המוסד לביטוח לאומי
מינהל המחקר והתכנון
שד' ויצמן 13, ירושלים 91909

National Insurance Institute of Israel

Research and Planning Administration

Analysis and Diagnosis regarding Claimants of

Income Support Benefit

Due to Drug Addiction

1988--1993

Printed in Jerusalem, April 1994
Survey No. 116

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Tamar Haron

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FOREWORD

The first Diagnostic and Orientation Center for Drug Addiction was established in Jaffa in 1988 with the aim of verifying justification of claims for benefits under the "Income Support Benefit" law by persons purported to be addicted to drugs and in order to provide orientation regarding the appropriate therapy suitable for addicts within the various community services. An additional such Center was established in Beer Sheva in May 1991.

In addition to the importance of the Centers in analyzing and ascertaining the claimants' rights to benefit, the Centers provide a unique opportunity to identify and "Follow Up" on this "At-Risk" population, which has regrettably been increasing in Israel in recent years.

Whilst in most countries, surveys on drug addiction focus on small groups of persons who partake in detoxification therapy, we in Israel do not, to the best of our knowledge, have available such data reservoirs which permit the identification of addicts, the study of drug addiction in all its aspects at the various stages of its development, including characteristics of the addicted, their needs, and most important, the assembly of data concerning children in families where one or both parents are addicted to drugs.

This report is the second of a series of reports on this "At-Risk" population, addicts and their families, and it is our hope that these reports will help us to better understand the phenomena, in order to decide on the appropriate means and methods to cope with this severe social problem.

This report was prepared and written by Mrs. Tamar Haron, Senior Researcher at the "Long Term Benefits Department" of the National Insurance Institute of Israel headed by Mrs. Brenda Morgenstin, who has monitored the activity of the Centers for a number of years.

First and foremost, our thanks is given to Dr.Ely Elbaz, who heads the Diagnostic Center in Jaffa, his team of workers and interviewers as well as the Center's secretary for their efforts, assistance and close cooperation. We also thank Mr. Haim Mekler, Analyzer at the "S.L.A. Center" in Beer Sheva. Special thanks to Dr. Yair Caspi for his advice in the field of drug addiction; to Mr. Yacov Moav Director of the "Methadone Therapy Center" in Jaffa for his assistance in expanding the questionnaire; to David Alexander Galia who guided and advised us on data processing; to the team of encoders: Tal Eyal and Vered Karnis in Jaffa, Adi Stein and Yifat Noah in Beer Sheva, for their responsible and selfless efforts. Special thanks to Orly Abutbul, who Designed the tables and gave the finishing touch to the manuscript.

Shlomo Cohen,

Deputy Director General,
Research and Planning.

Contents

Introduction

Addiction to "Hard" drugs is one of the contingencies which entitle persons to income support benefits from the National Insurance Institute of Israel {N.I.I.}under Para.2A' {2}of the Income Support Law. In directive No.4-6 of the Law's Guidance and Procedure's Handbook published by the "Income Support Service" on February 16th.1993, claimants of support benefits due to addiction, are referred to the "Diagnostic and Orientation Center" established in Jaffa by the N.I.I. in conjunction with the Ministry of Health - Public Health Association, in order to be formally classified as "Addicted". [See Survey No. 71 of the National Insurance Institute, 1990].

Claimants from Haifa and its suburbs are referred for diagnosis to the "Haifa Rehabilitation Center" whereas claimants from the Beer Sheva local branch and its subsidiaries were requested to go to Jaffa for diagnosis, and as of May 1991, have been referred to the S.L.A. Center in Beer Sheva.

Addicts who suffered physical and bodily disabilities resulting from drug abuse and who claim "Disability Benefits" are processed through our "Disability Branch" and are appraised by "Medical Boards" who decide on entitlement for this type of allocation. When the diagnosis is positive, handling of disabled entitled addicts is transferred from the "Income Support Service" to the "Disability Branch" of the Institute.

