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ORIGINAL RESEARCH

# Exploring Alcohol and Substance Addiction among Syrian Migrants in Turkey: A Qualitative Study Integrating Perspectives of Addicts, Their Relatives, Local and National Institutions

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**Main Points**

- Conducting global and national interventions for the prevention, treatment, and rehabilitation of addictions of refugees requires a good scientific knowledge base. This study aimed to contribute to the global understanding of obscure states and dynamics of addictions among migrants in the context of Syrian migrants in Turkey.
- On the individual aspect, migrants who are adolescents, singles, have low educational levels, do not go to school, are unemployed, have trauma histories, are far from their families, or have low socioeconomic statuses may be seen as risk groups for alcohol and substance addictions. Having a family, being a woman, adherence to religion and culture, regular employment, a high education level, and laws are possible protective factors. These findings provide a basis for future descriptive and intervention studies.
- On the environmental aspect, illegal substance trafficking, tough work conditions, risky business sectors, child labor, uninsured employment, lack of social support and guidance, and social exclusion appear to be the major predisposing factors for alcohol and substance abuse.
- On the policy aspect, lack of the multisectoral approach in services and integration between institutions; poor monitoring of addictions in refugees; inability to access necessary and sufficient health, education, and social services; limited personal rights of refugees; underutilization of trained health workforce within the refugee community; and drug trafficking at the macro level should be policy priorities to act on.

**Abstract**

Turkey is the country that hosts most migrants worldwide. Although migrants are a risk group for alcohol and substance addiction (ASA), literature is limited. This study aims to explore and identify the present state and influencing factors of ASA among Syrian migrants in Turkey by integrating perspectives of addicts, their relatives, and local and national institutions. This qualitative study was designed by the grounded theory approach and took place in 5 cities in Turkey between 2018 and 2019. It is composed of 4 focus group discussions with 77 informants from local governmental, non-governmental, and academic organizations; 11 key person interviews with heads of national organizations; and in-depth interviews with 45 addicted Syrian migrants and 21 relatives. Themes that emerged from the data are characteristics of addicted migrants, types of addictions, predisposing and exacerbating factors, preventing factors, obtaining alcohol and substances, manners of use, consequences of use, public services and utilization of them, and the experiences of addicted migrants. The findings of this study provide guidance for future research and policies. Addicted migrants have awareness and motivation to quit but face many environmental barriers. Activities of institutions in Turkey on ASA in Syrian migrants are insufficient. Specific, well-coordinated action is needed. It should also utilize Syrian human resources.
**Keywords:** Migrants, refugees, addiction, alcohol, substance

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## Introduction

In terms of public health, diseases that are most common, most disabling, and most deadly are described as "important diseases" (Güler & Akın, 2015). In this context, alcohol and substance addiction (ASA) is an important public health problem.

ASA accounts for approximately 6.5% of the global disease burden and causes 5 million deaths per year (Lim et al., 2012). Alcohol addiction is a leading health problem in adolescent and young adult age groups, especially in high-income countries (Gore et al., 2011).

According to a study by the United States (US) Department of Health, the annual cost of ASA to the US economy in 1999 was $510 billion. For the same year, this figure constitutes 5.3% of the gross domestic product. In the 33 most costly disease rankings, alcohol addiction ranks second ($191.6 billion), tobacco addiction ranks sixth ($167 billion), and substance addiction ranks seventh ($151 billion). The cost-benefit ratio of activities against ASA is 1:18 (Miller & Hendrie, 2008).

If effective intervention programs were implemented, the age of starting a substance addiction can be delayed by 2 years, and the use of marijuana can be reduced by 11.5%, cocaine use by 45.8%, and smoking by 10.7% (Miller & Hendrie, 2008).

One of the social groups at risk for ASA is forcibly displaced people (UNODC, 2018). According to the studies conducted, harmful alcohol use in this group ranges between 4% and 36%, alcohol dependence between 1% and 42%, and substance use between 1% and 20%. Harmful alcohol use in refugee camps ranges between 17% and 36% (Horyniak et al., 2016). When these prevalence values are evaluated together with the number of refugees worldwide, it can be seen that ASA is an important public health problem in this risk group. In addition to illegal use and addiction, there are also substance usages that are considered culturally normal. For example, khat use is normal in eastern African societies (Beckerleg & Sheekh, 2005), as is betel quid use in Burmese in Australia (Furber et al., 2013).

According to an extensive study in Turkey, alcohol and drug use prevalence in Turkey is 22.1% and 3.1%, respectively (Turkey Republic Ministry of Interior, 2018).

It is stated in the literature that migration occurs for 3 reasons: war, disasters, and development (Horyniak et al., 2016). The migrants mentioned in this study were mostly forced to migrate because of war and conflict in Syria. According to reports from the United Nations Refugee Agency, there are currently 79.5 million forcibly displaced people around the world. Approximately 40% of these people are children, 85% live in developing countries, and 27% offer the least developed countries asylum. Of these, 45.7 million are forced to migrate within their own country and are described in the literature as "internally displaced persons (IDPs)." In total, 26 million of them are refugees. Overall, 4.2 million asylum seekers have applied for asylum in other countries and are awaiting approval. As of 2019, 4.2 million people live in 76 countries without any immigration status. The most refugee-generating country in the world is Syria (6.6 million), whereas the most refugee-hosting country is Turkey (3.6 million) (UN Refugee Agency).

Studies on refugees in the field of ASA show that many health problems accompany ASA. Some of these health problems may be the cause and the result of ASA in refugees. The frequency of mental health problems, such as post-traumatic stress disorder, depression, and anxiety disorder, is high in the refugee community (Horyniak et al., 2016). Publications are showing a strong relationship between mental health problems and ASA (Liang et al., 2011; Schuckit, 2006). It is also stated that health problems, including ASA, can be at different levels in different refugee groups. For example, IDPs in regions where there are already conflicts and internal disturbances are disadvantaged in terms of worse health conditions than the cross-border immigrant group (Toole & Waldman, 1997).

The risk factors of ASA in refugees are a well-studied subject in the literature. The factors specified in the literature can be divided into two as related and not related to the migration process. Factors related to the migration process can be clustered as factors before, during, and after migration: before migration, torture, armed conflict, economic difficulties, hunger, and physical exhaustion; during migration, separation from family and social environment, physical and sexual violence, extortion, human trafficking, life threats in overseas trips, long-term covered land vehicles, and walking long distances; post-migration, unemployment, social exclusion, loneliness, acculturation, low refugee status, arrest, and socioeconomic status (Priebe et al., 2016). In addition, male gender, widowing, low education level, immigration at a young age, and the asylum application process uncertainties directly affect mental health and play a facilitating role for ASA.

The protective factors against ASA stated in the literature are as follows: membership of an institution, support of social networks (Hall et al., 2014), adherence to the original culture (Bongard et al., 2015), female gender, higher education level, advanced age, and regular home life (Qureshi et al., 2014).

According to the studies carried out, the causes of ASA can be summarized under the following categories: 1) acculturation (Blanco et al., 2013; Buchanan & Smokowski, 2009; De La Rosa, 2002), 2) social exclusion (Priest et al., 2013), 3) self-medication (Brune et al., 2003; Kluttig et al., 2009), and 4) coping with stress (Zaller et al., 2014). In addition to these, there are also facilitating factors. Lack of knowledge about ASA, lack of access to services, lack of health insurance, and absence of a protective social environment have a facilitating effect for ASA (Ezard et al., 2011; Ojeda et al., 2011; Reid et al., 2001).

Direct and indirect health problems and social problems caused by ASA are expressed as follows: mental health problems, stigma, peer violence, neglect and care of children, sexual violence, and sexually transmitted diseases (Rachlis et al., 2007). In a study conducted, ASA increases the risk of major depression by 3 times (Larrance et al., 2007).

Studies in the literature also focus on the level of ASA in different refugee generations, the difference in use between the local community and the refugee community, gender differences, and onset of addiction patterns. However, scientific studies are not standardized, and it becomes difficult to interpret and generalize the presented results. For example, in a study comparing ASA in Hispanic and non-Hispanic adolescents, ASA is higher in the

third generation and later than the first generation. However, this information can only be generalized to Latin adolescents in the US. Many studies compare the level of ASA in the refugee community and the local community. According to most studies, the prevalence of ASA is lower in immigrants than in the local population. Even in comparisons between those born in the host country and those born in the source country, the frequency of addiction is higher among the first group (Szaflarski et al., 2011).

Information about accessing ways and methods to alcohol and substances is limited in the literature. It is stated in the studies that living in an area that enables the access to alcohol and substances facilitates accessing (Karriker-Jaffe, 2011), selling alcohol in entertainment venues affects the addictive behavior (Zaller et al., 2014), and addicts access alcohol and substances by creating a common budget (Horyniak et al., 2016).

In one study, it was determined that refugees traded hemp to make a living when they first arrived. Another study has shown that selling alcohol in refugee camps can be a method for earning money (Streel & Schilperoord, 2010).

The inadequate utilization of the host country's health system can also cause existing problems to remain unsolved and cause additional health problems, creating a risky environment for ASA. Refugees refrain from accessing the service because of reasons such as the language barrier, the risk of being reported to the security forces, and fear of deportation (Dorn et al., 2011; Gunn & Guarino, 2016; Teunissen et al., 2014). However, as the time spent in the host country increases, the rate of service utilization also increases (Whitley et al., 2017). The refugee community's own culture and internal dynamics also affect service-seeking behavior (Kamperman et al., 2007).

In the literature, recommendations such as the necessity of effective intervention studies, the policies that decision makers should implement, standardizing humanitarian aid efforts for refugees to include ASA monitoring and service provision and making a qualified record for all services offered to refugees are listed (Priebe et al., 2016; Sphere Association, 2018).

The concept of the refugee paradox is frequently expressed in studies comparing the ASA behavior of the host community and the refugee community (Vaughn et al., 2014). This concept means that the disadvantaged refugee community is in a better condition in terms of health, education, addiction prevalence, and crime rates than the local community with much better opportunities, and therefore the word "paradox" is used. The concept that states the health status is better in the refugee society than the host community is the healthy migrant effect. Three main arguments are presented as the reason for this situation: 1) only healthy and high-level refugees can migrate; 2) the exclusion of the unhealthy ones during admission to the country; and 3) the return of the unhealthy and the poor in the country of origin (Horyniak et al., 2016).

One concept that is frequently discussed in the literature is acculturation. The concept expresses how the refugee community adapts to and influences local community norms, behaviors, and attitudes (Canfield et al., 2017). According to the studies, the norms of the host society affect immigrant society; for example, a long stay in the United Kingdom is an enhancing risk factor for alcohol use (Canfield et al., 2017).

It can be said that the studies conducted in the field of ASA in refugees focus on the size of the problem, risk factors and protective factors, the determinants and effects of ASA, the determination of priority areas of application and risk groups, and the types of substances. Studies are generally cross-sectional and descriptive (Horyniak et al., 2016). Qualitative and/or intervention studies are very few (Canfield et al., 2017). Research designs do not have sufficient standardization to evaluate the subject as a whole and to generalize the findings. Scientific publications on the subject are mostly made in developed countries, but 80% of the refugee society lives in middle- and low-income countries (UN Refugee Agency, 2014). In this context, the studies to be carried out in these countries are important to extend the scope of scientific publishing. To monitor the trend in different generations of refugees, it is expected to design longitudinal studies, to conduct studies specific to ASA risk groups, to design prospective cohort studies on the subject, and to study the cost effectiveness of the services to be provided on the subject of ASA.

This study aims to explore and identify the present state and influencing factors of ASA among Syrian migrants in Turkey by integrating perspectives of addicts, their relatives, and local and national institutions.

## Methods

This paper reports the study following Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007) and Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014) guidelines (Checklists are available in the digital appendices 1 & 2). This qualitative study was designed by the grounded theory approach. The study took place in 5 cities (Gaziantep, Hatay, Mardin, İstanbul, and Ankara) in Turkey between January 2018 and November 2019.

### *Triangulation*

To ensure scientific rigor of the study, 4 kinds of triangulation were adopted, using 1) various data sources, 2) various data collection methods, 3) multiple interviewers or facilitators in data collection, and 4) multiple researchers in data analysis.

Three combinations of those triangulations that were the best fitting in the existing context in Turkey were employed as 3 phases of the study. First, to understand the phenomenon from an institutional perspective, focus group discussions were conducted with informants from local governmental, non-governmental, and academic organizations in 4 different cities. Second, to widen the perspective from local to the national and regional level, key person interviews were conducted with heads of national organizations that have responsibilities on Syrian migration. Finally, to understand personal perception and experience, interviews were conducted with addicted Syrian migrants and their relatives in 4 cities.

To increase the effectiveness of hard yet very valuable interviews with addicts and their relatives, 2 other methods were preceded. After each phase, researchers discussed data and adjusted the study approach accordingly.

***Characteristics of the Research Team***

Focus groups and key person interviews were conducted by researchers. At the time of the study, MT and HS were public health professors and working as faculty members in different universities; AU and HK were medical doctors and public health Ph.D. students and working in a family health center and local health government, respectively. MT and HS were experienced in qualitative research, especially in disadvantaged groups. AU and HK had previous training in qualitative research.

The addict and relative interviews were conducted by 1 of the 4 Syrian interviewers, because pilot testing showed that Syrian migrant addicts and their relatives are indisputably refusing interview requests with a non-Syrian interviewer or even with a Syrian interviewer accompanied by a non-Syrian researcher.

Syrian interviewers had graduate (n=2) and post-graduate (n=2) degrees and were aged 22 to 39. One of them was a student in social sciences, 2 of them were working as translators in local migration administration, and 1 of them was a family physician. They were provided online training on the interview method, data collection method, and privacy policy of the study. They signed a non-disclosure agreement. Telephone consultation was provided by researchers whenever needed.

***Focus Groups***

Four focus group discussions were practiced face-to-face in February and May 2019 in 4 cities, Gaziantep, Hatay, Mardin, and İstanbul. In addition to hosting the most Syrian migrants, these cities were selected to create variation in data because of their specific socioeconomic environments.

Meeting venues were meeting rooms of an academic institution in Gaziantep, hotels in Hatay and Mardin, and the headquarter of the Turkish Green Crescent Society in İstanbul.

Managers of local Green Crescent branches were contacted several weeks before each discussion for the arrangement of meeting settings and mediation of the communication with local organizations.

Participants of focus groups were from purposively sampled governmental, non-governmental, and academic organizations that are working related to either migration or addiction in each city. Organizations were asked to send a competent officer that was working related to migration or addiction by official letters and consecutive telephone calls on behalf of the trusted Green Crescent Society.

A total of 77 participants (18 to 22 in each) attended focus group discussions. Some organizations refused to send an officer because of their workload or organizational uninterest on the topic (De-identified lists of focus group participants are available in the digital appendix 3).

Overall, 33.8% of the participants were women, 54.6% were public servants, 39% were working for non-governmental organizations (NGOs), and 6.5% were academicians.

MT facilitated focus group discussions in Gaziantep, Mardin, and İstanbul; HS facilitated the Hatay focus group discussion. AU and HK attended all discussions as reporters. Two observers from the funding agency attended the Gaziantep discussion.

At the beginning of each focus group, facilitators explained the aim and method of the focus group discussion and privacy policy of the study with a plain language. Informed consent of participants for data collection (including voice recording) was received verbally. To establish rapport, facilitators emphasized the sense of common purpose with participants and the independence of both the research team and funding institution. Translations were provided for Syrian participants when needed.

Focus group discussions were semi-structured. Although facilitators mostly tried to keep groups on the predefined topics, they also let the group talk on unexpected topics that may contribute to the discussion. After each focus group, the predefined topic list was revised by researchers.

The duration of the discussions was a minimum of 110 and a maximum of 140 minutes. Data were collected by audio recordings and field notes that reporters wrote during discussions.

***Key Person Interviews***

Interviews were practiced face-to-face from July to September 2019 in participants' offices or meeting rooms of academic institutions.

Key people were sampled purposively as they were responsible in the organizations that have national and international roles in Syrian migration in Turkey. A total of 11 key people from 7 organizations participated in key person interviews. Some institutions refused the interview invitation by redirecting researchers to the Ministry of Health (n=2), and some did not answer at all (n=2) (De-identified lists of key people are available in the digital appendix 3).

Overall, 4 participants were from 3 governmental organizations, and 7 participants were from 4 regional and international NGOs. Eight of the participants were high- and medium-level managers of their organizations, and 1 of the participants was a woman.

MT conducted key person interviews. The researcher explained the aim and method of the focus group discussion and privacy policy of the study. Informed consent of participants for data collection (including voice recording) was received verbally. Prior professional relationships of the researcher with most of the participants provided required rapport.

The duration of each interview was approximately 30 minutes. Interviews were semi-structured. Data were collected only via written notes.

