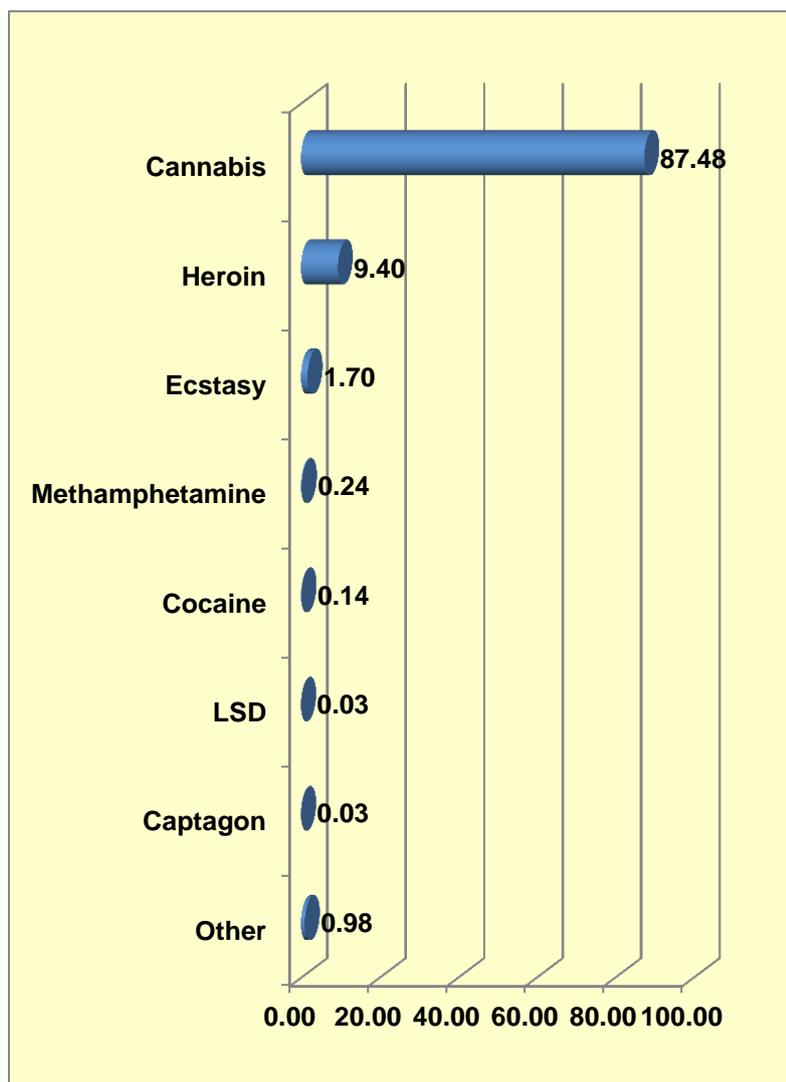
Graph 9-37: The First Substance Used by Drug Users (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the first substance (including cigarette and alcohol) used by drug users is taken into consideration, it can be concluded that a large portion of drug users (84.06%) began using substances with cigarettes (Graphic 9-37). Hence, cigarettes are deemed to be a step leading to drug use.

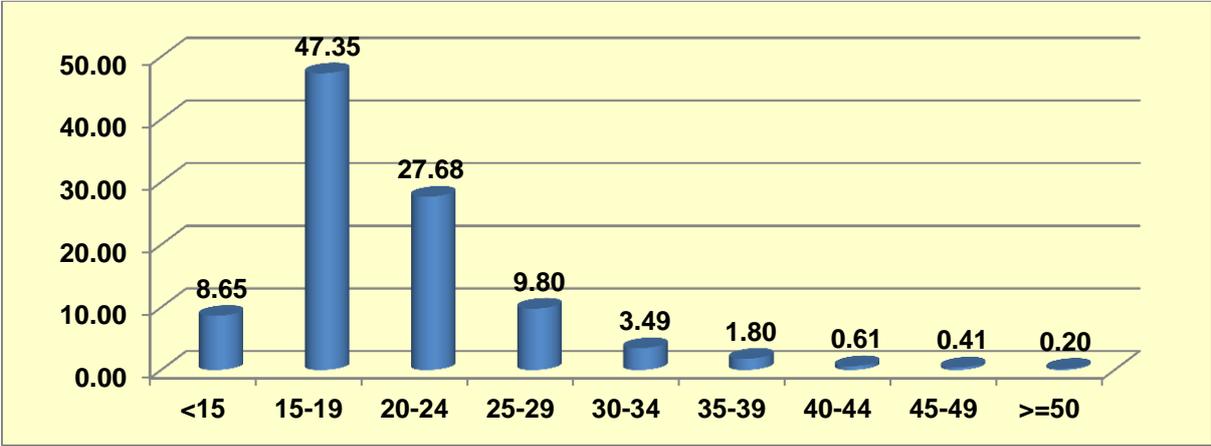
Graph 9-38: First Illegal Substance Used by Drug Users (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the results of the U-Form, the first substance used by drug users, excluding cigarettes and alcohol, was cannabis, with a significant rate of 87.48%. It is observed that drug users begin using cannabis after using cigarettes (Graphic 9-38).

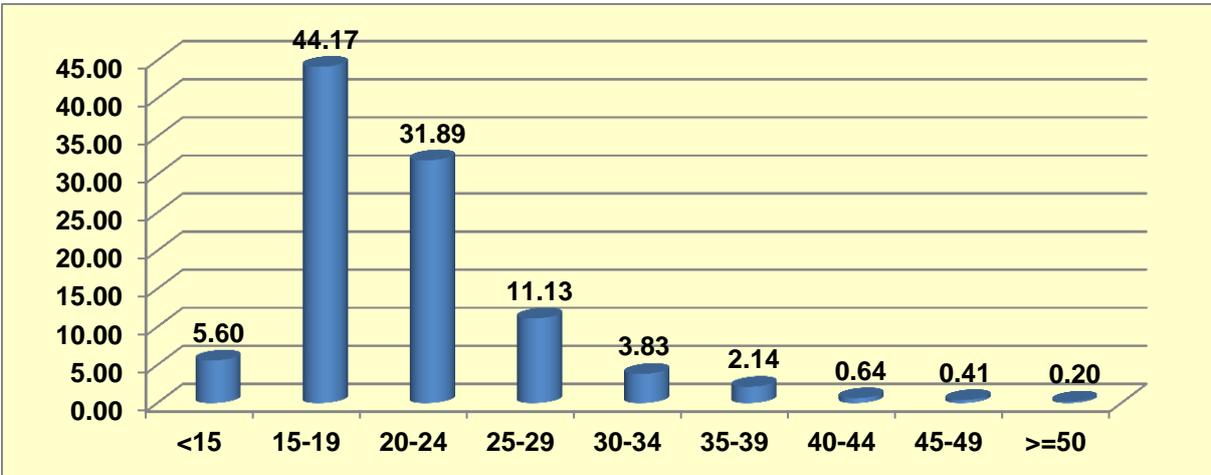
Graph 9-39: Age Range for First Drug Experience (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the age range of the drug users for the first use of drugs is considered, it is observed that the youngest age to try drugs was 10, while the oldest age was 61, and average for first trial was 20.01. Furthermore, it is clear that large portion of drug users (75.03%) tried drugs between the age ranges of 15-24 (Graphic 9-39). Accordingly, it is very important to address this age range in particular when carrying out drug addiction prevention activities.

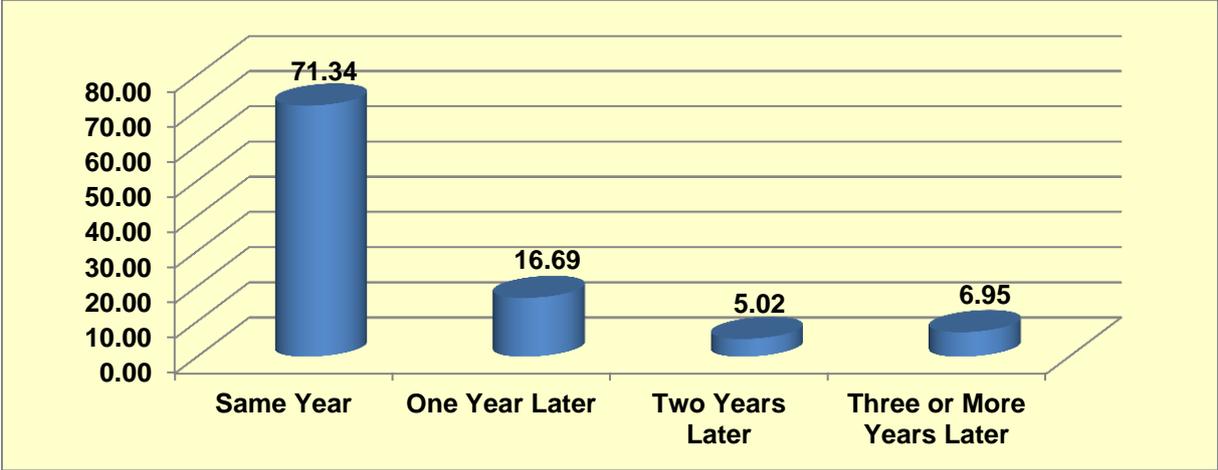
Graph 9-40: Age Ranges of Beginning to Use Drugs (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the ages in which drug users “begin” using drugs are considered, it is observed that the youngest age to begin drugs was 10 years, while the oldest age was 62 years, and the average age was 20.65. It is observed that a large portion of drug users (76.05%) began using drugs regularly between the ages 15-24, as was the case of the first experience (Graphic 9-40).

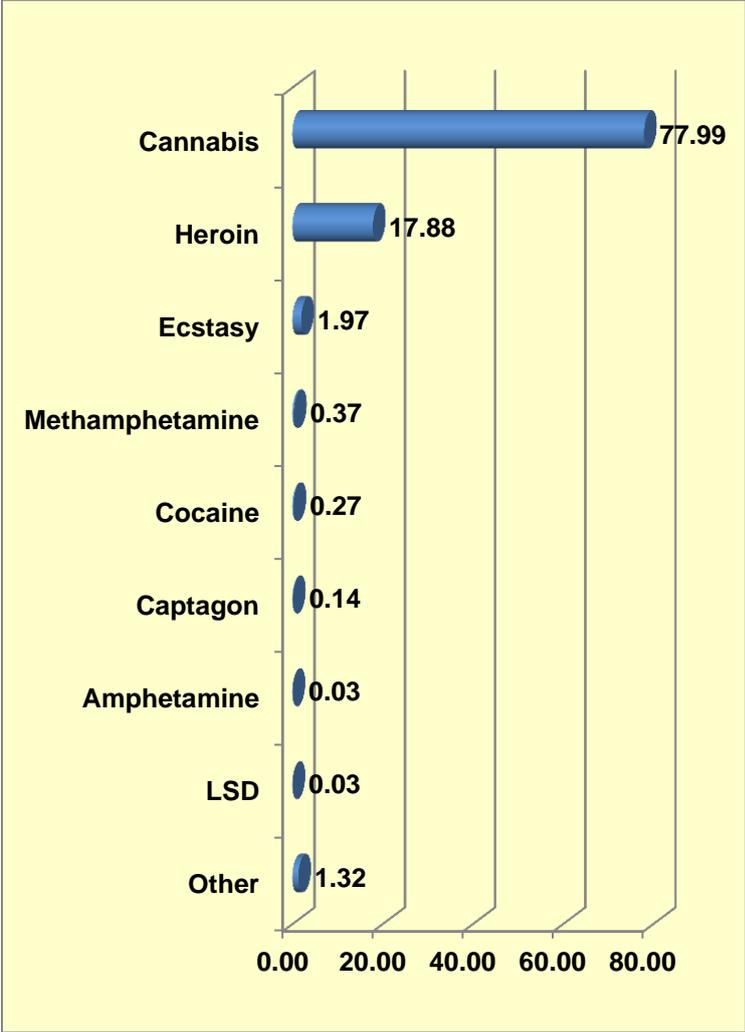
Graph 9-41: Duration of Beginning to Use Drugs (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When we consider the time period when drug users begin using drugs, we see that 71.34% of the users began to use drugs regularly within the same year after their first experience, while 16.69% began regularly using a year after, 5.02% began regularly using two years after, and 6.95% began regularly using three or more years after their first experience (Graphic 9-41). The fact that a majority of drug users began using drugs within a year after their first experience indicates that drug addiction can develop in a short period of time.

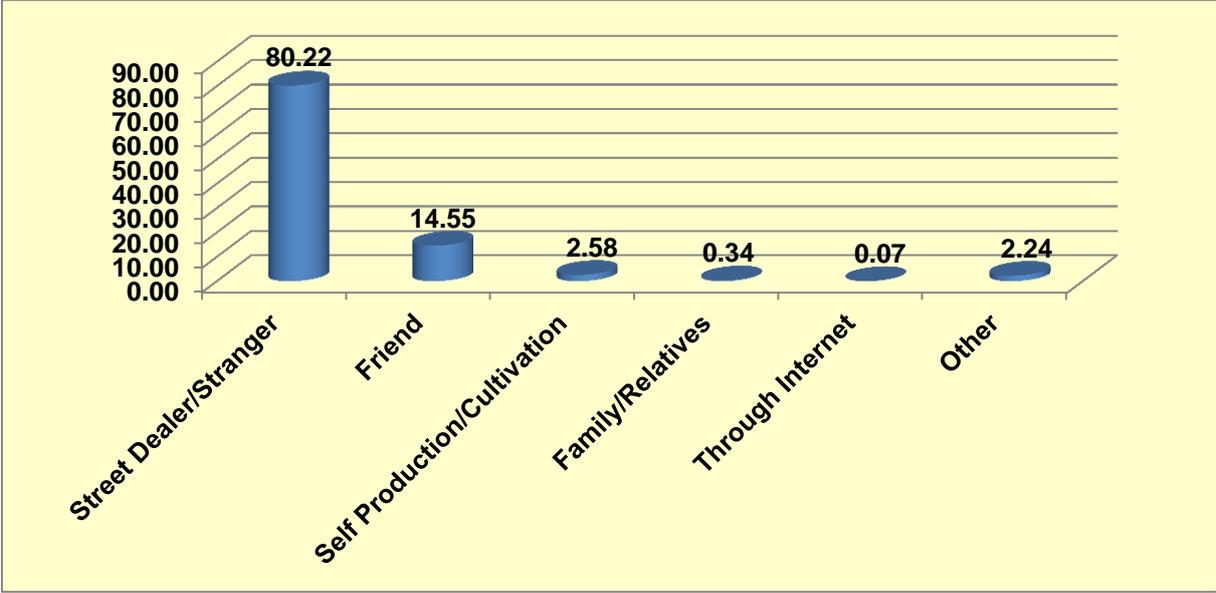
Graph 9-42: The Most Frequently Used Drug (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the U-Form data, the most frequently used illicit substance by a majority of drug users (77.99%) is cannabis (Graphic 9-42). When the drug-related cases in 2013 are taken into consideration, it is observed that the number of cannabis-related cases and suspects, and amount of cannabis seizures were greater compared to other drugs. The second most frequently used drug was heroin (17.88%).

Graph 9-43: Drug Supply Method (%)

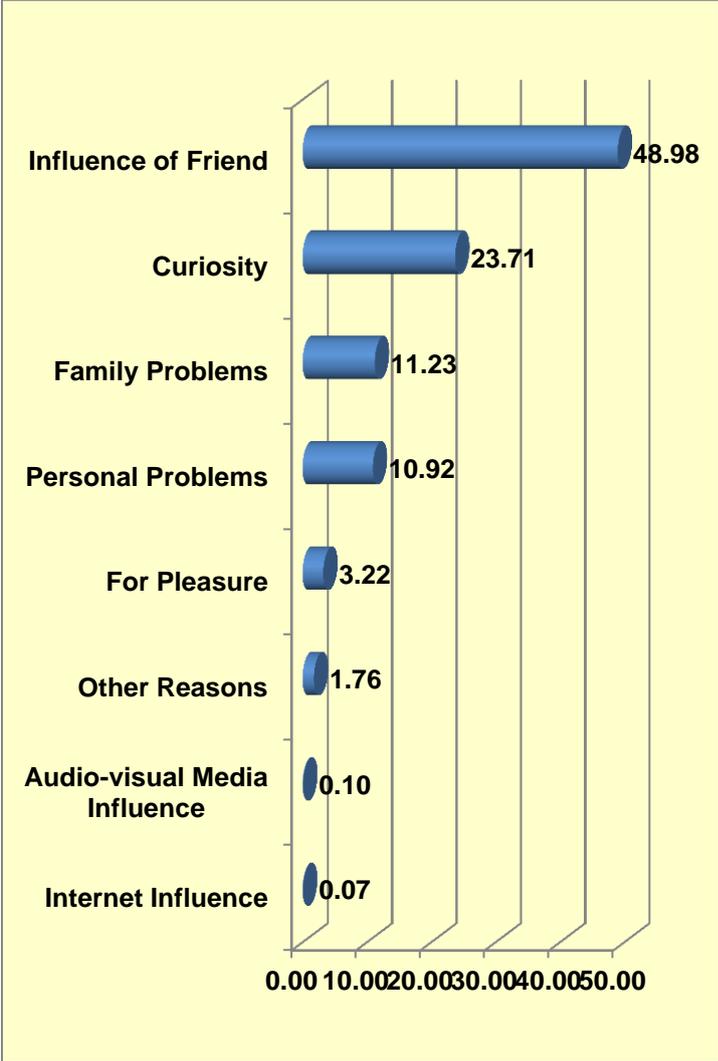


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the drug supply methods are considered, it is clear that a majority of the drug users (80.22%) were supplied with drugs by street dealers or strangers. “Friends” were the second most frequently addressed intermediary (14.55%) to supply drugs (Graphic 9-43). However, it should be noted that the participants may have stated their primary dealers to be street dealers/strangers as they do not wish to lose their resources, or want to protect their friends.

When we consider the locations for drug supply, it is observed that 60.34% of ecstasy was supplied by street dealers/strangers, while this figure was 77.64% and 93.74% for cannabis and heroin, respectively. On the other hand, 5.31% of heroin was supplied from friends, while this figure was 16.27% for cannabis, and 37.93% for ecstasy.

Graph 9-44: Reasons for Using Drugs

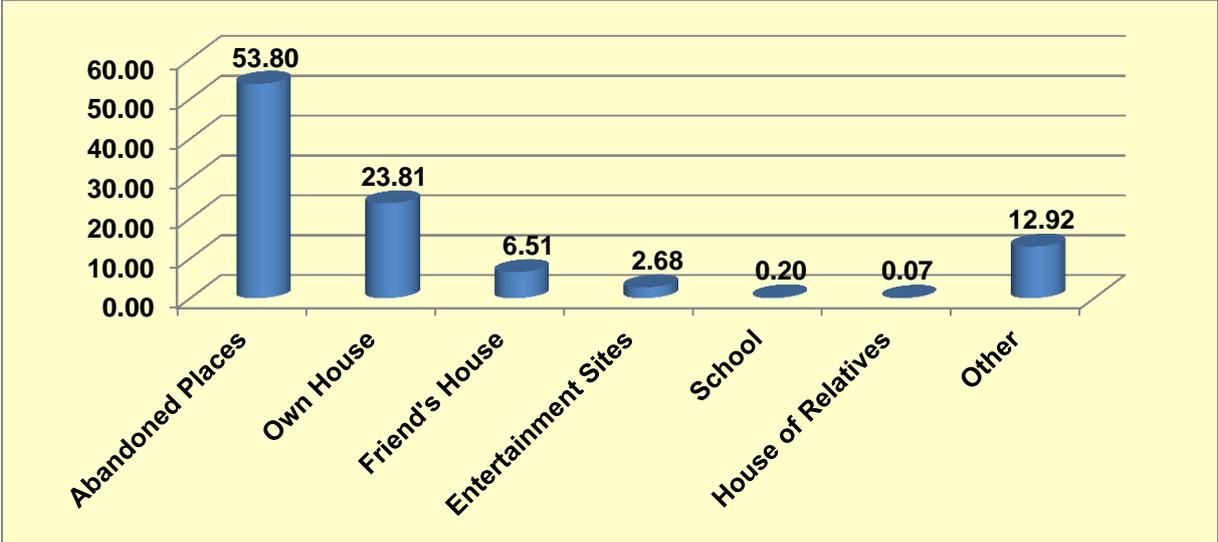


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the U-Form data, the first two reasons to begin using drugs are friends (48.98%) and curiosity (23.71%) (Graphic 9-44). These are followed by family issues (11.23%) and personal problems (10.92%).

In this sense, the interest of the target population should not be aroused while conducting drug-related prevention activities. Furthermore, families should pay attention and get to know the friends of their children, and attempt to prevent the problems likely to occur with the influence of friends.

Graph 9-45: Location for Drug Use (%)

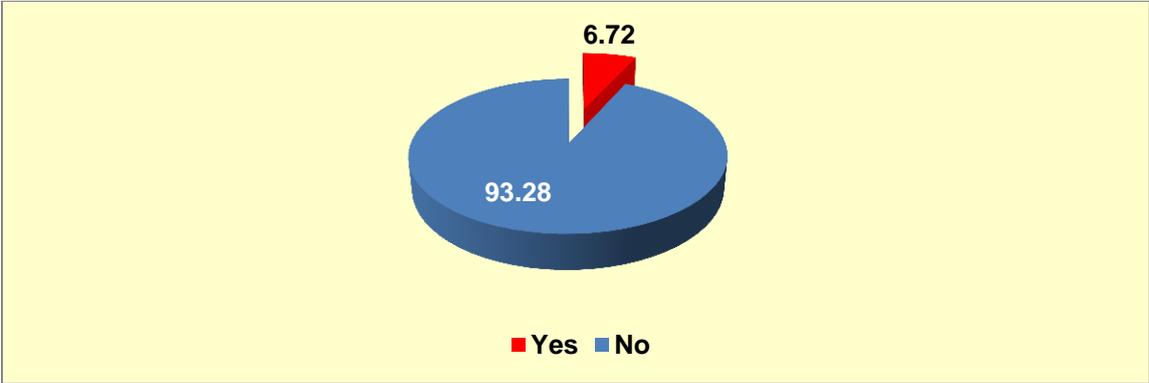


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the locations where drugs are used are taken into consideration, it is observed that most of the users (53.80%) used drugs in abandoned buildings (Graphic 9-45). Police forces should increase their controls in abandoned buildings to prevent drug use in such locations; furthermore, the municipalities should rehabilitate such places.

The second most frequently used place for using drugs was the houses of drug users (23.81%) (Graphic 9-45). Heroin users in particular were observed to prefer their own houses. Hence, families are required to be very careful, and consult a qualified institution if they find clues of drug use in their houses (for example, materials required to use drugs, etc...) without blaming their child.

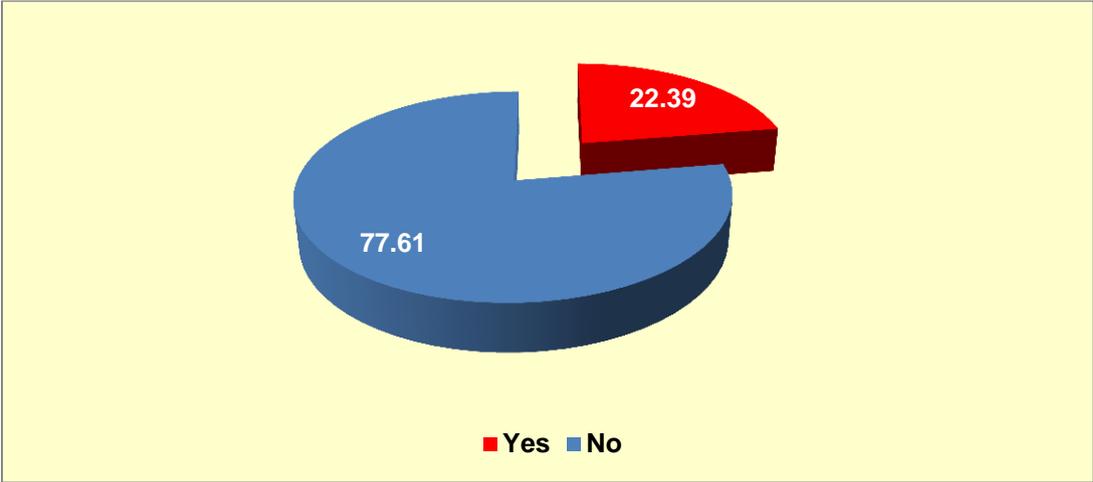
Graph 9-46: Attendance at a Briefing Event (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the U-Form data, 93.28% of drug users had never attended a drug-briefing event (seminar, conference, theatre, etc...) before beginning to use drugs (Graphic 9-46). Hence, the scope of prevention activities should be extended and at risk groups in particular should be informed in a timely and appropriate manner.

Graph 9-47: Knowledge about the Harms of Drugs (%)

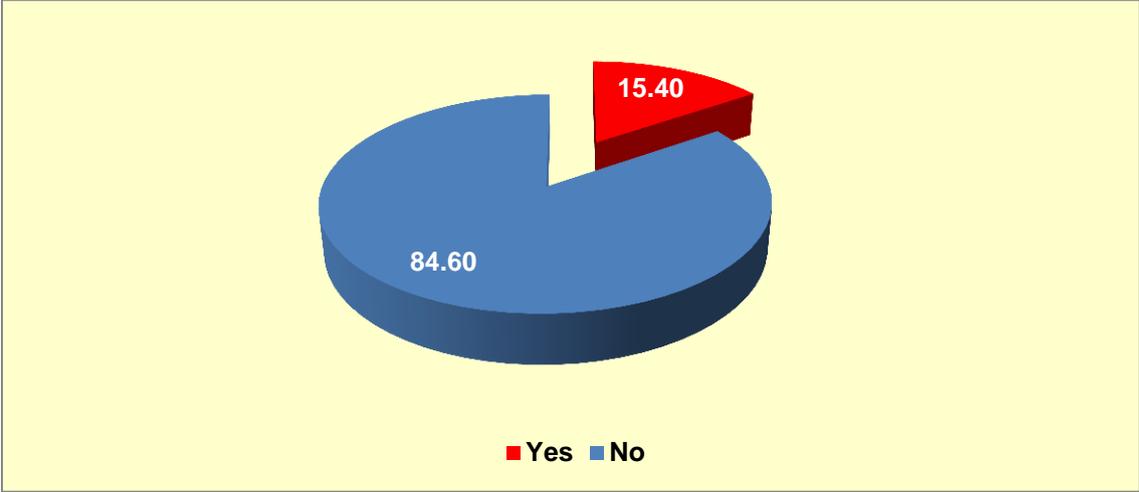


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

77.61% of drug users stated that they had no knowledge about the harms of drugs before using them, while 22.39% remarked that they were aware of the harms of drugs (Graphic 9-47).

However, 96.02% of drug users who began using drugs without knowing their possible harms made the following statement: *“I would have never begun using drugs if I knew the harms.”* Within this scope, timely and accurate briefings, to be made by experts, about the harms of drugs are deemed to be a significant and effective method in preventing drug use.

