Overlooked Youth: How Does National Drug Discourse Influence Recovery in Azerbaijan?

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***Brief Study Report*[i][ii]**

Through decades drug use has been one of the most stigmatized and moralized as well as scariest phenomena, and yet is also one of the least understood among other social issues concerning our societies. Too much attention around illegal trafficking, monitoring, confiscation, and criminalization result in neglect of social aspects, individual users and communities affected by drug use as well of as their stories, experiences, and needs. Along with moralization, prohibitionist policies or the so known Western "war on drugs" have proved to be ineffective and identified as reinforcing violence, racism, and inequality. Furthermore, prohibitionist approaches failed to address basic questions on why people use drugs, what drug users need in order to stay on the safe side, where the limits are, and whether all drugs are truly "bad". It is imperative – we need to know more to address these questions and beyond.

Fortunately, there is a growing body of research as well as political debates around alcohol and other drug (AOD) use, liberalization, treatment, and harm reduction. However, these predominantly happen in the West, and with some exceptions in Latin American [1] and African countries [2] while in post-Soviet nations such discussions are yet to be encouraged. International coalitions for safer drug use and harm reduction may financially support a few initiatives in these countries

(e.g. by The Global Fund, UNAIDS etc.), but they are oftentimes implemented on a superficial level, without culturally appropriate adaptation, thus, resulting in insignificant effects. Implementation of such program with poorly developed drug policies like in Azerbaijan mostly serve the purpose of showing willingness in international cooperation in order to avoid penalties on a state level [3]. Thus, there is a growing need in research and more empirical data on drug user and users' perspectives to address the gaps in policy and treatment.

The described independent doctoral project took start in 2014 in Germany with the purpose to understand how young drug users experience treatment and recovery in two German states: Lower Saxony and Hessen, and in order to draw comparisons later with the same data sample from Baku. In this brief report, I discuss the case of Baku alone with the aim of emphasizing issues that need to be addressed both on scientific and political levels. One of the main aims of this project also include addressing the period of adolescence in light of interdisciplinary discussions on vulnerability and risky practices often ascribed to this particular life stage and even more often linked to drug use as practices of maturation and experimentation [4], [5]. In most meta theories, representation of adolescents as irrational, risk-taking, emotionally unstable, and physiologically as well as neurologically immature reinforces believes that adolescents are not able to make rational decisions or take responsible actions when engaged in 'risky practices' such as drug use. Although, some of these believes might have cultural, social, and economic variations, in most cases, the period characterized as 'teenage years' has more similar definitions than differences in common Western understanding. In this study, I aim to discuss adolescence and drug use on a multidimensional level to avoid the one-sided portrayals by depicting cultural, economic, psychological, legal and political challenges adolescents go through while using and

recovering.

Research design

In this article, I briefly report on research purpose, design, and only partial results from the doctoral dissertation project. The study comprises of narrative interviews with adolescent drug users aged between 16 and 21 who were undergoing recovery process from AOD use, excluding tobacco. Most used drugs included brown heroin (known as *"kokos"* in local language), cannabis and derivatives, opioid-based prescription drug Tramadol[i], anticonvulsant Pregabalin[ii], and MDMA (also known as Ecstasy). Majority of study participants were recruited via snowball sampling, as in organizations commissioned to provide residential care the number of adolescent patients was rather low. Only four people out of 11 were interviewed inside the treatment center[iii] (from now on, I will refer to interviewed individuals as *research participants*). Narrative interviews were designed to elicit as much biographical information as possible in a free-flowing structure and with no time limit. Additionally, informal field interviews were conducted with doctor-narcologists, other staff members, mental health professionals, and NGO representatives during six weeks of data collection period. Below, I discuss only results from the interviews and field observations with adolescent users and patients, focusing mainly on treatment conditions and concepts surrounding its delivery.