***Addict and Addict Relative Interviews***

Addicts and their relatives were included the study by snowball sampling in 4 cities. Although it was not possible to know the number of non-participants because of the sampling process, they were generally afraid of being exposed and prosecuted or simply not interested. A total of 45 addicts and 21 relatives participated. Distribution of in-depth interview participants by their participation category and city is given in Table 1.

All interview participants, except 1 relative, were men. The mean age of addicts was 27.04 $\pm$ 6.35 years and relatives, 26 $\pm$ 7.45 years. The marital statuses of addicts were as follows: 12 married, 30 single, and 3 others. Overall, 25 of them were only alcohol

Table 1.
*Number of In-Depth Interview Participants by Participation Category and City*

| City | Alcohol User | Substance User | User Relative | Total |
|---|---|---|---|---|
| Gaziantep | 5 | 4 | 5 | 14 |
| Hatay | 7 | 4 | 5 | 16 |
| Mardin | 4 | 6 | 6 | 16 |
| İstanbul | 9 | 6 | 5 | 20 |
| Total | 25 | 20 | 21 | 66 |

users, and 20 of them were substance users. Their duration of living in Turkey was a mean of 5.3 years and ranged from 2 to 9 years (48 were answered). In terms of legal migration status, 25 were under temporary protection, 4 were illegal migrants, 1 was a refugee, and others were unknown (Other characteristics of participants are available in the digital appendix 4.).

To be able to evaluate their addiction status, they were asked to fill Arabic translations of the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993) and/or Drug Use Disorders Identification Test (DUDIT) (Stuart et al., 2003) after interviews. Results confirmed that this study achieved reaching real addicts as their mean AUDIT score was 23.5 $\pm$ 6.6 (n=25) and mean DUDIT score was 25.7 $\pm$ 6.8 (n=20) (Further statistics and visualizations are available in the digital appendix 5).

Four Syrian interviewers conducted addict and addict relative interviews. The interviewers explained the aim and method of the interview and privacy policy of the study with a plain language. Informed consent of participants for data collection (including voice recording) was received verbally.

Interviews were practiced in Arabic and face-to-face in various independent venues that were mostly chosen by convenience to participants. Interviews were 12.6 minutes long on average (range=8:49 – 20:05).

Questions were prepared both in Turkish and Arabic languages and revised after pilot testing on 5 migrants. Although these interviews were well structured for not missing any aspect in any interview, participants were encouraged to share extra thoughts and express feelings (Questionnaire for addict and relative interviews is available in digital appendix 6.). Data were collected with the help of both printed forms and audio recordings.

**Data Analysis**

Data saturation was evaluated after each of the focus group discussions and after roughly every 20 interviews. Although the first 3 discussions reached saturation, the Istanbul focus group provided new insights as expected owing to its specific socioeconomic conditions. Data from the addict and relative interviews showed wide variation and reached saturation around the 40th interview, and they were completed after 1 more batch.

Audio recordings from focus groups and interviews were transcribed, enriched by field notes, and de-identified. All participants were given codes. Addict interviews are coded with a letter representing their participation category (A for alcohol users, S for substance users, and R for relatives) and a number. Work information of focus group participants and key persons are kept in unidentifiable level for interpretation purposes. Transcripts of addict and relative interviews were translated into Turkish by interviewers. Focus group discussions were analyzed in Atlas.ti v8; key person, addict, and relative interviews were analyzed in NVivo v12 software. Data were coded individually by 2 researchers (HK & AU) along with the study process and discussed after each phase. A prior coding tree was not employed, and researchers relied solely on data. Continuous data analysis and discussions evolved the structure of questions in focus group discussions and interviews. Redundant questions or topics were removed, and emerged topics were utilized in immediate sessions. This iterative process further provided a common language for coding. Codes, categories, and themes emerged from each phase synthesized in the discussion. Findings were visualized in tables and figures (Tables and figures that cannot be included in the paper because of publication limitations are available in the digital appendices 4 & 5).

***Ethical Approval***

Ethical approval was obtained from the Clinical Research Ethical Committee of İstanbul Medeniyet University Göztepe Training and Research Hospital, on 5 December 2017 (no: 2017/0373).

## Results

By synthesis of data of focus group discussions, key person interviews, and addict and addict relative interviews, the following 9 main themes emerged:

1. Characteristics of addicted migrants
2. Types of addictions
3. Predisposing and exacerbating factors for addictions
4. Preventing factors for addictions
5. Obtaining alcohol and substances
6. Manners of alcohol and substance use
7. Consequences of alcohol and substance use
8. Public services and utilization of them
9. Experience of addicted migrants

Each theme is detailed in subthemes and supported by direct quotations in this section.

## Characteristics of Addicted Migrants

***Gender***

In focus group discussions, addicted Syrian migrants were usually mentioned to be men. A woman participant who works as a social worker in migration management in Gaziantep suggested that Syrian migrant women were protected because of their limited involvement in social life. However, another participant who works in an NGO in Gaziantep claimed that Syrian migrant women were becoming susceptible to alcohol addiction because of the transition to a more open culture by the migration. A physician NGO president in Mardin noted that he observed several antidepressant abuse cases among Syrian migrant women who were older than 40 years old.

All addicted migrants who participated in interviews were men, and interviewers could not reach an addicted woman.

### *Age*

Participants of focus groups shared cases of addicted Syrian migrants whose ages ranged from 9 to 50; however, most of the mentioned cases were between 15 and 30 years old. A psychologist from the addiction treatment facility in Gaziantep guessed the age range as 18 to 30 years old, relying on their clinical experience with more than 300 addicted Syrian migrants in 2018. A physician and NGO manager in Mardin speculated a similar age range of 20 to 30 years old. Many participants shared concerns about the age of substance use getting lower in recent years, especially for some specific substances. Although Syrian migrants who are alcohol addicts were mostly thought to be above 40 years old, a social worker participant working in the addiction treatment facility in Gaziantep remarked that there was bias in those observations because of the late manifestation of socioeconomic consequences of alcohol addiction.

Most of the key person interview participants stated that the child and young age groups use alcohol or substances more often. One participant stated that the middle age group is prone to use because of being on a quest.

Interviewed addicted Syrian migrants were mostly in their twenties. Age distribution was wider, and the median age was lower in substance users (median=23, interquartile range [IQR]=9.25) than alcohol users (median=26, IQR=6). Figure 1 represents the age distribution of participants. When they were asked about how long they were using, the responses also revealed that the median age to start alcohol use was 19 (range=10 – 33, IQR=8.25) and for substance use was 19.5 (range=12 – 40, IQR=12.25). Figure 2 represents the distribution of ages of starting to use alcohol and substances.

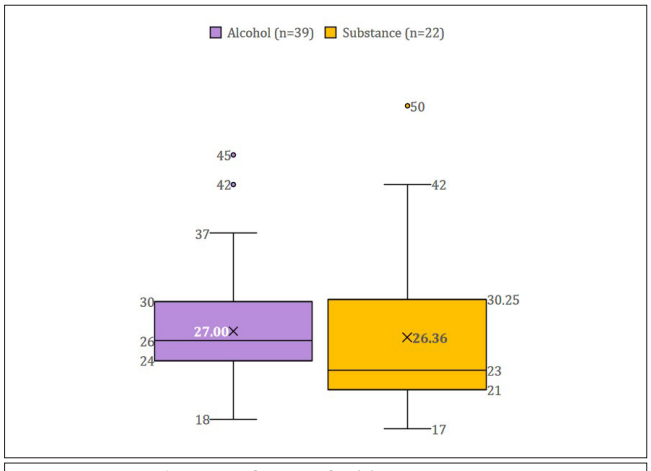


Figure 1. Distribution of ages of addict interview participants.

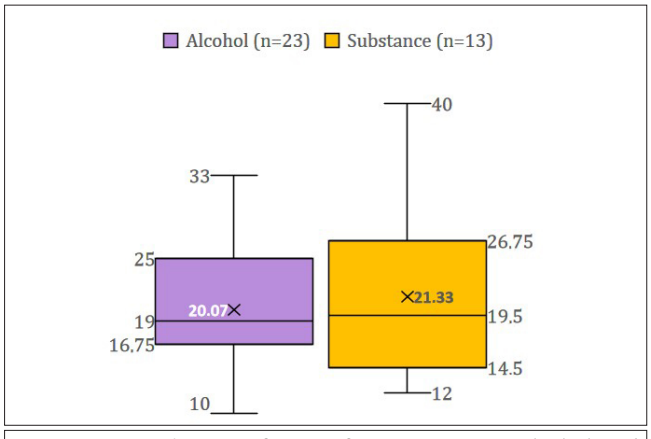


Figure 2. Distribution of ages of starting to use alcohol and substances.

### *Education*

Focus group participants emphasized the role of attending to formal education on addiction prevention for migrants but did not provide further explanation about the relationship between the education status of migrants and addiction.

The majority of participants of the addicted migrant interviews (36 participants answered) had lower levels of education. Table 2 presents frequency distribution by educational levels. Some participants who were students in high school or university in Syria had to drop out when affected by conflicts. After migration, the need to work was another prominent factor in school dropouts in Syrian migrants.

### *Marital Status*

Most of the addicted Syrian migrants who participated in interviews were single (n=30). Table 3 presents the frequency distribution by marital status. However, focus group discussions did not provide any noteworthy insight into the relationship between marital status and addiction, although it has been questioned especially.

### *Employment*

One of the most significant characteristics of addicted migrants that emerged from the data was their employment and occupation status.

Table 2.
*Distribution of Addicted Participants by Educational Level*

| | Substance User | | Alcohol User | |
|---|---|---|---|---|
| **Educational Level** | **Count** | **Percent** | **Count** | **Percent** |
| University | 3 | 23.08% | 2 | 8.70% |
| High school | 4 | 30.77% | 6 | 26.09% |
| Secondary school | 2 | 15.38% | 3 | 13.04% |
| Primary school | 2 | 15.38% | 7 | 30.43% |
| Illiterate | 2 | 15.38% | 5 | 21.74% |
| Total | 13 | 100% | 23 | 100% |

Table 3.
*Distribution of Addicted Participants by Marital Status*

| | Substance User | | Alcohol User | |
|---|---|---|---|---|
| **Marital Status** | **Count** | **Percent** | **Count** | **Percent** |
| Married | 5 | 25% | 7 | 29.17% |
| Single | 13 | 65% | 17 | 70.83% |
| Divorced | 1 | 5% | 0 | 0 |
| Engaged | 1 | 5% | 0 | 0 |
| Total | 20 | 100% | 24 | 100% |

According to the experience of a focus group participant from police headquarters in Istanbul, most of the migrants who were arrested because of the drug trade have been unemployed and exploited by drug networks. A police participant from the Mardin focus group supported this idea. Another participant who was a manager in an NGO in Hatay mentioned that unemployment makes young migrants feel hopeless and prone to addictions.

Three scenarios for the relationship between the employment status of migrants and addictions appeared in focus groups:

1. Unemployment or work conditions make migrants prone to addictions (the latter was mentioned mostly in the context of child labor.).
2. Migrants are seeking a way out from unemployment and poverty with drug trade and transportation (Those do not always have to be users of the drug.).
3. Migrants who are already addicted cannot afford the drugs when they become unemployed and then seek a solution in the drug trade.

The generality of participants of key person interviews stated that the economic situation of Syrians is bad.

In interviews, addicted migrants repeatedly mentioned the difficulty of finding a job. None of them had a secure and insured job. Most of them even did not have a regular job and were working to barely sustain a livelihood daily. They are working for long hours, and yet, they earn way less than the native counterparts did.

"There is no job no money in here. I work in construction. One day I have a job another day don't. Life is tough. I am always seeking a job." (A17)

"People here are looking/treating us bad. They put a lot of work on us yet pay a small amount. They only treat Syrians in this way. No insurance. We must work (for them) otherwise we can't afford our needs. I wish I could go to Europe a year ago with my friends, but I couldn't." (M65)

Several participants evaluated their work and income by considering if it is enough for drinking.

"I work in any kind job; I asked many businesses, but none of them give a job to me. So, I am buying and selling socks as a vender. It's enough if I can earn per diem, it's enough if can get drunk." (A39)

***Occupation***

From focus groups, several migrants from some occupations emerged as risk groups for addictions: construction workers, long-distance drivers, shoemakers, furnishers, bakers, and taxi drivers.

Some focus group participants identified several occupations as risk groups for addictions: construction workers (psychologist, NGO, Gaziantep), bakers, taxi and long-distance drivers (social worker, addiction treatment facility, Gaziantep), shoemakers (officer, probation administration, Gaziantep), and furnishers (psychologist, NGO, Gaziantep). The latter 2 were associated with chemicals used in production.

Those risk groups were endorsed in the following focus group discussions. Participants especially underlined that a lot of migrants are working in constructions even they have higher skills previously.

"There are not many Syrians could work while sitting in offices like us. Mostly they work in constructions and constructions are open for this (addictions). Drugs etc. are common in construction sites. (…) Syrians in districts of Mardin were from across (the border) in Syria. They were poor already. They couldn't open a workplace or own property since there is not much citizenship opportunity." (Case manager, NGO, Mardin)

Remarkably, a psychologist working in an NGO in Gaziantep noted that some employers are giving drugs to migrants to boost their energy and work performance in intense jobs such as construction work. Several other participants from different focus groups agreed with or repeated that.

An officer in probation administration in Gaziantep mentioned that many substance users in the region were "pigeon breeder" based on his observations of probation files. A psychologist working in an addiction treatment facility in Gaziantep supported this. However, there was no further explanation about its relationship with addiction or whether it is more prevalent in addicts than the general population. Only one of them mentioned a story where a pigeon was used to transfer a drug into a migrant camp.

Many occupations of interviewed addict migrants were in the list of risk groups that emerged from focus group discussions.

Occupations of alcohol addicts were as follows: cook, barber, vender, porter, construction worker, taxi driver, tailor, and unskilled worker. They were working in the following sectors: shoemaker, bag shop, restaurant, carpenter, shop, furnisher, and textile.

Occupations of substance addicts were as follows: barber, porter, construction worker, butcher, caregiver, and unskilled worker. They were working in the following sectors: health, shoemaker, disco, restaurant, carpenter, and social media.

Although the income of few migrants who have relatively higher status occupations (such as cook, social media content creator, and salesperson) was roughly about minimum wage, others were earning approximately half of the minimum wage. Some of them mentioned that they cannot practice the profession that they had before migration.

Pigeon breeding was detected also in several addict interviews (n=11), but further details on a possible relationship with addiction could not be obtained.

## Types of Addictions

***Alcohol***

A psychologist who counsels Syrian migrants in Gaziantep argued and focus group participants agreed that prevalence of alcohol addiction is not high for Syrian migrants.

"I am counseling Syrian migrants for three years. I observed at most three alcohol addiction cases or less in these three years." (Psychologist, NGO, Gaziantep)

Other focus groups were in agreement.

"I am working for Syrian migrants for five years. I have seen that alcohol addiction cases are very few, so very, very, very few. I would not say anything if personally suppressed emotions would come out here (in Turkey). Because we know what kind of administration there is (in Syria) and what it is against." (Officer, migration office, Istanbul)

It is predicted that the prevalence of alcohol addiction is not high in Syrian migrants since before migration. However, it may be increased to the level of the locations that they came to as a result of social adaptation, according to some participants. Some others mentioned that they think alcohol addiction prevalence varies by region. It is higher in the Aegean and Marmara regions than it is in the Southeastern Anatolia region.

The participants of key person interviews also stated that the prevalence of addiction among Syrians is low.

Despite that, other reasons for the possible low prevalence of alcohol addiction are argued to be due to the toleration effect and the lack of health-seeking behavior in the early stages of alcohol addiction. This may explain why some physicians and health worker participants expect alcohol addiction mostly after 40 years of age based on hospital admissions. Considering the migrants are more disadvantaged in terms of health-seeking behavior and access to health care services, alcohol addiction in earlier aged migrants should not be overlooked.

Addicts listed the alcoholic products they use in in-depth interviews as beer, raki, whiskey, vodka, wine, and champagne. Special names were made for special alcohol types, for example, white milk for raki.

"Raki, beer, wine... Just to be stoned, I will drink whatever." (A39)

***Substances***

Although there are similar protective factors for substance addiction as alcohol addiction, focus groups estimated a high prevalence of substance addiction among Syrian migrants.

Some substances that were named by participants of focus groups are as follows: opioids, benzodiazepines, amphetamines, heroin, cannabis, synthetic cannabinoids, and volatile substances.

Supported by many participants, the drug addiction profile of Syrian migrants seems to be changed in recent years. A psychologist working in the field on behalf of an NGO stated that, although heroin addiction was at the forefront a few years ago, opioid addiction has become prominent nowadays.

"… We are not able to prevent Tramadol, Zolam, and Baltan right now." (Psychologist, NGO, Gaziantep)

A social worker at an addiction treatment facility also said that opioids have replaced benzodiazepines and confirmed that methamphetamine use has increased.