Graph 9-48: Previous Treatments (%)

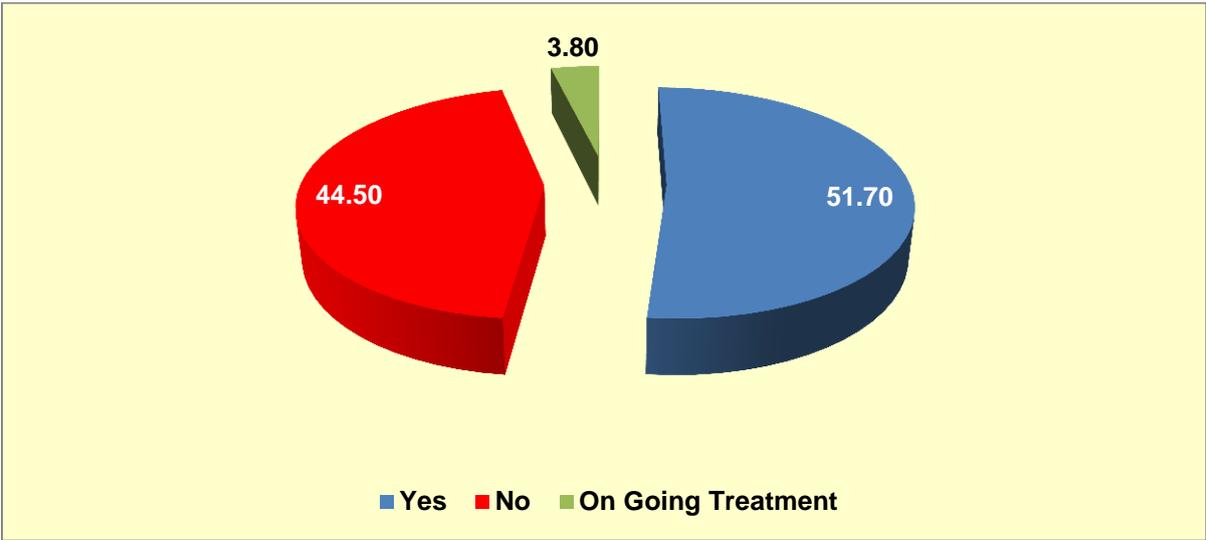


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to the data from the U-Form, a large portion of drug users (84.60%) had not received any treatment for their drug use habits (Graphic 9-48).

When previous treatments of the users are taken into consideration according to the drugs they used, it is observed that 88.30% of cannabis users had never received any treatment. When it comes to heroin users, the number of heroin users with treatment history was found to be greater compared to cannabis users with treatment history, and it is observed that approximately one third of heroin users (32.64%) had previously received treatment. The fact that 29.03% of cannabis users and 54.08% of heroin users, who were admitted to hospitals in Turkey in 2013, had had previous treatment history supports this data (EMCDDA Standard Table 34, 2014).

Graph 9-49: Treatment Demand (%)

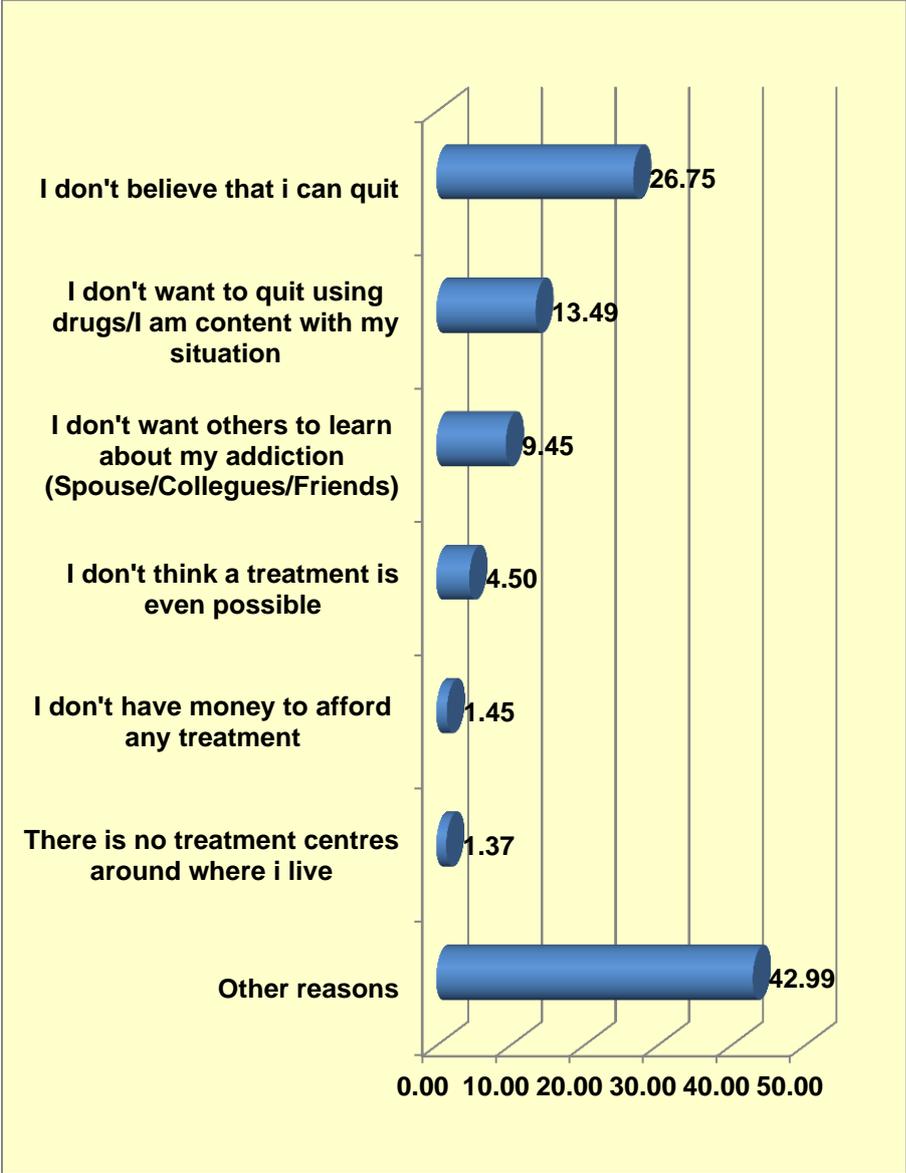


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The above-given table illustrates that 51.70% of drug users wished to receive treatment, while 44.50% had no intention of receiving treatment and 3.80% were still receiving treatment (Graphic 9-49).

Then the treatment demands of drug users were compared to the drugs they used, the willingness to seek treatment by cannabis users was observed to be lower compared to the users of other drugs, and it was observed that 47.50% of cannabis users did not want to receive any treatment. On the other hand, treatment willingness of heroin users to seek treatment was noted to be higher compared to cannabis users, and it was observed that 67.17% of heroin users wanted to receive treatment. The fallacy among cannabis users indicating that cannabis is harmless or less harmful is deemed to be the reason behind users' unwillingness to receive any treatment. The most frequently used illicit substance is cannabis in Turkey; however, heroin is ranked first among the drugs for which users receive treatment in AMATEM, and this is the indicator of the above-mentioned fallacy (EMCDDA Standard Table 34, 2014).

Graph 9-50: The Reason for Unwillingness to seek Treatment (%)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

According to data from the U-Form, the three most popular answers among drug users for not demanding to receive any treatment include: they do not believe that they can quit using drugs, they do not want to quit this habit, and they are afraid of the fact that it will be known by their relatives that they have been using drugs (Graphic 9-50).

Within this scope, the following steps should be taken to ensure that drug users begin their treatment:

- Addicts should be informed that it is scientifically possible to treat drug addiction, and that this treatment is required be offered by experts in special treatment units.

- Certain measures should be taken in order to ensure that addicts receive treatment without that information being disclosed in the community.
- The harms of drugs on human health should be explained by experts, using accurate methods.
- The number and quality of treatment centers should be increased.
- Certain improvements should be made to cover all kinds of needs of addicts during their treatment and deinstitutionalization processes (transportation, accommodation, medicine, tests, etc...) under social security.

9.3.3. Money Laundering/Laundering of Proceeds of Crime²⁷

Today, a substantial portion of considerable amounts of the proceeds of crime, especially the proceeds earned through illicit drug trafficking, can be used to provide continuance of the organized crime activity concerned, and to finance terrorist activities.

The financial proceeds from crimes and/or introduced to the legal financial system through money laundering have miscellaneous unfavorable effects on the economic, financial and legal system of the country, as well as the social and ethical structure of the community.

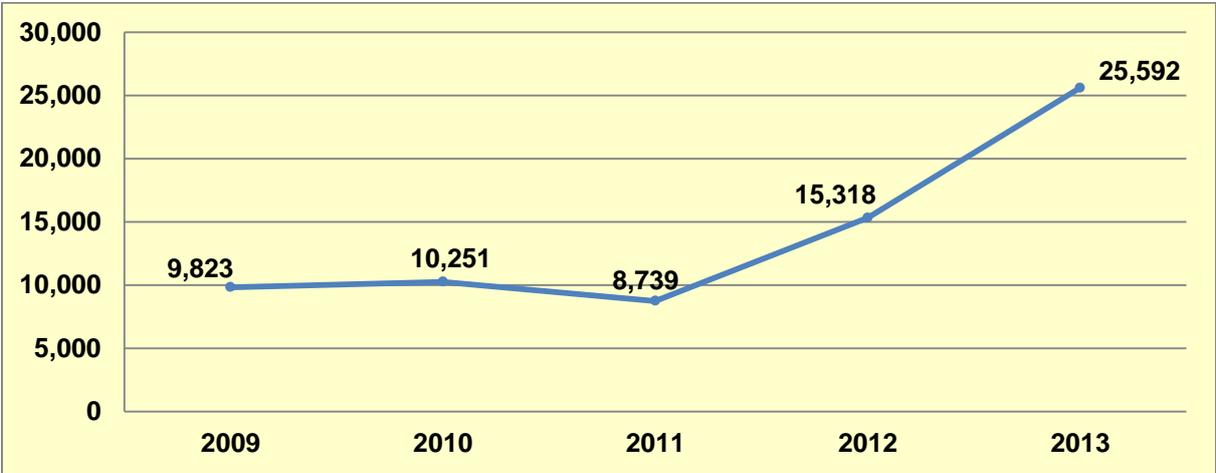
It has been understood that targeting crime-related revenues in fighting against drugs, or in other words, through the determination, follow-up and seizure of such revenue, is a more effective method than arresting and penalizing those criminals who directly committed the preceding crime. In this sense, preventive and suppression measures against the laundering proceeds from crime, and measures to seize such gains have become a current issue in the agendas of law makers of several countries.

Turkey has adopted a strategy to fight against money laundering, which corresponds to international standards, and within this scope, legal regulations related to the suppression and preventive aspects were prepared, and significant developments have been made especially in the field of prevention. Preventive measures (knowing customers, reporting suspicious transactions, constant reporting, training, etc...) adopted by Law No.5549 on the Prevention of Laundering Proceeds of Crime and concerned regulations, which is applied to financial institutions and other liabilities listed in the Article 2 of the same law, have a significant function in avoiding the proceeds of crime being introduced into the legal financial system or in the determination, follow-up and seizure of such proceeds in the system. In particular, the

²⁷ This section was prepared by MASAK (Financial Crimes Investigation Board).

suspicious transaction notices required to be reported by those liable to MASAK (Financial Crimes Investigation Board) in the case of any suspicion that the assets used in the transactions they carry out or mediate might have been obtained through illegal methods or that such assets are to be used for illegal intentions are significant sources of financial intelligence in unveiling laundering or other crimes. These notices are also an indicator of awareness of liable groups about the crime of laundering. The number of suspicious transaction notices increases as can be observed from the table below, thanks to the training and supervision activities carried out by MASAK.

Graph 9-51: Number of Suspicious Transaction Notices by Year



Source: MASAK Activity Report 2012, www.masak.gov.tr.

The laundering of proceeds of crime was first accepted as a crime with Law No. 4208 on the Prevention of Money Laundering, entered into force on November 19, 1996. This law terminated as laundering-related provisions thereof were amended by Article 282 of Turkish Penal Code No.5237 dated June 01, 2005, under “Laundering the assets obtained through crime”, and the crime of laundering was included into the general penal code of Turkey. Accordingly, the first paragraph of Article 282 of the Turkish Penal Code was amended to state: “Individuals who export their assets that have been obtained through a crime requiring at least a six-month or more prison sentence or those who carry out certain transactions on such assets in order to hide their illicit resource or to shape an opinion that such assets have been acquired through a legal method shall be penalized with prison sentences from three to seven years and a judicial fine up to 20,000 days”. The following paragraphs of the same article refer to the penalty increase factors, as well. This amendment has a significant role in fighting crimes that are the sources of crime-related revenues, in particular illicit drug trafficking.

Another significant regulation to fight against laundering crime-related revenues is Article 17 of Law No.5549 on the Prevention of Laundering Proceeds of Crime. Accordingly, the assets of the relevant individuals can be seized as per the practice stated in Article 128 of the Code of Criminal Procedure No.5271, in cases where there is an intense suspicion about laundering and terrorism financing. As a result of the analysis, assessments and researches conducted by MASAK in order to determine any procedures of laundering the proceedings of crime, between 2009 and 2013, criminal complaints were filed against 130 individuals who appeared to commit laundering crimes in connection with drug trafficking (MASAK Activity Report, 2013).

Another important measure in fighting against crime is seizing the proceeds from crimes without considering whether they have been laundered or not. With the “revenue confiscation” stated in Article 55 of the Turkish Penal Code No.5237, it is stated that all types of material benefits that have been obtained from a crime, that are the subjects of crime, or which have been acquired to commit a crime, and all kinds of economical acquisitions obtained by using the same can be seized. As effective follow up, the determination and confiscation of proceeds from crime will eliminate the reasons behind benefit-oriented crimes, success of revenue confiscation will reduce the predecessor crimes directly.

In the current Turkish Penal Code, the prosecution is liable to prove that the assets of the defendants/convicts for drug-related crimes with unexplained resources have been gained through a crime. However, in America and certain European countries, the convicts have to prove that they obtained such assets legitimately, provided that they are sentenced for drug-related crimes. In this sense, introducing extended confiscation to Turkish regulation will be very beneficial in fighting against drug dealers.

9.4. Other Crimes Related to Drugs

No New Data

9.5. Prevention of Drug Related Crimes

No New Data

9.6. Interventions in the Criminal Justice System

9.6.1. Alternatives for Prisons

In Turkish Penal Code No.5237, purchasing, accepting or possessing drugs or stimulants were defined to be crimes, while using the same is not defined to be a crime as required by the crime policy applied. Individuals who use drugs or stimulants are actually in need of treatment. Hence, Article 191 of the Turkish Penal Code No.5237 anticipates probation measures to be applied in order to ensure individuals receive treatment and prevent them from using drugs or stimulants again.

No sentence is applied to individuals who accept to receive treatment and act in accordance with the requirements of probation measures, for purchasing, accepting, or possessing drugs or stimulants. In other words, the court will not impose any sentence on those individuals who purchased, accepted, or possessed drugs or stimulants to use; instead, probation measures and treatment or only probation measures will be applied.

The duration of the treatment required to be received by drug or stimulant users is not defined in the laws because treatment is a medical fact. Individuals who use drugs or stimulants are liable to meet the requirements of the treatment in order to get over the effects of the substance. Furthermore, individuals are subject to probation measures during the treatment process.

Probation measures continue even when positive results are obtained from the treatment and after the treatment has been brought to an end, as it is not required anymore. Such measures are applied for at least one year on the day on which the treatment ends. However, the court may decide to extend this duration up to three years.

A criminal case filed is dismissed at the end of this period, provided that the individual concerned acts in accordance with the probation measures.

Guidance service to be offered to drug addicts is determined to be the duty of the probation directorates under the provision "Conducting guidance services as per paragraph three of Article 191 pertaining to Turkish Penal Code No.5237", which is referred to in paragraph 1(d) of Article 14 pertaining to the Probation Services Law.

No duty was defined for probation directorates for the treatment of drug users. The treatment of addicts is a medical issue and this process is conducted by the Ministry of Health.

The Ministry of Health General Directorate of Healthcare Services issued Circular No.2009/82 dated December 22, 2009. Treatment procedures for addicts should be conducted in

accordance with this Circular. However, the duration and method of treatment required by drug users was not identified within the scope of the Law. Treatment and psycho-social support and guidance services should be offered by the personnel of the Ministry of Health in accordance with the Circular No.2009/82.

As per the law, the main duty of probation directorates is to ensure treated addicts to stay clear from drugs for at least one year, and to support addicts by conducting certain activities to reintegrate them into society. The guidance and rehabilitation services for addicts are offered by the personnel of probation directorate in accordance with Articles 37 and 72 of the Regulation on Probation Services dated March 05, 2013. Accordingly, guidance and rehabilitation activities conducted by probation directorates include all kinds of activities that keep addicts away from drugs and that reintegrate them into society such as assessment, face-to-face interviews, group sessions, spare time structuring, social and cultural activities, family and school visits, seminars, and conferences.

Assessment: During this process, the probation expert determines what kind of guidance program and support is required to be given to the individuals sent to the probation directorate after their treatment. Such assessment is finalized at the end of the first or second face-to-face interview conducted by the expert assigned for the individual concerned. After the assessment process, guidance programs and problems to be supported are defined, and addicts are invited to the programs prepared especially for them.

Face-to-face Interview: Working with addicts during probation begins with face-to-face interviews. The first two sessions of such interviews aims at assessing individuals and determining their needs. In cases where face-to-face interviews have been decided to be maintained, the concerned individual continues his/her guidance studies with the help of an expert. Face-to-face interviews consist of twelve sessions, and each session has a structured content. Those sessions are revised according to changing needs. Cooperation is ensured with universities, and academicians are consulted in creation of the contents.

Structured group therapies: Provided that the individual concerned is found to be suitable for group therapies, guidance and rehabilitation studies continue with group therapies. Groups mean collective guidance program for addicts with similar situations. Group therapies make greater contributions to rehabilitation of addicts, and individuals who want to eliminate such addiction may motivate each other positively within the dynamics of groups. Group therapies can be conducted by probation experts within or outside of the institution.

The Cigarette, Alcohol, and Drug Addiction Treatment Program (Turkish Abbreviation: SAMBA) is commonly used in probation group therapy programs, developed with the support of academicians; furthermore, other programs such as anger control, stress management, and common criminal behavior are additionally implemented. Positive feedback is received from those who attended such programs, and people may eliminate drug use through such programs.

Family and School Visits: Strengthening family relations of young drug addicts and ensuring that they attend school are very important for them to quit their addiction. Hence, families should be included in the treatment and guidance period.

Probation personnel visit families and cooperate with the family members within the scope of the guidance in order to avoid addiction. During this process, families are informed about drug addiction, and provided support for their behavior towards young addicts. Guidance services in schools should be coordinated in order to ensure that addicts do not drift away from the school environment or become distanced from education. Probation experts contact the guidance services in schools if it is deemed necessary while working with addicts.

Structuring of spare time: It is very important to fill the spare time of individuals who have completed their face-to-face interviews and group studies in the probation directorates and who do not have a job or pastime activity, and to direct those people to educational, social, cultural, artistic, or athletic activities in order to ensure that they avoid drug use. Structuring the spare time of addicts with educational, social, cultural, artistic or sportive activities changes their perspective of drug use, and ensures that they stay away from using drugs. Activities offered by other institutions, which address the fields of interests of addicts, are used. Non-isolation and non-discrimination of addicts by concerned institutions or NGOs while structuring their spare time bears great significance in reintegrating these people to community. Within this scope, opportunities offered by the Provincial Directorates of the Ministry of Youth and Sports, the Ministry of Family and Social Policies, the Ministry of National Education, and Turkish Labor Agency (İşkur), together with the means offered by municipalities, the Green Crescent, and concerned NGOs should be used for addicts as well.

Vocational courses and employment: Addicts are gradually isolated from the society, and lose their jobs in the proceeding period of addiction. Directing the addicts, who have no occupation or have lost their jobs, to occupational courses after treatment, bears great significance in ensuring them to refrain from addiction and avoiding the re-use of drugs. Accordingly, it is attempted to ensure that individuals, who completed their guidance program within the scope

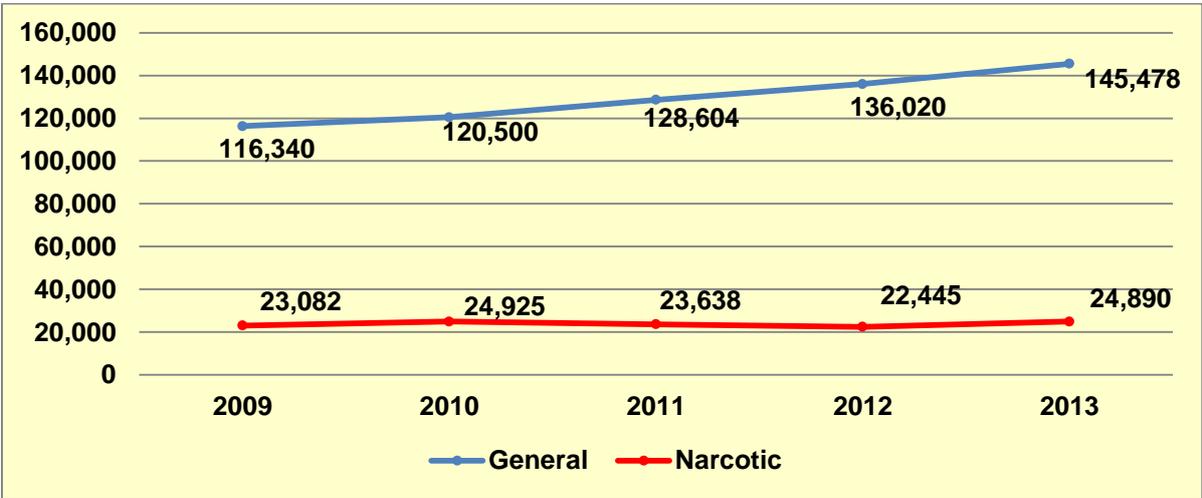
of probation, to acquire a profession or to find job to live an orderly life and to stay away from drug use. With this object in mind, vocational courses have been initiated for addicts and certificates are given to successful participants. On the other hand, people who have a profession but are unemployed are supported in opening their own business or finding a job.

With these activities targeting drug or stimulant users, addicts are rehabilitated, and the harm of drug use on the individual, social cycle, and society is attempted to be minimized. The aim is to reduce drug-related crimes.

9.6.2. Other Interventions in the Criminal Justice System

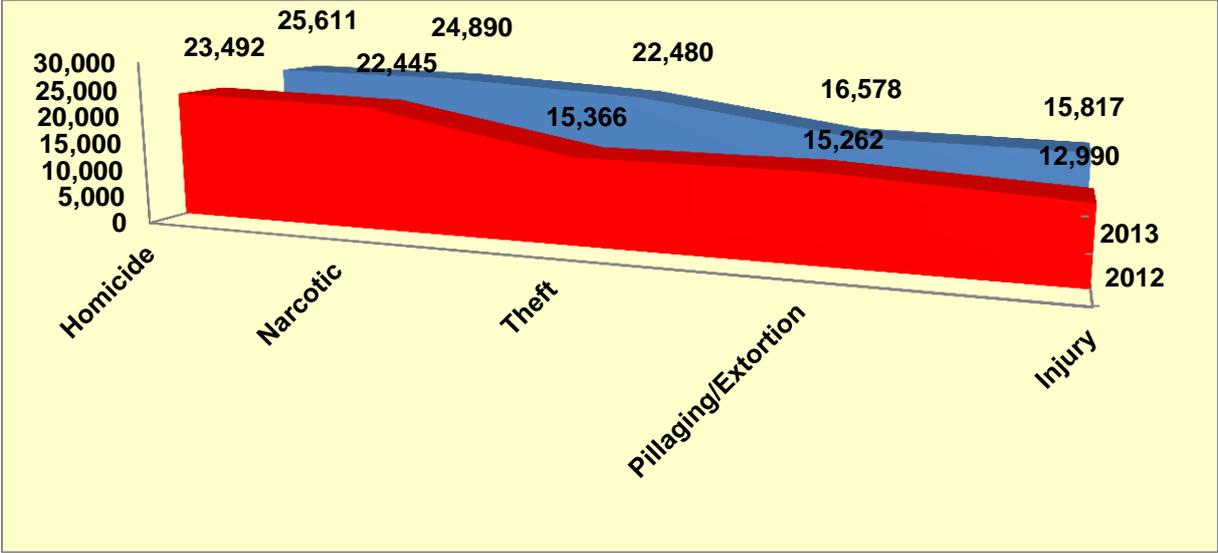
Data obtained from the Ministry of Justice General Directorate of Prisons and Detention Houses emphasizes the scope of drugs and drug-related crimes in Turkey for 2013. In 2013, there were 24,890 convicts/prisoners in penal institutions for drug related crimes. This figure was 22,445 in 2012, and indicates a 0.89% increase in 2013.

Graph 9-52: Distribution of the Total Number of Prisoners in Penal Institutions, and the Number of Convicts of Drug-Related Crimes by Year



Source: Ministry of Justice General Directorate of Prisons and Detention Houses, 2014

Graph 9-53: Comparison of 2012 and 2013 according to Crime Group



Source: Ministry of Justice General Directorate of Prisons and Detention Houses, 2014

According to the data of the Ministry of Justice General Directorate of Prisons and Detention Houses, in 2013, there were 24,890 convicts in penal institutions for drug related crimes. The total number of convicts in penal institutions for the same year was 145,478. In light of these figures, it can be concluded that the convicts of drug-related crimes constituted 17.1% of the general number of convicts in penal institutions for the concerned period.

With several affiliated General Directorates, the Ministry of Justice has duties and responsibilities in the field of drug addiction and the fight against drugs. Penal institutions and probation branches affiliated with the Ministry of Justice General Directorate of Prisons and Detention Houses conducts several studies for the prevention and rehabilitation of drug addiction.

The Alcohol and Drug Addiction Program is one of the main studies conducted by the psycho-social aid service for alcohol or convicts/prisoners that are addicted to drugs the penal institutions.

The Alcohol and Drug Addiction Program conducted in penal institutions consists of 16 one and a half hour sessions delivered over the course of four weeks. This program was prepared using a model that aims at minimizing harm through cognitive-behavioral therapy. The objective of the program is to raise awareness of drug users for receiving treatment. During this program, studies are planned to be conducted with the participation of convicts who use

drugs or are involved in drug-related crimes, and it aims at working together in acknowledging the harms of drugs and minimizing such harms.

The Cigarette, Alcohol, and Drug Addiction Treatment Program (SAMBA) was developed in coordination with Prof. Dr. Kültegin ÖGEL in order to increase the function of the Alcohol and Drug Addiction Program and to include cigarettes, which are a common addiction substance in Turkey, in the program. In order to spread this program in penal institutions, psychologists and social workers of 20 penal institutions were offered training of trainers program. Psychologists and social workers who participated in the training of trainers program will provide dissemination trainings to other psychologists and social workers in penal institutions personnel training centers in 2015.