Partial results

As in many other socially taboo topics, for a lot of people including professionals and lay people hearing stories of drug use were not as intriguing as was expected when starting field work in Azerbaijan, Baku. Strong stigmatization and lack of knowledge surrounding drug use motives and practices are one way of explaining this lack of interest. On the other hand, most people including drug users themselves said to believe in

two scenarios: that either drug use is inevitable death or that one can only 'survive' it by a *strong will*. This narrative is also popular in many other cultures and has been rightfully challenged by a number of AOD scholars [6]. Furthermore, talking in detail about one's drug career seems irrelevant almost for any purpose – even therapeutic. Doctor-narcologists (*narcologia* – a study of intoxicating substances) who are responsible for the treatment processes and procedures in the residential facilities, believe they cannot hear anything new from their patients and thus treat them in a very hierarchical manner. A user, in this discourse, is seen as someone who does not know what to do with their lives, someone who made irresponsible choices and thus needs an authority to follow. This often includes shaming and berating although might be delivered in a softer manner in therapeutic context. Rarely drug users are seen as experts of their own careers. In part, this indicates the moralized perspectives of treatment providers and specialists themselves, which in turn means the policies designed for regulating drug use and providing subsequent health care are also informed by same values and believes. This results in superficial and ineffective treatment methods.

Next, I discuss three dimensions of influence on recovery experiences of adolescent drug users in Baku: 1) concept and provision of treatment; 2) legal forces 3) stigma, discrimination, and demoralized identities. These broad definitions envisage all aspects of recovery experiences as narrated by research participants, while also inclosing events of recovery and single occasions. For this purpose, I will provide quotes from the interviews to further support central arguments.

Recovery in residential treatment facility

The study shows that young people seeking treatment for habitual drug use are not provided with many options. In fact, the only available treatment is detoxification (cleansing of

blood from toxins) which can be received either in a residential clinic or at home by a nurse. The procedure usually lasts 21 days and the patient is believed to be "cured" at the end of it. Because of this rather superficial approach towards drug use treatment, many young people are unaware of other possibilities of treatment and experience strong feelings of self-depreciation and blame when relapsing almost immediately after being released from treatment. The following passage from Ilkin (18) illustrates this experience vividly:

"Impossible, it is impossible to quit it. You leave [the center], 1 or 2 months, and back here again. 1 or 2 months, and then again, the same guys, same streets, same neighborhood, same spot, same place. Like you stay there just smoking, someone comes saying "we got this or that" [drugs]. Impossible. It is not a decent thing for a man to do. I am 18 years old, and this is the third time in treatment in just one year. I can't quit."

The primary reason for that is that the treatment fails to address the post-detoxification period where person might require social and psychological support. Some patients need more intervention on a daily basis and a follow up that ensures they are safe and secure in their further use practices. Strengthening social bonds, re-integrating back into society are multidimensional phases and should be supported by social care services, as well as social workers and therapists who guide the patient along the way to long-term recovery. However, relapse cases are also partially explained by the fact that there are no educational programs, treatment promotion, and effective harm reduction initiatives. The situation is exacerbated by strong stigma surrounding drugs, drug use, and drug users. For many young people who do not have choice of affording private clinics – of which there is only one in Baku – governmental treatment facilities are not an option. This is primarily due to two reasons: Firstly, state-funded facilities do not guarantee a 100% anonymity and

some sort of registration is required. This data is then stored in the archives and can be used if requested by higher administrative state institutions. Secondly, having been diagnosed with problematic drug use, young people are deprived from a variety of future employment chances as well as from the obligatory military service which is oftentimes required for governmental job positions. Furthermore, criminalization of drug use also contributes to avoiding seeking help and opening up about one's problematic use. Interestingly, in countries with repressive drug policies, as recently reported by the Global Drug Survey of 2018 [7], young people said to consider reaching for help if more liberal drug policies were introduced.