"When they can't find benzodiazepine, 2-3 patients of us, they turn to opiates. They have been told (by other addicts): 'this will relieve your pains'. And it does." (Social worker, addiction treatment facility, Gaziantep)

A participant who is a manager at the Provincial Directorate of Family, Labor, and Social Services (FLSS) in Istanbul noted that they are helping many children who are addicted to heroin and Bonzai (a synthetic cannabinoid). A participant who is a social worker focused on young people in Hatay suggested that they believe that migrants would have low financial access to heroin and cocaine. A social worker, based on family interviews they conducted in Şanlıurfa, stated that the use of cannabis is at high prevalence in high school age youth because of its easy access. Several participants also supported this view.

The most striking finding of substance addiction types was that participants from various institutions and professions talked about drug misuse, abuse, and addiction in all focus group interviews. The fact that the substances with medical use are at the forefront among the substances mentioned by the participants above aligns with this view.

According to the key person interview participants' statements, the substance type that stands out in the amount of use is cannabis.

Substances mentioned in in-depth interviews are the same as those in focus groups: cannabis (marijuana, weed, kubar), opium, synthetic cannabinoids (Bonsai), Captagon, Baltan, tramadol, Zolam, and Romodil.

Some migrants said they use any substance they can find. Similar to alcohol products, special names are made for substances, as in candy for pills.

"I take pills, not cannabis. They call it candy. I pop it like a pill." (S46)

"While I was working at the carpenter, there was a friend, he always told me to come and use it. "Look, this is the stone." He used to say. He used to use it, can do his works without getting tired." (S49)

***Hookah and Cigarettes***

Although it was not investigated in the scope of this study, migrants' hookah use was repeated very much both in focus group discussions and in-depth interviews. It is undoubtedly the most prevalent and obvious addiction in Syrian migrants. It was seen as a cultural fact or a social norm by focus group participants.

It is stated that migrants use hookah until late at night in key person interviews.

Only a few of many strong statements of Syrian migrants about hookah were as in the examples below.

"I use hookah, there is no Syrians don't use hookah." (A39)

"Hookah is my life; it is everything for me. You can do anything to me, but don't take my hookah from my hands" (M2)

"I use hookah every day ever since I could remember" (M7)

It is an important point that some addicts (e.g., M15, M16, M43) were first introduced to the substance as it was contained within hookah or cigarettes by their friends. Although some of them first reacted by mentioning religious prohibition (haram), hookah and cigarette forms might facilitate the adoption because those two were seen acceptable by the Syrian community.

## Predisposing and Exacerbating Factors for Addictions

One participant in key person interviews stated that people did not care about alcohol or substances in the early days of migration, but they were exposed to risk factors after the acute phase of migration was overcome.

Key person interview participants expressed reasons of alcohol or substance use as in the following list: unawareness, organizations working in favor of alcohol and substance, ghettoization and social isolation, encouraging campaigns in social media, efforts to keep troops awake and obedient in fighting groups, illegal and uncontrolled drug use owing to lack of access to some drugs in Turkey, missing out on education, exposure to long working hours, family losses, and distribution of the substance by the Syrian state to prevent people from fighting against the regime forces.

Interviewers of addicts and relatives noted that users are mostly are either from the same family or friends.

Predisposing and exacerbating factors for addictions are presented in Figure 3.

### *Family*

An addicted family member can affect being an addict and restarting after treatment.

The participant who works as a social work specialist in an addiction treatment facility in Gaziantep mentioned that family members can refer people to the substance in the form of drug advice.

It is also seen that substances with relatively lower effects are recommended as a replacement for addicts in the family.

"Patients are doing everything they can do to change in a 21-day or 6-month period. But when they go into the same family dynamics, when the family's perspective is the same, they can hear things like this: 'Don't use it, son, use cannabis instead', 'There is no sin in weed' or in social settings or at weddings 'Drink a beer, what can happen?'" (Psychologist, municipality, Gaziantep)

It was stated by multiple participants that migrant children who lost their parents or whose parents remained in Syria and remained unsupervised were very vulnerable to addictions. Domestic violence, ill communication, or child neglect were listed as other possible predisposing factors for addictions.

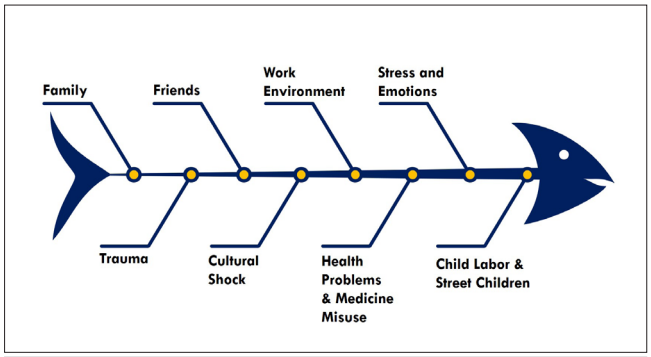


Figure 3. Predisposing and exacerbating factors for addictions in Syrian migrants.

Based on the experiences of the participant working as a Child and Adolescent Mental Health Specialist in a children's addiction treatment facility in Istanbul, it can be suspected whether families with many children are a risk group.

Addict interviews confirmed the effect of the family especially in starting to use alcohol.

"My grandfather is used to drink raki, I learned from him in Syria, my family is used to drink." (A3)

"My father used to drink with me when I was little, and I always admired him, I thought it was a good thing, I always wanted to drink, then I tried once, and then I got used to it." (A24)

Additionally, it is noteworthy that hookah use is considered as a family activity and observed during the home visits made by many participants. The situation depicted in the following statement was repeated by different participants in different cities:

"We go to home visits. Social worker colleagues would know it in more detail. When we go, generally the whole family lives in one single room because of financial limitations. The cigarette or a hookah smoke in there harms all other family members and make them passive smokers." (Manager, Red Crescent, Hatay)

### *Friends*

Participants said that the use of alcohol and substances was encouraged between youth and it is seen as a way of acceptance and self-expression. It is noteworthy that the children started to use or even sell substances to be accepted among their friends.

One participant of a focus group meeting in Istanbul described the same situation as follows:

"Syrians also suffer this thing; I believe they (locals) have included Syrians in this circle. For example… Young people are talking amongst themselves… To become one of them… For example, I came across such things in Gaziantep, such as 'Do you want to be included in our environment?', 'Yes, I want to.', 'This is our way, you should do it too'. For example, a simple one, recyclable waste collector. If they are doing something, he (the migrant) is doing with them." (Coordinator, Migration Office, Istanbul)

The claim that local children affect migrant children was found in 3 different focus group meetings (Gaziantep, Hatay, Istanbul). Because it is known that most of the migrant children and young people face adaptation problems, addiction in migrant youth becomes an important concern.

It was also stated that friends may also offer an addictive substance in the form of medical advice as families might do.

According to in-depth interview participants, some alcohol use and most substance use were initiated by their friends, either migrant or local.

"About one hundred percent of my friends are drinking." (A22)

"We were staying in the bachelor house; we had a Turkish friend and he used to come to hang out with us every night. (...) He was bringing vodka, raki, beer. The first day he brought, I didn't drink, and the day after that I wondered, I drank, I liked it, I continued to drink." (A48)

"He learned Turkish when he first came, he was on his job. After learning Turkish, he got Turkish friends in the work environment. After a while, he quit work. Then we investigated, and we understand that he becomes addicted to a substance." (R30)

***Work Environment***

Some focus group participants claimed that Syrian workers are given substances by their employers to increase work performance and production.

"Child labor among Syrians is very common. In all textile ateliers, that substance is now used. Because tramadol gives some energy, gives a little better power, increases attention. Foremen are giving it to children now. Those drugs are available in textile ateliers and markets." (Psychologist, NGO, Gaziantep)

Focus groups argued that some workplaces, such as construction sites, ateliers, and industrial areas, are high-risk places for substance use.

The addict and relative interviews also supported the effect of the work environment on the introduction to alcohol and substances with many stories. Some relatives (R27, R32) explicitly accused a shoemaker atelier for the addiction of his/her relative; another (R31) pointed to a foreman in the workplace. Many narratives of addicts include a relation with their work, workplace, or colleagues. Some of them were working in environments where alcoholic beverages are available, such as a restaurant (A50) or a disco (S40).

There was strong evidence in in-depth interviews as well on substance use for performance enhancement in work, either voluntarily or forced.

"There was a friend that never sleeps. So, I asked him. 'How do you work without sleeping like this?' And he said, 'There's a pill, I'm taking it.' And I said, 'Use some for me.'" (S1)

"I haven't slept in 4 days because I work as a porter. I am taking a pill to not sleep. There is a white pill, I take it. I am going to get married. You also need money. I had no money in Syria. I have to use it. Life in Turkey too expensive. We need money too. My money is not enough to eat and drink. There is a night job in the marketplace. I need to take pills to not sleep. I cannot work if I do not drink." (S1)

"We were starting to work in Syria at 8 am, but we were going home at 2 pm. Here we start at 4 in the morning, until 8 in the evening. The boss always says 'Work!'." (S59)

"I buy it. I go home after work. I drink. I get to rest. I rest my head. Then I wake up in the morning and start doing my job." (A25)

***Trauma***

Mental problems may arise because of war injuries, witnessing death, receiving death news, or the migration event itself.

One participant of key person interviews stated that the poor sections of the society that migrated were facing disability, death, and great difficulties. It was also stated that the rich sections migrated by smugglers for $1,000 to $1,500.

The addict and relative interviews revealed stress and trauma in their migration experience. The stories of most of the participants were composed of serious problems, such as waiting and walking for a long time, fear of death, starvation, being under fire, custody, escaping from the military, hiding, boat transportation, diseases, loss of a family member or a friend, robbery, assault, bribery, and significant expenses.

Quotations depicting the extent of the trauma that they were exposed to are shown below:

"We had troubles at the border. They fired on us; thank God we didn't get any damage. Our entrance took about eight days." (R35)

"They made us wait for about seven hours. We entered Turkey illegally. They wanted a lot of money to bring us here. We had a lot of trouble. We worried and stressed a lot about what would happen to us." (A17)

"It was very difficult. It was winter and the human smuggler made us walk for 3 hours in the mud at 2 am in the night. I was worried about my children. I was frightened a lot. In the end, you can't know what would happen at the border." (S63)

"I walked from Aleppo to Latakia for 6 days, day and night. We were passing across uninhabited places and into the mud. They withheld us at the border. We said, 'there is a war back there, we cannot bear any more' and then fled to Turkey." (S20)

"Half of my family died in the war; the other half fell apart. I don't even know where some of them are now. I wish it hadn't been like this." (S2)

"I was very worried in the last days of military service. My friends were dying before my eyes. I could not take off my clothes for 15 days at a time. It was very difficult." (A57)

When they were asked about how long they have been using, it was revealed that the majority of alcohol (74%) and substance (60%) users that were interviewed had started to use after 2011, the beginning of the Syrian conflict. Almost half of the participants had started to use alcohol (17 of 38 answered) and substances (8 of 15 answered) after their migration.

***Cultural Shock***

In general, Syrian culture is defined as free from ASA, according to the focus groups. On the other hand, cigarette and hookah addiction is expressed as a part of their culture.

Participants argued that culture shock and efforts to adapt after migrating to Turkey have increased alcohol use, especially in young people and women. A Syrian-originated woman NGO representative who is in close contact with Syrian migrants in her fieldwork said:

"As they grow up in a conservative society, there is actually a problem with girls, they are introduced to a new cultural conflict. (…) I witnessed alcohol addiction of women a lot. Their lives in Syria were very limited. Also, they are affected by what they see on television." (Officer, NGO, Gaziantep)

Syrian participants claimed that they were affected by the relatively western culture after immigration. They said this indirect-

ly affects the use of alcohol and drugs. However, their defensive tone on this issue was noted by the reporter.

One participant, who worked in both the Southeastern Anatolia region and in Istanbul, stated that cultures in the border provinces are mostly similar to Syrian culture, but that migrants experience a culture shock after they migrate to the western regions.

Addicts in in-depth interviews claimed that another rationale for substance or alcohol use is social exclusion.

"There are so many reasons to drink here. Wherever we go, "Syrians came." Boss acts badly. Everyone sees us as beasts. They are not seeing us as humans. There is distress, there is cruelty. In other words, there are many reasons for Syrians living here to drink." (A21)

***Health Problems and Drug Misuse***

In all focus group discussions, drug misuse and abuse were mentioned as an important cause of substance addiction in Syrian migrants.

Two psychologists in the Gaziantep focus group discussed underlying mental problems, such as post-traumatic stress disorder, psychosis, bipolar disorder, and personality disorders, in addicted migrants. Focus groups agreed on the fact that mental problems can cause addiction in migrants and vice versa.

In addition, treatment of diseases, particularly post-traumatic stress disorder, or more generally relieving any pain seems one of the primary causes of substance use among Syrian migrants.

Various drug misuse or abuse scenarios from different participants' expressions are summarized as follows:

1. Abuse of the drug prescribed with an indication by the physician
2. Abuse of the drug that was first received with a wrong indication and later continued by getting prescriptions from a physician or obtaining it illegally
3. Abuse of drugs that are recommended by non-physicians and obtained by illegal means because the drug that is originally prescribed by the physician is not available
4. Abuse of drug that is recommended by non-physicians and obtained by illegal means to relieve pains without consulting a physician

The latter is described in the following narrative:

"Since informal migrants do not have any official documents, passports, and the like, they cannot benefit from health institutions in any way. Therefore, these informal Syrians provide medicines as follows: By suggesting to each other. 'I have this disease'. Thus, he actually started his addiction by assuming that he had somehow cured his illness with the suggested drugs." (Officer, NGO, Gaziantep)

A participant working at an addiction treatment facility in Gaziantep stated that migrants are very afraid of being addicted to any kind of medication prescribed to them. The reason for this situation is thought to be a fear that spreads through people who witness or hear about the consequences of drug abuse cases within the migrant community.

A Syrian physician who participated in a meeting in Hatay spoke with an attitude of defending Syrian migrants and said the following about drug use:

"Syrian immigrants' addiction status is very simple. It seems like they have almost nothing to do with addiction. Refugees from Syria have become drug addicts rather than cannabis and other addictions, and they have become addicted because they use too much." (Physician, NGO, Hatay)

It was suspicious that an alcohol addict in an in-depth interview said that a doctor recommended him to drink to relieve his kidney stone pains.

"I was very helpful when my kidneys had pain. My pain was going away." (A57)

"I had a foot fracture after a work accident. I started because I had a lot of pain. I started using it as a pain reliever and sedative." (S55)

***Drug Trade***

Focus groups thought that there is an increase in the number of Syrian migrants selling drugs.

Existing drug trade networks are abusing the disadvantages of migrants. Failure to sustain a livelihood can be considered as a risk factor for migrants to become sellers. Migrants are said to be used by existing drug networks in exchange for small daily fees (50 – 100 ₺).

"There are people who use the disadvantages of them. The malicious people are out there. So, "How can I use this?" There are people trying to pull this into their own space. So, if we support them here, it's not monetary only; like education, health, we are very likely to save them. This happens with the state policy. Individuals or NGOs to some extent." (Coordinator, migration office, Istanbul)

Another participant in Hatay stated as follows:

"These people are so financially desperate that they get into it even though they know they will be deported when they are caught, or that they will be punished with very serious prison sentences… Because if someone who has no financial opportunity earns a good amount of money in a month or he is said "If you take this to Adana from here, we will give you this.", he takes the risk… In other words, if we do not include Syrians both in employment and socialization, this problem will continue." (Manager, NGO, Hatay)

Migrants can be deceived by drug dealers with statements such as "You are not even registered; nothing happens if you are caught."

Another participant, who is the manager of an NGO in Hatay, expected that people who transport or sell the drugs should not necessarily use them:

"Our young people in Hatay, do not use drugs in a serious amount. Because this is a transition zone. In other words, there are very few people to taste what they carry. Many will be sellers and carriers." (Manager, NGO, Hatay)

***Child Labor and Street Children***

Child labor and street children were repeatedly mentioned in focus group discussions as phenomena that create a predisposition to addictions. Many migrant children are working in unauthorized textile ateliers owned by locals (psychologist, NGO, Gaziantep; manager, FLSS, Gaziantep; social worker, migration office, Gaziantep) or constructions (case manager, NGO, Mardin). Some of them are introduced to substances in the workplace and even sometimes by employers for performance enhancement. When detected, those children are protected by injunctions and socioeconomic support is provided. However, these solutions are not seen as sufficient in focus groups.

A manager from FLSS in İstanbul drew attention to street children:

"Based on past experiences, I think that as the time children stay on the street increases, their contact with the substance increases. The more they stay on the street in nights for working and begging, the time spent in the streets and time to return home are increasing and so their familiarity with substance. Because children really need something to be protected. In the past, mobile teams showed us that. Our colleagues working in the field will probably confirm the same thing." (Manager, FLSS, İstanbul)

Other focus groups were aligned with this idea. It was interesting that the same participant indicated similarities between the current situation of Syrian migrant street children and the situation of street children who were internal migrants and came from southeast Anatolia to İstanbul at the beginning of the 2000s.