So far, concerning diagnostic results, a great deal of the data which has accumulated at the Diagnostic Centers in the biological, psychological and sociological fields has yet to be processed and analyzed, and this survey is intended to provide the basis for a wider range of "In Depth" research to be carried out in conjunction with bodies outside the National Insurance Institute, in order to make use of the big quantity of data at our disposal..

General Background

The accepted concept in the Welfare field of today is the "All Embracing" approach, which entails concurrent relating to the whole gamut of the patient's problems, whether he is young or old, retarded or addicted to drugs. In this type of approach, diagnosis is effected with reference to all the fields: medical, emotional and socio-economic, which prompted the patient's application to the Institute as well as the mutual influence of these fields on each other, resulting in the current predicament of the applicant. With this in mind, detoxification therapy must be tailored to meet each applicant's specific needs and means, as diagnosed by the professionals in each relevant field. Study and diagnosis of drug addiction is now carried out with the aim of guiding each addict towards the most appropriate type of therapy available within the means at his disposal.

Research on drug addiction in Welfare States shows that there is no fixed or uniform attitude towards addicts who are in need of long term financial assistance. In countries such as Great Britain, Holland, Germany , Canada and Finland, it has been found that there is no separate classification of "Drug Addicts" for the purpose of providing maintenance benefits; but rather, these are included in other categories such as "Sick", "Disabled" and "Unsuited for Employment" [Burg, 1984].

Research has been concentrating on fields relating to the drugs themselves, methods of prevention surveys on the use of drugs by the public at large as well as by various specific sectors of the population [small groups of users or addicts undergoing therapy or orientation, "volunteers" from within groups identified as being drug users or surveys on large heterogeneous populations according to a limited number of variants], and no special attention has been devoted to the diagnosis or orientation of the addicted. The very important differentiation between "Users" and "Addicted" has not always been adhered to and this may lead to confusion in classifications, status descriptions and conclusions.

It is apparent in Israel as well, that so far, insufficient research [by volume and scope] has been conducted into the characteristics of the population addicted to hard drugs or to the orientation of those who have deteriorated to the bottom of the socio-economic ladder and who turn to the Institute for help, not necessarily for detoxification or rehabilitation. This group, although not large in number [about 3,000 i.e. about 5% of the total number receiving monthly income support benefits, stands out by its characteristics. This is a "Hard Core" group by length of dependency upon institutional assistance and by its limited potential to escape from this dependency: 25% of the "Addicted" spend at least 4 years within the "Income Support" system as against only 15% for other classifications of recipients of this assistance. Although "Alcoholics" tend to be a more problematic group, they are only about one sixth in size [Approx. 500 recipients of "Income Support" as against 3,000 for the group addicted to hard drugs].

The roots of the addicted population claiming income support from the National Insurance Institute are found in the underprivileged classes and the poorer neighborhoods; most of them are born to large families [60% with 6 children or more], and many from broken homes [10% are children of divorced or seperated parents]. The addicted population is in economic- social -emotional distress and has a high delinquency factor [57% of the interviewed]; its members are not consistent in any framework. This commences in early school years, continues through military service and start of employment: 38% of the interviewed did not complete 8 years of schooling, about 42% did not serve in the army and 63% of those who served did not complete their full term of service. 34% had no employment whatsoever and the majority of the remainder had no profession and did not hold regular employment. Even at the present stage of diagnosis, about one third dropped out without completing the "Diagnostic Procedure", completion of which is the stipulated condition for receipt of benefits. This population utilizes drugs as a means of escape from reality in addition to its being expression of their revolt and antagonism towards the system [i.e. the Authorities]. After the drugs have caused deterioration and collapse, this population turns mainly to the National Insurance Institute, not for detoxification and rehabilitation, but mostly in order to receive financial assistance.