Aside from these efforts, significant developments have been made in recent years, such as recruiting qualified personnel to support improvement activities; furthermore, the number of psychologists and social workers has been increased. In addition to this, psychologists, social workers, and sociologists have attended trainings on both these programs and other improvement activities, and the reports prepared after such trainings are deemed to be instructive in conducting the studies. Furthermore, alcohol and drug addiction-related seminars are given in penal institutions in cooperation with the Provincial Directorates of Security and Provincial Directorates of Health; moreover, scientific studies conducted in penal institutions are supported and the required permits are provided.

9.7. Drug and Problem Substance Use in Prisons

Individuals with the risk of addiction are determined through identification and follow-up forms completed by psychologists and social workers during their acceptance to penal institutions.

Firstly, face-to-face interviews are conducted with convicts and prisoners who are at risk of addiction by psychologists and social workers, and their alcohol and drug addiction history is prepared. Furthermore, the addiction substance and whether they have any deprivation symptoms are determined.

Individuals with intense deprivation and intoxication symptoms and those who have an urge to use drugs are referred to the healthcare service of the institution, from which they are referred to emergency rooms and psychiatry polyclinics.

Healthcare services and psycho-social services conduct a joint study for individuals with previous drug addiction history and on-going treatment.

The following steps of the Cigarette, Alcohol, and Drug Addiction program are applied by psychologists and social workers on the individuals under the risk of addiction:

- They are informed about the effects of such addiction.
- They are motivated to quit such habit.
- The methods to cope with the desire and impulse to use substances are examined.
- The methods to keep clean are examined.
- They are informed about alcohol and drug addiction group intervention program, and the willing individuals are directed to group sessions.

Legal regulations prohibit drug access to penal institutions, and legal and executive processes are initiated, provided that any substance is determined.

9.8. Solutions for Drug-Related Health Issues in Prisons

Health organizations in Turkey have opened the doors for a new era with the “Law No.5258 on Family Medicine Pilot Project,” which entered into force in November 24, 2004. According to this law, community health centers will be closed, and primary healthcare services will be offered by “family physicians.”

As per the protocol signed between the Ministry of Health and the Ministry of Justice, penal institutions were defined to be one of the locations in which family physicians are to give mobile services. Accordingly, family physicians in the penal institutions provide primary healthcare services to convicts and prisoners. Furthermore, in cases where the penal institutions are organized as a campus, healthcare services can be offered by the district polyclinics in the region. The other unit to be referred by penal institutions for various health-related issues other than treatments is the community healthcare center in the concerned district (Manual for Healthcare Services in Penal Institutions, 2012).

Primary healthcare services are offered by family physicians in penal institutions, and concerned healthcare institutions are referred for health problems requiring advanced tests and treatments. Within this scope, individuals are referred to healthcare institutions in order to receive treatment services for drug use. Furthermore, within the scope of the Circular on Expanded Immunization Program No.18607-2006/120, dated November 20, 2006, which covers routine vaccination procedures against Hepatitis B and which was stipulated by the

Ministry of Health in order to avoid contagious diseases in penal institutions, and Hepatitis B control program strategies, the Provincial Directorates of Health are contacted to supply vaccinations and to ensure that all convicts, prisoners, and personnel are vaccinated periodically.

The Ministry of Health, which is responsible for the health services in Turkey, issues circulars and conducts control programs regarding diseases because diseases, whether contagious or not, are the concern of the entire community. Hence, studies regarding control of contagious diseases are conducted in parallel with the policies and procedures of the Ministry of Health (Manual for Healthcare Services in Penal Institutions, 2012).

9.9. Drug Users' Reintegration to Society after Their Evacuation from Prisons

As the convicts held in penal institutions for a definite period time are removed from their social lives, leaving them in the society without any effective supervision and support system bears high risk both for themselves and for the society. In light of this perspective, Article 105/A was introduced to the Law No.6291 entered into force on April 11, 2012 and Law No.5275 on the Execution of Sentences and Security Measures in order to ensure convicts harmonize with the outside world and to maintain and sustain their relations with their families by applying probation measures for a definite part of their prison sentences. As per this article, upon request, the judge of execution may decide to apply probation for convicts with good conduct, who completed the last six months of their sentence in open penal institutions without any interruption, and who have one year or less to be paroled, for the duration until the date of parole. Furthermore, child convicts, female convicts having a child/children between the age of 0 - 6, and the convicts who cannot live alone due to a serious disease, disability, or old age can enjoy this procedure in a greater scope. This procedure has significant importance in reintegrating convicts with good conduct to society.

Considering the amendments made to the regulation on convicts' transfer to open penal institutions upon entrance into force of the Law No.6291, the requirement to stay in an open penal institution for six months for one time only was cancelled with Provisional Article 2 of the Law No.6352 that entered into force on July 05, 2012. Furthermore, with Law No.6411 that entered into force on January 31, 2013, the requirement to stay in an open penal institution for six months until December 31, 2015 was cancelled again. The Assessment and Evaluation Form (ARDEF) is applied to the convicts who were released within the scope of 105/A and who are subject to probation until the date of parole, and to individuals with a high risk of addiction are supported by individual or group sessions. Furthermore, structuring spare time

and socio-economic support activities are also conducted in cooperation with other institutions and organizations for the convicts with addiction problems. Provided that drug or stimulant addiction is determined based on the results of risks and needs assessment of the convicts who applied to probation directorate, the convict is supported to terminate their drug addiction and avoid the negative effects of drugs with the help of the Cigarette, Alcohol and Drug Addiction Treatment Program (SAMBA), which is successfully applied in Probation Directorates, and SAMBA Family and SAMBA Reading Group activities in 2013. Furthermore, other studies are conducted with the support of several academicians, for structuring face-to-face interviews made with the convicts who are thought to be drug addicts.

All types of activities that keep addicts away from drugs and which reintegrate them into society, such as assessment within the scope of guidance and rehabilitation studies, face-to-face interviews, group studies, spare time structuring, social and cultural activities, family and school visits, and seminars and conferences are also available for the convicts subject to probation, who were determined to be drug or stimulant addicts.

Drug addicts can be treated and reintegrated to the society only if concerned institutions work in cooperation and conduct their activities in full coordination. Applying the appropriate treatment, post-treatment support, and long-term supervision bear great significance in helping people to refrain from addiction and reintegrating them into society.

SECTION 10

DRUG SUPPLY

Bülent DEMİRCİ²⁸

10.1. Introduction

The main institutions that participate in the fight against illicit drug trafficking in Turkey are the General Directorate of Security (Turkish National Police), the General Command of Gendarmerie, Coast Guard Command, and the General Directorate of Customs Enforcement. Additionally, the Soil Products Office, Council of Forensic Medicine, Financial Crimes Investigation Board, and Turkish Pharmaceuticals and Medical Devices Agency play significant roles in the monitoring of drugs. The duties and responsibilities of these institutions are established by the relevant laws and inter-institutional protocols.

While national police forces counteract the illicit trafficking and smuggling of addictive substances in urban areas, the gendarmerie forces work in rural areas, customs officers work within the Turkish customs zone (political boundaries of the Republic of Turkey), and coast guards work on all coasts and in territorial waters.

The government bodies that are active in the fight against drugs in Turkey utilize different data collection and storage methods for the activities that are conducted as part of their respective duties and responsibilities. There is no shared database that gathers all the relevant data on drugs. Though the lack of a shared database causes certain problems in collecting and analyzing data, the efforts exerted in recent years by the Turkish Monitoring Center for Drugs and Drug Addiction (TUBİM), which is responsible for nationwide monitoring, have significantly contributed to sound data collection and reporting. As a result, national needs are covered on the one hand, and international data collection standards are met on the other hand.

Data provided by the Turkish National Police, General Command of Gendarmerie, Coast Guard Command, and General Directorate of Customs Enforcement as Turkey's law enforcement units, data compiled from the relevant standard tables of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the relevant academic studies, and national and international reports contributed to the sections entitled "Supply to and within the Country" and "Seizures." Data from the "Drug Price Project" that was prepared by TUBİM

²⁸ TUBİM

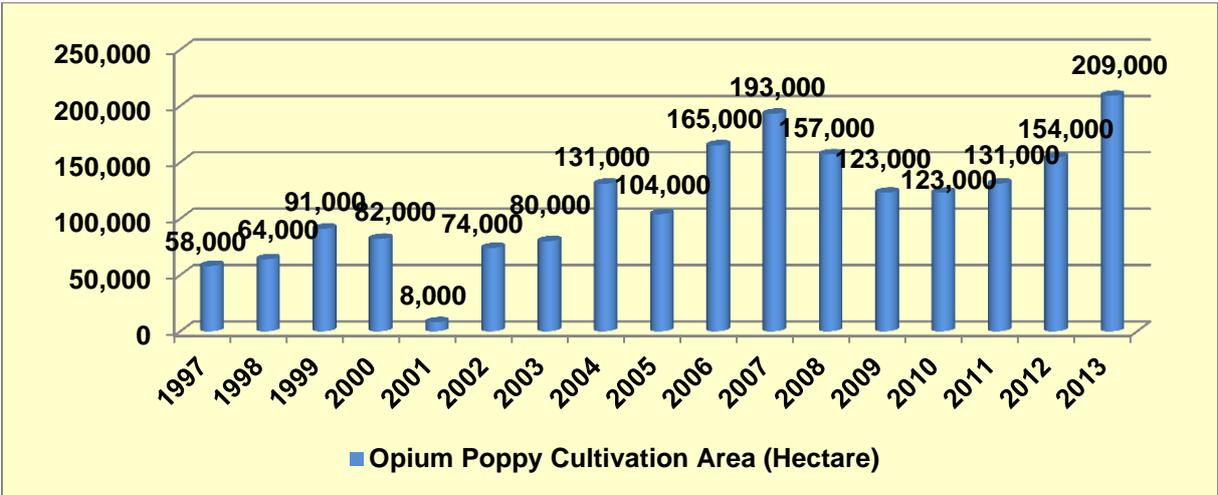
and gathers the data by the Turkish National Police through Polnet (Police intranet) web contributed to the section entitled “Street-Level and Wholesale Prices of Illicit Substances,” and data by the Police and Gendarmerie Criminal Laboratory, and Council of Forensic Medicine contributed to the section entitled “Purity/Potency of Illicit Substances, and the Formation of Illicit Substances and Tablets.”

10.2. Supply to and within the Country

Due to its strategic location, Turkey is a frequent location of legal and illegal trade flows of various products between Asia and Europe. In this context, Turkey was again heavily affected by the smuggling of opium and derivatives from Afghanistan in 2013.

In 2013, illicit opium poppy plants were cultivated on a total area of 296,720 hectares throughout the world, which hit an all-time high since the first calculations available since 1998. The total area under poppy cultivation in Afghanistan, the lead opium poppy producer in the world, expanded for a third consecutive time in a row (Graph 10-1). The same holds true for Myanmar, where the area under poppy cultivation reached 57,800 hectares. (World Drug Report, United Nations Office on Drugs and Crime – UNODC, 2014:21). However, Afghanistan recorded the largest growth in its lands under poppy cultivation; from 154,000 hectares in 2012 to 209,000 hectares in 2013 with a 36% increase (UNODC Afghanistan Opium Survey, 2013:10).

Graph 10-1: Area under Opium Poppy Cultivation in Afghanistan (Hectare)

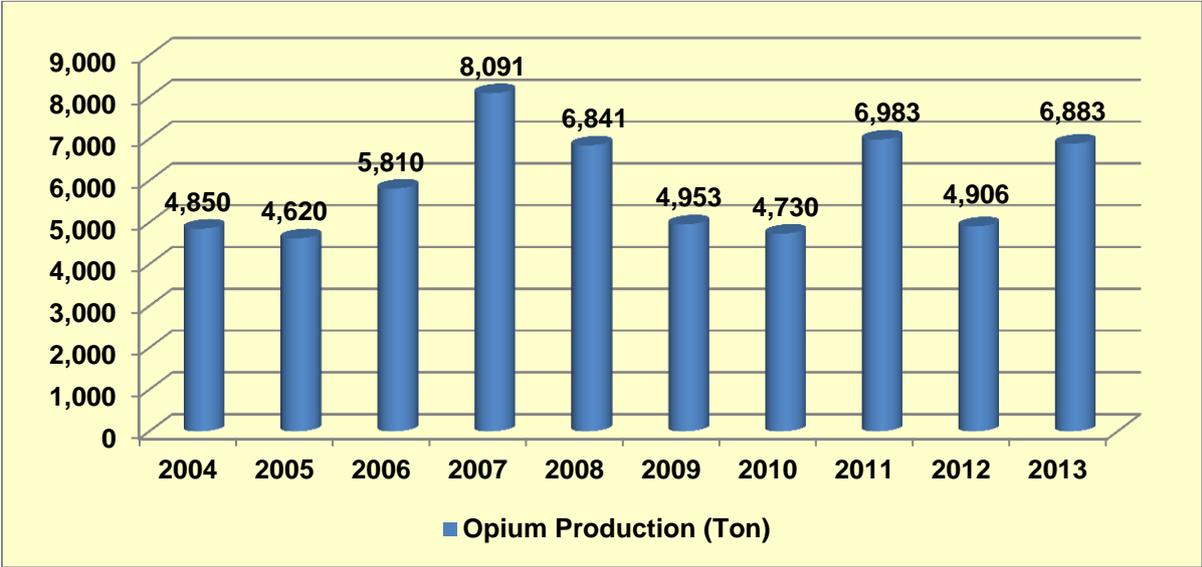


Source: UNODC World Drug Report, 2014.

Global potential opium production was estimated to be 6,883 tons in 2013, indicating a 40.3% increase compared to 2012 (Graph 10-2). Potential opium production in Afghanistan was

estimated to be 5,500 tons in 2013 with a 49% rise compared to 3,700 tons in 2012 (UNODC Afghanistan Opium Survey, 2013:10). Afghanistan accounts for 80% of the global opium production (UNODC World Drug Report, 2014:21)

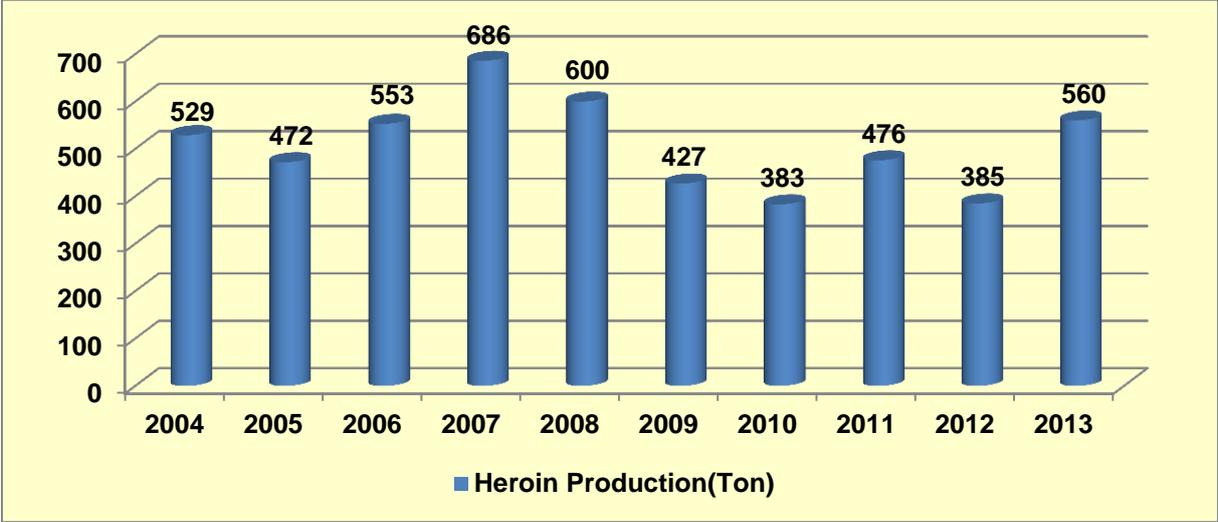
Graph 10-2: Global Potential Opium Production (Ton)



Source: UNODC World Drug Report, 2014.

Potential heroin production reached 560 tons globally in 2013 with a 45.5% increase compared to 2012 (UNODC World Drug Report, 2014:21)

Graph 10-3: Global Potential Heroin Production (Tons)



Source: UNODC World Drug Report, 2014.

The Balkan route, extending from Afghanistan to Western and Central Europe via Iran and Turkey, seems to remain a corridor for the transit of Afghan heroin to the lucrative markets in Western and Central Europe, but its importance has declined due to various factors such as more effective law enforcement and a shrinking market in Western and Central Europe, and thus, the flow of heroin has declined (UNODC World Drug Report, 2014:23). However, the Southern Route that supplies heroin from Southern Afghanistan to Europe, via the Near and Middle East and Africa, as well as directly from Pakistan, is expanding (UNODC World Drug Report, 2014:24).

Below is a summary of the main trends observed in Turkey in 2013 related to opium and derivatives:

- Heroin illegally trafficked from Afghanistan and the Islamic Republic of Iran entered Turkey through Eastern provinces, mainly Hakkari, Van and Ağrı; however recently, heroin from Northern Iraq entered Turkey through the Iraq border gate as well.
- Sea routes were still important for heroin traffickers. It has been determined that recently heroin is tried to be shipped Europe in the Eastern Mediterranean Route through Africa and in the Northern Black Sea Route through Georgia.
- The Black Sea coast line in Turkey became an important route for heroin traffickers in recent years.
- Drug trafficking by means of cargo deliveries continued.
- In order to minimize risk, narcotics crime organizations were tailored to target a greater number of shipments that contain smaller amounts of substances. In previous years large amounts of substances were confiscated at once. In addition, there has been an increase in high-stakes heroin seizures in border gates in 2013 compared to previous years.
- Different routes such as the Islamic Republic of Iran-Turkey-Georgia-Ukraine-European countries, and the Islamic Republic of Iran-Turkey-Syria-Lebanon were identified (2013 Anti-Smuggling and Organized Crimes Report by the Turkish National Police, 2014).

Cannabis continues to be the most widely used and most frequently seized substance in Turkey, as was the case throughout the world. Cannabis produced in Turkey is placed on the domestic market by criminal organizations. It is mostly produced and consumed in the form of powder in Turkey. While cannabis herb is grown in almost every country in the world, the production of cannabis resin is confined to only a few countries in North Africa, the Middle East and South-West Asia. (UNODC World Drug Report, 2014:39). Flows of cannabis from the Islamic Republic of Iran and Syria into Turkey were detected. Greenhouse cultivation that is

not common in Turkey was revealed as a result of an operation conducted in Antalya, and 1 ton 854 kilograms of cannabis was confiscated (2013 Anti-Smuggling and Organized Crimes Report by the Turkish National Police, 2014).

Turkey is affected by cocaine trafficking both as a transit and destination country. The cocaine trafficking that is destined for Turkey departs from Argentina, Brazil, Ecuador, Paraguay, and Venezuela. In a large number of cases where Turkey is a country of destination, cocaine is first dispatched to West Africa, and then to Turkey. Cocaine is shipped from South America to Turkey either via sea or air cargo. Furthermore, it can be forwarded to inner regions via roads once it reaches Europe and the Middle East. Cocaine operations in Turkey mostly target drug mules at the airports. While West Africans constituted the majority of drug mules seized in previous years in Turkey, the number of European mules increased in 2013 (2013 Anti-Smuggling and Organized Crimes Report by the Turkish National Police, 2014).

Turkey is a country of destination for ecstasy as well. The majority of ecstasy seized in Turkey in 2013 originated from the Netherlands and Belgium. Ecstasy is dispatched from European countries to Turkey by sea, air, and land routes. High quality ecstasy has reappeared in the drug market in recent years. This appears to result from illicit producers importing non-controlled or 'masked' chemicals for the manufacture of the drug (EMCDDA European Drug Report, 2014:14). In parallel with the increased amount of MDMA contained in ecstasy tablets, a higher level of purity in the ecstasy tablets confiscated in Turkey in 2013 was observed.

Turkey is again both a country of transit and a destination for captagon, as the brand name of an amphetamine type stimulant. The production of captagon is gradually growing in the Middle East in recent times (UNODC 2011). Analyses performed on captagon tablets seized in recent years in Turkey suggest that many of them contain amphetamine as the active substance.

Methamphetamine seized in Turkey generally originates from the Islamic Republic of Iran. Methamphetamine trafficked from the Islamic Republic of Iran mostly by land routes is transferred through Turkey to Asia-Pacific countries such as Malaysia, Thailand, Singapore, Japan, Indonesia, Vietnam, and Australia by means of drug mules and cargo. Methamphetamines are also delivered to European countries and Syria via land routes through Turkey (2013 Anti-Smuggling and Organized Crimes Report by the Turkish National Police, 2014).

Turkey is a country of destination in the trafficking of synthetic cannabinoids, which illegally enter Turkey from European countries, the USA, and China. Active substances that are

shipped to Turkey are mixed with or sprayed onto dried herb leaves such as sage and damiana, packed in two-to-three gram packages, and released to the market. In Turkey, synthetic cannabinoids are seized in liquid, powder, and tablet forms as well.

10.3. Seizures

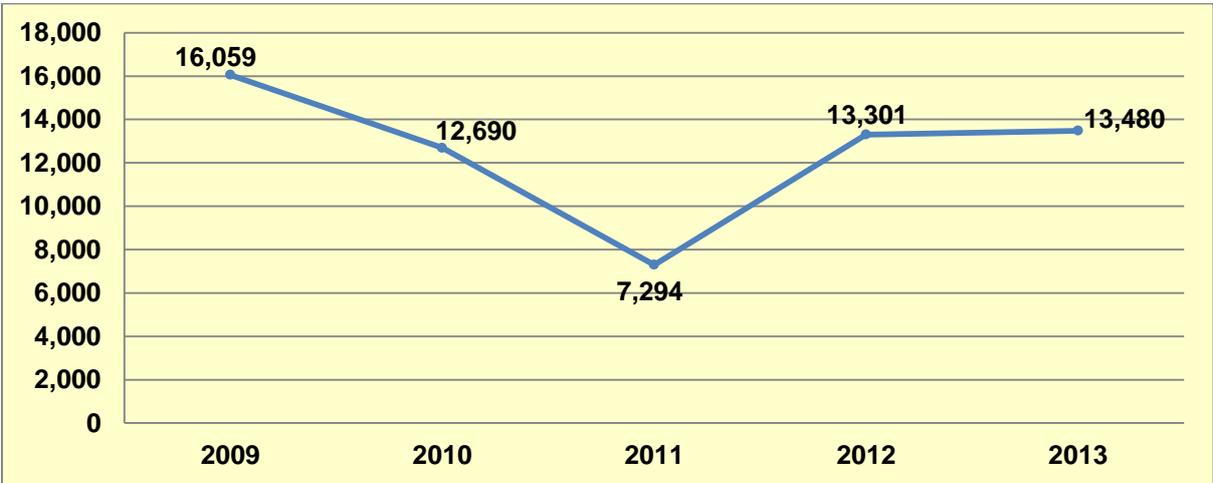
10.3.1. Opium and Derivatives

210 kilograms of opium were confiscated in Turkey in 2013. There is scarcely any demand for opium in Turkey’s domestic market. In 2012 and 2013, the majority of opium substances were seized while they were to be shipped by cargo to Canada, the USA, England, Australia, and Albania.

Only 55,838 kilograms of morphine base were seized in the last four years including three kilograms of morphine base that were seized in 2013. This is due to drug organizations producing heroin in the regions close to the areas under opium poppy cultivation. Indeed, 98.44% of the opium and derivatives that were confiscated in Turkey in 2013 were in the form of heroin.

In 2013, 13,480 kilograms of heroin were seized in Turkey. The downward trend observed in heroin seizures since 2009 reversed in 2012, with a substantial increase as high as 82.36% compared to the previous year. There was a 1.35% rise in heroin seizures in 2013 compared to 2012.

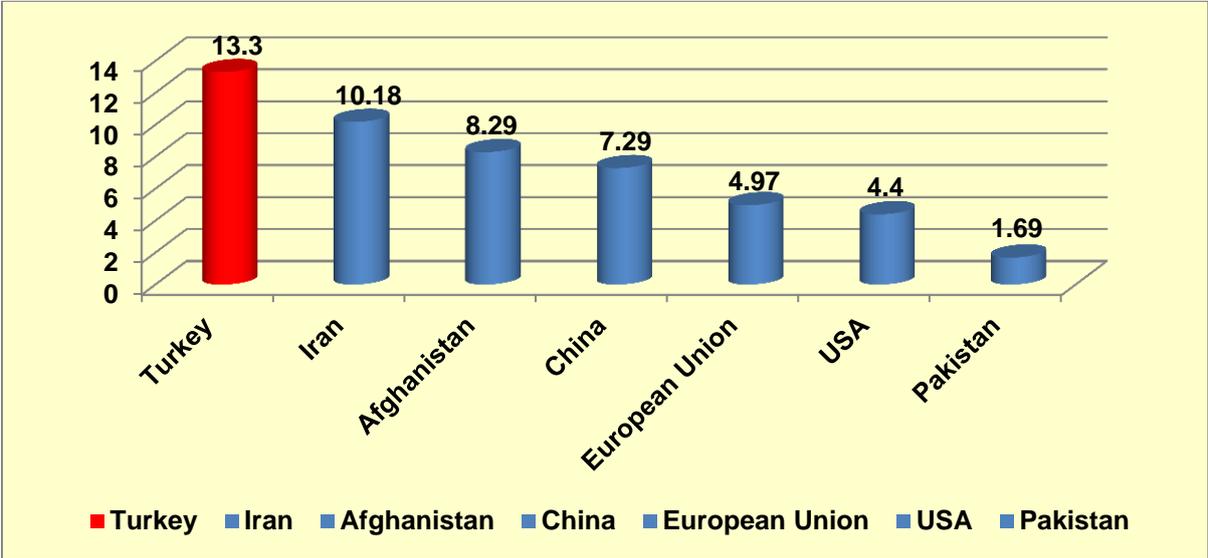
Graph 10-4: Total heroin amounts seized by year (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

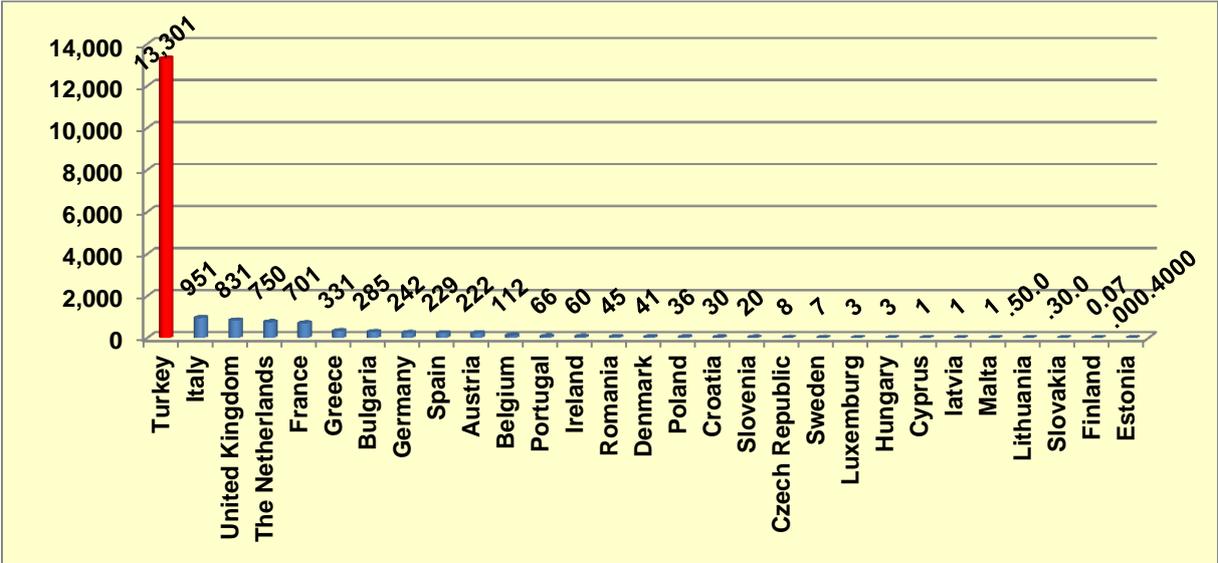
Turkey reported the largest amount of heroin seized in the world in 2012 (UNODC World Drug Report, 2014), and each year since 2006, more heroin was seized in Turkey than in all EU countries combined (EMCDDA European Drug Report, 2014:21, 22).