***Stress and Emotions***

Some addicts reported in in-depth interviews that they use alcohol or substances to forget about their problems or because of loneliness.

"Life is hard. When I take these pills, I calm down a bit, I forget my troubles, I do not think of financial difficulties." (S63)

"Life is so hard. We cannot tell anyone about our troubles. Nobody understands us, so alcohol becomes our consolation." (A21)

"My family is not with me. Now I will continue to drink with those who come here. Because I am used to it. Work is hard, money is short, this is my only fun." (S65)

Longing for a family was reported as a rationale by addicts for alcohol use.

"I am abroad. I am longing for a family. I have trouble, I drink. They say, 'Drink, get drunk, forget about your troubles.'" (A39)

Taking the whole burden of their family is also reported as a factor by relatives.

"The whole burden of the family was on my brother. My father was not working, he is old. My brother was providing for all of us. There were a lot of burdens." (R28)

## Preventing Factors for Addictions

***Family***

Family is accepted as a protective factor for ASA in focus groups. Problematic family relations are seen as defects in this protective function and even risk factors for addictions.

***Rules of Religion and Law***

Focus group participants emphasized the preventive effect of religious-based Syrian bans on alcohol use. In addition, most of the participants stated that the effect of religion is not limited to official bans but is also because of personal moral attitudes and social acceptance.

"When it is hookah, the religious factor is not at the forefront. But while consuming alcohol, there is also a sense of sin. It requires a suitable environment. Drinking alcohol at home is unusual. It would cause people to be excluded by their families." (Officer, NGO, Hatay)

As in alcohol addiction, religious factors and governmental regulations seem to play a protective role for substance addiction, according to focus group participants.

"You could drink just a bit of alcohol, in hidden corners, but there were serious punishments for drug use. You know, it would even end up with execution, that is to say, even if it happened, we would not know. Usually, it is not exposed." (Physician, NGO, Mardin)

According to observations based on home visits of an officer of religious affairs in Mardin, Syrian adult migrants are mostly religious people, and thus addictions are rare among them. However, he noted that youth might be different from this perspective.

It was stated in key person interviews that if a bottle of alcohol was seen in the hand of a person in the Free Syrian Army region, their hand could be cut, and they could be executed.

Social reactions and legal prohibitions on alcohol in Syria are higher than it is in Turkey. Therefore, it is easier to access alcohol in Turkey. Accordingly, some relatives (R13, R14, R27, R30) state that this situation increases the consumption of alcohol by Syrians.

"For example, alcohol use is unrestricted here (in Turkey). It exists there (in Syria) but only in certain regions. It is everywhere here. That's why it has increased more here." (R30)

***Education and School***

Not attending school, working on streets, or other inappropriate environments were mentioned in focus groups as strong risk factors for migrant children's addiction. Thus, keeping them in schools is accepted as an effective prevention strategy.

A child and adolescent psychiatrist at the Child and Adolescent Substance Abuse Treatment Center (ÇEMATEM) in İstanbul add another aspect to this preventive function of the school as the teachers would have more information and observation on the risk of addiction of a child than their families.

A guidance teacher in Istanbul shared his regret about the closure of the Temporary Education Centers that caused more migrant children to drop out of school because of adaptation difficulties in local schools or bullying and end up in the streets. The effect of the peer pressure and bullying of local children was underlined in the Gaziantep and Hatay focus groups.

***Non-governmental Organizations***

An officer in FLSS in İstanbul mentioned the complementary role of NGOs in shortages in public services to protect migrants from addictions. This idea was repeated in 2 other focus groups.

## Obtaining Alcohol and Substances

***Financial Access***

According to a social worker from the Research, Treatment and Education Center for Alcohol and Substance Addiction (AMATEM) in Gaziantep, synthetic cannabinoids are more prevalent in children because of their cheapness. In contrast, according to an officer from FLSS in Gaziantep, financial access to alcohol is lower. A Syrian physician and NGO manager in Mardin confirmed that alcohol seems less accessible than some substances such as cannabis in the migrant population. An officer from Red Crescent in Hatay noted that access to heroin or cocaine is hard for Syrian migrants because of their price.

According to in-depth interviews with addicts, to obtain money to buy alcohol or substances, addicts use ways such as working for money, using their savings, postponing their essential needs, using a common budget with friends, obtaining from relatives, borrowing, selling or exchanging personal and household goods, begging, and theft. One said they see weddings as free alcohol sources (A38). One of them stole weed from a farm (M16).

"I am a daily worker; I drink according to how much I earn daily. If not, I borrow and drink." (A18)

Some addicts reported postponing their essential needs:

"We cannot buy clothes. I think, 'Why would I buy clothes, instead I would drink.' We always wear the same things." (A8)

"I get some food; the rest goes to alcohol always. As if it was my only need." (A22)

Using a common budget with friends to buy alcohol is seen:

"When we don't have money, we get from anyone from the group who do. They bring, we use. When we have it, we buy it. Otherwise, we cannot do it any other way." (S37)

Some of them borrow on behalf of their family and the debts may remain on the family:

"Sometimes when he can't find money to drink, he borrows and drinks. But he doesn't pay his debt. Like a beggar. It disgraces us, our family. We do not want this to happen. We give whatever we have in our hands." (R12)

Some addicts commented on the amount of money to get substance or alcohol as below.

"I work here, I take my money and drink. All my money goes to alcohol. I work, I earn money, but I have no money. I'm drinking with all of them." (A9)

"I work one day; I drink one day. Sometimes I work half a day, sometimes I drink half a day. Anyway, we work half a day until we get the alcohol money. Then I keep drinking." (A36)

"Others are expensive so I can't buy them. Beer doesn't get me drunk. This is where raki is abundant. They do it themselves in the villages. I buy it from there, I drink it. Otherwise, I cannot buy the raki from the markets." (A25)

"I do not drink much because it is expensive in Turkey." (A38)

Many addicts mentioned that they couldn't buy enough alcohol for getting drunk because alcohol is expensive in Turkey. Hence, they were using a substance which is cheaper (S20, S59). This finding is aligned with the findings of focus groups.

"Alcohol is already very expensive in Turkey. You cannot drink. You will not get drunk if you drink. We don't have that much financial capability to drink alcohol. We can't do it every day." (S20)

"What's more available than substance? It is sold on the street. Captagon is sold for 3 liras. I get 50-60 of them. It is enough for me for about 10 days. (⋯) Tramadol one pill is 10 TL. The ecstasy is 20 TL. A pack of Baltan 35, Zolam 15 TL." (S59)

***Physical Access***

In the Gaziantep, Hatay, and Mardin focus groups, it was stated that access to substances might be high because those cities are on the border, and substance transport might be overlooked in peak times of migration. One participant working in the police department in Mardin talked about how the surrounding cities are open to terrorism and drugs are a financial source for terrorism. A psychologist from FLSS in Mardin and a social worker from AMATEM in Gaziantep agreed on the role of being on the border.

"Mardin might be a susceptible place. I mean, I don't use and don't have any friends using, don't know where it (substance) is sold. But I can find it with a single phone call. Even I can be cheaper. There is a rumor that it is available in markets in Kızıltepe (district)." (Representative, NGO, Mardin)

However, an NGO manager in Hatay stated that even Hatay was a transition region, end-users were mostly in the other cities such as Adana, Antalya, and İstanbul. Thus, for him, even Syrian migrants in there might transport substances they would not use. Many participants from different groups supported the assumption that migrants in western cities are more prone to addictions.

One key person interview participant stated that Urfa is an important province where people are made addicted and made part of this trade. Another participant has stated that cities in Turkey would not much differ in terms of addiction.

Some neighborhoods and districts are listed in focus groups as high accessibility areas: Vatan and Hacıbaba in Gaziantep; Eski Mardin and Kızıltepe in Mardin; and Kağıthane, Esenyurt, Başakşehir, and Ümraniye in İstanbul.

In key person interviews, some specific areas were provided also. Those were Kızıltepe and Yalı in Mardin; in Gaziantep, they were Vatan, Karataş, and a region demolished by the municipality where the Iranian market is located.

Although some speculated a possibility, migration camps, in general, were not seen as suspected places for alcohol or substance use in focus groups because of the security measures and lower financial capacity of migrants in there.

One participant of key person interviews stated that security guards in refugee camps could be used as an intermediary for dealing.

During the Gaziantep focus group meeting, participants mentioned about 2 ordinary shops that are selling the drugs to Syrians they brought illegally from Syria, and this was confirmed by many participants.

According to the in-depth interviews with addicts, the people who provided alcohol or substances can be listed as follows: their friends, dealers, employers, or work contacts. Those were either Turkish or Syrian people. It is remarkable that physical access seemed very easy for migrants.

"I buy from both Turks and Syrians. I think the Syrians have Turkish bosses who provide for them." (S43)

"There are dealers in our neighborhood, they buy from them. You just need to have money; you can get it from anywhere." (S49)

"I lived in Adana for 7 years. At first, we met women. The same women are doing drug dealing. Adana is not like even Kızıltepe. It is sold secretly in Kızıltepe, but in Adana women, children, and everyone both buy and sell. There are all kinds, you cannot even imagine." (S59)

One participant explained a kind of a delivery application for substance orders:

"I receive the substance with 'dilivari' (this might be a mobile application and name might be derived from the word "delivery"). I call the people I bought, and I ask for 'olives', and they bring. It's like 'yemeksepeti' (a known application for food orders)." (S42)

## Manners of Alcohol and Substance Use

Alcohol and substance use patterns of participants of addict interviews were evaluated by AUDIT and DUDIT scales. The majority of participants were using alcohol or substances more than 4 times in a week. Again, the majority of them were using more than 5 standard units of alcohol or substances (Frequency distributions for all items of scales are available in the digital appendix 5.).

"We drink morning, noon, evening without noticing (the time). I drink all the time; my life goes by drinking." (A3)

"I use every day, it's like water, like food. You can't live without water or food, can you? There is no time that I don't use." (S4)

Participants of addict interviews were using alcohol or substances for 7 years, on average. It should be kept in mind that most of them were young adults. Some interview participants said that alcohol and substance usage increased after they came to Turkey. Only 1 migrant said that it had decreased.

Most of the participants were using alcohol or substances in the house. This is thought to be because entertainment venues are expensive (A22) and addicted migrants tend to hide their usage. Others mentioned using in pubs, taverns, discos, streets, coasts, ruins, and work.

Although alcohol was mostly used by a group of friends, substances were used individually. Alcohol was used along with foods; substances were used with tobacco in hookah or cigarette.

Focus groups or key person interviews did not provide significant insights into the manner of usage.

## Consequences of Alcohol and Substance Use

Although some consequences were identified in focus groups, those were not specific to Syrian migrants. This can be interpreted as participants do not have enough knowledge about Syrian migrants' life after being addicted.

Identified consequences were as follows: family problems and domestic violence, mental disorders (psychotic disorders), financial losses (even losing home furnishings), involvement in crime (stealing), and drug trade. (social worker, AMATEM, Gaziantep; psychologist, AMATEM, Gaziantep; psychiatrist, university, Gaziantep; psychologist, health administration, Mardin; psychologist, FLSS, Mardin). Those consequences occur mostly for finding the money for the addictive substance.

A psychologist from FLSS in Mardin said that they detected that most of the Syrian migrants who are detained or involved in violence or abuse have a background of substance use.

A manager in a branch of the Green Crescent Society drew attention to the fact that the crime rate in Syrian migrants is much lower than it is presumed.

In all focus groups, it was stated that all users are potential sellers. Police officers in İstanbul indicated that the number of arrested migrants because of the drug trade is increasing in recent years. He emphasized the need for support and monitoring activities after detention in the coordination of public institutions. Otherwise, they would go back to the drug trade in the same environment.

When the participants of key person interviews were asked about their observations and information about the results of alcohol use, the themes arisen from the answers given are as follows:

1. Addicted Syrians are stigmatized by society.
2. Addicts are prone to crime and theft.
3. Social pressure on this issue causes the addiction to remain hidden and the health care – seeking behavior is restrained.

The addict and relative interviews also indicated similar but more extended consequences than focus group discussions and key person interviews did. As a result of alcohol and substance use, they identified health, familial, work-related, social, financial, and criminal problems. Subcategories of those consequences are shown in Figure 4.

### *Health Problems*

Several health problems as a result of ASA were mentioned, such as a variety of diseases, memory loss, loss of control, non-specific symptoms, psychological problems, injuries, disabilities, and death. Although they shared details of related events, most of the health problems were known as the effects of alcohol and substances and did not present features specific to migrants. However, the handling of health problems presents important features because of migrants' limited access to health and social services (please see the section "Public services and utilization of them").

### *Familial Problems*

These include domestic violence, family budget and debt problems, exclusion and stigmatization of family members, the health status of family members, abandonment, and divorce by the spouse.

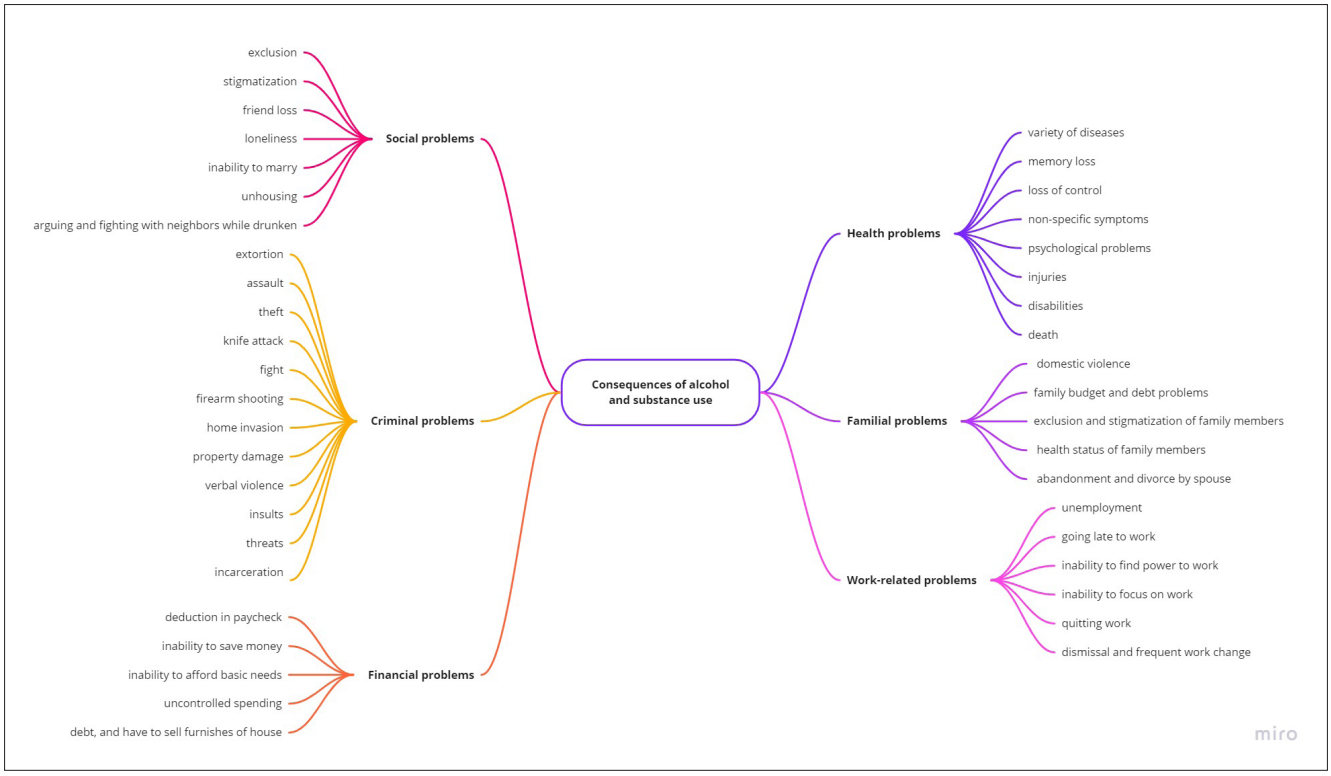


Figure 4. Consequences of alcohol and substance use.

"My wife went to her mother because I drink, took my kids, and she didn't want the kids to be like me." (A24)

"So, it has bad effects on us, too, but most of it has an effect on his own family, on his daughters and wife. They're unhappy because of him, and in the future, his daughter will grow up, his son will grow up, there will be much more effect. No one marries his daughter. They will say '(she is the) daughter of a drunken'." (R26)

***Work-Related Problems***

These include not working, going late to work, inability to find the power to work, inability to focus on work, quitting work, dismissal, and frequent work change.

"I can't get up in the morning after I've had a drink. Every week I have problems with my work because of the drink." (A5)

***Social Problems***

These include exclusion, stigmatization, friend loss, loneliness, inability to marry, unhousing, arguing, and fighting with neighbors while drunk.