The size of this group has been increasing all the time, [from approx. 1,500 recipients of monthly benefits four years ago, to approx. 3,000 in 1993], thus compelling the Institute to focus its attention on providing it with therapy and assistance. The group is a burden on society and a source of suffering and danger to the public whom they subject to crimes of violence and property. Worst of all, this group is bringing into the world an additional generation of "Hard Core Distressed". According to a number of studies, infants born to addicted mothers will tend to develop a hereditary tendency towards addiction [Butcher, 1988], in cases where the mother is addicted, the drug is likely to be absorbed into the fetus before the baby is born. These children will be raised in a sub-culture in which the main objective is the obtaining and use of drugs and they will absorb its "Life Style" and morals [or lack of same]. These children are often abandoned, beaten and also exploited sexually, economically, socially, culturally as well as in employment; and do not learn from their parents how to socialize successfully. They grow up with feelings of anger and bitterness against society and will most likely grow up to be criminals addicted to hard drugs [Levy, 1992--Griffith et al., 1988] which means pain and death to them and a heavy burden on the shoulders of society and its institutions.

Procedures

Claimants to income support benefit due to drug addiction are referred to the Centers by the claims personnel at the local branches of the National Insurance Institute in order to undergo diagnosis. For a number of reasons, mainly those connected with the addict's personality and "Life Style", many of those referred fail to appear at the Center after referral by the Branch while others drop out after the first interviews, before final diagnosis is completed. These "Drop Out"s are classified as "Non Cooperative" and are not entitled to maintenance income. As a rule, they are allowed to re-approach the Center two or three times even if they drop out at the height of the diagnostic procedure but before they are classified as "Non Cooperative". Some of them return to complete the process while others renew their claims for assistance through the branch. A file based upon the information provided by the branch is opened at the Center for each such person referred, even if he or she fails to appear at the Center. The interview, the diagnostic procedure and its conclusions are documented in the personal file of each claimant.

The Center in Jaffa is now directed by a Psychologist assisted by a team comprising a Medical Doctor, Psychiatrist and [Intake] interviewers who are either Social Workers or Psychologists. Likewise, claimants in Beer Sheva are referred to their Municipal Detoxification Center for diagnosis. This team of professionals- each one at his own "desk": Interviewers, Doctors and Psychiatrist [when needed], check on the veracity of the claimant's declarations, mainly according to claimant's background, physical and mental condition, in order to obtain a complete picture of the claimant's "Life Style" and thereby evidencing him clearly to be "Addicted". Each diagnosis is individual and requires at least three visits to the Center in order to perform urine tests so as to ensure, as far as possible, that the claimant is truly addicted to drugs.

The Diagnostic Centers were founded by the National Insurance Institute in conjunction with the Ministry of Health and are intended not only to diagnose addiction, but also to give an overall estimate of the addict's condition as well as his or her ability to extricate themselves from their dependency upon institutional assistance. This being the case, the Centers function as orientation units for referral of the addicted to the various therapy frameworks, based upon the results of each addict's diagnosis. The interviewers now also appraise the addict's ability for detoxification and rehabilitation and they then register the appropriate address on the interview form.

Providing financial assistance permits the Institute to make this aid conditional upon the addict's willingness to cooperate by entering the therapeutic framework that has been recommended for him. Claims personnel at the branches approve payment to the addict only after they have made sure that the Center's recommendations have been acted upon.

The Institute's personnel continue monitoring after the addict has been referred to the therapeutic framework recommended by the Center, and if the addict is consistent in his attendance within the framework, financial assistance is approved. Addicts who have entered detoxification and rehabilitation frameworks continue to receive their maintenance allowance as long as their therapists confirm their attendance within the framework [consideration is being now given to limiting attendance within these frameworks to one up to two years]. In addition to these frameworks, addicts are also serviced by the "Adults Probation Service" as well as by a small number of private institutions operating according to law and subject to the regulations of the National Insurance Institute.

The amount of effort and resources expended on average therapy for the addict is dependent upon exact and reliable diagnosis. The large quantity of information collected so far at the Centers as a result of physical checkups and interviews, permits an all-inclusive appraisal of the capabilities of the addict, his specific needs and the recommendation as to which therapeutic framework he is most suited.