Graph 10-5: Countries that seized the largest amounts of heroin in 2012 (tons)



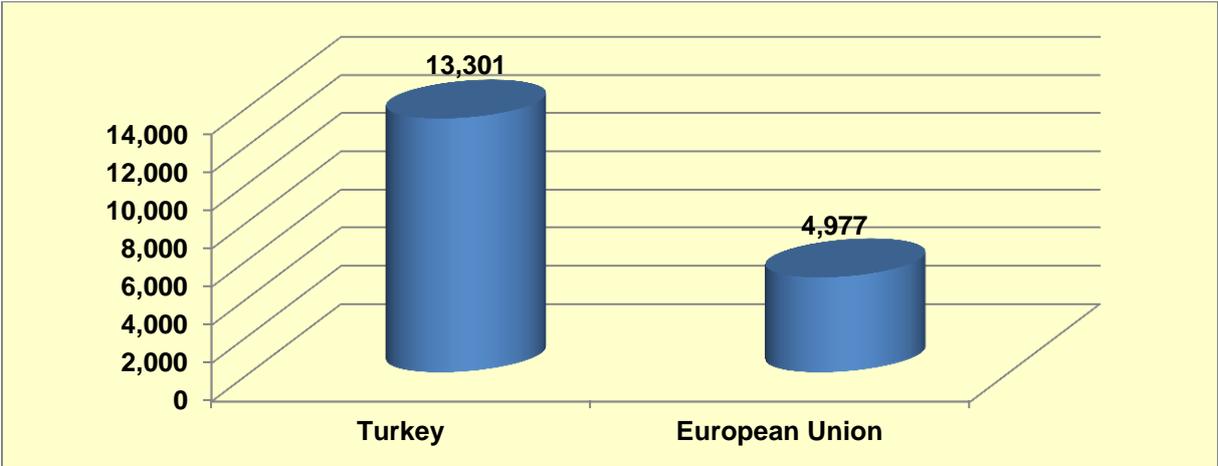
Source: UNODC World Drug Report, 2014.

Graph 10-6: Heroin seizures in the EU and Turkey in 2012 (kg)



Source: EMCDDA European Drug Report, 2014.

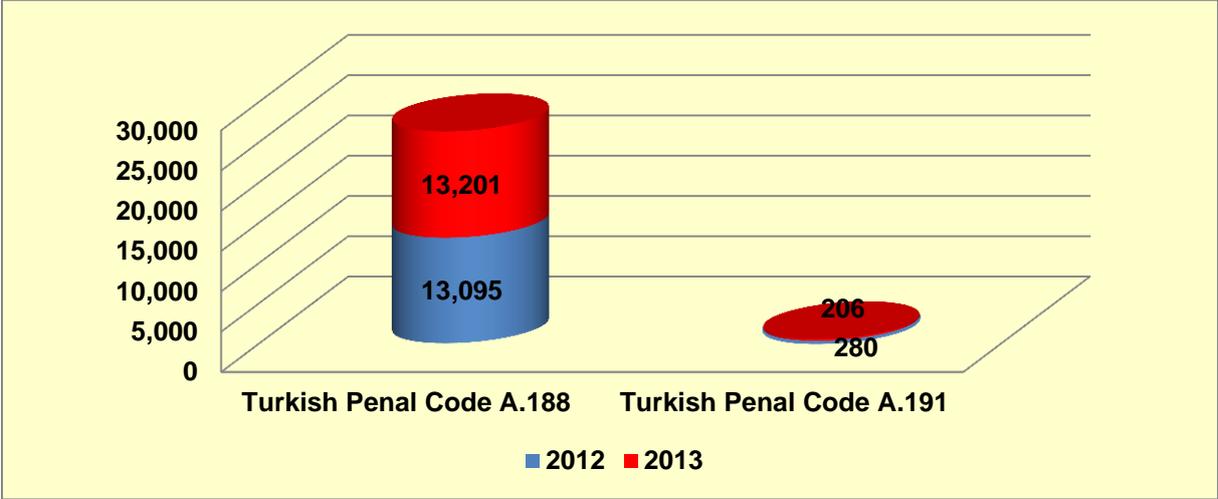
Graph 10-7: Comparison of heroin amounts seized in the EU and Turkey in 2012 (kg)



Source: EMCDDA European Drug Report, 2014.

When the amounts of heroin that were seized in Turkey in 2013 are analyzed in terms of type of crime, it is reported that 13,201 kilograms (97.93%) of heroin were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 280 kilograms (2.07%) of heroin were seized as part of Article 191 of the Turkish Penal Code related to the purchasing, accepting, or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-8).

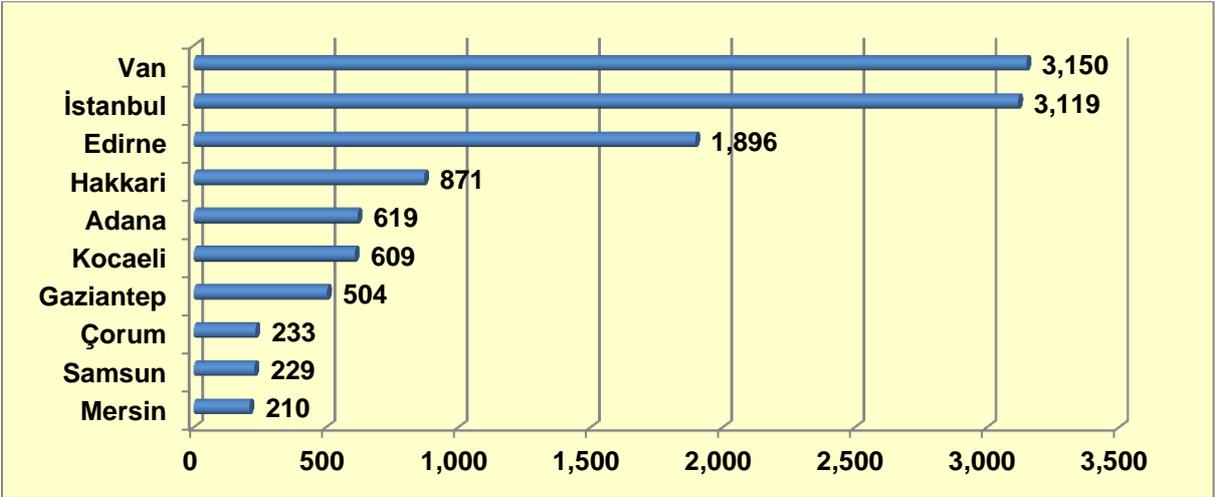
Graph 10-8: Distribution of the amount of heroin seized in 2013 by type of crime (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

In terms of the distribution of the amount of heroin confiscated in Turkey by province, the largest amounts of heroin were seized in Van, İstanbul, Edirne, and Hakkari, and the amount of heroin seized in these provinces constituted 67% of the total amount seized. Afghan heroin enters Turkey through Iran from Van and Hakkari, and exits Turkey for Europe from İstanbul and Edirne.

Graph 10-9: Top ten provinces with the largest amounts of heroin seized in 2013 and the amounts seized (kg)

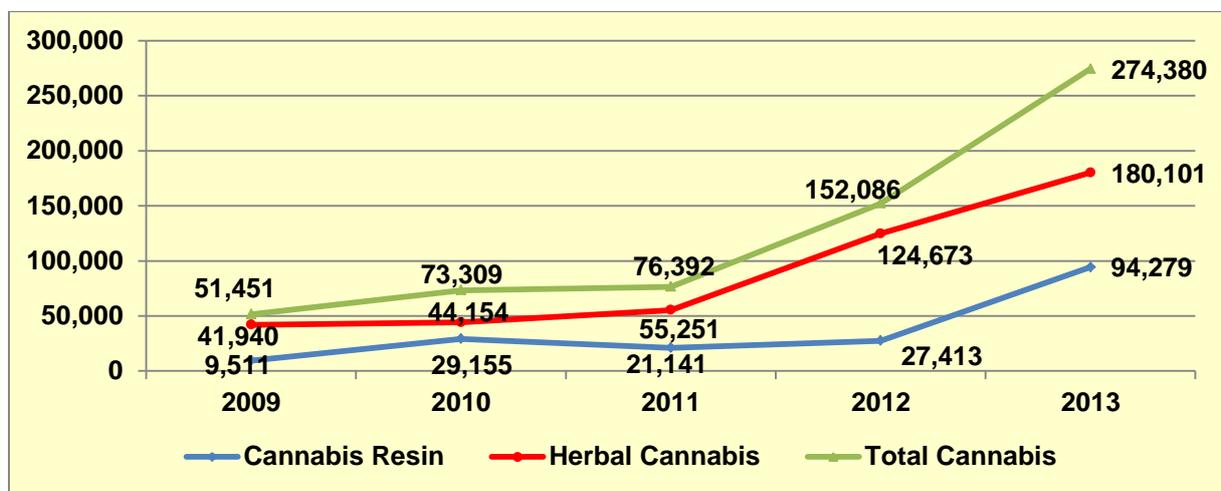


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.3.2. Cannabis

In 2013, 274,380 kilograms of cannabis were confiscated in Turkey. The upward trend observed in cannabis seizures for a long time continued in 2013. An increase of 433% was recorded in cannabis seizures in the last five years. The amount of cannabis seized in 2013 rose by 80.41% in 2013 compared to 2012. There was a 243% increase in the amount of cannabis resin, and 44.46% increase in the amount of herbal cannabis seized in 2013 compared to 2012.

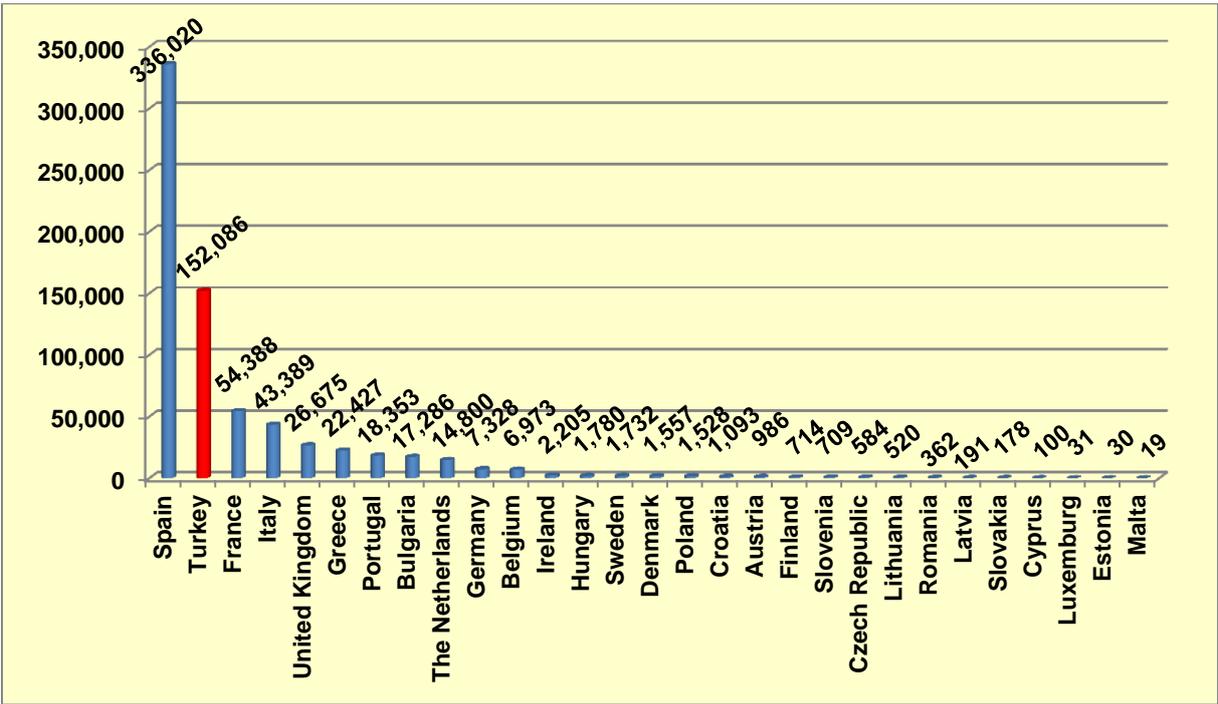
Graph 10-10: Total amounts of cannabis seized by year (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Turkey became the second country that seized the largest amount of cannabis throughout Europe in 2012 (Graph 10-11).

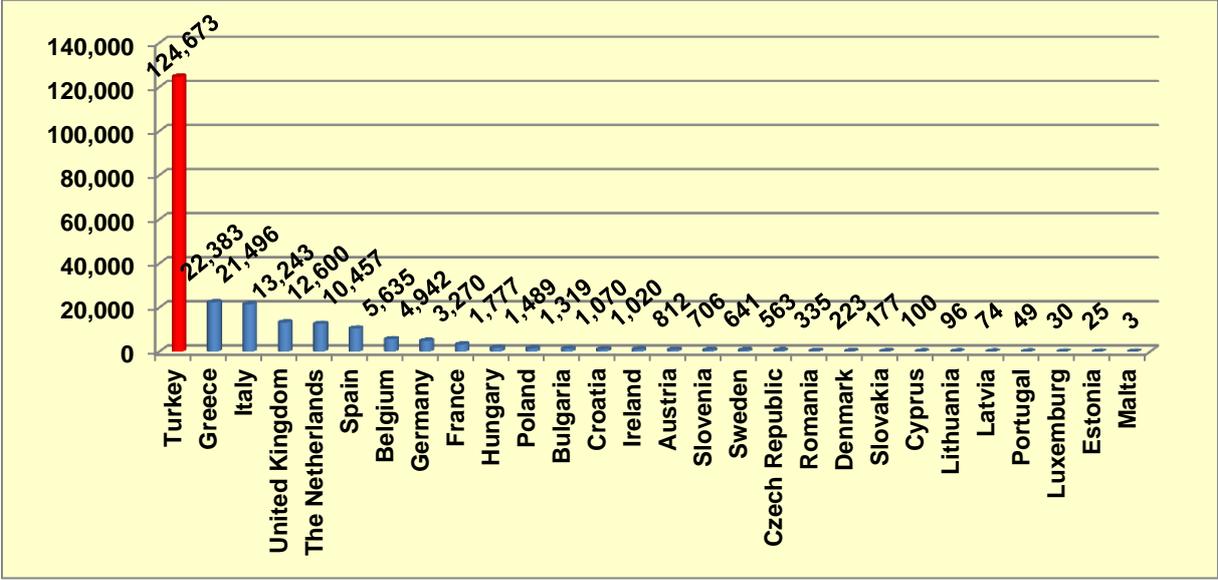
Graph 10-11: Cannabis Seizures in the EU and Turkey in 2012 (kg)



Source: EMCDDA European Drug Report, 2014.

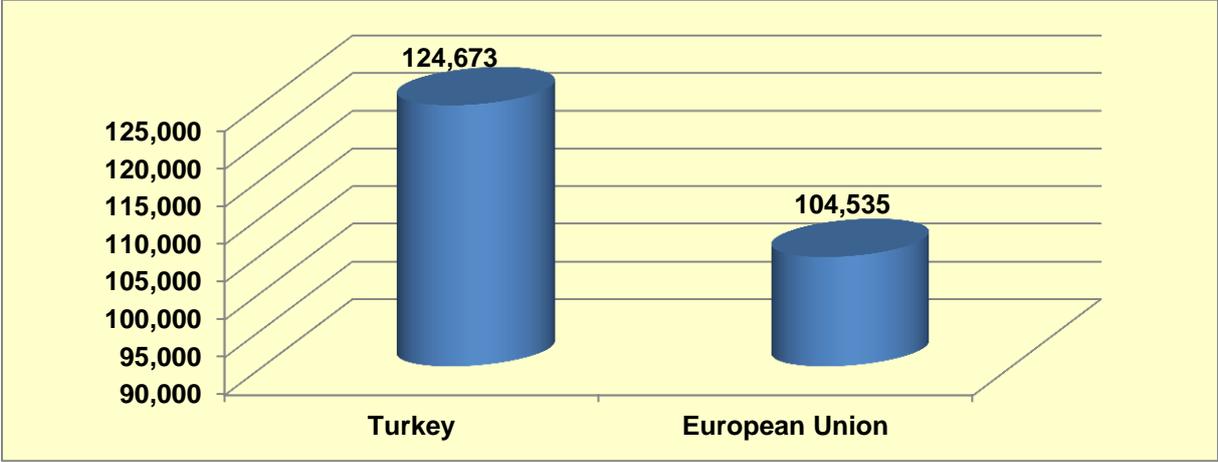
Since 2007, Turkey has seized larger quantities of herbal cannabis than any of the EU Member States (EMCDDA European Drug Report, 2014:20). There continues to be evidence that cannabis resin is decreasing in popularity in Europe. Whereas cannabis resin had previously dominated the market, now there are nearly equivalent levels of resin and herb seizures, implying a continuing shift away from imported resin coming mainly from Morocco to more locally or regionally produced cannabis herb (UNODC World Drug Report, 2014:42).

Graph 10-12: Herbal cannabis seizures in the EU and Turkey in 2012 (kg)



Source: EMCDDA European Drug Report, 2014.

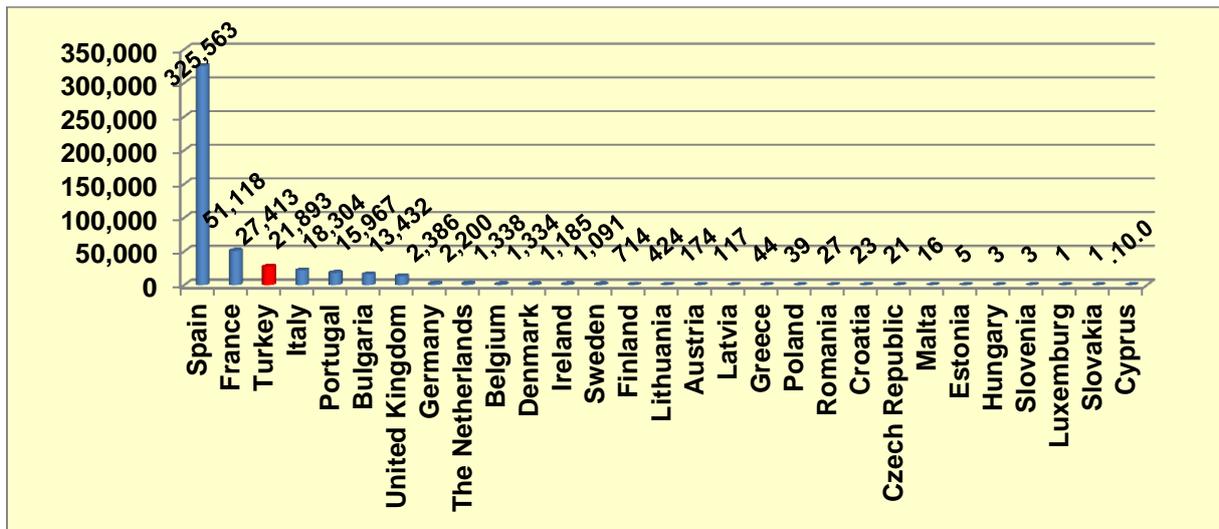
Graph 10-13: Comparison of the amounts of herbal cannabis seized in the EU and Turkey in 2012 (kg)



Source: EMCDDA European Drug Report, 2014.

Turkey became the third country to seize the largest amount of cannabis resin in Europe in 2012. Considering the significant 243% increase in the amount of cannabis resin seized in Turkey in 2013, Turkey is envisaged to rank among the top countries to seize the largest amount of cannabis resin.

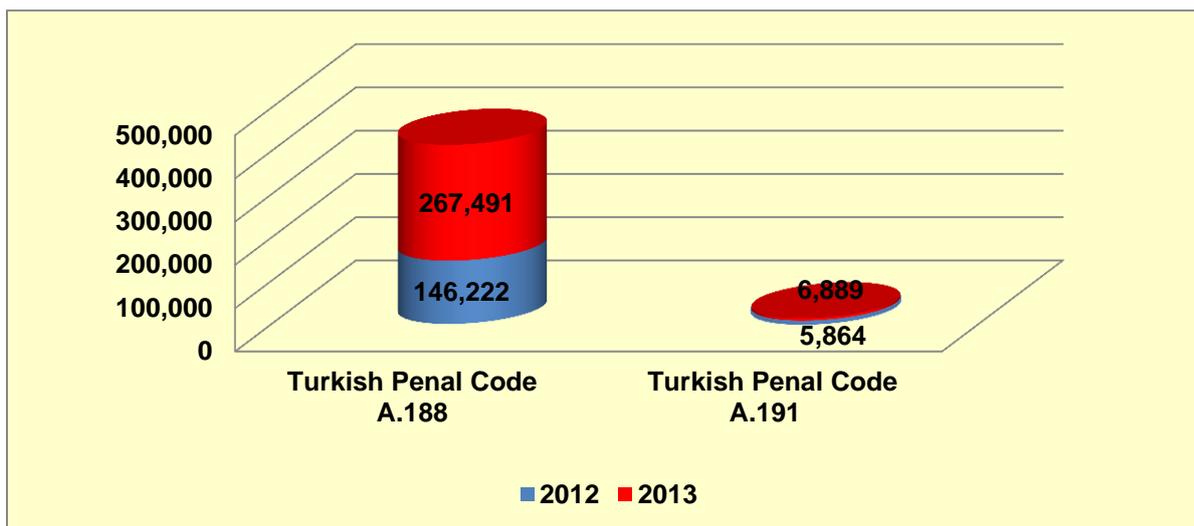
Graph 10-14: Cannabis resin seizures in the EU and Turkey in 2012 (kg)



Source: EMCDDA European Drug Report, 2014.

When the amounts of cannabis that were seized in Turkey in 2013 are analyzed in terms of type of crime, it is reported that 267,491 kilograms (97.49%) of cannabis were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 6,889 kilograms (2.51%) of cannabis were seized as part of Article 191 of the Turkish Penal Code related to the purchasing, accepting, or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-15).

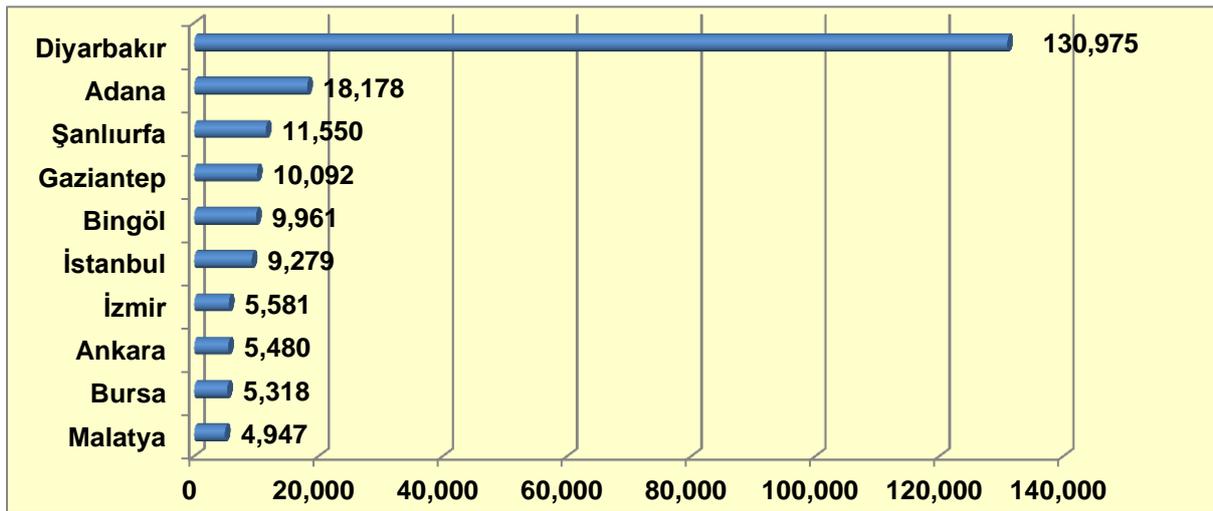
Graph 10-15: Distribution of the amounts of cannabis seized in 2013 by type of crime (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The largest amount of cannabis was seized in Diyarbakır in 2013, as was the case in recent years. The amount of cannabis seized in this province accounted for nearly half (47.73%) of the total amount.