"I want to quit; it's psychologically damaging to me. I always want to be alone. Society doesn't have to exclude me; I exclude myself from them." (S40)

"He gets drunk and argues with everyone, he can't get along with anyone, so he's always bothering everyone when he is drunk. People are fed up with him. These big problems that affect us a lot." (R29)

***Financial Problems***

Alcohol and substance use of migrants might result in financial problems as follows: deductions in the paycheck, inability to save money, inability to afford basic needs, uncontrolled spending, debt, and having to sell furnishings of the house.

"I buy some food, and the rest goes for a drink, and it's like all I need. This is the effect of it on my life." (A22)

"It has never had any positive effect, always had a negative effect on us. Because of him we always owe debts. He borrowed from every acquaintance, they come to our door and say, 'your brother borrowed from us, you will give us'. The neighbors are also very uncomfortable, too, the landlord is going to throw us away because of him. We don't know if we should consider his rental debt or his alcohol debts." (R27)

***Criminal Problems***

Extortion, assault, theft, knife attack, fight, firearm shooting, home invasion, property damage, verbal violence, insults, threats, and incarceration are criminal problems that were mentioned in the addict and relative interviews. They did not mention about if they were involved in the drug trade or not.

## Public Services and Utilization of Them

***Types of Services***

Participants of focus groups were asked about services that they provide for addicted migrants. Their answers were summarized and grouped (The table is available in the digital appendix 4.).

It is important to see that many institutions do not have specific services for addicted migrants. Most of the participants are only stated that they are referring addicted migrants to a relevant institution (i.e., addiction treatment facilities) as it ought to be. Some of them stated directly that they do not provide any services, and some others gave examples from their services for migrants or addicts. Even some addiction-related services seem open to migrants too; considering that the migrants face a variety of barriers in access to services, many of the services would not reach migrants in need.

Additionally, the lack of rehabilitation services following treatment was mentioned in 3 focus group discussions as a problem for all addicts.

***Barriers***

Barriers in migrants' access to public services that were defined in focus groups are grouped as follows and supported by findings of addict and relative interviews:

1. Lack of information about services

   Most of the interviewed addicts and relatives (56 out of 63) said that they do not know which services are available and how to access them. Only 2 participants consulted a health facility for their addiction. One of them stated:

   "I don't know where to apply, how could I know. I know some people using medicines to quit substance, but that might not happen for alcohol. How can I know? I'm a refugee." (A38)

   "I wish someone came out and establish an NGO or something and lead us for quitting. It would be simpler. I don't know where to apply." A48

2. The service is incompatible for the migrant because of the language barrier (specialist psychologist, addiction treatment facility, Gaziantep)

   An addicted migrant described a helpless situation because of the language barrier:

   "I don't speak Turkish, I can't talk to people, I can't tell anyone about the situation I've fallen into. If I would tell Syrians here, they are going to look me bad. They have enough problems they can't solve mine." (A39)

3. The migrant is incompatible for the service because that migrant could not or did not obtain a temporary protection ID card (officer, NGO, Gaziantep; psychologist, NGO, Gaziantep) or migrant is living in a city different than that he/she was registered (officer, NGO, Gaziantep; psychologist, NGO, Gaziantep; social worker, Red Crescent, İstanbul)

4. Hesitancy to get contact with an official institution because of fear of prosecution or deportation (psychologist, NGO, Gaziantep; psychologist, AMATEM, Gaziantep)

   Addicted migrants expressed their worries as follows:

   "If we go to treatment to quit, they'll cause a ton of trouble." (A21)

   "It is not allowed to use it, you know, I'm a refugee, and I can't admit anywhere or even search for these things." (S40)

It has been stated by most of the key person interview participants as well that the addicts hide their situation and resist obtaining information on this issue, and even families do not seek solutions for their children with the fear of deportation or imprisonment.

Those barriers and inaccessibility to services may defect prevention of addiction in migrants in the following levels:

1. Primary prevention defect: Because of those barriers, migrants in need of health care or social support might end up seeking a remedy from illegal ways or incompetent people or relatives. Considering the previously mentioned roles of drug misuse and socioeconomic problems in addictions among migrants, inaccessibility to health and social services might be an important path to addiction.
2. Secondary prevention defect: Migrants who started to use alcohol or substance plausibly develop an addiction.
3. Tertiary prevention defect: Migrants who have been addicted already could not receive timely and appropriate care and worse outcomes of addictions occur.

Roots and consequences of barriers to access in public services for addicted migrants are presented in Figure 5.

***Adherence to Treatment***

Some participants shared anecdotes about addicted migrant children who do not adhere to and even escape from addiction treatment (social worker, Red Crescent, İstanbul; manager, FLSS, İstanbul; child and adolescent psychiatrist, AMATEM, İstanbul).

Although most of the participants of key person interviews stated that Syrian addicts do not have a seeking behavior to quit alcohol or substances, the Syrian physician working in Mardin stated that 3 to 4 addicts per month reach them.

***Lack of Collaboration and Coordination***

Whereas most of the focus group participants underlined their organizations' pledge to collaboration, there was very little evidence for active collaboration and effective coordination between local organizations. Even some organizations showed a lack of coordination between their subdivisions. Although there was an anti-addiction coordination committee in each city, integration of health and social services had not been achieved yet. NGOs and universities seem underutilized in most narratives.

"We (as institutions) pay much attention to meetings and training each other. In fact, we fall short on real practical works. As a person who attends many pieces of training on addiction in years, I can say that there is a lack of coordination between public institutions. Everyone doing something by themself, but those things are disconnected and overlapping." (Guidance teacher, Ministry of National Education, İstanbul)

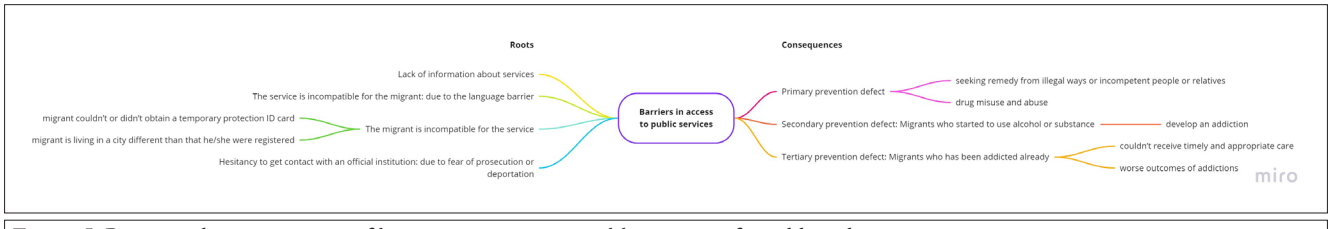


Figure 5. Roots and consequences of barriers in access to public services for addicted migrants.

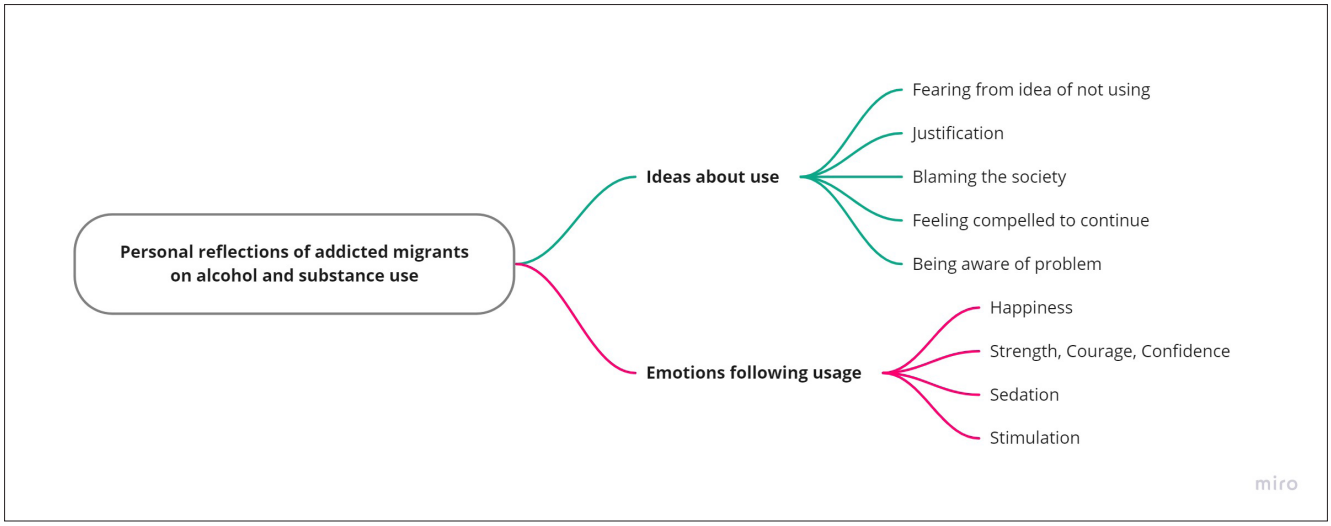


Figure 6. Personal reflections of addicted migrants on alcohol and substance use.

## Experience of Addicted Migrants

***Personal Reflections (Thoughts, Beliefs, Emotions, Attitudes)***
Personal reflections of addicted migrants are presented in Figure 6.

Emotions experienced by addicts after substance or alcohol use were categorized as happiness, strength/courage/confidence, sedation, and stimulation. Some quotations from participants were as follows:

"But I don't think I'll quit. Because it makes me feel comfortable. It is very enjoyable to drink. On an occasion, it makes the conversation good." (A50)

"You even speak English when you use this substance. This unseals one's lips. This substance makes you self-confident, makes you happy, makes you the bravest person in the world. A man wouldn't be afraid of anything if he took it. Look, we are taking here in Antep, Şahinbey. We are not afraid of anything, neither society nor the police. Because this substance encourages people. Everything will be fine when you use it. Even if you try, you cannot quit this substance. But it is a nice thing to use. That's all I will say." (S4)

Ideas about alcohol or substance use were grouped into the following categories: fearing from the idea of not using, justification, blaming the society, feeling compelled to continue, and being aware of the problem. Some quotations from participants were as follows:

"How much I regret it. I think for hours that I have sinned again. I am suffering remorse. It is a very bad thing; people still cannot quit. He is drinking again. Regret does not benefit from this alcohol. No matter how much you regret it, you continue the same. Look, I try to hold myself to avoid drinking on Thursdays. I am afraid of sin; I am most afraid of it. I am afraid of sin, not health or something." (A6)

"There is not a single day that I do not regret. It is forbidden and my money is gone. I always regret it." (A17)

"But it got in my blood. I will drink tomorrow if I do not drink today. I will drink the next day if I do not drink it tomorrow. So, my body will ask for it because it got in my blood." (A44)

"Why should I care, drinking is not a bad thing. (⋯) What could be worse than war? I wish the war had never happened. Even society sees me as the worst, there are so many worst things than me. The alcohol I drink is nothing." (A3)

"I do not harm anyone, but I am the worst since I always drink." (A24)

"I'm not a bad guy. I usually use it at home. I'm just financially harmful to myself." (S63)

"I have some advice for you, don't sit with the man who drinks. We fell, I hope you do not fall. Hope it is useful. If young people do not start, something good happens." (A47)

"Catch big traders instead of treating addicts. Bring traders to account. These problems will not remain then. But today, this thing would be solved if these large traders are caught by a big country like Turkey. (...) So now, I am a user, why come and catch me? Go catch the big seller men who sell in trillions." (S59)

***Intention to Quit Alcohol and Substance Use***
Overall, 64 people made statements about quitting in in-depth interviews. Of these, 39 attempted to quit but did not get any results. Only 1 addict stated that he quit because he spent the last 6 months in jail. In total, 16 of them are still considering quitting. Some others think they cannot quit because of learned helplessness.

People state that they quit for very short periods ranging from 1 day to 3 months. However, it is seen that the vast majority can last for a few days.

"I took everything except heroin. When I took Bonzai (a synthetic cannabinoid), I was losing myself for 5-6 hours, but thankfully nobody asked me when I went to jail, and I was alone in prison. There was no family, no friends. I quit after that. I quit it myself." (S59)

The reasons for wanting to quit can be listed according to the statements of the addicts as follows: feeling like the living dead, not being able to save money, thinking that his health is deteriorated, thinking that his psychology is spoiled, desire to unite with the girl he loves, and witnessing the bad endings of his friends.

"There were people who gave us a lot of advice. They said 'Quit, it is so bad, it kills you' but what should we do? We have already seen the deaths. This is nothing we use. I haven't tried to quit too much." (S7)

Almost half of the people (n=33) complained about not being given advice. In fact, the addict may think that he is not given any advice and support because he is not important to anyone. The fact that family relatives who can give advice and support are away or lost because of war is also seen as an important factor of people not thinking about quitting.

"Neither my family nor my friends helped me to quit, neither in here nor in Syria. Nobody gave me a hand. It means that I do not matter in the eyes of people. They do not help me at all. In other words, nobody guided me. Actually, I would love to quit." (A44)

"Then, when I lost those who were already with me and advised me to quit, there was no one to stop me. I continued taking." (S46)

"If somebody helps me and guides me, I go. Why shouldn't I go? But I don't know where to apply." (S46)

***Public Attitudes toward Addicted Migrants***

In all focus group discussions, social conflict was seen as a predisposing factor for addiction in migrants rather than a result of it.

In the Hatay focus group, a manager of an NGO mentioned migrants' hookah use as a conflict caused between locals and them. Although locals themselves are also using the hookah, they have been irritated by migrants' manner of use. He detailed this particular case in Hatay as migrants were using hookah extensively and with larger groups in a centrally located park because of a lack of space in their small houses, and thus locals become uncomfortable from this view in the park over time. Locals even made up a name for this park as "Syrian's park."

It was noteworthy that most of the focus group participants repeatedly indicated the importance of social cohesion. They were selecting their words carefully to avoid misunderstanding and hence harm the cohesion. However, focus groups were insufficient to describe addicted migrants' experiences.

All participants (n=66) of in-depth interviews with addicts and relatives made statements regarding social reactions to addiction. They are feeling as though they are subjected to dislike, gossip, despise, disgust, hate, and hence exclusion by society. They said that they are distanced by friends and kicked out of the house by landlords. They could not get employed or married.

In the face of social reactions, they are hiding their addiction and limiting themselves to a small circle of friends, who are also mainly addicted people.

"Such things are not welcome in Islamic society. I cannot handle the words of society. Everyone is escaping from us, but not asking why we are drinking. So, this is another problem. The society makes us drink more with these behaviors. But if we were rich, nobody would interfere with us, they say that it's for joy. In other words, society does not like people who are troubled." (A18)

"Society doesn't need to exclude me; I exclude myself from them." (S40)

"In the eyes of society, a dog has more value (than ours)." (R14)

"You know, it is a Muslim society. They blame you. They say it is forbidden if you drink. They exclude you instead of holding your hand." (A48)

## Discussion

Studies in the scientific literature on addiction in immigrants are mostly carried out in developed countries. However, 80% of refugees live in underdeveloped and developing countries. For this reason, the coverage of academic literature on the subject is low (Horyniak et al., 2016). In this context, studies to be carried out in the countries where refugees are concentrated are an important need to address the issue more comprehensively. This is the first and most comprehensive study about addiction in Syrian refugees in Turkey. The subject was comprehensively evaluated through studies conducted in 3 phases: focus group discussions, key person interviews, and in-depth interviews.

The AUDIT and DUDIT tests applied to the participants in the user interviews showed that the participants included were mostly at the addiction level. This shows that the target audience is sufficiently reached.

***User Demographics***

All addicts accessed during the study were men. Medicine misuse, especially antidepressants, is more common among women, and women tend to hide their condition owing to more social exclusion than men according to refugee society sociocultural norms.

In our study, the age to start alcohol and substance use was 10 and 12 years, respectively. The age distribution of addicts was concentrated in the 12 to 20 age range. Substance addiction was prominent in the children and young age group, and alcohol addiction and medicine misuse in the middle age group. These findings point to age groups that can be targeted for prevention and intervention studies. The adolescent age group should have priority in prevention and intervention studies.

It can be said that users are more in metropolitan cities such as Istanbul and Gaziantep. This situation could be related to the large populations of the provinces and higher job opportunities in these provinces.

Remarkably, the education level of the participants is low. Those with higher education also had to abandon their education because they migrated. This situation suggests that education may have a protective effect on addiction. However, the fact that addicts have to work for their livelihood is also a barrier to continuing education. For this reason, continuing education may be an important issue in prevention studies. People who left the university and started using substance/alcohol because of the war while in higher education before the Syrian war may have priority in rehabilitation programs.

Those working in higher status jobs such as a cook, a social media expert, and a clerk are very few. The average earnings of workers in this group are at a level close to the minimum wage in Turkey. In contrast, the incomes of unskilled workers, construction workers, and diary workers are approximately half of the minimum wage. It is seen that most of the participants work in very difficult conditions.