The only treatment provided in state-funded residential facilities is detoxification which is accompanied with opioid-based painkillers and sleep injections that are supposed to ease the withdrawal symptoms of patients. A patient receives in average three such 'cocktail' injections [8]during the day from a nurse that pays visit to every ward in all departments. In each ward there is about 8 to 10 patients, male and female separately, and of mixed age groups. Patients are free to walk inside the department-building, however, are accompanied by guards if they need to leave the building for any reason. Strict and patronizing attitudes of guards often cross the limits and end in physical violence and verbal abuse towards patients. [9]

Observations shows that moral preaching is part of the treatment. Doctor-narcologists perform a role of an authoritative person whose 'duty' is also to remind a young patient that it takes dedication and strong will to overcome the habit. This again underpins the moralizing attitudes on drugs and drug use among specialists and treatment providing institutions. Unfortunately, individual struggles, social and economic factors as well as personal capacities of recovering subject are almost completely not taken into consideration. This neglection results in a number of unfortunate events such

as suicide attempts, strengthened feelings of self-depreciation, and relapse cases. For the research participants interviewed at a treatment facility, relapse is an inevitable result of treatment. In case of Tural[iv] (18)

"In fact, I know that when I leave my door, there is heroin in the next one. That's why I can't quit. Because, I know, if I leave here and go there, there is heroin. I see people going in there and coming out with heroin. That's why I can't quit the habit. So, I came here, right, because treatment is free here."

Additionally, age differences are not taken into consideration when organizing treatment procedures. For example, some research participants reported of sharing rooms with up to 10 other patients with longer (sometimes decades-long) experiences of injecting drug use and of being exposed to information (in open conversations) they would not want to know.

Below, Karim (17) tells a story of how he was accepted in the treatment but was placed in one of the common wards which he had to leave. Karim enrolled into treatment via connections through his aunt – who is a doctor – that ensured he will get the best narcologist-doctor in the department and a more comfortable accommodation.

"We came here through an acquaintance, right, we have been told that the Dr. X is the best in town. So, at the beginning I did not like it here, but they talked to me nicely and slowly convinced to stay. I am staying in an isolator-ward, with one more guy."

Karim's case is one of the few where parents/caretakers can afford paying extra to allow a relatively better treatment of their child. As seen from the quote above, there is an explicitly pronounced difference in treatment of patients based on their financial resources. If a person is able to pay extra to the doctor, semi-private double rooms and better

personal care during the residence of a patient is provided. This will also enable staying in a slightly better department of a facility. Some young users or their parents/caretakers are in position to afford long-term therapies outside of the country (Russia and Turkey being the common destinations). In these cases, youth are introduced to variety of addiction concepts, recovery models, and methods of controlling one's desires or preventing relapse cases. These treatment programs help to develop personal narratives and reflections about one's own drug career. However, similar narration, development of personal reflections, or encouragement of questioning is none-existent in Azerbaijani context.

In the next passage from Karim's narrative, he describes the reasons for having the chance to stay in an isolator-ward mentioned earlier. Most wards do not distinguish between younger and older patients and offer equal treatment concepts to all. This failure of acknowledging risks of younger patients staying with patients who have decades more of experience is another aspect that needs to be addressed both in practice and in drug policy of the country.

"I can't stay in the others [rooms], they smell, I can't take it. But also, there are people, like worst people you can meet, those that would do anything in life. That's why I did not want to stay there long"

However, patients completely dependent on state-funded treatment will face extreme challenges and stay in departments with poor conditions (e.g. no shower, rotten beds, and malnourishment) and in addition to that face physical and verbal abuse from guards. Tural (18) has been accepted to treatment 3 days before the interview and had already experienced multiple threats by abusive guards and poor care from his doctor. Below, he describes one incident of verbal abuse from guards:

"(..) Why me, why should they beat me? Why would anyone beat

an ill patient (.)? Like the other day, I stand there at the smoking area (.) tells me "stand away", with such a face, that you wanna remind him he can ask kindlier. Tells me, "you, stand away, you or I'll kick your face and smash into pieces". The other day, he hit someone on the head, without a reason. (..) No, I am not staying here, anymore, I will leave. There is no reason for staying. They even do not treat me right (.) those two pills (.) Tramadol (..) I could buy it outside on my own, you know."