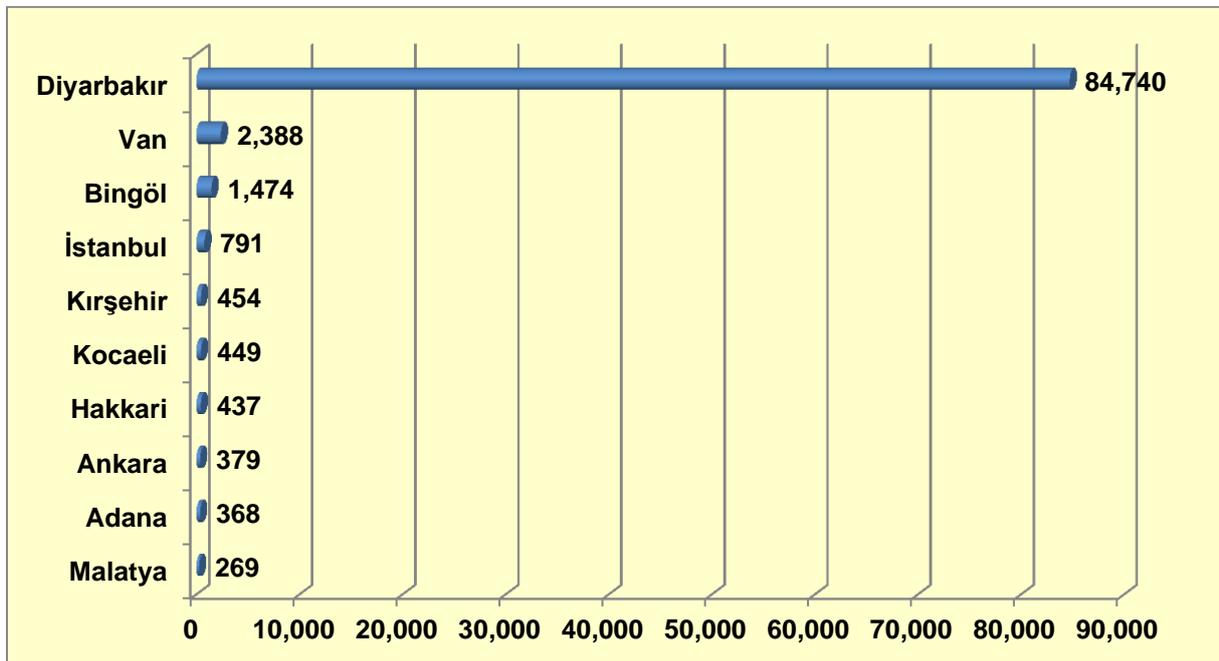
Graph 10-16: Top ten provinces with the largest amounts of cannabis seized in 2013 and the amounts seized (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The largest amount of cannabis resin was seized in Diyarbakır in 2013. The amount of cannabis resin seized in this province accounted for nearly the whole amount (89.88%).

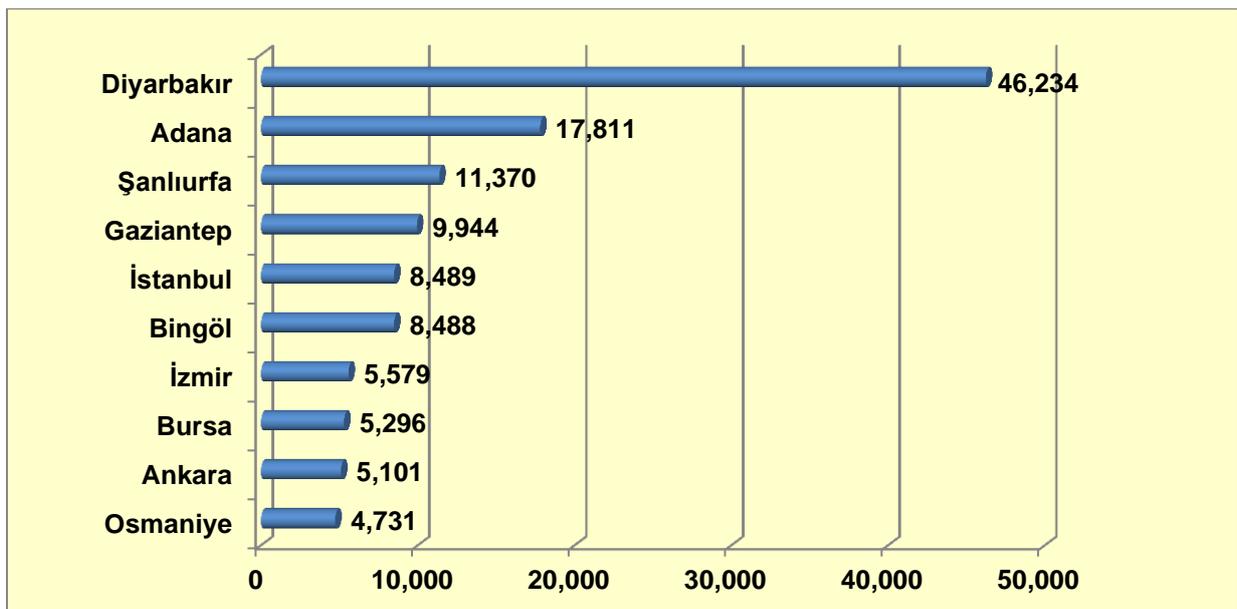
Graph 10-17: Top ten provinces with the largest amounts of cannabis resin seized in 2013 and the amounts seized (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014

The largest amount of herbal cannabis was seized in Diyarbakır in 2013. The amount of cannabis herbs seized in this province accounted for 25.67% of the total amount.

Graph 10-18: Top ten provinces with the largest amounts of herbal cannabis seized in 2013 and the amounts seized (kg)

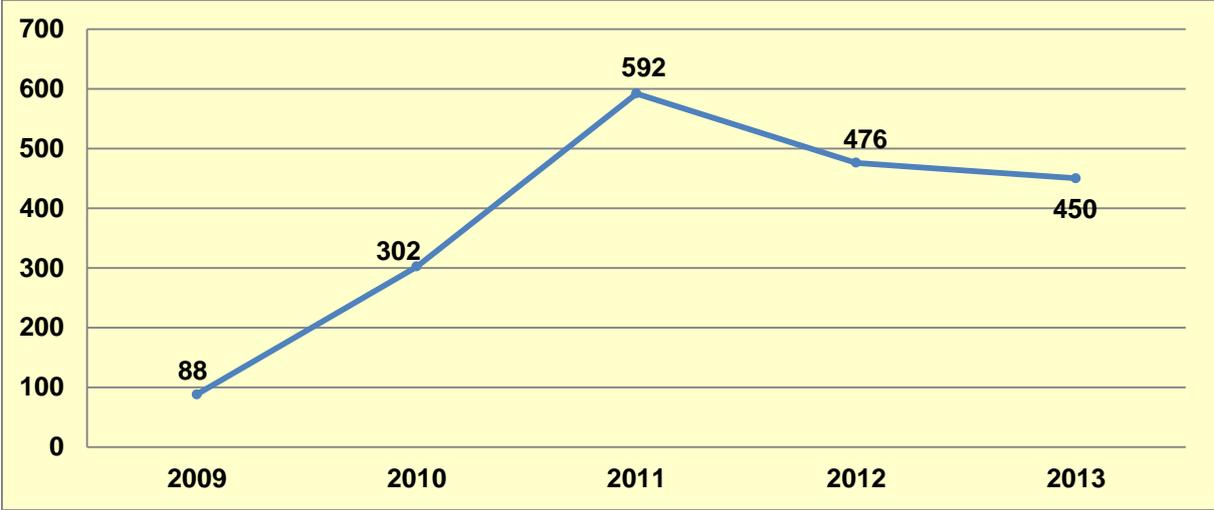


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014

10.3.3. Cocain

450 kg cocaine was seized in Turkey in 2013. While cocaine seizures increased in 2009 – 2011 period, there was a decrease in 2012 and 2013 years. Compared to the previous year cocaine seizures fell by 5.46 % in 2013.

Graph 10-19: Total Amounts of Cocaine Seized by Years (kg)

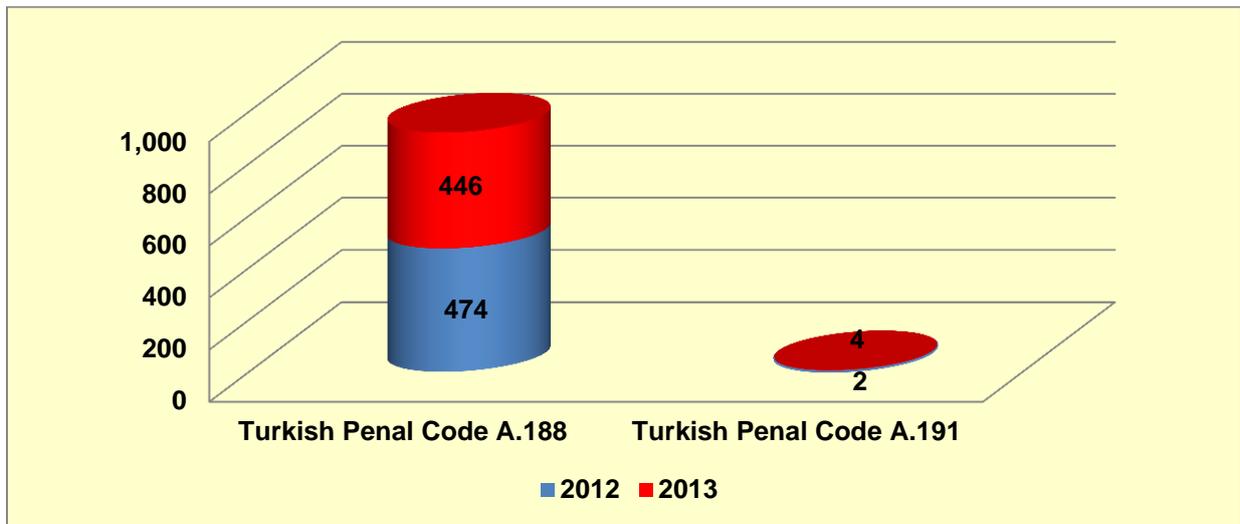


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Coca bush cultivation, which remains limited to Bolivia, Colombia, and Peru, continued to decline in 2012, the lowest levels since the beginning of available estimates in 1990. That decline was driven mainly by a 25% decline in coca bush cultivation in Colombia (UNODC World Drug Report, 2014:34).

When the amounts of cocaine that were seized in Turkey in 2013 are analyzed in terms of type of crime, it is reported that 446 kilograms (99.11%) of heroin were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 4 kilograms (0.89%) of heroin were seized as part of Article 191 of the Turkish Penal Code related to the purchasing, accepting, or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-20).

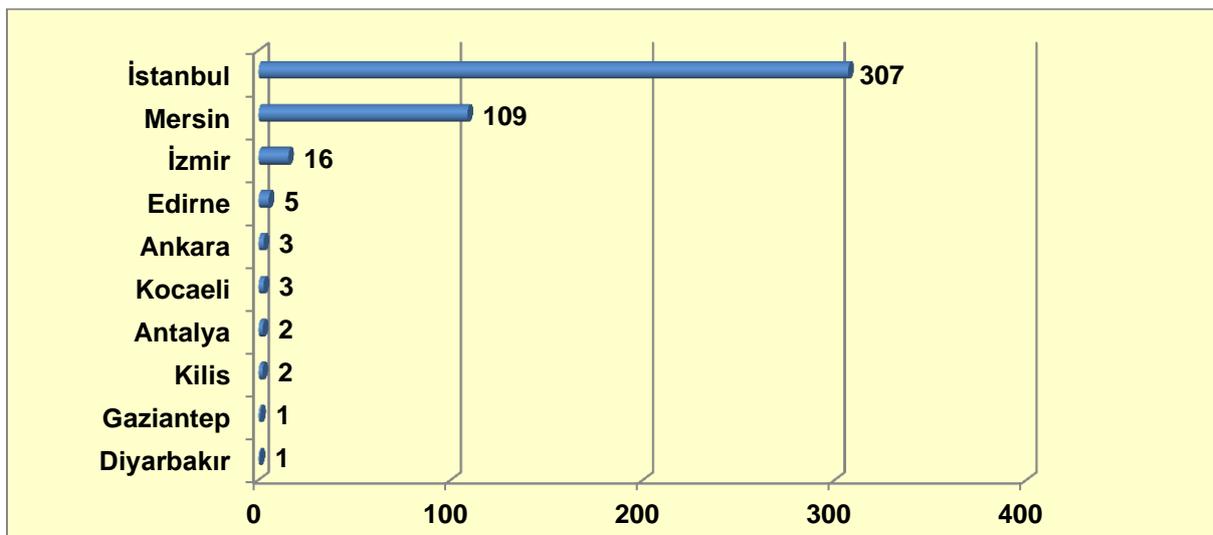
Graph 10-20: Distribution of the amount of cocaine seized in 2013 by type of crime (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

In terms of the distribution of the amount of cocaine seized in Turkey by province, the largest amounts of heroin were seized in Istanbul and Mersin. The amount of cocaine seized in these provinces constituted 92.44% of the total amount seized. In 2013, there were cocaine seizures in 40 provinces out of 81 in Turkey.

Graph 10-21: Top ten provinces with the largest amounts of cocaine seized in 2013 and the amounts seized (kg)



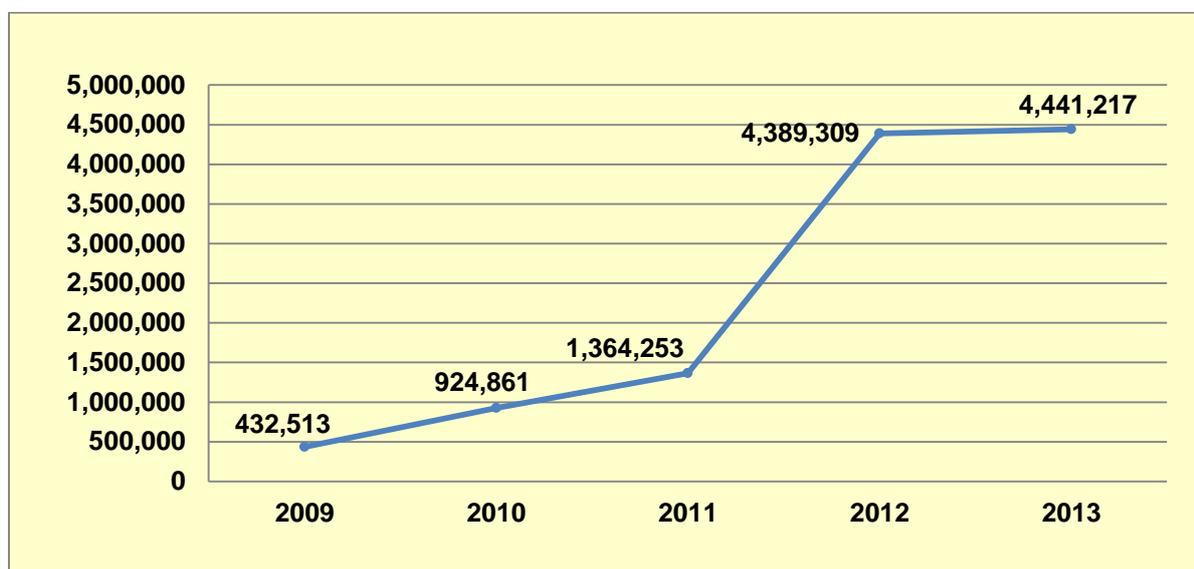
Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.3.4. Ecstasy

In 2013, 4,441,217 ecstasy tablets were seized in Turkey, with a 1.18% increase compared to 2012.

Turkey reported a downward trend in ecstasy seizures between 2005 and 2009. The downward trend resulted from a reduction in demand for ecstasy due to the release of poor quality tablets and alternative tablets into the market, as active substances such as MDMA, MDA, and TMA were replaced by other substances. However this trend reversed as of 2010 with an increase in the number of ecstasy tablets seized. This rise can mainly be attributed to reduced production costs due to low-price alternative chemicals used in ecstasy tablets. SRO (safrole rich oil) and MMDMG (Methyl 3-[(methylenedioxy)phenyl]-2-methyl glycidate) were used as an alternative to PMK (3,4 Ethylenedioxyphenylacetone), which is a high-price substance used in the manufacturing of ecstasy, thus reducing production costs. Lower-price tablets that were placed on the market boosted the demand for ecstasy, thus led to increased seizures.

Graph 10-22: Total amounts of ecstasy tablets seized by year (piece)

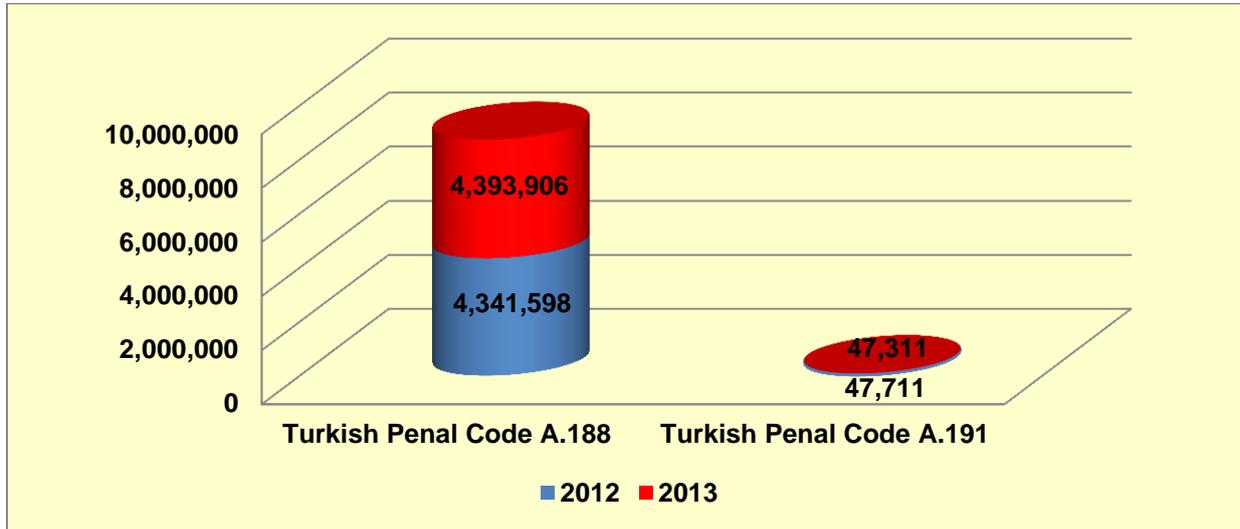


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the amounts of ecstasy that were seized in Turkey in 2013 are analyzed according to type of crime, it is reported that 4,393,906 (98.93%) ecstasy tablets were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 47,311 (1.07%) ecstasy tablets were seized as part of Article 191 of the Turkish

Penal Code related to the purchasing, accepting, or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-23).

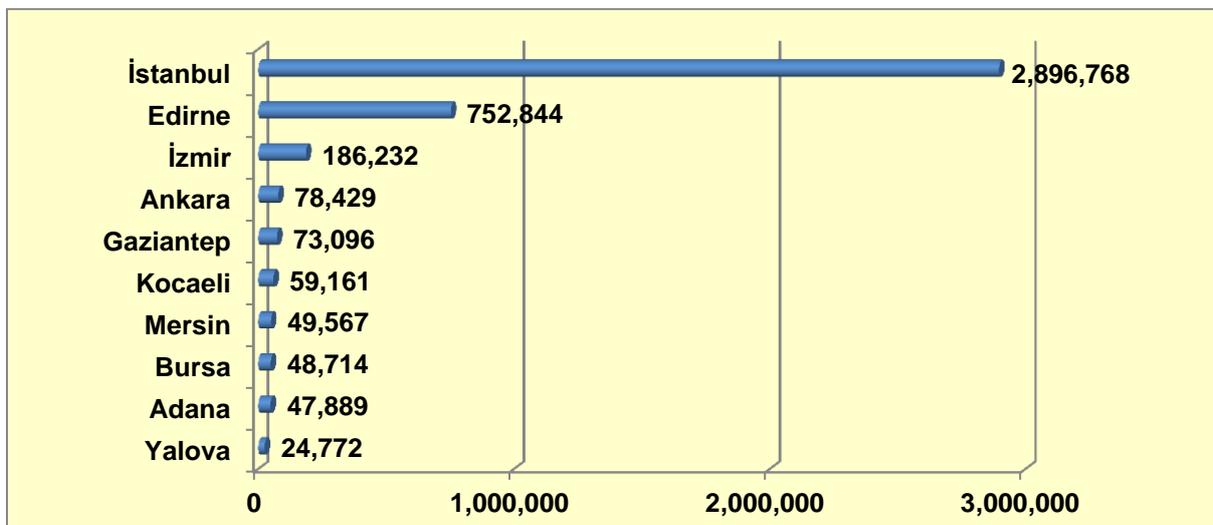
Graph 10-23: Distribution of the amount of ecstasy seized in 2013 by type of crime (piece)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Ecstasy tablets are generally seized in urban areas in Turkey. Istanbul recorded the highest amount of ecstasy seized in 2013, accounting for 65.22% of the total amount seized across Turkey. Istanbul is followed by Edirne, Izmir, and Ankara, respectively.

Graph 10-24: Top ten provinces with the largest amounts of ecstasy seized in 2013 and the amounts seized (piece)

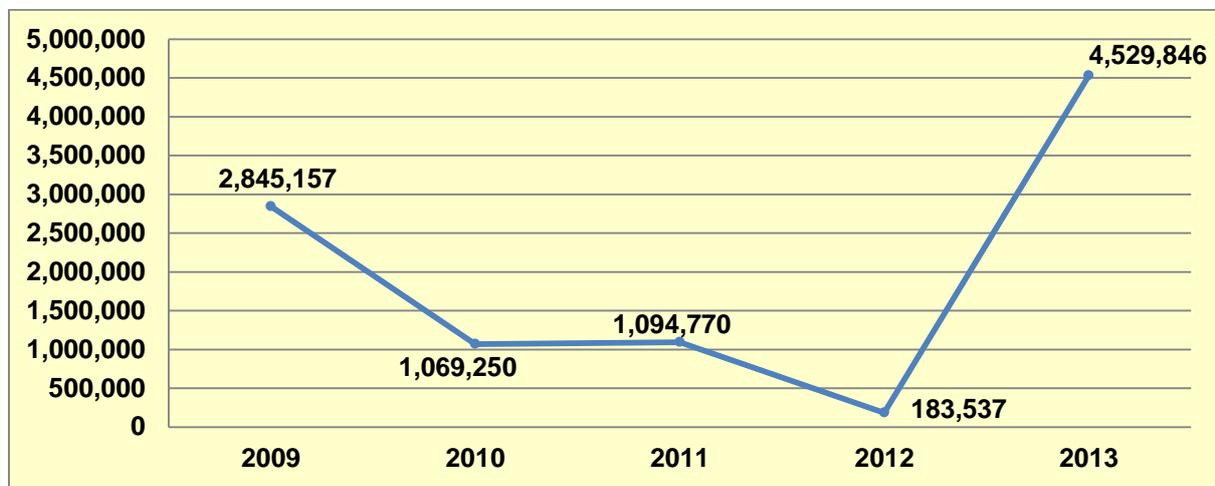


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.3.5. Captagon

In 2013, 4,529,846 captagon tablets were seized in Turkey, with an increase equal to 23.68 times more than the amount seized the previous year. This increase is due to nearly 4,200,000 captagon tablets caught in a single operation in Hatay. It was reported that the captagon tablets seized in this operation were intended to be manufactured in Syria and shipped to the Arabian Peninsula through Turkey (2013 Anti-Smuggling and Organized Crimes Report by the Turkish National Police, 2014).

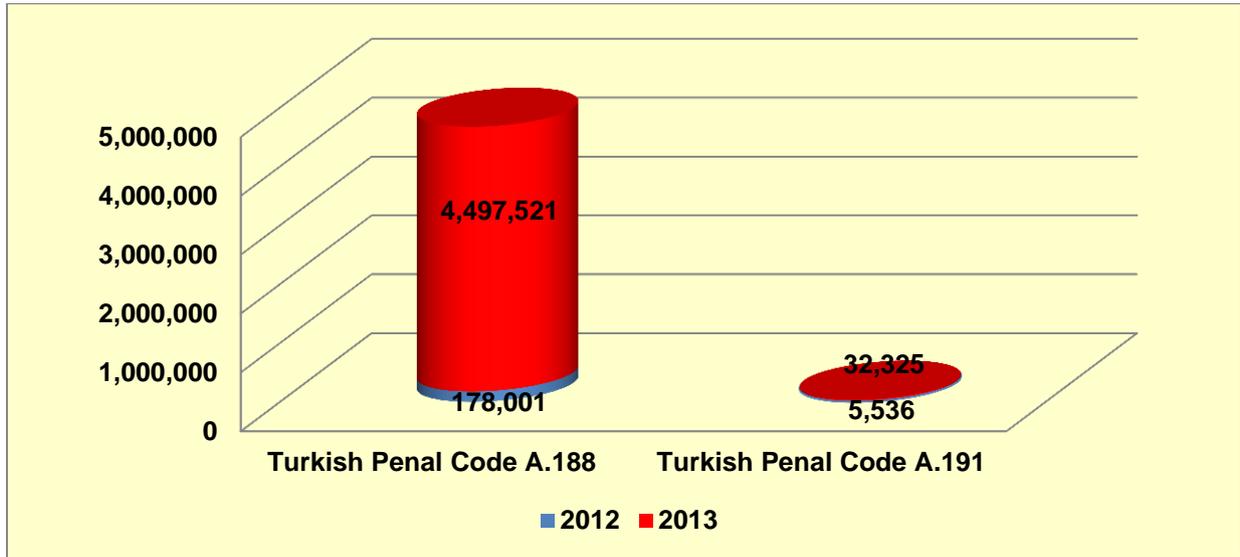
Graph 10-25: Total amounts of captagon tablets seized by year (piece)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the amounts of captagon that were seized in Turkey in 2013 are analyzed according to type of crime, it is reported that 4,497,521 (99.29%) captagon tablets were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 32,325 (0.71%) captagon tablets were seized as part of Article 191 of the Turkish Penal Code related to the purchasing, accepting, or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-26).

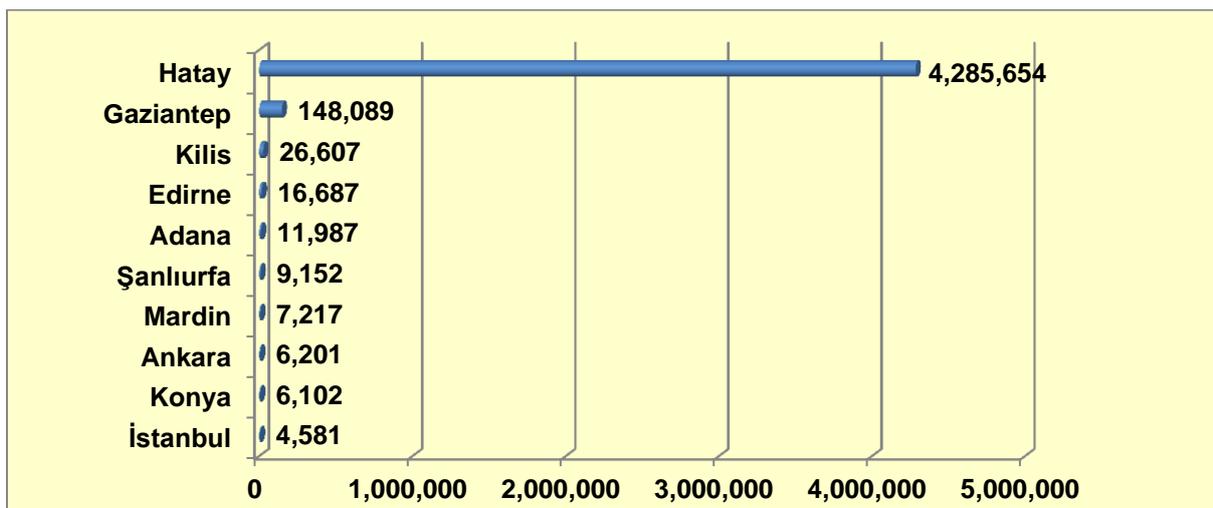
Graph 10-26: Distribution of the amount of captagon tablets seized in 2013 by type of crime (piece)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The largest amount of captagon was seized in Hatay. The amount of captagon seized in this province accounted for nearly the whole amount seized (94.61%). Captagon seizures are concentrated in the provinces that are located on the border with Syria.