***Addiction Causes***

Findings regarding the causes of alcohol and substance use are summarized in the Ishikawa diagram in Figure 3. The findings show that the reasons for use are quite complex. The causes often trigger each other. For example, it is necessary to save money to plan a marriage; for this, it is necessary to work hard; to work hard, the person seeks to stay more alert and stronger and starts to receive stimulants. To increase efficiency in the workplace, employers can offer stimulants to employees. The way of working to save the day makes it difficult to make financial savings for the future and to dream about the future. The desire for the short-term happiness of the individual who does not dream about the future and thinks daily creates a facilitating ground for addiction.

Users usually work daily for low wages. It was stated in focus group interviews that immigrants arrested for drug trafficking are generally unemployed, and users can both earn money via drug trafficking and buy substances with the money they earn. At this point, regular employment and equal pay for equal work can be a component of prevention.

Except for the lack of acculturation and health insurance, the findings support the reasons for the use specified in the literature (Brune et al., 2003; Ezard et al., 2011; Kluttig et al., 2009; Ojeda et al., 2011; Priest et al., 2013; Reid et al., 2001; Zaller et al., 2014). Syrian refugees in Turkey are covered by health insurance. Law, religious, and cultural norms in Syria reduce access to alcohol. In contrast, migrants said they have access to alcohol more easily because of the lack of restrictions on the use of alcohol in Turkey. In terms of acculturation highlighted in the literature, no finding was found for the interaction of the 2 cultures (Horyniak et al., 2016). Current findings do not provide sufficient evidence to mention a one-way negative interaction between migrants and the host community.

Users express that they face very different difficulties during migration. It can be said that severe traumas detected in this study make individuals prone to addiction. In particular, the loss of family members eliminates the protective effect of the family and makes the person open to addiction. For this reason, rehabilitation studies have a high significance in interventions for users.

Peer influence has a high effect on substance and alcohol use. In addition, the presence of users in the family and the workplace is an important risk factor. In the absence of access to healthcare, peer advice and drug abuse play an important role in starting use. Peer education, family, and workplace colleague education should be given priority in intervention studies.

In our study, users' awareness of their situation, feelings, thoughts, beliefs, attitudes, and ideas about quitting were also investigated. Each identified emotion, thought, belief, and attitude constitute the inputs of the models to be used in behavior change studies. Effective interventions to control these inputs are an important determinant for the success of behavior change studies. Modeling complex determinants of addiction and determining the effects of each determinant by quantitative methods is an important requirement and a qualified field of study.

***Frequency of Use***

The statements made by the users and their relatives about the frequency of alcohol and substance use in Syrians show that the frequency of use may be around 10%. This value is consistent with the frequency values determined in studies conducted on other immigrant societies (Horyniak et al., 2016). This frequency value cannot be generalized because of the research design, but a study on the frequency of alcohol and substance use among Syrian migrants has not been performed in the literature review. For this reason, the estimated prevalence value of 10% may be a guide for further research on this subject. This value is under the prevalence of alcohol use in Turkey (22%) and above the prevalence of drug use (3.1%) (Turkey Republic Ministry of Interior, 2018).

A comprehensive study conducted in Syrian refugee camps in Turkey on addiction has not been found in the literature. However, it was stated in key person interviews that addicts could be seen sporadically in the camps.

Hookah use is common among participants. Participants expressed that this is very common in Syria, and most of the participants use hookah. With this aspect, hookah and tobacco addiction can also be considered as a subtopic of addiction in immigrants.

***Obtaining Alcohol and Substances***

Information on access to alcohol and substances has not been well studied in the literature. The findings in this study confirm the current literature and additionally present the subdimensions of access in a more detailed way (Horyniak et al., 2016). The financial resources required for access, access venues and methods, and persons from whom alcohol and drugs were obtained were studied in detail in this study.

We found that there are 10 different methods for obtaining money to get alcohol and substances. The most frequently used method for meeting instant needs is a common budget. The next is the use of handmade alcoholic beverages produced by the local community, not the alcoholic products sold in the market. In addition, selling the common belongings of the people they live with, borrowing on behalf of the family without the consent of the family, and theft are the other common methods of getting money. These criminal methods also negatively affect the relations between the user's family and the social environment and can cause the family to be excluded by society.

Because the access cost is low and can provide enough for instant use, the demand for substance use is higher than alcohol. It was stated by many participants that alcohol is much more expensive than substances. When users compare alcohol and substances by unit cost, they state that the substance is more cost effective than alcohol in obtaining the effect they are looking for. The fact that the users attach importance to cost effectiveness indicates that harmful substances can be replaced with less harmful ones in harm reduction studies that can be done in addition to prevention activities for substance use.

Users also stated the alcohol and substance prices at the time of the study. The fact that the prices of different substances are in the range of $0.5 to $7 means that access to the substance is very easy even with very little budget.

Users stated that they had access to alcohol and substances in 11 different places. For this reason, it is important to target these areas of use in intervention studies.

The social response to users leads them to create their own private and confidential environments. For this reason, alcohol and substances are used in these confidential meeting places with other users. For example,, derelict buildings and dark areas of parks are enabling factors for users. This situation distracts the users from the protective effect of the familial environment and creates a vicious circle.

Users prefer to use at home because the entertainment venues are expensive. Weddings can also be preferred by users to access free alcohol. In addition, they can obtain substances through theft from the farmlands in which hemp is grown. For this reason, it is easier to access the substance in the countryside, whereas it is easier to access alcohol in the city center.

The view that employers provide substances to workers to increase performance expressed in focus group interviews was experienced by a drug user. In addition, materials can be obtained from colleagues in the workplace. The workplace environment has strategic importance for intervention studies.

In the key person and focus group interviews, there were not enough findings to support the views that the camp officials could mediate for the refugees living in the camps and that the substance was transported by pigeons outside the camps.

Although it was stated that there was a positive correlation between substance use and pigeon feeding in focus group interviews, only 17% of the addicts were found to have an interest in feeding pigeons. This does not provide enough evidence to support such an association.

***Consequences of Addiction***

The effects of ASA on users' life have been examined in 6 categories. The findings in our study are consistent with the results in the literature, but the results in the literature are not clustered adequately (Rachlis et al., 2007). In our study, the findings obtained from the focus group discussions and key person and user interviews were clustered separately and analyzed with their subdimensions.

Similar to addiction reasons, addiction results are also complex. Each problem triggers another problem, so the problems experienced increase rapidly. For example, addicted migrants tend to turn to the drug trade as the easiest way to earn money because they cannot earn money and obtain drugs when they are unemployed. Following this, other family members are also drawn into this illicit trade, and drug trafficking is carried out through social networks. This chaotic and unsolvable situation that emerges as a result of addiction keeps users away from coping with problems and leads them to use alcohol and substances to forget everything. Thus, the results of use turn into reasons for reuse, vicious cycles occur, and users cannot get out of these cycles.

Perceiving the costs of ASA only as direct healthcare costs is a rather incomplete approach. The results of use summarized in the findings section show that the use of alcohol and substances directly threatens physical mental and social well-being and has a great cost to social life. A single user in a family affects their family members first and then the family's relationship with the whole society, and the social environment that the family lives has to bear this cost. In this respect, addiction is a global and public health problem for which the whole society pays the cost. For this reason, multisectoral work and community participation are of strategic importance in the work to be done.

Work against addiction must focus on prevention rather than treatment and rehabilitation. As mentioned in the introduction, the cost-benefit ratio of the activities on this subject is 1:18 (Miller & Hendrie, 2008). It is insufficient to deal with the treatment and rehabilitation studies to be performed only at the level of medical treatment or medical rehabilitation. Users experience mental health and social problems and need psychosocial support. Social rehabilitation should have a central role for the addicted individual to hold back to normal life.

***Risk Factors***

Risk factors for addiction in refugees are well studied in the literature (Priebe et al., 2016). In this study, risk factors for Syrian addicts were investigated in detail.

Some factors in alcohol and substance use were considered as facilitating and enabling factors, not as causes. For example, not feeling a familial responsibility because of being single, having acquired a social environment with unhealthy behaviors, easy access to alcohol and low social pressure in Turkey compared with Syria, the absence of family members who may recommend giving up ASA, inviting sellers who are generous at first, and weakness of personal will are leading facilitating factors.

Risk factors for addiction in refugees can be listed as follows: early age, being single, male gender, exposure to war conditions, loss of family members, peer pressure, unemployment and related stress, illegal work and being without social security, long working hours and heavy working conditions, child labor, not going to school, working in recreational venues, living in big cities, living in areas with widespread use and easy access, and low socioeconomic status. Among these factors, the most important risk factor is the severe traumas experienced during the migration process. Considering the protective effect of the immediate social environment and especially the family environment in the development of addiction, the loss of many relatives of some users is an important factor in alcohol and substance use.

The work sector is also an important determinant. Construction and long-distance driving stand out as risky business lines because of heavy working conditions, shoemaking and furniture manufacturing because of the chemicals used, and unlicensed textile workshops because of child labor.

***Protective Factors***

In our study, the protective factors for addiction in Syrian refugees were identified as female gender; living with family; adherence to religion and culture; high education level; regular employment; and state and civil society interventions, laws, and sanctions. Religious beliefs for alcohol addicts and laws and sanctions for substance addicts are prominent protective factors. The similarities between Syria's and Turkey's cultures are protective factors that increase social cohesion around the border region. The religious and cultural structure of the immigrant society could be an opportunity in intervention studies for addict refugees.

Economical cost is an important barrier for users to access alcohol and has a protective effect. The high prices in Turkey are a

disincentive for alcohol addiction. Military service is also a protective factor that keeps a person away from alcohol and drugs. One of the addicted immigrants stated that they quit while doing military service.

It was also stated in the focus group discussions that women are more protected in terms of addiction because they do not participate in social life in the Syrian refugee society. It may not be right to accept and encourage this situation as a protective factor, but this factor should also be considered as an opportunity in studies.

***Social Response***

It was observed that the users have seen a violent reaction from their own communities because of alcohol and substance use and have been exposed to stigmatization. In our study, 38 different response types encountered by users were determined at the keyword/sentence level.

The defense mechanisms of the users against social reactions are generally in the form of closing their friends' environment and hiding usage. Defense arguments against social reactions strengthen their attitudes and beliefs in favor of use.

Society reacts to hookah use of Syrians in Turkey. However, it is observed that hookah use is considered normal in the refugee community.

***Healthy Migrant Effect***

This study is not a prevalence study, so it does not provide sufficient findings to evaluate the immigrant paradox or the healthy migrant effect. Users state that the amounts paid to smugglers during the migration are between $1,000 and $1,500 per person. This indicates that the refugee group coming through smugglers may have a high economic status and that the healthy migrant effect may occur because of this selection.

***Access to Public Services***

ALO 191, a call center to tackle substance addiction, and AMATEM and ÇEMATEM centers offer services in Turkey. No services are provided specifically for addict refugees through the state or civil society. In contrast, most of the users and user relatives state that they are ready and willing to receive services to quit but do not know where to apply. With this aspect, users and their relatives are in search of service.

Studies in the literature indicate that insufficient health coverage for refugees in the countries of immigration is an important barrier to access to services (Ezard et al., 2011). However, the national insurance system in Turkey (SGK) includes refugees in Turkey. Refugees can access health services provided by the state and can obtain medicines free of charge.

Some users are afraid to contact official institutions because of a habit left behind by the totalitarian regime in Syria. They also refrain from receiving health services for fear of being deported or being followed by intelligence agencies. In addition, not knowing a language, not having an identity card, and not knowing where and how to get service are barriers to accessing the service. These findings support the information in the literature (Ezard et al., 2011; Ojeda et al., 2011; Reid et al., 2001).

***Intention to Quit***

In our study, most of the addicted participants are aware of their situation and the harms they have been exposed to and have the necessary motivation to quit. As an indication of this, most of the participants stated that they constantly tried to quit but failed. At this point, it can be said that the participants have health-seeking behavior. The motivation of users to quit is an important opportunity for intervention studies. Individual and environmental barriers that prevent this motivation from creating behavioral change can be important focal points for further research.

It is seen that the group who did not intend to quit had awareness about the harms of use, but they established a benefit-harm equation and developed an attitude accordingly. This situation is compatible with the advantages and disadvantages of comparison behavior in the transtheoretical model, which is one of the health behavior models (Norcross & Goldfried, 1994). The information, attitude, behavior, thought, and belief arguments stated in favor of use are summarized in the Results section. These arguments are of strategic importance for studies targeting behavior change.

***Recommendations***

Turkey is the country with the most refugees in the world with more than 3 million Syrian refugees, including 500,000 unregistered. However, the issue of addiction in refugees is not on the agenda enough, so the subject should become visible.

Overall, 58% of the participants do not intend to return to Syria. In this case, addiction behavior among Syrian refugees should be considered as a persistent health problem in Turkey, and it is necessary to develop a policy about it. Current policies are insufficient to prevent the problem. NGOs founded by people of Syrian origin are not sufficiently utilized. It has been observed that many institutions do not carry out activities specific to addicted migrants. The obstacles and problems encountered in addiction activities are expressed in 4 categories: 1) access to services, 2) adherence to treatment, 3) rehabilitation, and 4) problems of cooperation and coordination among institutions. These problems should be taken into consideration in planning activities specific to immigrants.

Terrorist organizations at the southern and eastern borders of Turkey are a central component of international trade of substances. Prevention efforts should be carried out beyond the border, on the Syrian side.

In the literature, studies of intervention in the field of addiction among immigrants are very limited (Horyniak et al., 2016). Scientific evidence should be produced to plan intervention studies on the subject, to measure their effectiveness, and to create evidence-based and cost-effective intervention programs.

The following fields of study can play a key role in successful prevention strategies: 1) knowledge strengthening, 2) socioeconomic strengthening, 3) capacity building, 4) monitoring of immigrant children, 5) activating NGOs, and 6) assessment of Syrian human resources.

In prevention programs, the activities of institutions and organizations, family, religion, schools, and protective factors of laws and sanctions should be considered.

An effective and efficient registration system is an important need for the monitoring of addiction in immigrants and access to addicts.

Syrians who are employed in official institutions to communicate with immigrants during migration processes can play a key role in accessing users in field research. NGOs formed by Syrians are also an important stakeholder of the issue.

Before the Syrian war, those who dropped out of university because of the war and started using drugs or alcohol while in higher education may have priority in rehabilitation programs.

Various thoughts, defensive arguments, self-criticisms, and beliefs developed by the users regarding alcohol and substance use were also listed within the scope of the study and guide intervention studies.

## Limitations of the Study

Efforts to reach users are one of the most time- and labor-intensive parts of this research. Official institutions do not have any registration system on Syrian addicts, which makes it very difficult to access addicts. Addicts hide their situation because of social pressure and legal sanctions, and most of the people contacted refused to meet. New practices for the deportation of unregistered Syrians are a factor that makes access to users more difficult as it increases the fear of deportation among immigrants. The addicts only agreed to meet with Syrian interviewers. The alcohol and substance use of the interviewees during the interviews also put interviewers in a difficult situation. We were not able to return transcripts or findings to participants to get their feedback.

## Conclusion

Without intervention, problems faced by refugees, whose numbers are rapidly increasing worldwide because of wars, disasters, and development problems, are reflected in society as more complicated and costlier problems. At the end of the day, the whole society pays the bill. In this respect, the problems of refugees should be considered within the scope of global public bads.

Conducting global and national interventions for the prevention, treatment, and rehabilitation of addictions of refugees requires a good scientific knowledge base. This study aimed to contribute to the global understanding of obscure states and dynamics of addictions among migrants in the context of Syrian migrants in Turkey.

On the individual aspect, migrants who are adolescents, singles, have low educational levels, do not go to school, are unemployed, have trauma histories, are far from their families, or have low socioeconomic statuses may be seen as risk groups for alcohol and substance addictions. Having a family, being a woman, adherence to religion and culture, regular employment, a high education level, and laws are possible protective factors. These findings provide a basis for future descriptive and intervention studies.

On the environmental aspect, illegal substance trafficking, tough work conditions, risky business sectors, child labor, uninsured employment, lack of social support and guidance, and social exclusion appear to be the major predisposing factors for alcohol and substance abuse.

On the policy aspect, lack of the multisectoral approach in services and integration between institutions; poor monitoring of addictions in refugees; inability to access necessary and sufficient health, education, and social services; limited personal rights of refugees; underutilization of trained health workforce within the refugee community; and drug trafficking at the macro level should be policy priorities to act on.

A famous Turkish proverb says: "Let the people live so that the state lives!" Prevention of addictions in refugees can be an indicator of the value of the people in the host society.

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**Ethics Committee Approval:** Ethics committee approval was received for this study from the Clinical Research Ethical Committee of İstanbul Medeniyet University Göztepe Training and Research Hospital, on 5 December 2017 (no: 2017/0373).

**Informed Consent:** Informed consent of participants for data collection (including voice recording) was received verbally.