Because there is no intrusion by doctors or other staff members in the ways guards behave, it suggests that this type of abusive behavior is encouraged, even if not explicitly instructed. All the research participants who narrated abusive behavior from the guards did not report it to their doctors or other staff members assuming that this might not bring any results. Encouragement of such violence in treatment centers once again highlights how severely drug use is stigmatized. Some drug researchers have written about this type of stigmatization, where drug users are seen as convicts, moral losers, and criminals. These believes eventually transform into policies that considers drug users as 'undeserving citizens' [10] who are believed not deserving care, social services or even a humane treatment. Regretfully, this wide-spread believes also impact the way drug users perceive themselves as undeserving and demoralized. It then informs their further decisions and influences the ways in which their drug careers progress (e.g. wishing for one's own death, choosing deliberate overdosing, and giving up on the idea of recovery or healthier life).

Concluding remarks

It is imperative, that Azerbaijan's drug policy goes through major reforms and adapts better harm reduction and care policies for people who use drugs and for people who seek help for their problematic use. Improving knowledge, encouraging open discussions about drug use, and addressing young people's

drug use in a non-stigmatizing and non-scaring tactics might be some of the effective strategies. In light of recent fire case at the national drug center in Baku, we can say that media reports describing inhuman conditions in which patients were held – far from what a treatment center might look like and more reminding almost incarceration – have the potential of raising awareness and more lively debates about improvement in health care system addressing AOD treatment.

[i] Tramadol Hydrochloride (brand names ConZip, Ultram, Contramal) is a pain medication prescribed to treat medium to severe pain.

[ii] Pregabalin (brand name Lyrica) is a medication used to treat epileptic seizures.

[iii] Names, locations and other identifications are anonymized for confidentiality purposes.

[iv] All names are pseudonyms used to protect the confidentiality of research participants

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Bibliography

[1] A. M. Lajous, “The Constitutional Costs of the ‘War on Drugs,’” 2014.

[2] C. Herrick, “The Relevance of ‘Western’ Alcohol Research and Policy to Developing Countries,” in *The SAGE Handbook of Drug & Alcohol Studies: Social Science Approaches*, 1st ed., T. Kolind, B. Thom, and G. Hunt, Eds. SAGE, 2017, pp. 559–575.

[3] I. S. Obot, “The Relevance of Western Research to Developing Countries: Narrowing the North-South Divide in Drug

Policy and Practice," in *The SAGE Handbook of Drug and Alcohol Studies*, T. Kolind, B. Thom, and G. Hunt, Eds. Sage Publications, Inc, 2017.

[4] L. Holleran Steiker, *Youth and Substance Use: Prevention, Intervention, and Recovery*. Chicago: LYCEUM BOOKS, INC., 2016.

[5] B. M. Newman and P. R. Newman, *Development through life: a psychological approach*, 8th ed. Belmont, California, 2003.

[6] M. Valverde, *Diseases of the Will: Alcohol and the Dilemmas of Freedom*. New York: Cambridge University Press, 1998.

[7] A. Winstock, M. Barrat, L. Maier, and J. Ferris, "Global Drug Survey (GDS)," 2018.

[8] H. Stöver, "South Caucasus Anti-Drug Programme: Country assessment mission report Azerbaijan," 2007.

[9] T. Rhodes and S. Bivol, "'Back then' and 'nowadays': Social transition narratives in accounts of injecting drug use in an East European setting," *Soc. Sci. Med.*, vol. 74, no. 3, pp. 425–433, 2012.

[10] S. Bernays, T. Rhodes, and K. Janković Terźić, "'You should be grateful to have medicines': continued dependence, altering stigma and the HIV treatment experience in Serbia," *AIDS Care*, vol. 22, no. sup1, pp. 14–20, Jul. 2010.

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