The diagnosing teams are continually seeking additional methods of approach to their task. From time to time, the Diagnostic Centers in Jaffa and Beer Sheva examine methods of classification and characterization carried out in Israel and elsewhere throughout the world. For example, testing by photography of the retina [a form of concentration and control test] has been tried, as well the S.A.S.I. and A.S.I. tests. We shall refer at a later date to an additional method now being tried out.

We are still short of sufficient "Frameworks" to absorb all persons requiring therapy during the period of their addiction and many appear on the long waiting lists for induction into therapy. From time to time, we are notified of the opening of a new "Care and Rehabilitation Unit" but these are not always sufficient to guarantee the reduction of uncontrolled use of drugs on the street. As stated before, use of drugs is partly engendered by revolt against society and unwillingness to cooperate with the "System"; so much so ,that even when we distribute Methadone at nominal prices or even provide Heroine injections, no change occurs in the behavioral pattern --nor does this bring all addicts to the Care and Rehabilitation Units placed at their disposal by the Institute. These units however, substantially increase our connection with this population, its monitoring and potential of extricating it from the influence of drugs and "Pushers" on the streets.

Assembly of Data

The assembly and processing of data has been expanded this past year in order to create a data base which will enable us to :-

A] Become acquainted with all the aspects of the addicted population which claims benefits under "Income Support" from the National Insurance Institute.

B] Get to know addicts' personal reasons- physiological and emotional, their social background and reasons connected with why they became and why they remain addicted; this in order to develop reliable means of diagnosis so as to provide proper orientation and addicts' referral to organized therapeutic frameworks. These factors are today considered to be the best indicators regarding potential success in detoxification [Simpson et al., 1988].

The following forms are filled for the applicants during the course of diagnosis:-

1] Initial interview form containing the following:- Personal data - Origin of family Education - Military service - Basic family nucleus - Employment - Criminal record - Use of drugs and therapy.
As of April 1992 this form has been expanded by additional information about the applicant, appraisal by the interviewer and his recommendations.

2] Medical Form.

3] Results of urine tests.

Data processing of all the forms will provide a comprehensive picture about drug users who claim "Income Support".

This report is based on the following factors:-

1] Approximately 6,000 files of claimants who were referred to the Diagnostic Centers in Jaffa and Beer Sheva.

2] Approximately 4,000 "Intake Forms" of claimants who appeared at the Centers.

3] Approximately 700 cases for whom "Expanded Intake Forms" were completed.

Findings

Volume of Referrals

Approximately 6,000 claimants were referred to the Diagnostic Centers in Jaffa and Beer Sheva during the period between June 1988 and September 1993. Table No.1 shows the breakdown of all referrals to the Centers according to the emanating Branch and the Conclusive Diagnoses issued with regard to claimants' rights to receive "Income Support", i.e. whether the claimant is :-

1] Addicted, or
2] Not Addicted, or has
3] "Dropped Out" during the course of Diagnosis, or
4] Did not appear at the Center, i.e. "No Show".

Claimants in the latter three categories are not entitled to receive "Income Support" but may however renew their claim. Should this be the case, they have to go through the diagnostic process again.

This table shows that the percentage of "Addicted" out of the total number referred stands at about 70%; the total of "Not Addicted" stands at about 3%; the total of those referred who "Dropped Out" during the course of diagnosis stands at approximately 7% whereas the total of referred who never arrived at the Centers [i.e. were "No Show"] stands at about 20%.

There were fewer "No Show"s and a higher proportion of "Addicted" from local branches located close to the Centers: i.e. From Tel Aviv, 81% were "Addicted" and 11% "No Show"s and from the Jaffa branch, 78% were "Addicted" and 14% "No Show"s. For Beer Sheva, the proportion of "No Shows" fell from 29% in 1989 before their Center was established, to 21% today and the percentage of "Addicted" rose from 61% to 69%. A lower percentage of "Addicted" is identified in cases of smaller and further away branches, i.e.: Tiberius- 38%, Hadera- 50%, Netivot- 54%. Jerusalem is the last branch to refer claimants for diagnosis and part of its data has not yet been processed; of the 132 claimants so far referred by Jerusalem, 41% proved to be "Addicted" and 21% were "No Show".