Graph 10-27: Top ten provinces with the largest amounts of captagon seized in 2013 and the amounts seized (piece)

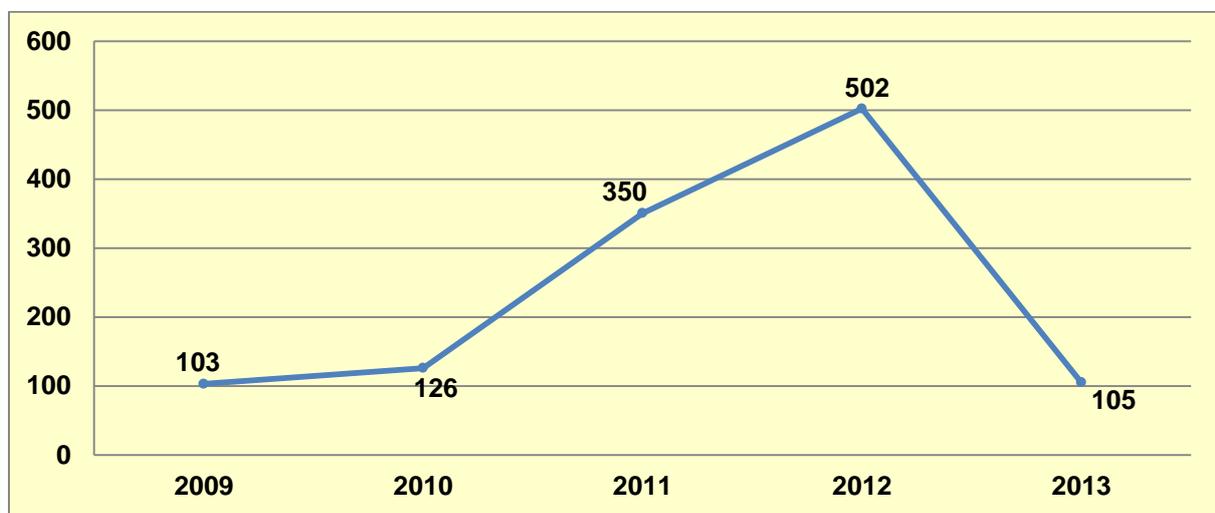


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.3.6. Methamphetamine

In 2013, 105 kilograms of methamphetamine were seized in Turkey. The steady upward trend in methamphetamine seizures between 2009 and 2012 was halted by a 79.08% decrease recorded in 2013 compared to the previous year. As the cause of the sharp decline in methamphetamine seizures is being evaluated starting to use of alternative routes and methods of smuggling and with additional measures especially taken by Customs administrations in eastern border gates from start seeing the substance.

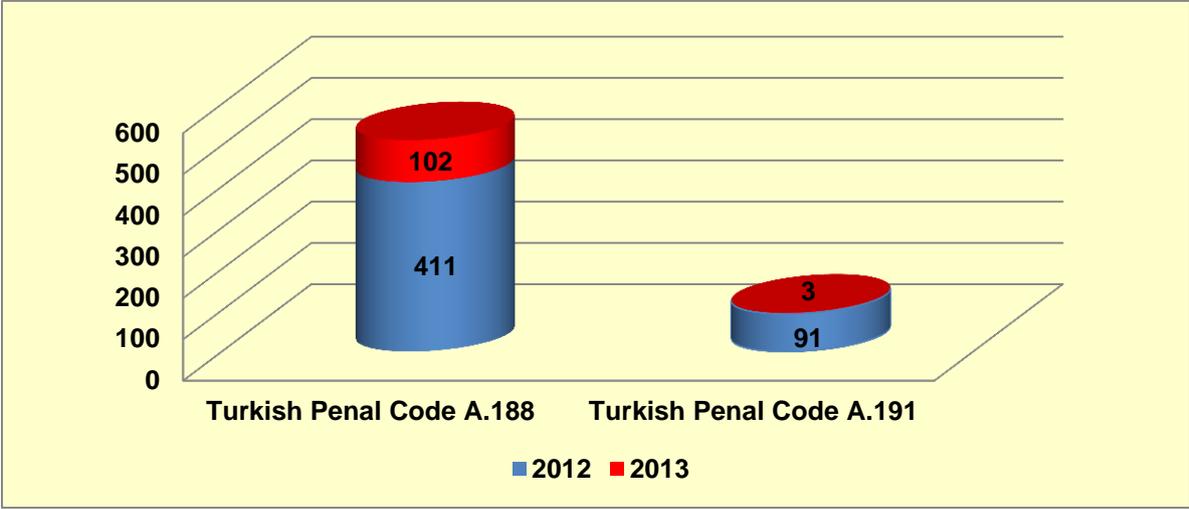
Graph 10-28: Total amounts of methamphetamine seized by year (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the amounts of methamphetamine that were seized in Turkey in 2013 are analyzed according to type of crime, it is reported that 102 kilograms (97.14%) of methamphetamine were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 3 kilograms (2.86%) of methamphetamine were seized as part of Article 191 of the Turkish Penal Code related to the purchasing, accepting or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-29).

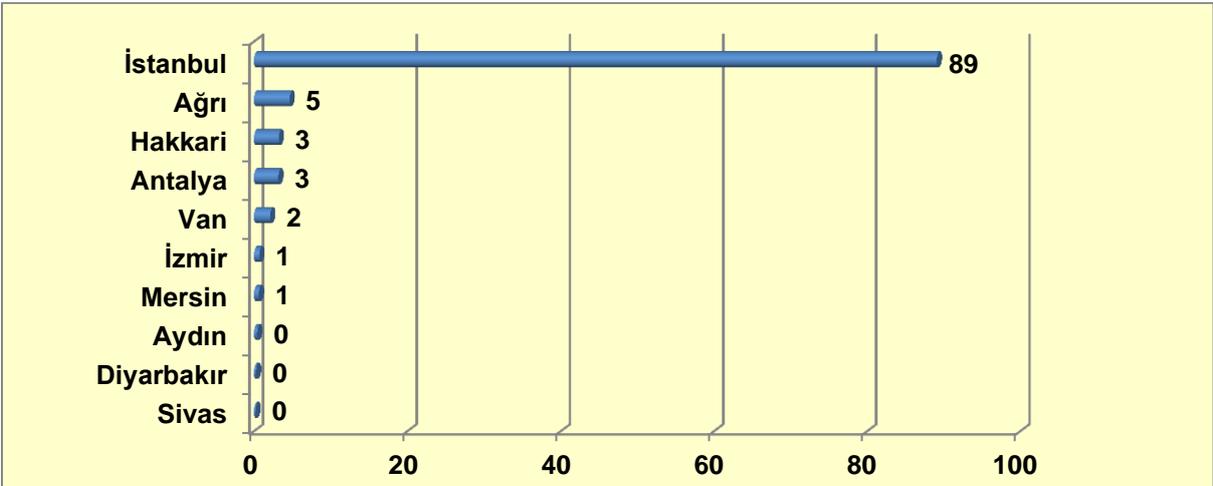
Graph 10-29: Distribution of the amount of methamphetamine seized in 2013 by type of crime (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The majority of methamphetamine seizures took place in Istanbul, accounting for 84.76% of the total seizure across Turkey. Istanbul was followed by Ağrı and Hakkari, where methamphetamine enters Turkey through the Islamic Republic of Iran.

Graph 10-30: Top ten provinces with the largest amounts of methamphetamine seized in 2013 and the amounts seized (kg)

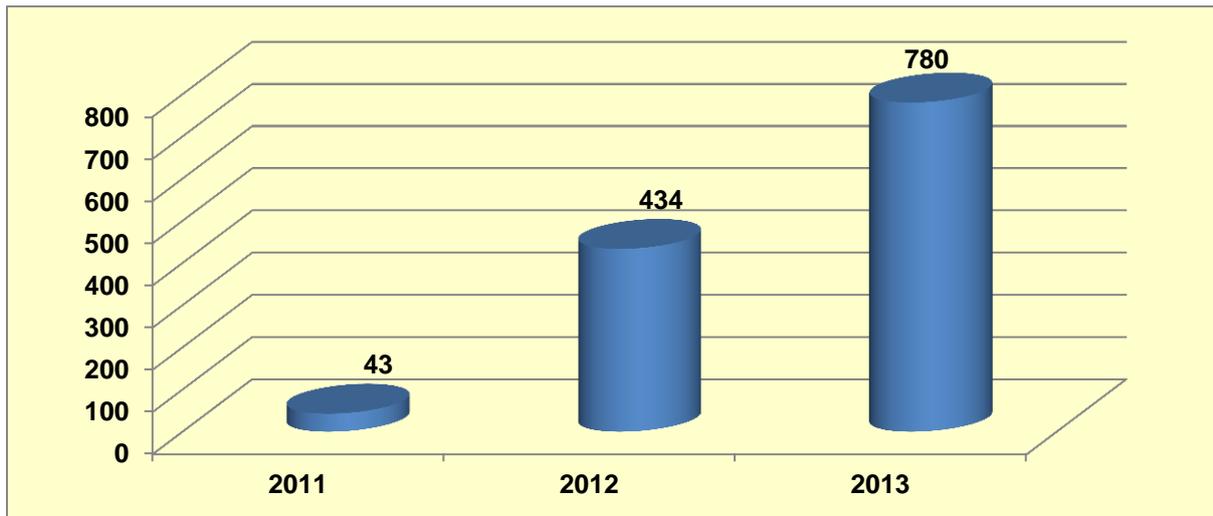


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.3.7. Synthetic Cannabinoids (Bonsai etc.)

In 2013, 780 kilograms of synthetic cannabinoids were caught in Turkey, with a 79.72% increase in seizures compared to the previous year (Graph 10-31). The amount of synthetic cannabinoids seized has increased 17 times since 2011 when they were first seized in Turkey.

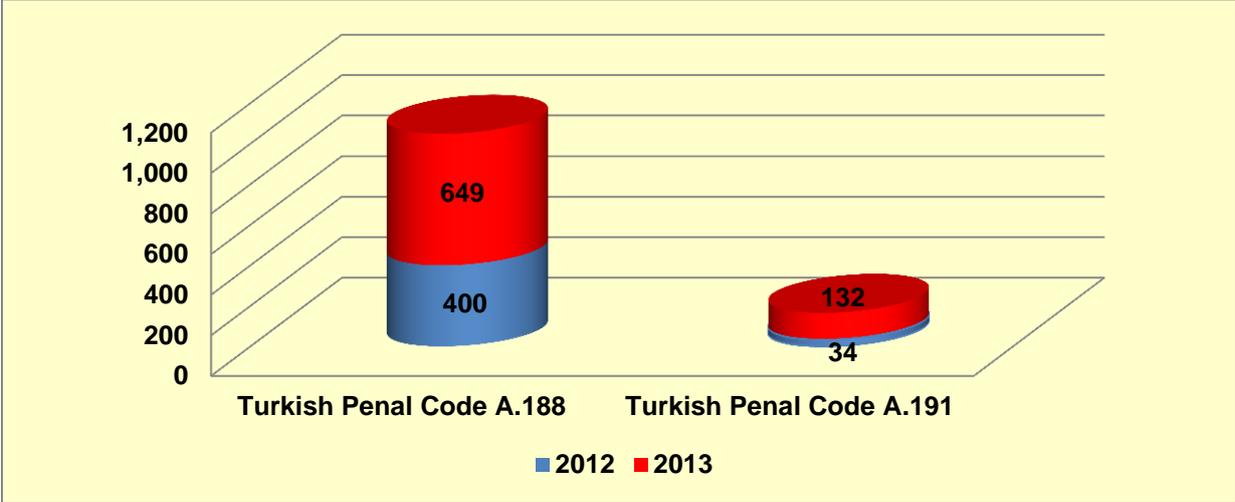
Graph 10-31: Total amounts of synthetic cannabinoids seized by year (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

When the amounts of synthetic cannabinoids that were seized in Turkey in 2013 are analyzed according to type of crime, it is reported that 649 kilograms (83.21%) of synthetic cannabinoids were seized as part of Article 188 of the Turkish Penal Code related to the manufacturing and trafficking of drugs and stimulants; 132 kilograms (16.79%) of synthetic cannabinoids were seized as part of Article 191 of the Turkish Penal Code related to the purchasing, accepting, or possessing drugs for consumption (EMCDDA Standard Table 13, 2014) (Graph 10-32).

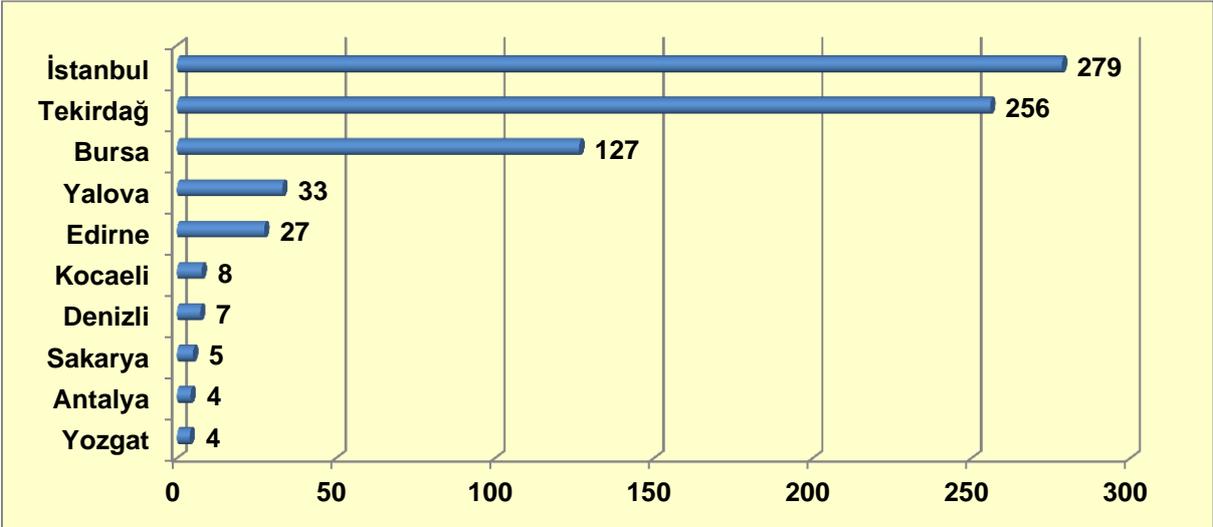
Graph 10-32: Distribution of the amount of synthetic cannabinoids seized in 2013 by type of crime (kg)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

The largest amounts of synthetic cannabinoids were seized in Istanbul, Tekirdağ, and Bursa. The amount of synthetic cannabinoids seized in these provinces accounted for 84.87% of the total amount seized throughout the country (Graph 10-33).

Graph 10-33: Top ten provinces with the largest amounts of synthetic cannabinoids seized in 2013 and the amounts seized (kg)

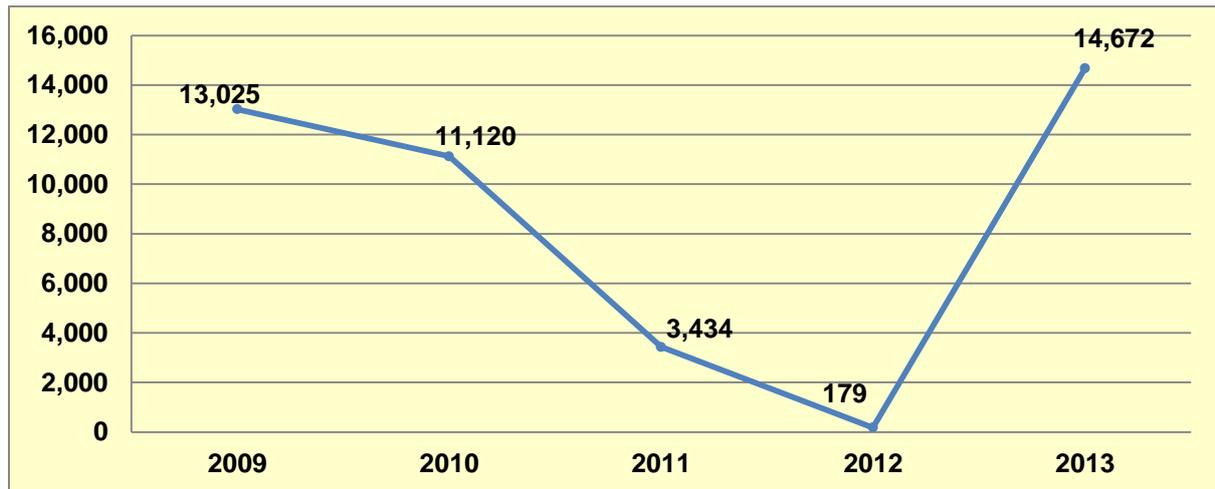


Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.3.8. Acetic Anhydride

In 2013, 14,672 liters of acetic anhydride were seized in Turkey. Nearly 12 tons of acetic anhydride seized in a single operation in the province of Edirne in 2013 pushed the amount seized far beyond that of 2012.

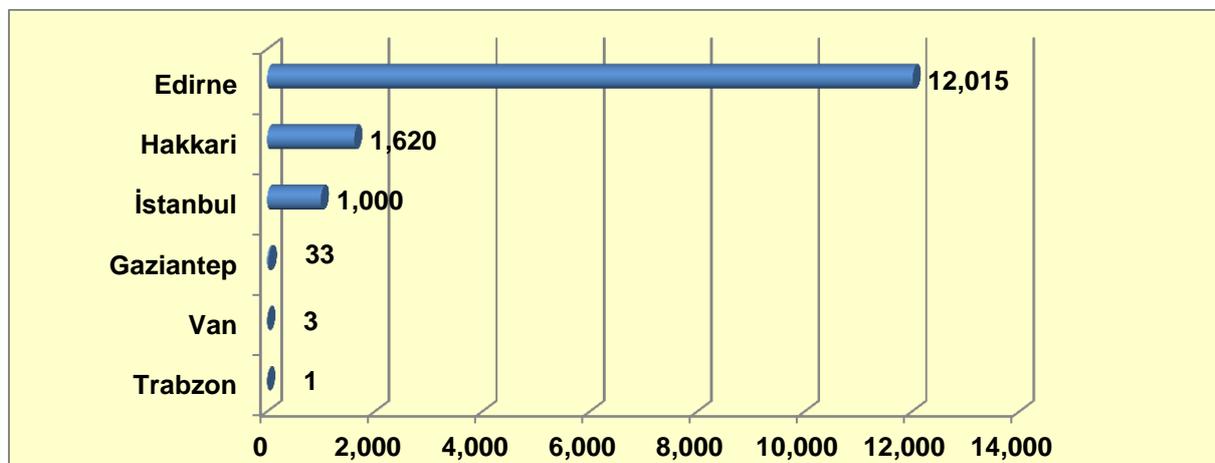
Graph 10-34: Total amounts of acetic anhydride seized by year (liter)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

81.89% of the acetic anhydride seized in 2013 was seized in a single operation conducted in Edirne.

Graph 10-35: Top provinces with the largest amounts of acetic anhydride seized in 2013 and the amounts seized (liter)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

10.4. Availability

10.4.1. Street-Level and Wholesale Prices of Substances

Tülay ÇERÇİ²⁹

It is very significant to determine “wholesale and street-level prices of drugs” via scientific methods in order to ensure an accurate understanding of the drug problem, and define suitable combatting strategies.

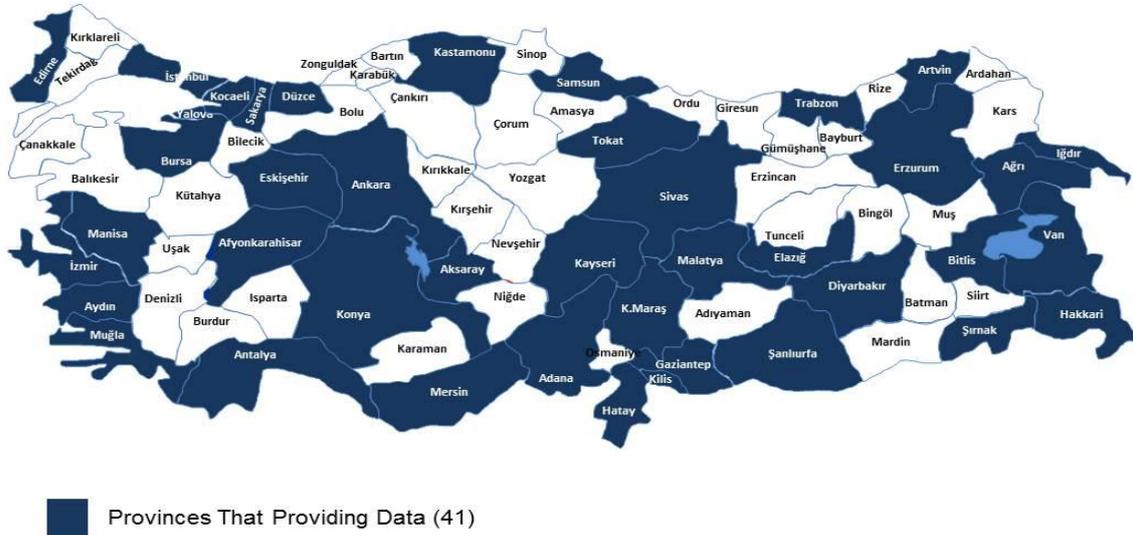
In line with the circular issued by TUBİM and delivered to 81 provinces in Turkey in 2007, drug prices have been notified twice a year, in January and June, through a printed form attached to the circular letter.

In order to determine drug prices in the country more scientifically, and to ensure adequate data entry regarding Turkey in EMCDDA, the Counter-Narcotics Department under the Directorate of Security in Istanbul developed software entitled “*Drug Price Project*” in 2011 that was coordinated by TUBİM. The aim of the project was to ensure the collection of the relevant data through Polnet. Wholesale and street-level prices of drugs are now gathered by means of this project.

The web-based software developed as part of the project ensured the collection of the relevant data digitally on Polnet three times a year. At the first stage, 21 provinces were identified as pilot provinces and included in the project according to several criteria such as geographic location, amount of seizures, variety of drugs seized, and number of drug-related cases. With 20 more provinces added in 2012, the relevant data have been gathered from 41 provinces (Figure 10-2).

²⁹ TUBİM (Turkish Monitoring Center for Drugs and Drug Addiction)

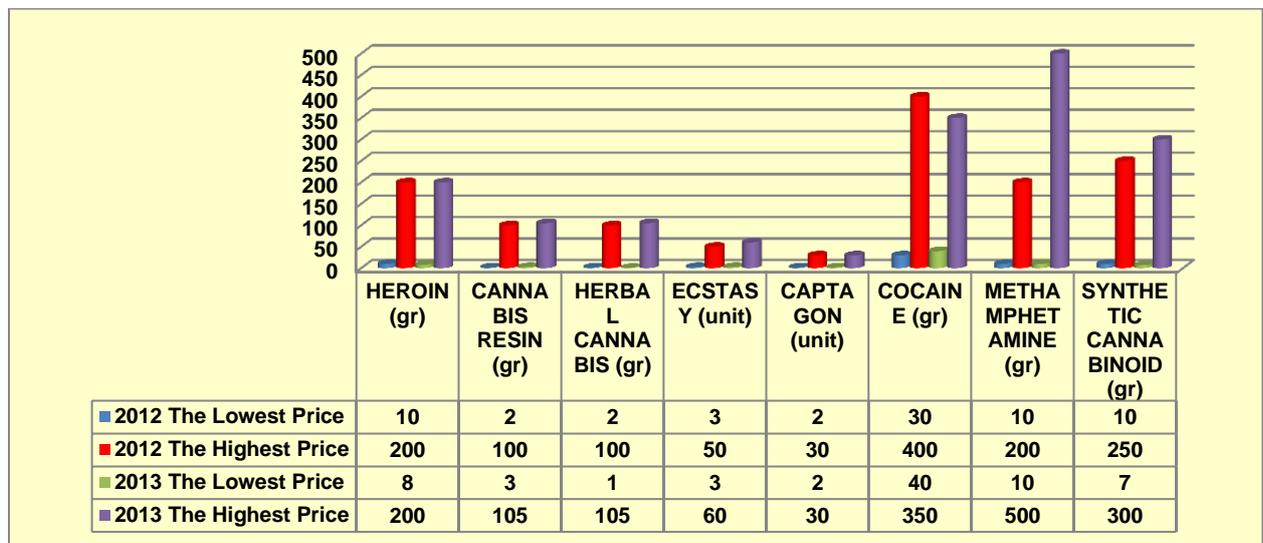
Figure 10-2: Provinces that provide data for the Drug Price Project



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

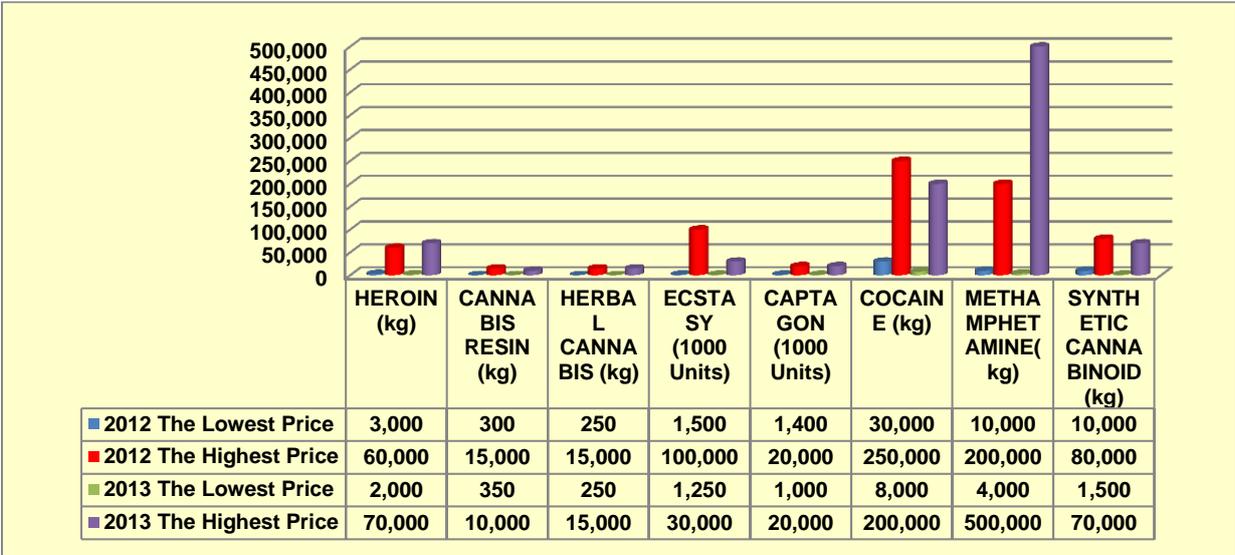
Two training meetings about the project in general and data entry were organized at TUBIM for the officials of the Provincial Directorates of Security. The first one was held on April 10, 2011 for the first 21 pilot provinces, and the second one was organized on April 12, 2012 for 20 provinces included in 2012.