**Peer-review:** Externally peer-reviewed.

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**Appendix 1.**

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

| No | Item | Guide questions/description | Control |
|---|---|---|---|
| **Domain 1: Research team and reflexivity** | | | |
| Personal Characteristics | | | |
| 1. | Interviewer/facilitator | Which author/s conducted the interview or focus group? | ✓ |
| 2. | Credentials | What were the researcher's credentials? *E.g. PhD, MD* | ✓ |
| 3. | Occupation | What was their occupation at the time of the study? | ✓ |
| 4. | Gender | Was the researcher male or female? | N/A |
| 5. | Experience and training | What experience or training did the researcher have? | ✓ |
| Relationship with participants | | | |
| 6. | Relationship established | Was a relationship established prior to study commencement? | ✓ |
| 7. | Participant knowledge of the interviewer | What did the participants know about the researcher? e.*g. personal goals, reasons for doing the research* | ✓ |
| 8. | Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic* | ✓ |
| **Domain 2: study design** | | | |
| Theoretical framework | | | |
| 9. | Methodological orientation and Theory | What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis* | ✓ |

| No | Item | Guide questions/description | Control |
|---|---|---|---|
| Participant selection | | | |
| 10. | Sampling | How were participants selected? *e.g. purposive, convenience, consecutive, snowball* | ✓ |
| 11. | Method of approach | How were participants approached? e.g. *face-to-face, telephone, mail, email* | ✓ |
| 12. | Sample size | How many participants were in the study? | ✓ |
| 13. | Non-participation | How many people refused to participate or dropped out? Reasons? | N/A |
| Setting | | | |
| 14. | Setting of data collection | Where was the data collected? e.g. *home, clinic, workplace* | ✓ |
| 15. | Presence of non-participants | Was anyone else present besides the participants and researchers? | ✓ |
| 16. | Description of sample | What are the important characteristics of the sample? *e.g. demographic data, date* | ✓ |
| Data collection | | | |
| 17. | Interview guide | Were questions, prompts, guides provided by the authors? Was it pilot tested? | ✓ |
| 18. | Repeat interviews | Were repeat interviews carried out? If yes, how many? | ✓ |
| 19. | Audio/visual recording | Did the research use audio or visual recording to collect the data? | ✓ |
| 20. | Field notes | Were field notes made during and/or after the interview or focus group? | ✓ |
| 21. | Duration | What was the duration of the interviews or focus group? | ✓ |

| No | Item | Guide questions/description | Control |
|---|---|---|---|
| 22. | Data saturation | Was data saturation discussed? | ✓ |
| 23. | Transcripts returned | Were transcripts returned to participants for comment and/or correction? | ✓ |
| **Domain 3: analysis and findings** | | | |
| Data analysis | | | |
| 24. | Number of data coders | How many data coders coded the data? | ✓ |
| 25. | Description of the coding tree | Did authors provide a description of the coding tree? | N/A |
| 26. | Derivation of themes | Were themes identified in advance or derived from the data? | ✓ |
| 27. | Software | What software, if applicable, was used to manage the data? | ✓ |
| 28. | Participant checking | Did participants provide feedback on the findings? | ✓ |
| Reporting | | | |
| 29. | Quotations presented | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.*g. participant number* | ✓ |
| 30. | Data and findings consistent | Was there consistency between the data presented and the findings? | ✓ |
| 31. | Clarity of major themes | Were major themes clearly presented in the findings? | ✓ |
| 32. | Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | ✓ |

Adapted from:

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

**Appendix 2.**

Standards for Reporting Qualitative Research (SRQR)

| No. | Topic [a] | Control |
|---|---|---|
| | **Title and abstract** | |
| S1 | Title | ✓ |
| S2 | Abstract | ✓ |
| | Introduction | ✓ |
| S3 | Problem formulation | ✓ |
| S4 | Purpose or research question | ✓ |
| | **Methods** | |
| S5 | Qualitative approach and research paradigm | ✓ |
| S6 | Researcher characteristics and reflexivity | ✓ |
| S7 | Context | ✓ |
| S8 | Sampling strategy | ✓ |
| S9 | Ethical issues pertaining to human subjects | ✓ |
| S10 | Data collection methods | ✓ |
| S11 | Data collection instruments and technologies | ✓ |
| S12 | Units of study | ✓ |
| S13 | Data processing | ✓ |
| S14 | Data analysis | ✓ |
| S15 | Techniques to enhance trustworthiness | ✓ |
| | **Results/findings** | |
| S16 | Synthesis and interpretation | ✓ |
| S17 | Links to empirical data | ✓ |
| | **Discussion** | |
| S18 | Integration with prior work, implications, transferability, and contribution(s) to the field | ✓ |
| S19 | Limitations | ✓ |
| | **Other** | |
| S20 | Conflicts of interest | ✓ |
| S21 | Funding | ✓ |

[a] Elaborations for standards are available in the original study cited below.

Adapted from:

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for Reporting Qualitative Research. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

# Appendix 3.

Table 1. Details of focus group participants

| City | No | Sector | Institution | Job | Gender |
|---|---|---|---|---|---|
| Gaziantep | 1 | NGO | Green Crescent | Manager | Male |
| Gaziantep | 2 | Public | Provincial Directorate of Health | Nurse | Female |
| Gaziantep | 3 | NGO | Red Crescent | N/A | Female |
| Gaziantep | 4 | Academia | University | Manager | Female |
| Gaziantep | 5 | Academia | University | Researcher | Female |
| Gaziantep | 6 | Academia | University | Psychology Student | Female |
| Gaziantep | 7 | Academia | University | Psychology Student | Female |
| Gaziantep | 8 | Public | Provincial Directorate of Famliy, Labor and Social Services | Project Coordinator | Male |
| Gaziantep | 9 | Public | Addiction Treatment Facility (AMATEM) | Psychologist (Specialist) | Male |
| Gaziantep | 10 | Public | Addiction Treatment Facility (AMATEM) | Social Worker | Male |
| Gaziantep | 11 | NGO | Red Crescent (Community Center) | Manager | Male |
| Gaziantep | 12 | NGO | (Hidden) | Manager | Male |
| Gaziantep | 13 | NGO | (Hidden) | Psychologist | Male |
| Gaziantep | 14 | NGO | Red Crescent (Community Center) | Officer | Female |
| Gaziantep | 15 | NGO | Red Crescent (Community Center) | N/A | Female |
| Gaziantep | 16 | Public | Municipality | Psychologist | Female |
| Gaziantep | 17 | Public | Provincial Directorate of Migration Management | Social Worker | Female |
| Gaziantep | 18 | Public | Provincial Directorate of Migration Management | Officer | Male |
| Gaziantep | 19 | Public | Provincial Probation Directorate | Officer | Male |
| Gaziantep | 20 | Academia | University (School of Medicine) | Psychiatrist | Male |
| Gaziantep | 21 | NGO | (Hidden) | Officer | Female |
| Gaziantep | 22 | NGO | (Hidden) | Manager | Male |
| Hatay | 1 | Public | Provincial Directorate of Migration Management | Officer | Female |
| Hatay | 2 | Public | Provincial Directorate of Health | Manager | Male |
| Hatay | 3 | Public | Provincial Directorate of Youth and Sports | Manager | Male |
| Hatay | 4 | NGO | (Hidden) | Manager | Male |
| Hatay | 5 | NGO | (Hidden) | Manager | Male |
| Hatay | 6 | NGO | Red Crescent (Community Center) | Manager | Male |
| Hatay | 7 | NGO | Red Crescent (Community Center) | Social Worker | Male |
| Hatay | 8 | Public | Provincial Directorate of National Education | Manager | Male |
| Hatay | 9 | NGO | Red Crescent (Community Center) | Officer | Male |
| Hatay | 10 | NGO | Green Crescent | Manager | Male |
| Hatay | 11 | Public | Provincial Directorate of Famliy, Labor and Social Services | Psychologist | Male |
| Hatay | 12 | NGO | (Hidden) | Manager | Male |
| Hatay | 13 | Public | Mutfi's Office (Religious Affairs) | Manager | Male |
| Hatay | 14 | NGO | Red Crescent (Community Center) | Social Worker | Male |
| Hatay | 15 | NGO | Red Crescent (Community Center) | Social Worker | Female |
| Hatay | 16 | NGO | (Hidden) | Manager | Male |
| Hatay | 17 | NGO | Red Crescent (Community Center) | Officer | Male |
| Hatay | 18 | NGO | Red Crescent (Community Center) | Officer | Female |
| Mardin | 1 | Public | Provincial Police Department | N/A | Female |
| Mardin | 2 | Public | Provincial Police Department | Police Officer | Male |
| Mardin | 3 | NGO | (Hidden) | Manager | Male |
| Mardin | 4 | Public | Provincial Directorate of Disaster and Emergency Management (AFAD) | Officer | Male |
| Mardin | 5 | Public | Provincial Directorate of Migration Management | Officer | Female |
| Mardin | 6 | Public | Provincial Directorate of Famliy, Labor and Social Services | Psychologist | Male |
| Mardin | 7 | Public | Governorship | Reeve | Male |
| Mardin | 8 | NGO | Green Crescent | Manager | Male |
| Mardin | 9 | Public | Provincial Directorate of Health | Psychologist | Male |
| Mardin | 10 | Public | Provincial Directorate of Youth and Sports | Manager | Male |
| Mardin | 11 | Public | Mutfi's Office (Religious Affairs) | Manager | Male |
| Mardin | 12 | Public | Mutfi's Office (Religious Affairs) | Imam & Preacher | Male |
| Mardin | 13 | NGO | (Hidden) | Case Manager | Male |
| Mardin | 14 | NGO | Green Crescent | Manager | Male |
| Mardin | 15 | NGO | (Hidden) | N/A | Male |
| Mardin | 16 | Public | Provincial Directorate of National Education | Voluntary Trainer | Male |
| Mardin | 17 | Public | (Hidden) | N/A | Male |
| İstanbul | 1 | Public | Provincial Directorate of National Education (High School) | Guidance Teacher | Male |
| İstanbul | 2 | NGO | Red Crescent (Community Center) | Social Worker | Female |
| İstanbul | 3 | NGO | Green Crescent | Psychologist (Specialist) | Female |
| İstanbul | 4 | Public | Provincial Directorate of National Education (High School) | Guidance Teacher | Female |
| İstanbul | 5 | NGO | Red Crescent (Community Center) | Officer | Female |
| İstanbul | 6 | Public | Governorship | Officer | Female |
| İstanbul | 7 | Public | Municipality | Social Worker | Male |
| İstanbul | 8 | Public | Provincial Police Department | Police Officer | Male |
| İstanbul | 9 | Public | Provincial Police Department | Police Officer | Male |
| İstanbul | 10 | Public | Provincial Police Department | Police Officer | Female |
| İstanbul | 11 | Public | Mutfi's Office (Religious Affairs) | Officer | Male |
| İstanbul | 12 | Public | Provincial Directorate of National Education (High School) | Guidance Teacher | Male |
| İstanbul | 13 | Public | Provincial Directorate of Disaster and Emergency Management (AFAD) | Social Worker | Female |
| İstanbul | 14 | Public | Addiction Treatment Facility (ÇEMATEM) | Social Worker | Female |
| İstanbul | 15 | Public | Provincial Directorate of Famliy, Labor and Social Services | Manager | Female |
| İstanbul | 16 | Public | Municipality | Manager | Male |
| İstanbul | 17 | Public | Provincial Directorate of Migration Management | Manager | Male |
| İstanbul | 18 | Public | Addiction Treatment Facility (ÇEMATEM) | Psychiatrist (Child and Adolescent) | Female |
| İstanbul | 19 | Public | Provincial Directorate of Health | Officer | Male |
| İstanbul | 20 | NGO | Red Crescent | Manager | Male |

Table 2. Details of key person interview participants

| Sector | Institution | Number of participant(s) |
|---|---|---|
| Public | Ministry of Health, General Directorate of Public Health | 2 |
| Public | Disaster and Emergency Management Presidency (AFAD) | 1 |
| Public | Mardin Directorate of National Education | 1 |
| NGO | Turkish Red Crescent | 3 |
| NGO | An NGO in Gaziantep | 2 |
| NGO | World Health Organization Turkey Office | 1 |
| NGO | An NGO in Mardin | 1 |

**Exploring Alcohol and Substance Addiction among Syrian Migrants in Turkey:**
A Qualitative Study Integrating Perspectives of Addicts, Their Relatives, Local and National Institutions

## Appendix 4.

*Table 1. Services provided for addicted migrants in different cities.*

| | Specific to Addicted Migrants | Specific to Addicted People | Specific to Migrants | Non-Specific |
|---|---|---|---|---|
| **Gaziantep** | **Social Service**: Addiction awareness training for Syrian women<br>**Red Crescent**: Anti-Addiction Trainings<br>**Migration:** Inter-institutional correspondence<br>**NGO:** Reporting | **Municipality:** Education to families during the children's treatment process<br>**AMATEM**: Treatment, Forensic consultation, Research, Seminars for high schools<br>**University:** Treatment<br>**Social Service**: Family Education<br>**NGO:** Routing | **Social Service**: Social cohesion studies.<br>**Migration:** Camps (Closed and transferred to AFAD.)<br>**University:** Research, The symposium<br>**NGO:** Psychosocial support<br>**Justice:** Individual and group interviews<br>**Red Crescent**: Red Crescent Card (Economic Support) | **Governor:** Public Relations (Open Door)<br>**Social Service**: Socio Economic Support, Home visits, Activities for child labor, Injunctions |
| **Hatay** | **Education:** Activities of consultant teachers at the Temporary Education Center<br>**Red Crescent**: Anti-Addiction Training, Awareness activities, Volunteering for young people, Routing<br>**Police and Municipality:** Get hookah users away from the parks. | | **Social Service**: Adaptation of immigrant children<br>**Red Crescent**: Social activities, Language Courses, Home visits, Increasing school attend<br>**Migration:** Consulting<br>**Social Service and Police:** Mobile team for children on the street, Family interviews | |
| **Mardin** | **Health:** None<br>**NGO:** Awareness seminars. | **Health:** Routing and tracking patients in addiction treatment facilities in the near cities, Training to improve driver behavior<br>**Religious:** Anti-Addiction Coordinators. Field work of imams. Sermons. In-service training.<br>**Police:** Activities for supply. Awareness activities.<br>**Social Service**: Routing to treatment facilities, Family Education, Artistic and sporting activities (planning)<br>**Youth:** Sporting activities | **AFAD**: Social cohesion studies<br>**Youth:** Sporting activities, Turkish language trainings<br>**Religious:** In-service training<br>**NGO:** Financial assistance | **Social Service**: Socio Economic Support, Injunctions, Home visits, Activities for children who are involved in crime and work on the street, Increasing school attend<br>**Religious:** Youth Coordinators, reading activities and scholarships, Social projects |
| **İstanbul** | **Red Crescent**: Anti-Addiction Training, Routing<br>**Municipality:** None | **Governor:** In-service training for public relations personnel, The dependency centers of the prefectures<br>**AFAD**: None<br>**Police:** Public education and public education in public institutions, in-service training<br>**Religious:** Addiction Coordinators<br>**Health and Municipality:** Rehabilitation Center<br>**Health:** Secretariat of the Provincial Anti-Addiction Board<br>**Education:** The training by guidance teachers. | **Red Crescent**: Unaccompanied children and women who are victims of war, Routing<br>**Social Service**: Social Cohesion Units | **Governor:** Public Relations (Open Door), Demolition of abandoned buildings<br>**Social Service**: Child Support Center, Social Services Centers, Mobile teams, and home visits.<br>**Municipality:** Activities for the homeless, In-kind and cash support<br>**NGO:** Human trafficking training<br>**Education:** Guide teacher reports |

**Descriptions of abbreviations in the table**
**AFAD**: Disasters and Emergency Management Presidency
**AMATEM**: Alcohol and Substance Addiction Treatment Center
**Education**: Ministry of National Education
**Governor**: Governorship of Province
**Health**: Ministry of Health
**Justice**: Ministry of Justice
**Migration**: Migration Management
**Municipality**: Municipality of the city
**NGO**: Non-governmental organizations
**Police**: Police Department
**Red Crescent**: Turkish Red Crescent Society
**Religious**: Religious Affairs
**Social Service**: Ministry of Family, Labor, and Social Services
**University**: A university in the city
**Youth**: Ministry of Youth and Sports