Table No.1: Breakdown of Referrals to Centers according to Branch and Diagnostic Results

Branch	Total Number	%	Addicted	Not addicted	Dropped out	No show
Total	5,813	100	70	3	7	20
Tiberius	50	100	38	2	18	42
Safed	16	100	56	6	6	31
Kyriat Shmone	15	100	60	0	0	40
Afula	25	100	32	4	20	44
Nazareth	92	100	65	3	9	33
U. Nazareth	15	100	73	7	13	7
Naharya	299	100	66	1	8	25
Hadera	64	100	50	5	12	33
Natanya	228	100	67	4	8	21
Kfar Saba	90	100	64	6	11	19
Herzlia	90	100	72	3	4	20
Petah Tikva	251	100	70	4	6	18
Ramleh	558	100	70	3	6	21
Rehovoth	252	100	71	3	5	21
Rishon le Zion	164	100	69	2	6	23
Ashdod	172	100	70	1	9	20
Kiryat Malachi	42	100	69	0	5	26
Kiryat Gat	85	100	73	1	4	22
Ashkelon	201	100	58	2	11	29
Tel Aviv	620	100	81	2	5	11
Jaffa	1,113	100	78	3	5	14
Holon	298	100	72	5	5	17
Ramat Gan	203	100	70	5	5	20
Or Yehuda	63	100	83	3	6	8
Jerusalem	132	100	41	25	7	27
Beer Sheva	493	100	69	2	8	21
Ofakim	55	100	64	2	16	18
Netivot	26	100	54	4	4	38
Dimona	83	100	66	0	10	24
Arad	18	100	78	0	11	11

Table No. 2; Breakdown of referrals according to local branch and year of referral [%]

Local Branch	Total Numbers	%	1988	1989	1990	1991	1992	1993
Total	5,813	100	5	16	22	28	19	10
Tiberius	81	100	0	0	2	65	24	9
Afula	26	100	0	0	0	35	27	38
Nazereth	107	100	0	1	0	45	34	21
Naharya	229	100	0	3	28	37	24	8
Hadera	64	100	0	0	25	48	14	13
Netanya	228	100	0	0	25	39	25	10
Kfar Saba	118	100	6	26	21	18	19	10
Petah Tikva	251	100	0	27	25	26	16	6
Ramleh	557	100	16	10	23	23	16	11
Rehovoth	916	100	0	24	25	27	17	6
Tel Aviv	620	100	20	17	22	21	13	7
Jaffa	1,411	100	0	15	28	27	20	10
Ramat Gan	267	100	15	11	20	22	19	13
Jerusalem	132	100	0	1	0	0	58	41
Beer Sheva	674	100	0	25	18	35	15	7

Table No. 2 displays the volume of claimants referred to the Centers for diagnosis. The increase in the amount of work performed by the Diagnostic Centers is to be noted: From 930 referrals in 1989 to 1,624 in 1991. In 1992 the Centers commenced "Follow Up" on the interviews so the figures remained as in 1991 and for 1993 we have only partial results.

Socio-Demographic Characteristics

The data on Socio-Demographic characteristics was gleaned from the initial "Intake Forms" so that the details in our possession refer to those claimants who arrived at the Centers and were interviewed. As of now over 4,000 claimants arrived [i.e. Addicted, Non Addicted and Drop Outs], in other words, about 80% of the claimants referred by the branches arrived at the Centers. Approximately 700 claimants have been interviewed using the expanded "Intake Form" which includes additional reference to family, personal appraisal and recommendations. In some of the cases, details are lacking due to claimants being recalcitrant at the time of interview.