Graph 10-36: Street-level drug prices in 2012 and 2013 (TL)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

Graph 10-37: Wholesale drug prices in 2012 and 2013 (TL)



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

A substantial difference is observed between the lowest and highest prices recorded in 2013 (Graph 10-36, 37). This significant difference is attributable to geographic circumstances, availability, and supply-and demand balance. Seizures by law enforcement officers and purity levels also play a role in price levels.

Regarding heroin prices at street-level, Van reported the lowest price of 8 TL per gram, whereas Düzce reported the highest price of 200 TL per gram. Düzce was followed by Edirne and Istanbul with 150 TL per gram. It was not unexpected for Van to have the lowest street-level prices, as it is one of the leading provinces where heroin enters Turkey from the Islamic Republic of Iran. Hakkari, another important point of entry for heroin, reported the lowest per kilogram price of 2,000 TL. Iğdır reported the highest per kilogram price of 70,000 TL.

Both minimum street-level and wholesale prices of heroin decline to a certain extent compared to 2012 (Street-level: 2012: 10 TL per gram - 2013: 8 TL per gram; wholesale: 2012: 3,000 TL per kg - 2013: 2,000 TL per kg) (EMCDDA Standard Table 16, 2014). Opium cultivation increased by 49% in Afghanistan in 2013 compared to 2012 (UNODC Afghanistan Opium Survey, 2013:10). This rise in Afghan opium is considered to lead to the increased amount of heroin confiscated, and reduced prices in Turkey.

Regarding minimum street-level prices for cannabis resin, Hatay and Diyarbakır reported the minimum price of 3 TL per gram, and Hakkari, Mersin, Şanlıurfa, Şırnak, and Van reported 5 TL per gram. Diyarbakır, Van, and Hakkari ranked first, second, and seventh, respectively, in

cannabis resin seizures in 2013 (See Graph 10-17). In Turkey, cannabis is mostly manufactured and consumed in the herb form. The majority of cannabis herb confiscated in Turkey originates from abroad. The provinces that report the lowest prices for cannabis resin are those located on the border with or close to the Islamic Republic of Iran and Syria. Artvin reported the highest price of 105 TL per gram. In terms of wholesale prices, while Hakkari reported the lowest per kilogram price of 350 TL, Kocaeli reported the highest per kilogram price of 10,000 TL.

Both minimum and maximum street-level prices of cannabis resin escalated compared to 2012 (min: 2012: 2 TL per gram – 2013: 3 TL per gram; max: 2012: 100 TL per kg – 2013: 105 TL per kg) (EMCDDA Standard Table 16, 2014). The amount of cannabis resin seized in Turkey in 2013 increased by 244% compared to 2012 (See Graph 10-10). Seizures by law enforcement officers may be effective in the rise in prices.

The minimum per gram price reported for herbal cannabis was 1 TL, and the maximum per gram price was 105 TL. While Hatay reported the minimum price, Artvin reported the maximum price. Diyarbakır, Içel, Şanlıurfa, and Şırnak reported 2 TL per gram. At the wholesale level, Diyarbakır and Düzce reported the minimum per kilogram price of 250 TL, and Kocaeli reported the maximum per kilogram price of 15,000 TL.

While the minimum street-level price of herbal cannabis declined in 2013 compared to 2012 (2012: 2 TL -2013: 1 TL), the maximum price increased (2012: 100 TL -2013: 105 TL) (EMCDDA Standard Table 16, 2014). While the minimum kilogram price of herbal cannabis at the wholesale level decreased in 2013, the maximum price did not change.

Out of 17 provinces, the minimum street-level price of cocaine was reported as 40 TL per gram, and the maximum price was reported as 350 TL per gram. As for wholesale prices, the minimum per kilogram price was reported as 8,000 TL, and the maximum per kilogram price was reported as 200,000 TL. There were more reporting for cocaine prices compared to previous years. While cocaine has been available only in certain metropolises until recently, reporting from higher number of provinces on cocaine price suggests that its availability throughout Turkey increased.

While the minimum street-level price of cocaine rose compared to 2012 (EMCDDA Standard Table 16, 2014), the minimum and maximum wholesale prices both decreased (min: 2012: 30,000 TL - 2013: 8,000 TL; max: 2012: 250,000 TL - 2013: 200,000 TL).

The minimum and maximum street-level per piece prices of ecstasy were reported as 3 TL and 60 TL respectively. The minimum and maximum wholesale prices of ecstasy per 1,000 pieces were reported as 1,250 TL and 30,000 TL respectively.

The minimum street-level price of ecstasy remained the same; however the maximum price increased (EMCDDA Standard Table 16, 2014). At wholesale level, both the minimum and maximum prices fell (min: 2012: 1,500 TL per kg. - 2013: 1,250 TL per kg; max: 2012: 100,000 TL per kg - 2013: 30,000 TL).

Out of 18 provinces that informed on street-level prices of captagon, Gaziantep reported the minimum per piece price of 2 TL, and Elazığ and Istanbul reported the maximum per piece price of 30 TL. At wholesale level, Gaziantep reported the minimum price of 1,000 TL per 1,000 pieces, and Ankara and Mersin reported the maximum price of 20,000 TL per 1,000 pieces. The lowest captagon prices were from Hatay and its vicinity, which is located on the border with Syria, and seized the largest amount of captagon in 2013.

There was no change in the minimum and maximum street-level prices of captagon compared to 2012 (EMCDDA Standard Table 16, 2014). While the minimum wholesale price decline in 2013 (2012: 1,400 TL - 2013: 1,000 TL), the maximum price remained the same.

The minimum and maximum street-level prices for methamphetamine were reported to be 10 TL per gram and 500 TL per gram, respectively. At wholesale level, Hakkari and Van reported the minimum per kilogram price of 4,000 TL, and Istanbul reported the maximum per kilogram price of 500,000 TL. Methamphetamine seized in Turkey is generally of Iranian origin, which is considered to be a determinant factor in the minimum prices reported from Hakkari and Van that are situated on the border with the Islamic Republic of Iran.

While the minimum street-level price of methamphetamine did not change in 2013 compared to 2012, the maximum price increased (EMCDDA Standard Table 16, 2014). The minimum wholesale per kilogram price declined (2012: 10,000 TL - 2013: 4,000 TL) whereas the maximum price increased (2012: 200,000 TL - 2013: 500,000 TL).

The street-level per gram prices of synthetic cannabinoids varied between 7 TL and 300 TL. At wholesale level, the minimum per kilogram price was reported as 1,500 TL, and the maximum price was reported as 70,000 TL.

The minimum street-level price of synthetic cannabinoids decreased in 2013 compared to 2012 (2012: 10 TL - 2013: 7 TL) whereas the maximum price increased (EMCDDA Standard Table 16, 2014). At wholesale level, both the minimum and maximum per kilogram prices declined in 2013 (min: 2012: 10,000 TL per kg - 2013: 1,500 TL per kg; max: 2012: 80,000 TL per kg - 2013: 70,000 TL per kg). Synthetic cannabinoids that were first seized in 2011 in Turkey became rapidly available across the country, and they were seized in 70 provinces out of 81 in 2013. Indeed, availability and prevalence acted on each other; in other words, low-cost and easy manufacturing led to reduced prices, and reduced prices in turn boosted the prevalence and availability.

10.4.2. Purity/Potency of Drugs

Hasan DURMUŞ³⁰

Pursuant to the relevant legislation in Turkey, qualitative and quantitative analyses of the substances defined as narcotic drugs are performed by the Criminal Laboratories of the Police and Gendarmerie, and the Council of Forensic Medicine. In this section, data from ST14 and ST15 tables provided by the Criminal Police Laboratory in Istanbul for 2013 will be presented.

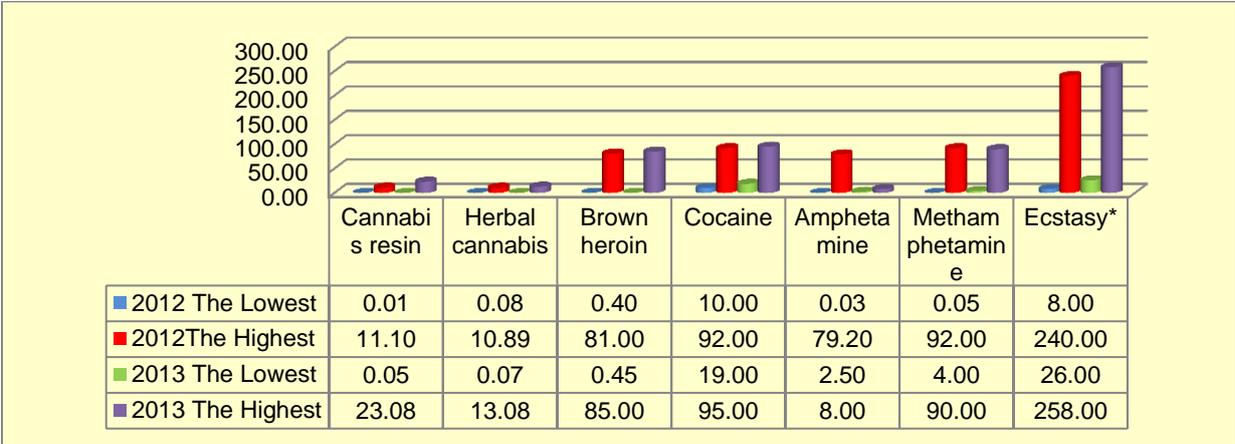
Purity in street-level changes according to increased or decreased availability of a given substance in the market, and the availability is affected by seizure operations conducted by counter-narcotics units. Thus, the monitoring of the changes in purity levels will ensure that the impact of the efforts exerted by the counter-narcotics units on the availability of drugs in the market becomes more visible.

Purity levels in drugs may vary due to various reasons. For instance, the level of the psychoactive chemical delta-9-tetrahydrocannabinol (THC) that is used to establish the level of purity in cannabis can be reduced due to various procedures such as drying, curing, and crushing. Furthermore, THC levels may vary according to type of plant. As for natural or semi-natural products, impurities contained in raw materials used, and the condition of the equipment utilized determines the level of purity in an end product. Apart from those, substances that are added to drugs to alter the level of potency (adulterants), or to increase the amount of a substance (cutting agent) affect the level of purity.

³⁰ Criminal Police Laboratory in Istanbul

Data about street-level and wholesale purity levels of drugs in Turkey have been collected through a form prepared by TUBIM at the end of 2011.

Graph 10-38: Street-level purity levels of drugs



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

*While the purity of ecstasy is expressed in terms of mg, the purity of other substances is expressed in terms of percentage (%).

The purity of cannabis is calculated according to the amount of delta-9-THC that is responsible for the hallucinogen effect though the plant contains various cannabinoids. According to the graph, the minimum purity level in herbal cannabis did not change significantly in 2013 compared to 2012 (2012: 0.08%, 2013: 0.07%); however the maximum purity level hit the record high since 2010 (2013: 13.08%). The same applies to the maximum purity level in cannabis resin. A significant increase was detected in 2013 compared to the levels established in previous years (2013: 23.08%, 2011: 14.88%). The minimum purity found in cannabis resin was reported as 0.05%.

The upward trend observed in the purity levels of heroin continued. The minimum and maximum street-level purity levels were reported as 0.45% and 85.00%, respectively (ST14). A 41% average in street-level heroin purity is considerably higher compared to the levels reported in European countries. Being closer to the source of heroin plays a determinant role in such high rates. The minimum and maximum purity levels for heroin seized in bulk were reported as 34% and 84%, respectively. These levels suggest that heroin without any adulterant or cutting agent may become available on the streets as well.

The maximum street-level purity of cocaine continued to be found high (95%) in 2013 as was the case in previous years, but without any significant change compared to the previous year.

However, there was a considerable increase in the minimum purity level in 2013 (2013: 19%). Nevertheless, this rise was not reflected in the average purity.

The fluctuating trend observed in the amount of purity in amphetamine over the years took a downward trend in 2013. While the maximum level was reported as 8%, the minimum level was found to be close the average in recent years (2.5%).

The average purity of methamphetamine at user level was found to be high. Though the minimum purity was reported as 4%, the maximum and average purity levels were designated as 90% and 75.91%, respectively. These rates suggest that methamphetamine without any adulterant or cutting agent can be reached at the street level. While high efficiency in chemical reactions in methamphetamine production is the main reason for such high purity levels, being close to the source also plays an important role. Furthermore, high efficiency in chemical reactions indicates that methamphetamine synthesis/manufacturing procedures are conducted by professional labor force using professional equipment.

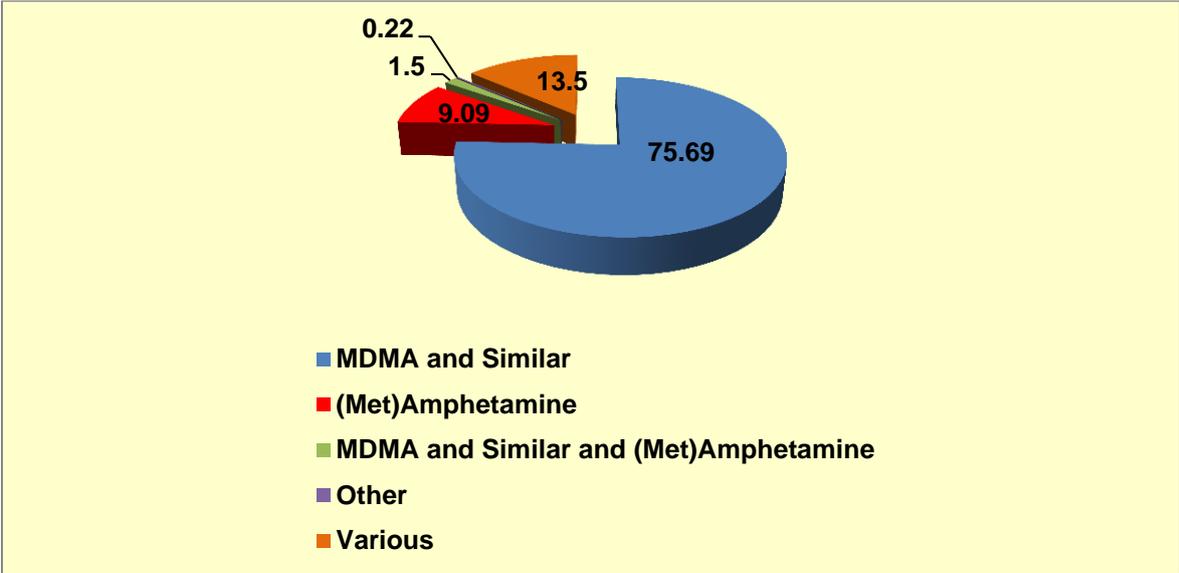
The maximum street-level purity of the tablets that contain MDMA and are popularly known as ecstasy did not change significantly in 2013 compared to the previous year (2012: 240 mg, 2013: 258 mg), however a rise was observed in the minimum purity (2012: 8 mg, 2013: 26 mg). The street-level purity of these tablets are considered to be the same as the purity determined in tablets that are seized in bulk, as the tableting procedure is performed in bulk. The same principle does not apply to other amphetamine derivate substances as they are available in powder form as well.

10.4.2.1 Composition of Synthetic Tablets

In addition to the levels of purity in substances, the distribution of tablet seizures by substance should also be presented in this section. The distribution of seizures by substance rather than the number of tablets seized helps to offer a different perspective of the issue. The data presented here are gathered from the EMCDDA Standard Table 15. As for the distribution of the number of seizures involving more than 2,500,000 tablets in Istanbul and neighboring provinces, the cases, where MDMA and similar tablets (MDEA, MDA, and combinations of these substances with other substances) were seized, constituted 75.69% of the tablet seizures. Particularly, the number of the MDMA seizures was dominant. The rate of the cases involving the seizure of amphetamine and methamphetamine corresponded to 9.09%. When assessing, it is important to consider that the data presented here covers only tablet seizures. One point five percent of the cases involved the seizure of both substances mentioned above,

and 0.22% of the cases involved the seizure of combinations of these substances with other drugs. 13.5% of the cases involved the seizure of the substances that are not included in List 1 and 2 prepared as part of the UN Convention on Psychotropic Substances from 1971 (caffeine, theophylline, BZP, mCPP, clonazepam, diazepam, methadone, and buprenorphine, etc...).

Graph 10-39: Distribution of tablet seizures by substance



Source: Turkish Monitoring Center for Drugs and Drug Addiction, 2014.

These data are related to the most synthetic substances. However, reliable data could not be collected on new generation synthetic drugs that have been posing a problem in Turkey, as is the case throughout the world. Detailed studies need to be conducted on the purity levels of synthetic cannabinoids, such as bonsai, which have recently become popular in Turkey. However, obtaining reference substances is the biggest challenge faced by both national and international laboratories that perform the relevant analyses.

PART B

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ANNEXES

Annex 1

Turkish Penal Code Number 5237

Production and trade of drug and stimulant substances

ARTICLE 188-(1) Any person who produces, imports or exports drug or stimulant substances without license or in contradiction with their license shall be punished by imprisonment, with sentences ranging **from twenty to thirty years** and receive a punitive fine up to twenty thousand days.

(2) The executed portion of the punishment imposed at the end of the trial proceedings in a country where the exportation of the drug or stimulant substance is considered as importation of the same in view of other country shall be off-set from the punishment to be imposed upon finalization of the trial held in Turkey due to exportation of drug or stimulant substances.

(3) Any person who sells, supplies, delivers, transports, stores, purchases, accepts, or possesses drugs or stimulant substances without license or in contradiction with their license shall be punished with imprisonment **for no less than ten years** and receive a punitive fine up to twenty thousand days. **However, in case the drug or stimulant substances were sold or supplied to a child, the punishment to be imposed for the person who sells or supplies the drug or stimulant substances shall be no less than fifteen years.**

(4) In case the offense involves heroin, cocaine, morphine or base-morphine, the punishment to be imposed according to the subclauses above shall be increased by half.

(5) In case of the offenses listed in the subclauses above are **committed together by three or more persons, the punishment to be imposed according to above subsections shall be increased by one half; and if the same offences are committed** within the scope of the activities of a crime organization, the punishment to be imposed according to the subsections above shall be increased by **one fold**.

(6) The provisions of the subclauses above shall be applied for all kinds of drugs substances and stimulants for which production is subject to the permission of official authorities, and for which the sale of is performed under prescription issued by a physician. **(Additional sentence: 29 June 2005 – 5377/Art. 22) However, the punishment to be imposed according to this subclause can be reduced by up to one half.**

(7) Any person who engages in the import, sale, purchase, transport, storage, or export of any product for which the import and production is subject to permission by official authorities with the purpose of using this product in the production of a drug or stimulant substance shall be

punished with imprisonment for no less than **eight** years and receive a punitive fine of up to twenty thousand days.

(8) In case the offenses mentioned in this article are committed by a physician, dentist, pharmacist, chemist, veterinary, health personnel, laboratory technician, midwife, nurse, dental technician, caregiver, health personnel, or a person rendering health services while also dealing with the production and trade of chemicals or with a pharmacy, the punishment to be imposed shall be increased by half.

Facilitating the use of drugs and stimulant substances

ARTICLE 190-(1) Any person facilitating the use of drugs and stimulant substances by:

- a) By providing a special place, equipment, or material;
- b) By taking measures to prevent the capture of users; or
- c) By providing information to others about the methods of use;

shall be punished with imprisonment from **five** years to **ten** years.

(2) Those who openly encourage the use of drug or stimulant substances, or who produces publications to this effect, shall be punished with imprisonment from **five** years to **ten** years.

(3) In case the offenses defined in this article are committed by a physician, dentist, pharmacist, chemist, veterinary, health personnel, laboratory technician, midwife, nurse, dental technician, caregiver, or a person rendering health services while also dealing with the production and trade of chemicals or with a pharmacy, the punishment to be imposed shall be increased by one half.

Purchasing, accepting, or possessing drugs and stimulant substances for use, or using drugs or stimulant substances

ARTICLE 191-(1) Any person who purchases, accepts, or possesses addictive drugs or stimulant substances for use or **uses drugs or stimulant substances** shall be punished with imprisonment from **two** year to **five** years.

(2) In a criminal case concerning this offence, the suspect's trial will be initially adjourned for five years regardless of whether the conditions in Article 171 of the Criminal Court Law number 5271 dated 4 December 2004 have been met. The public prosecutor will warn the suspect of the consequences of not abiding to his/her obligations or of violating the restrictions imposed during this period.

(3) During the adjournment period, the suspect will be maintained under supervised release for a minimum period of one year. During this period, the public prosecutor may further extend the duration of the supervised release in three month increments to a maximum of one year. The individual under supervised release may, if deemed necessary, be subject to treatment during his/her supervised release period.

(4) During the adjournment period of the trial, a criminal case will be opened once again in case the suspect:

a) Insists on not abiding by his/her obligations or the requirements of his/her treatment;

b) Once again purchases, accepts, or possesses drugs or stimulant substances for use; or

c) Uses drugs or stimulant substances.

(5) The purchase, acceptance, or possession of a drug or stimulant substance, or the use a drug or stimulant substance during the adjournment period by the person will be considered as violation of the fourth subclause, and will not be subject to a separate investigation or prosecution.

(6) After a criminal case is opened according to the fourth subclause, the trial will not be adjourned in accordance with the second subclause on the grounds that the offence defined in the first subclause has been repeated.

(7) In case the suspect abides by the obligations and does not violate the restrictions described in subclause four throughout the adjournment period, the suspect will not be prosecuted for the initial offence.

(8) For criminal cases associated with the offences described in:

a) Article 188 of this Law regarding the production and trade of drug and stimulant substances; and

b) Article 190 of this Law regarding the facilitation of the use of drug and stimulant substances,

there will be an arrest of judgement for the suspect's trial in case it is determined that the suspect's offence solely and exclusively falls into the scope of the current Article, rather than the abovementioned articles.

(9) Unless it is not specified otherwise in this article, the relevant provisions of the Code of Criminal Procedure's Article 171 regarding the adjournment of a criminal case and Article 231 regarding the arrest of judgement for a criminal case shall apply.

ANNEX 2

The Council of Ministers' Decision No. 2013/5742 dated 16.12.2013 (Published on the Official Gazette No. 28893 dated 25.01.2014)

1. 5F-AKB48 that known with the other name of AKB 48F, N-(adamantan-1-yl)-l-(4-fluorobutyl)-1H-indazole-3-carboxamide
2. Known with the name of A-796,260, 1-(2-morpholin-4-ylethyl)-1H-indol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone
3. Known with the name of AB-PINACA, N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide
4. Known with the name of ADBICA, N-{1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indole-3-carboxamide
5. Known analogue of JWH-018 quinoline carboxamide (QUPIC, PB-22), 1-pentyl-1H-indole-3-carboxylic acid 8-quinolinyl ester
6. Known with the name of 5F-PB-22, 1-(5-fluoropentyl)-1H-indole-3-carboxylic acid 8-quinolinyl ester
7. Known with the name of AB-FUBINACA, N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-1H-indazole-3-carboxamide
8. Known with name of STS-135, N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indole-3-carboxamide
9. Known with the name of AB-005, [1-[(1-methyl-2-piperidinyl)methyl]-1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl)-methanone
10. Known with the isomer of AB-005 azepane, (1-(1-methylazepan-2-yl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
11. Known with the name of AM-1248, 1-[(N-methylpiperidin-2-yl)methyl]-3-(adamant-1-yl)indole
12. Known with the name of QUCHIC, 1-(cyclohexylmethyl)-1H-indole-3-carboxylic acid 8-quinolinyl ester
13. Known with the name of WIN 55,212-2, (R)-(+)-[2,3-Dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-naphthalenylmethanone
14. Known with the name of α -Pyrrolidinopropiophenone, (RS)-1-Phenyl-2-(1-pyrrolidinyl)-1-propanone
15. Known with the name of BMDB, 2-Benzylamino-1-(3,4-methylenedioxyphenyl)butan-1-one
16. Known with the name of BMDP, 2-Benzylamino-1-(3,4-methylenedioxyphenyl)propan-1-one

17. Known with the name of Brepheдрone, (RS)-1-(4-bromophenyl)-2-methylaminopropan-1-one
18. Known with the name of N-ethylbuphedrone, 2-(ethylamino)-1-phenylbutan-1-one
19. Known with the name of DiButylone, 2-Dimethylamino-1-(3,4-methylenedioxyphenyl)butan-1-one
20. Known with the name of Ethcathinone, (RS)-2-ethylamino-1-phenyl-propan-1-one
21. Known with the name of Iso-ethcathinone, (\pm)-1-ethylamino-1-phenyl-propan-2-one
22. Known with the name of 3-FMC, (RS)-1-(3-Fluorophenyl)-2-methylaminopropan-1-one
23. Known with the name of 2-FMC, (RS)-1-(2-Fluorophenyl)-2-methylaminopropan-1-one
24. Known with the name of MDDM, (2-Benzo[1,3]dioxol-5-yl-1-methyl-ethyl)-dimethylamine
25. Known with the name of MPPP, (1-methyl-4-phenylpiperidin-4-yl) propanoate
26. Known with the name of Metamfepramone ismi, (RS)-2-dimethylamino-1-phenylpropan-1-one
27. Known with the name of 3-MMC, 1-(3-methylphenyl)-2-(methylamino)propane-1-one
28. Known with the name of Iso-pentedrone, 1-methylamino-1-phenyl-pentan-2-one
29. Known with the name of 25C-NBOMe, 2-(4-chloro-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl] ethanamine
30. Known with the name of 25B-NBOMe, 2-(4-bromo-2,5-dimethoxyphenyl)- N-[(2-methoxyphenyl)methyl]ethanamine
31. Known with the name of 25D-NBOMe, 2-(2,5-dimethoxy-4-methylphenyl) -N-(2-methoxybenzyl)ethanamine
32. Known with the name of 25H-NBOMe, 2-(2,5-dimethoxyphenyl) -N-(2-methoxybenzyl)ethanamine
33. Known with the name of 25I-NBOMe, 2-(4-iodo-2,5-dimethoxyphenyl) -N-[(2-methoxy phenyl)methyl] ethanamine
34. Known with the name of Bromo-Dragonfly, 1-(4-Bromofuro[2,3-f][1]benzofuran-8-yl)propan-2-amine
35. Known with the name of 2C-H, 2-(2,5-Dimethoxyphenyl)ethanamine
36. Known with the name of 2C-B-Fly, 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
37. Known with the name of N-Ethyl-2C-B, N-ethyl-4-bromo- 2,5-dimethoxyphenethylamine
38. Known with the name of Dimethylamphetamine N,N-dimethyl-1-phenylpropan-2-amine