**Appendix 5.**

# Additional characteristics of in-depth interview participants

## *Migration characteristics of participants*

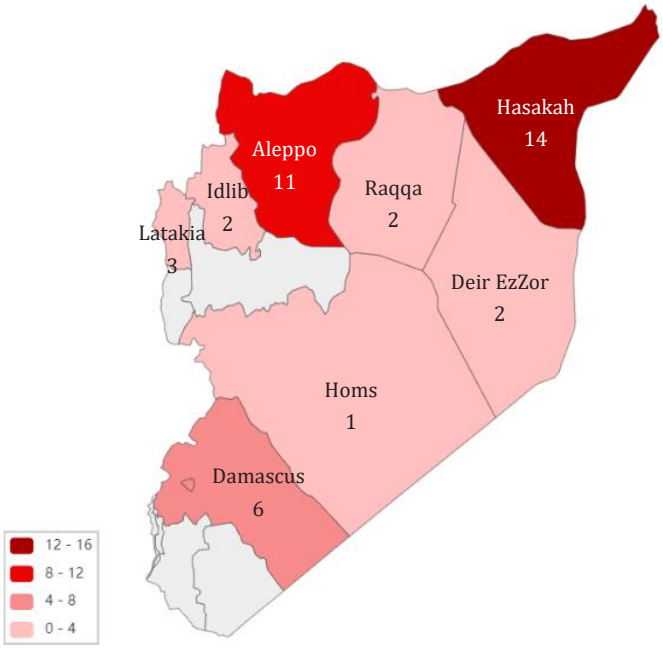


*Figure 1. Number of participants by their origin cities in Syria*

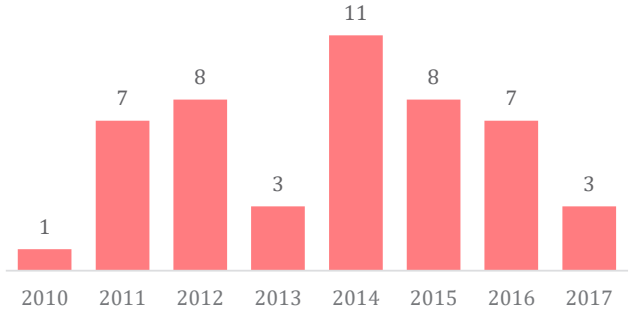


*Figure 2. Number of participants by their year of migration to Turkey (n=48)*

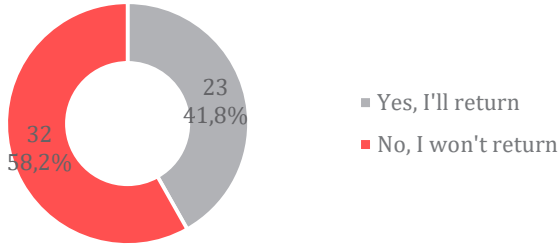


*Figure 3. Number of participants by their thoughts on returning to Syria (n=55)*

## *Alcohol Use Disorders Identification Test (AUDIT) results of participants*

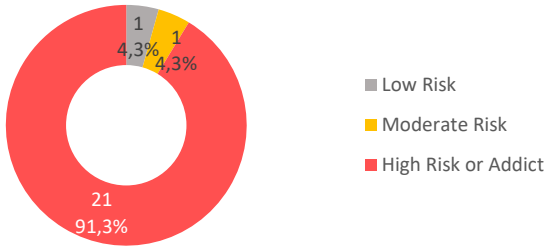


*Figure 4. Number of participants by their addiction classification according to overall AUDIT score (n=23)*

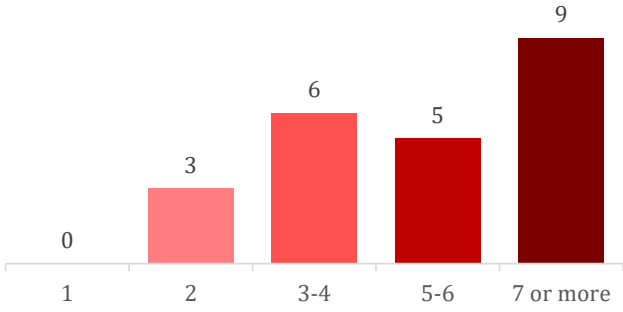


*Figure 5. Number of participants by times that they have standard drinks in a typical day (n=23)*

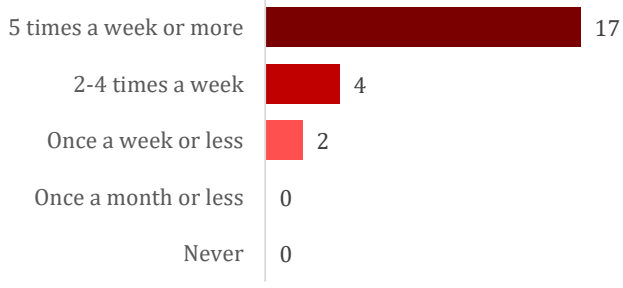


*Figure 6. Number of participants by their frequency of alcoholic beverage use (n=23)*

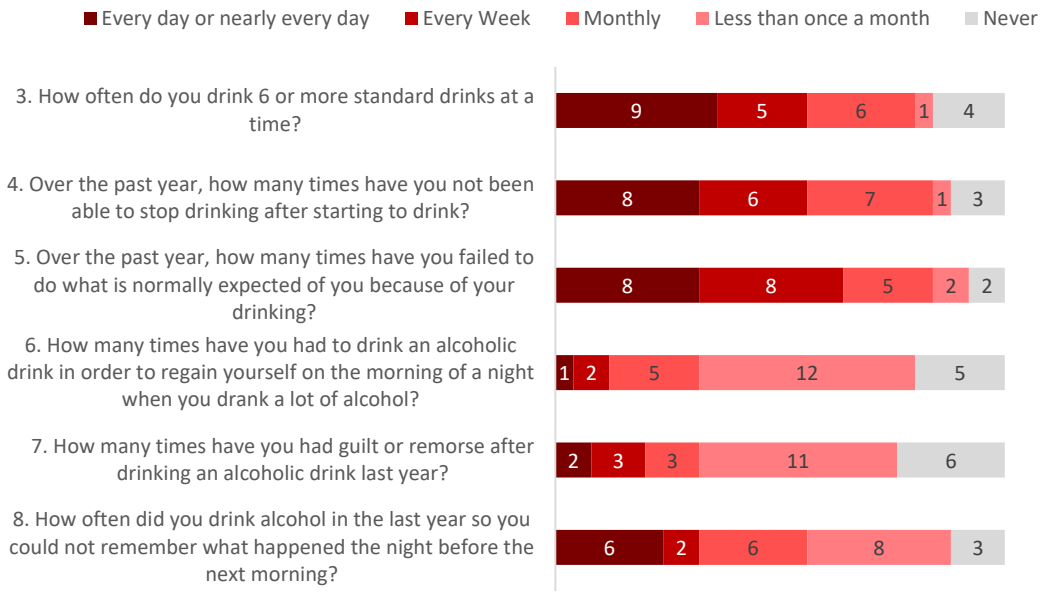


*Figure 7. Number of participants by their alcohol use patterns according to AUDIT (n=25)*

## *Drug Use Disorders Identification Test (DUDIT) results of participants*

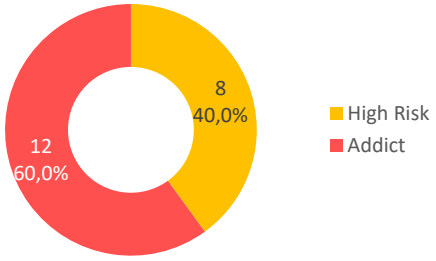


*Figure 8. Number of participants by their addiction according to overall DUDIT score (n=20)*

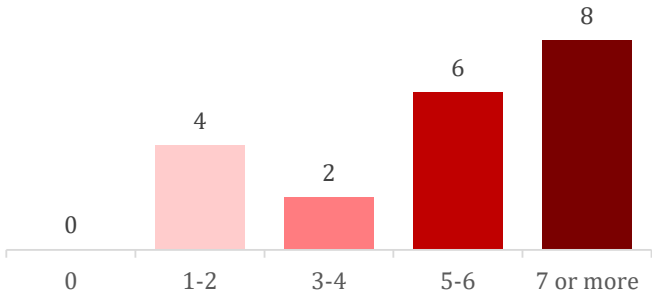


*Figure 9. Number of participants by times that they have substance use in a typical day (n=20)*

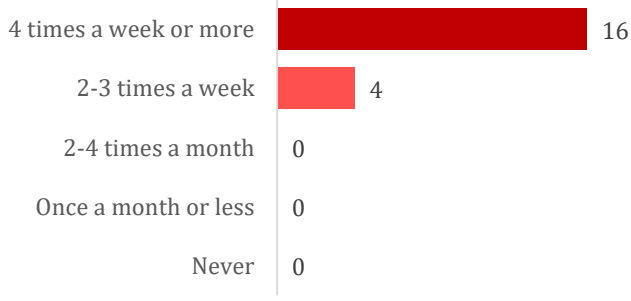


*Figure 10. Number of participants by their frequency of substance use (n=20)*

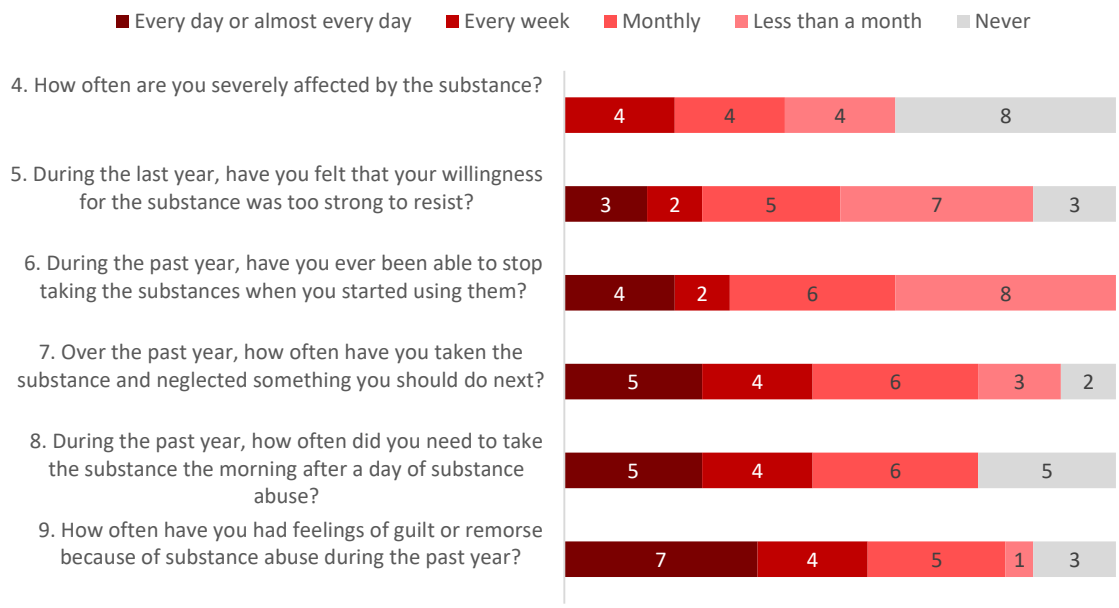


*Figure 11. Number of participants by their substance use patterns according to DUDIT (n=20)*

## *Alcohol and substance types that participants use*


*Figure 12. Number of participants by alcohol type that they use*

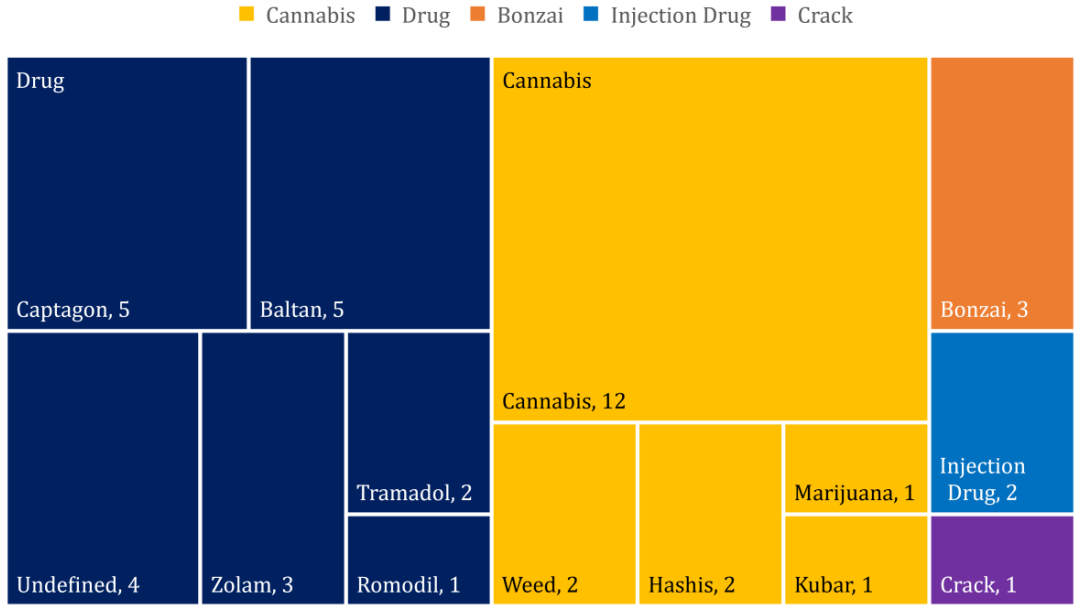


*Figure 13. Number of participants by substance type that they use*

## *Time of introduction to alcohol and substance use of participants*

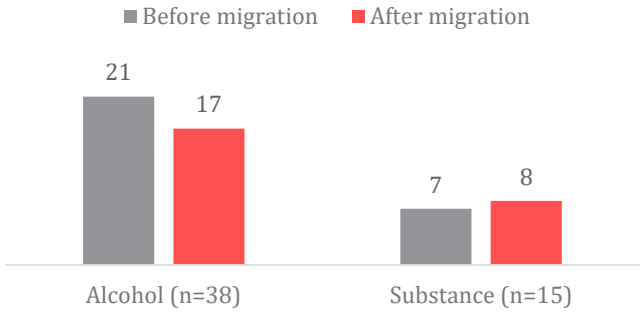


*Figure 14. Number of participants by their introduction time to alcohol (n=38) or substance (n=15) in relation to their migration time*

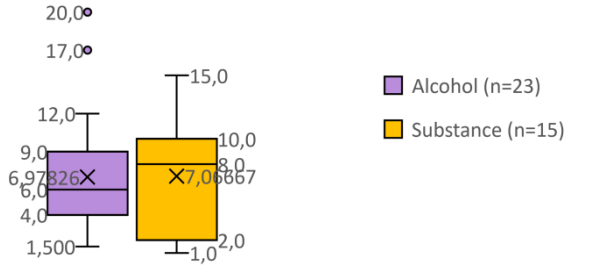


*Figure 15. Number of participants by their alcohol (n=23) or substance (n=15) usage duration in years*

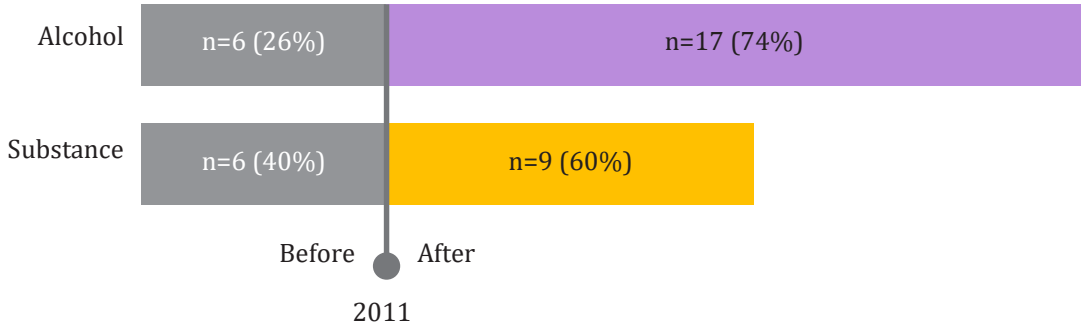


*Figure 16. Number of participants by their introduction time to alcohol (n=23) or substance (n=15) in relation to the start of Syrian conflicts in 2011*

## Appendix 6.

Questionnaire for Addict and Relative Interviews

**Personal Information**

1. City of residence
2. Age
3. Gender
4. Marital status
5. Education level
6. Hobbies and recreational activities
7. Occupational status

If occupied,

8. Industry
9. Insurance status
10. Income (daily, weekly, or monthly)

**Immigration Information**

11. Immigration status
    a. Temporary protection
    b. Refugee
    c. Citizenship
12. Time of migration
13. Duration of migration process
14. Origin city in Syria
15. Family members who died or were mutiled during the migration
16. Planning on going back to Syria

**Alcohol and/or substance use**

17. Alcohol or substance use in the last 12 months

    If quitted,

    a. Why and how quitted?
    b. Planning to re-start using if economic or social conditions were more favourable?
18. Types of used alcohol or substance
19. Duration of alcohol or substance use
20. How started to use
21. When started to use (before or after migration)
22. Obtaining money to buy alcohol or substance
23. Manner of alcohol or substance use
24. Reasons for alcohol or substance use
25. Impact of alcohol or substance use on life (negative or positive)

**Social status and access to the service**

26. Community response to addicts
27. Feeling of a social exclusion
28. Exclusion in public services
29. Exclusion in job entry
30. Experience of discrimination

**Quitting and help seeking**

31. Ideation of quitting alcohol or substances
32. Attempt to quit
33. Result of attempt to quit
34. If unsuccessful, reasons for re-starting
35. Knowledge about where to seek help