39. Known with the name of DOC, 1-(4-chloro-2,5-dimethoxy-phenyl)propan-2-amine
40. Known with the name of DOI, 1-(2,5-dimethoxy-4-iodophenyl)-propan-2-amine
41. Known with the name of DPIA, Di-(p-phenylisopropyl)amine
42. Known with the name of Ethylone, (RS)-1-(1,3-benzodioxol-5-yl)-2-(ethylamino)propan-1-one
43. Known with the name of β -Me-PEA, 2-phenylpropan-1-amine
44. Known with the name of 2-FA, 1-(2-fluorophenyl)propan-2-amine
45. Known with the name of 3-FA, (RS)-1-(3-fluorophenyl)propan-2-amine
46. Known with the name of 4-FA, (RS)-1-(4-Fluorophenyl)propan-2-amine
47. Known with the name of 2-FMA, (RS)-1-(2-fluorophenyl)-N-methylpropan-2-amine
48. Known with the name of 3-FMA, (RS)-1-(3-fluorophenyl)-N-methylpropan-2-amine
49. Known with the name of M-ALPHA, (\pm)-1-methylamino-1-(3,4-methylenedioxyphenyl)propane
50. Known with the name of 4-MA, 1-(4-methylphenyl)propan-2-amine
51. Known with the name of MDHOET, 2-(2-Benzo[1,3]dioxol-5-yl-1-methylethylamino)ethanol
52. N,N-dimethylphenethylamine
53. Known with the name of NMPEA N-Methylphenethylamine; N-Methyl-(3-phenethylamine
54. Known with the name of 2-PEA, 2-phenyl-2-ethanamine
55. Known with the name of 1-PEA, 1-phenylethan-1-amine
56. Known with the name of 1-Pheny 1-1-propanamine, 1-pheny 1-propyl-amine
57. Known with the name of TMA-6, 1-(2,4,6-Trimethoxyphenyl)propan-2-amine
58. Known with the name of TMA-2, 1-(2,4,5-Trimethoxyphenyl)propan-2-amine
59. Known with the name of 2C-B-BZP, 1-(4-bromo-2,5-dimethoxybenzyl)piperazine
60. Known with the name of pFPP, 1-(4-fluorophenyl)piperazine
61. Known with the name of Gelbes, 1-(3-chlorophenyl)-4-(3-chloropropyl)piperazine hydrochloride
62. Known with the name of pMeOPP, 1-(4-methoxyphenyl)-piperazine

63. Known with the name of 4-AcO-DET, 3-(2-Diethylaminoethyl)-1H-indol-4-yl acetate
64. Known with the name of 4-AcO-DiPT, 3-[2-[bis(1-methylethyl)amino]ethyl]-1H-Indol-4-ol acetate
65. Known with the name of 4-AcO-DMT, 3-[2-(Dimethylamino)ethyl]-1H-indol-4-yl acetate
66. Known with the name of 4-AcO-MET, 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl acetate
67. Known with the name of 4-AcO-MiPT, [3-[2-[Isopropyl(methyl)amino]ethyl]-1 H-indol-4-yl] acetate
68. Known with the name of AMT, alpha-methyltryptamine
69. Known with the name of DiPT N,N-diisopropyltryptamine, 3-[2-(diisopropylamino)ethyl]indole
70. Known with the name of 4-HO-DET, 3-(2-diethylaminoethyl)-1H-indol-4-ol
71. Known with the name of 4-HO-MET, 3-(2-(ethyl(methyl)amino)ethyl)-1H-indol-4-ol
72. Known with the name of 4-HO-DiPT, 3-[2-(diisopropylamino)ethyl]-1H-indol-4-ol
73. Known with the name of 4-HO-MiPT, 3-(2-[Isopropyl(methyl)amino]ethyl)-1H-indol-4-ol
74. Known with the name of 5-MeO-AMT, 1-(5-methoxy-1H-indol-3-yl)propan-2-amine
75. Known with the name of 5-MeO-DALT, N-allyl-N-[2-(5-methoxy-1H-indol-3-yl)ethyl]prop-2-en-1-amine
76. Known with the name of 5-MeO-DET, 5-methoxy-N,N-diethyltryptamine
77. Known with the name of 5-MeO-DiPT, 3-[2-(Diisopropylamino)ethyl]-5-methoxyindole
78. Known with the name of 5-MeO-DMT, 2-(5-methoxy-1H-indol-3-yl)-N,N-dimethylethanamine
79. Known with the name of 5-MeO-DPT, N-[2-(5-methoxy-1H-indol-3-yl)ethyl]-N-propylpropan-1-amine
80. Known with the name of MiPT, N-[2-(1H-indol-3-yl)ethyl]-N-methylpropan-2-amine
81. Known with the name of PCP (fensiklidin), 1-(1-phenylcyclohexyl) piperidine substance
82. Known with the name of Areca nut, Methyl-1-methyl-1,2,5,6-tetrahydropyridine-3-carboxylate
83. 3-amino-1-phenyl-butane
84. Known with the name of 2-Aminoindane 2,3-dihydro-1H-inden-2-amine
85. Known with the name of APB, 4-(2-aminopropyl)benzofuran
86. Known with the name of APB, 5-(2-aminopropyl)benzofuran
87. Known with the name of APB, 6-(2-aminopropyl)benzofuran

88. Known with the name of 4-Benzylpiperidine, 4-(phenylmethyl)piperidine
89. Known with the name of Camfetamine, N-methyl-3-phenylbicyclo[2.2.1]heptan-2-amine
90. Known with the name of Desoxypipradrol, (RS)-2-benzhydrylpiperidine
91. Known with the name of 2-Diphenylmethylpyrrolidine, (RS)-2-(Diphenylmethyl)pyrrolidine
92. Known with the name of Dimethocaine, (3-diethylamino-2,2-dimethylpropyl)-4-aminobenzoate
93. Known with the name of D2PM, diphenyl(pyrrolidin-2-yl)methanol
94. Known with the name of N-Acetyl-DOB, N-acetyl-2,5-dimethoxy-4-bromoamphetamine
95. Known with the name of Ethylphenidate, Ethyl 2-phenyl-2-(piperidin-2-yl)acetate
96. Known with the name of Etizolam, 7-(2-Chlorophenyl)-4-ethyl-13-methyl-3-thia-1,8,11,12-tetraazatricyclo[8.3.0.0^{2,6}]trideca-2(6),4,7,10,12-pentaene
97. Known with the name of (p-Fluorobenzoyloxy)tropane, (1R,5S)-(8-methyl-8-azabicyclo[3.2.1]octan-3-yl)-4-fluorobenzoate
98. Known with the name of 5-IAI, 5-iodo-2,3-dihydro-1H-inden-2-amine
99. Known with the name of Ibogaine, 12-Methoxyibogamine
100. Known with the name of 5-IT, 2-(1H-indol-5-yl)-1-methyl-ethylamine
101. Known with the name of Kratom, *Mitragyna speciosa* plant
102. Known with the name of mitragynine that is also psychoactive ingredient of Kratom Plant, (E)-2-[(2S,3S)-3-ethyl-8-methoxy-1,2,3,4,6,7,12,12b-octahydroindolo[3,2-h]quinolizin-2-yl]-3-methoxyprop-2-enoic acid methyl ester
103. Known with the name of 7 α -hydroxy-7H-mitragynine that is also psychoactive ingredient of Kratom Plant, (α E,2S,3S,7aS,12bS)-3-Ethyl-1,2,3,4,6,7,7a,12b-octahydro-7a-hydroxy-8-methoxy- α (methoxymethylene)indolo[2,3-a]quinolizine-2-acetic acid methyl ester
104. Known with the name of mitraphylline that is also psychoactive ingredient of Kratom Plant, methyl (1S,4aS,5aS,6R,10aR)-1-methyl-2'-oxospiro[1,4a,5,5a,7,8,10,10a-octahydropyrano[3,4-f]indolizine-6,3'-1H-indole]-4-carboxylate
105. Known with the name of LSA, (8 β)-9,10-didehydro-6-methyl-ergoline-8-carboxamide
106. Known with the name of MDAI, 6,7-dihydro-5H-cyclopenta[f][1,3]benzodioxol-6-amine
107. Known with the name of MPA, 1-(thiophen-2-yl)-2-methylaminopropane
108. Known with the name of 3-MeO-PCE, 3-Methoxyeticyclidine
109. Known with the name of MeO-PCP, 1-[1-(3-methoxyphenyl)cyclohexyl]-piperidine
110. Known with the name of MeO-PCP, 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine

111. Known with the name of Phenazepam Bonzai, Bonzai Supersleep, Phenazepam (7-Bromo-5-(2-chlorophenyl)-1,3-dihydro-2H-1,4-benzodiazepin-2-one)
112. Known with the name of 6-MAM, 3-hydroxy-6-acetyl-(5a,6a)-7,8-Didehydro-4,5-epoxy-17-methylmorphinan
113. Known with the name of 3-MAM, 3-acetyl-6-hydroxy-(5a,6a)-7,8-Didehydro-4,5-epoxy-17-methylmorphinan

ANNEX 3

The Council of Ministers' Decision No. 2014/5818 dated 03.01.2014 (Published on the Official Gazette No. 28906 dated 07.02.2014)

1. Known with the short name of A-834,735, 1-(tetrahydropyran-4-ylmethyl)-1H-indol-3-yl]- (2,2,3,3-tetramethylcyclopropyl)methanone,
2. Known with the name of EAM-2201, (1-(5-fluoropentyl)-1H-indol-3-yl)(4-ethyl-1-naphthalenyl)-methanone,
3. Known with the name of JWH-147, (1-hexyl-5-phenyl-1H-pyrrol-3-yl)-1-naphthalenyl-methanone,
4. Known with the name of JWH-098, 4-methoxynaphthalen-1-yl-(1-pentyl-2-methylindol-3-yl)methanone,
5. Known with the name of JWH-030, naphthalen-1-yl-(1-pentylpyrrol-3-yl)methanone,
6. Known with the name of JWH-145, Naftalen-1-yl(1-pentyl-5-phenyl-1H-pyrrol-3-yl)methanone,
7. Known with the name of JWH-368, [5-(3-Fluorophenyl)-1-pentyl-1H-pyrrol-3-yl]-1-naphthalenyl methanone,
8. Known with the name of A-836,339, N-[3-(2-Methoxyethyl)-4,5-dimethyl-1,3-thiazol-2-ylidene] -2,2,3,3-tetramethylcyclopropane-1-carboxamide,
9. Known with the short name of CP47,497-C9, 2-[(1R,3S)-3-Hydroxycyclohexyl]-5-(2-methyldecan-2-yl)phenol,
10. Known with the short name of CP55,940, 2-[(1R,2R,5R)-5-Hydroxy-2-(3-hydroxypropyl) cyclohexyl] - 5 -(2-methyloctan-2-yl)phenol),
11. Known with the name of JTE-907, N-(Benzo[1,3]dioxol-5-ylmethyl)-7-methoxy-2-oxo-8-pentyloxy-1,2-dihydroquinoline-3-carboxamide,
12. Known with the name of Levonantradol, [(6S,6aR,9R,10aR)- 9-Hydroxy- 6-methyl- 3-[(2R)-5- phenylpentan-2-yl]oxy- 5,6,6a,7,8,9,10,10a-octahydrophenanthridin- 1-yl] acetate,

13. Known with the name of URB-754, 6-Methyl-2-[(4-methylphenyl)amino]-4H-3,1-benzoxazin-4-one,
14. Known with the short name of 2-Methylmethcathinone, 2-MMC, 2-MeMC, 2-(Methylamino)-1-(2-methylphenyl)-1-propanone,
15. Known with the short name of BDB, 1-(3,4-Methylenedioxyphenyl)-2-butanamine,
16. N-Hydroxyamphetamine,
17. Known with the name of Lisdexamfetamine (Lisdeksamfetamin), ((2S)-2,6-diamino-N-[(2S)-1-phenylpropan-2-yl]hexanamide,
18. Known with the name of 1-Fenil-2-butylamin 1-phenyl-2-butylamine,
19. Known with the short name of UG6981, 3-(2H-cromen-7-yl)butan-2-amine,
20. Known with the name of Thiopropamine, 1-(Tiophen-2-yl)-2-aminopropane,
21. N-benzyl-1-phenethylamine,
22. Known with the name of 5-MAPB, 1-(Benzofuran-5-yl)-N-methylpropan-2-amine,
23. Known with the name of PMMA, Methyl-MA, 4-MMA, para-Metoxy-N-methylamphetamine,
24. Known with the name of 1-Aminoindan, 2,3-Dihydro-1H-inden-1-amine,
25. Known with the name of AH-7921, 3,4-Dichloro-N-[(1-dimethylamino)cyclohexylmethyl]benzamide,
26. Known with the name of Nimetazepam, 2-Methyl-9-nitro-6-phenyl-2,5-diazabicyclo[5.4.0]undeca-5,8,10,12-tetraen-3-one.

ANNEX 4

The Council of Ministers' Decision No. 2014/6330 dated 05.05.2014 (Published on the Official Gazette No. 28906 (Repeating) dated 23.05.2014)

1. Known with the name of APINACA or AKB-48, 1-pentyl-N-tricyclo [3.3.1.1^{3,7}] dec-1-yl-1H-indazole-3-carboxamide,
2. Known with the name of ADB-FUBINACA, N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide,
3. Known with the name of 5F-AB-PINACA, N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(5-fluoro) pentyl-1H-indazole-3-carboxamide}
4. Known analogue of AM 2201 benzimidazole, 1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl) (naphthalen-1-yl) methanone,
5. Known with the name of APICA, 1-pentyl-N-tricyclo[3.3.1.1^{3,7}]dec-1-yl-1H-indole-3-carboxamide,
6. Known with the name of FUB-PB-22, Quinolin-8-yl-1-(4-fluorobenzyl)-1H-indole-3-carboxylate,
7. Known with the name of SDB-006, N-benzyl-1-pentyl-1H-indole-3-carboxamide,
8. Known with the name of 4 MEC ET, 2-(diethylamino)-1-(4-methylphenyl)propan-1-one,
9. Known with the name of JWH-071, (1-ethyl-1H-indol-3-yl)-1-naphthalenyl-methanone,
10. Known with the name of 4'-Methoxy-a-PPP or MOPPP, (RS)-1-(4-methoxyphenyl)-2-(1-pyrrolidinyl)-1-propanone
11. Known with the name of Methedrone, (RS)-1-(4-methoxyphenyl)-2-(methylamino)propan-1-one,
12. Known with the name of Carfentanyl, 4-((1-oxopropyl)-phenylamino)-1-(2-phenylethyl)-4-piperidinecarboxylic acid methyl ester,
13. Known with the name of MBZP, 1-benzyl-4-methylpiperazine,
14. Known with the name of Dimethylone, 1-(1,3-benzodioxol-5-yl)-2-(dimethylamino)propan-1-one,
15. Known with the name of PMEA, N-ethyl-1-(4-methoxyphenyl)propan-2-amine,
16. Known derivative of UR-144 N-(5-chloropentyl), (1-(5-chloropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone,
17. Known with the name of 4-chloroamphetamine or 4-CA, 1-(4-chlorophenyl)propan-2-amine,
18. Known with the name of 3,4-Dimethylethcathinone (3,4-DMEC), 1-(3,4-dimethylphenyl)-2-(ethylamino)propan-1-one,

19. Known with the name of 5-APDB, 1-(2,3-dihydro-1-benzofuran-5-yl)propan-2-amine}
20. Known with the name of 5-EAPB, 1-(Benzofuran-5-yl)-N-ethylpropan-2-amine,
21. Known with the name of 6-APDB, 1-(2,3-dihydro-1-benzofuran-6-yl)propan-2-amine,
22. 6-EAPB ismi ile bilinen 1-(1-benzofuran-6-yl)-N-ethylpropan-2-amine,
23. Known with the isomer name of A-796,260, (E)-1-(1-(2-Morpholino-1-yl)ethyl)indol-3-yl)-3,4,4- trimethylpent-2-en-1 -one),
24. Known with the isomer name of AM-1248 Azepane, (adamant-1-yl)[1-(1-methylazepan-3-yl)-1H- indol-3-yl]methanone,
25. Known analogue of odAM-2201 indazolecarboxamide, N-1-naphtalenyl-1-(5-fluoropentyl)-1 H-indazole-3-carboxamide,
26. Known analogue of AM-2201 indazole, [1-(5-fiuroropentyl)-1H-indazol-3-yl] (naphthalen-1-yl)methanone,
27. Instead of AM-694 being as iodine, known as methyl substitute, 1-(5-fluoropentyl)-3-(2-methylbenzoyl) indole,
28. Known derivative of JWH 018 N-(5-bromopentyl), [1-(5-bromopentyl)-1H-indol-3-yl] (naphthalen-1-yl) methanone,
29. Known derivative of MAM-2201 chloropentyl, [1-(5-chloropentyl)-1H-indol-3-yl](4-methyl-1 -naphthalenyl) -methanone,
30. Known with the name of 4'-Methyl- α -pyrrolidinobutyrophenone or MPBP, (RS)-1-(4-methylphenyl)-2-(1 -pyrrolidinyl)-1 -butanone,
31. Known with the name of FDU-PB-22, 1-naphthyl 1-[(4-fluorophenyl)methyl]indole-3-carboxylate,
32. Known with the name of 5F-ADBICA, N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1 H-indole-3-carboxamide,
33. Known analogue of 5F-PB-22 indazole, quinolin-8-yl 1-(5-fluoropentyl)-1H-indazole-3-carboxylate,
34. Known with the name of ADB-PINACA, N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H- indazole-3 -carboxamide,
35. Known with the name of AM-679, 1-pentyl-3-(2-iodobenzoyl) indole,
36. Known with the name of DMMA, 2-(3,4-Dimethoxyphenyl)-N-methylpropylamine,
37. Known analogue of JWH-018 indazole, 1-naphthalenyl (1-pentyl-1H-indazol-3-yl)-methanone,
38. Known with the name of JWH-370, [5-(2-methylphenyl)-1-pentyl-1H-pyrrol-3-yl]-1-naphthalenyl- methanone,
39. Known analogue of PB-22 indazole, quinolin-8-yl 1-pentyl-1H-indazole-3-carboxylate,

40. Known with the name of UR -144 (-2H), [1-(pent-4-en-1-yl)-1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl)methanone,
41. Known derivative of UR-144 heptyl, (1-heptyl-1H-indol-3-yl) (2,2,3,3-tetramethylcyclopropyl)-methanone.

ANNEX 5

The Council of Ministers' Decision No. 2014/6800 dated 15.09.2014 (Published on the Official Gazette No. 29137 dated 02.10.2014)

1. Known with the short name of α -PVT, 2-(pyrrolidin-1-yl)-1-(thiophen-2yl)pentan-1-one
2. 4-chloromethamfetamin
3. Known with the short name of M5FPIC, Methyl-1-(5-fluoropentyl)-1H-indole-3-carboxylate
4. Known with the short name of AB-CHMINACA, N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide
5. Known with the short name of 5-Fluoropentylindole, 1-(5-fluoropentyl)-1H-indole
6. Known with the short name of FUB-144, (1-(4-fluorobenzyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
7. Known with the short name of NM-2201, naphthalen-1-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate
8. Methyl 1-pentyl-1H-indole-3-Carboxylate
9. Known with the short name of AM-6527 5-fluoropentyl and its derivative, 1-(5-fluoropentyl)-N-(naphthalen-2-yl)-1H-indole-3-carboxamide
10. Known with the short name of 4-Methyl-N-ethylnorpentedrone, 2-(ethylamino)-1-(4-methylphenyl)pentan-1-one
11. Known with the short name of JWH-031, (1-hexyl-1H-pyrrol-3yl)-1-naphthalenylmethanone
12. Known with the short isomer name of 5-fluoro PB-22 N-(2-fluoropentyl) quinolin-8-yl 1-(2-fluoropentyl)-1H-indole-3-carboxylate
13. Known with the short name of 4-Fluoroephedrine, (1R,2S)-1-(4-fluorophenyl)-2-(methylamino)propan-1-ol
14. Known with the short name of 3-Fluoro-isomethcathinone or 3-FIMC, 1-(3-fluorophenyl)-1-(methylamino)-2-propanone
15. Known with the short name of 2,4,5-Trimethylmethcathinone or 2,4,5-TMMC 2-Methylamino-1-(2,4,5-trimethylphenyl)propan-1-one
16. Known with the short name of N-methyl-2AI, 2,3-dihydro-N-methyl-1H-inden-2-amine
17. Known with the short name of DPT, 3-[2-(dipropylamino)ethyl]indole
18. Known with the short name of 25E-NBOMe, 2-(2,5-dimethoxy-4-ethylphenyl)-N-(2-methoxybenzyl)ethanamine

19. Known with the short name of 25G-NBOMe, 2-(2,5-Dimethoxy-3,4-dimethylphenyl)-N-(2-methoxybenzyl)ethanamine
20. Known with the short name of 25iP-NBOMe, 2-[2,5-Dimethoxy-4-(propan-2-yl)phenyl]-N-(2-methoxybenzyl) ethanamine
21. Known with the short name of 5-HO-DMT, 3-(2-dimethylaminoethyl)-1H-indol-5-ol
22. Known with the short name of 6-MAPB, 1-(benzofuran-6-yl)-N-methylpropan-2-amine
23. Known with the short name of Etaqualone, 3-(2-ethylphenyl)-2-methyl-quinazolin-4-one
24. Known with the short name of Methoxyphenamine or OMMA, 1-(2-methoxyphenyl)-N-methylpropan-2-amine
25. Known with the short name of α -ethylaminopentiophenone, 2-(ethylamino)-1-phenyl-pentan-1-one
26. Known with the short name of N-Propylamphetamine or PA, N-(1-methyl-2-phenylethyl)propan-1-amine
27. 1-(2,3-dichlorophenyl)-piperazine
28. Known with the short name of 3-methoxymethcathinone or 3-MeOMC, 1-(3-methoxyphenyl)-2-(methylamino)propane-1-one
29. Known with the short name of N-methyl-2C-B, 4-Bromo-N-methyl-2,5-dimethoxyphenethylamine
30. Known with the short name of bk-2C-B, 2-amino-1-(4-bromo-2,5-dimethoxyphenyl)ethan-1-one
31. Known with the short name of 4-AcO-DPT, 4-acetoxy-N,N-dipropyltryptamine
32. Known with the short name of 4-CMC, 1-(4-chlorophenyl)-2-(methylamino)propan-1-one
33. Known with the short name of 4-BA, 1-(4-bromophenyl)propan-2-amine
34. Known with the short name of 4-Fluorocathinone, 2-amino-1-(4-fluorophenyl)-1-propanone
35. Known with the short name of 4-fluoropentedrone, 1-(4-fluorophenyl)-2-(methylamino)pentan-1-one
36. Known with the short name of 3-MEC, 2-(Ethylamino)-1-(3-methylphenyl)propan-1-one
37. Known with the short name of 4-methylbuphedrone, N-benzyl and its derivative, 2-(benzylamino)-1-(4-methylphenyl)butan-1-one
38. Known with the short name of Hexedrone or β -propylmethcathinone, 2-(methylamine)-1-(phenyl)hexan-1-one
39. Known with the short name of Dipentylone, 1-(1,3-benzodioxol-5-yl)-2-(dimethylamino)pentan-1-one

40. Known with the short name of Eutylone, (\pm)-1-(1,3-benzodioxol-5-yl)-2-(ethylamino)butan
41. Known with the short name of 6-Bromo-MDMA, 6-bromo-3,4-methylenedioxy-N-methylamphetamine
42. Known with the short name of 4-methylpentedrone, 2-(methylamino)-1-(p-tolyl)pentan-1-one
43. Known with the short name of 2-Methoxyamphetamine, 1-(2-methoxyphenyl)propan-2-amine
44. Known with the short name of α -PEP, 1-phenyl-2-(1-pyrrolidinyl)heptan-1-one
45. Known with the short name of 4'-chloro- α -PPP, 1-(4-chlorophenyl)-2-(1-pyrrolidinyl)propan-1-one
46. Known with the short name of α -pyrrolidinohexanophenone or α -PHP, 2-(pyrrolidin-1-yl)-1-(phenyl)hexan-1-one
47. Known with the short name of 4F- α -PVP, 1-(4-fluorophenyl)-2-(pyrrolidin-1-yl)pentan-1-one
48. Known with the short name of 4-HTMPIPO, 4-hydroxy-3,3,4-trimethyl-1-(1-pentyl-1H-indol-3-yl)-1-pentanone
49. Known with the short name of 5F-AMB, Methyl 2-({[1-(5-fluoropentyl)-1H-indazol-3-yl]carbonyl}amino)-3-methylbutanoate
50. Known with the short name of 5F-AMBICA, N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1H-indol-3-carboxamide
51. Known with the short name of 5F-SDB-006, N-benzyl-1-(5-fluoropentyl)-1H-indole-3-carboxamide
52. Known with the short name of AM-6527, 1-pentyl-N-(naphthalen-1-yl)-1H-indole-3-carboxamide
53. Known with the short name of AM-694 ethyl substituted for iodine, 1-(5-fluoropentyl)-3-(2-ethylbenzoyl)indole
54. Known with the short name of EG-018, naphthalen-1-yl(9-pentyl-9H-carbazol-3-yl)methanone
55. Known with the short name of JWH-122 pentenyl 2-methylindole and its derivative, (4-methylnaphthalen-1-yl)(2-methyl 1-(pent-4-en-1-yl)-1H-indol-3-yl)methanone
56. Known with the short name of JWH-307 brominated and its analogue, (5-(2-bromophenyl)-1-pentyl-1H-pyrrol-3-yl)(naphthalen-1-yl)methanone
57. Known with the short name of JWH-412 5-fluoropentyl and its derivative, (4-fluoronaphthalen-1-yl)[1-(5-fluoropentyl)-1H-indol-3-yl]methanone

58. Known with the short name of Mepirapim, (4-methylpiperazin-1-yl)-(1-pentylindol-3-yl)methanone
59. Known with the short name of URB-597, [3-(3-carbamoylphenyl)phenyl]N-cyclohexylcarbamate
60. Known with the short name of MN-18, N-1-naphthalenyl-1-pentyl-1H-indazole-3-carboxamide
61. Known with the short name of Para-Methyl-4-methylaminorex or 4,4'-DMAR, 4,5-dihydro-4-methyl-5-(4-methylphenyl)-2-oxazolamine
62. Known with the short isomer name of AB-FUBINACA 2-fluorobenzyl N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(2-fluorophenyl)methyl]-1H-indazole-3-carboxamide
63. Known with the short name of MT-45, 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine
64. Known with the short name of W-15, 4-chloro-N-(1-(2-phenylethyl)piperidin-2-ylidene)benzenesulfonamide
65. N-(2-methoxyethyl)-N-(1-methylethyl)-2-(1-pentyl-1H-indol-3-yl)-4-thiazol-methanamine
66. N,N-diethyl-2-(1-pentyl-1H-indol-3-yl)-4-thiazol-methanamine

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