Most of the findings of this survey, except for small differences, concur with those findings and attitudes appearing in related literature. These differences may arise from the unique combination comprising Israel's population, or due to the laws and regulations which regulate entitlement to allocations under "Income Support", or possibly due to the Jewish way of life.

This is tangibly displayed in Table No.3: There is a major difference in percentages between men and women referred to the Centers for diagnosis. 8% of those referred are women, whereas 92% are men. It is a known fact that throughout the world, fewer women use hard drugs than men do, but the current differential in the world stands at about 15% for women and 85% for men [1988; 1992, Simpson et al.,].This difference is attributed to the fact that in Israel, mothers with children aged up to 7 are not compelled to take Income and Drug Diagnosis Tests in order to become eligible for "Income Support" and therefore these mothers are not referred to Diagnostic Centers.

Table No. 3: Breakdown of referrals to Centers according to religion and gender

Gender	Total	Jewish	Moslem	Christian	Druze and Others
Total %'s of population	100	82	14	3	2
Number Referred	4,209	3,571	502	47	29
[Same in %]	100	84	12	1	1
Male in %	92	91	99	91	100
Female in %	8	9	1	9	-

Table No. 3 displays breakdown of claimants referred for diagnosis, as per their religious affiliations. Comparatively to their section of the whole population, Jews are in a slightly higher proportion than Moslems. Noticeable also is the low proportion of female referrals in the non Jewish sector.

It is a known factor that immigration makes it difficult for newcomers to integrate into a society, weakens the family structure and normative behavior. The Swiss noted that there were substantial differences between addicts having one parent of foreign nationality and a control group: Incidence of drug addiction where one of the parents was of a foreign nationality was twice as high as in the control group [Zimmer-Hofler et al., i983]. Unlike Switzerland, Israel is a country of immigration and the majority of parents emanate from foreign countries. Most of the parents of the "Addicted" came from Eastern countries [North Africa, Middle East and Asia], and have undergone considerable hardship and difficulty in integrating and adapting to the Western culture prevalent in Israel: 71% of the fathers and 70% of the mothers of the interviewed were born in Eastern countries. These figures are noteworthy since three years ago, they stood at 86% for fathers and mothers alike.

Table No.4 presents the breakdown of referrals according to age and issuing branch, as compared to the age breakdown within the general population. The largest group of those referred [30%] belongs to the 30- 34 age group which stands at only 14% for the general population. This is followed by the 35-39 group [24% against 13% for the population], followed by the 25 -29 group [20% against 4% within the population]. This is in contrast to the age 50+ group which stands at only 3% referrals as against 21% within the general population.

Table No.4: Breakdown of referrals to Centers according to Branch and age.[%]

Age Group / Branch	N [%]	20-24	25-29	30-34	35-39	40-44	45-49	50+
Total within population 2,611, 600=N	100	16	14	14	13	13	9	21
Total Referr ed	100	5	20	30	24	13	5	3
Tiberius	100	18	15	31	26	3	8	0
Afula	100	0	44	44	11	0	0	0
Nazareth	100	2	31	33	18	15	1	0
Nahariya	100	6	17	36	23	12	4	2
Hadera	100	3	23	34	18	11	11	0
Netanya	100	2	23	31	31	8	2	2
Kfar Sava	100	4	23	32	22	14	4	1
Petah Tikva	100	4	23	29	24	12	4	4
Ramleh	100	5	17	29	28	10	7	4
Rehovoth	100	4	21	36	23	10	4	2
Tel Aviv	100	3	11	27	26	17	10	6
Jaffa	100	5	19	27	24	15	6	4
Ramat Gan	100	5	13	31	25	18	5	3
Jerusalem	100	2	20	26	30	9	9	4
Beer Sheva	100	7	28	32	20	8	2	3

The high proportion of referrals in the older age groups is to be noted in the Tel Aviv area as set against the high proportion of referrals in the younger age groups in outlying areas such as Tiberius, Afula and Beer Sheva. Although it is conceivable that this coincides with the general "Age Group" breakdowns in these locations, it is also indicative of the wider spread in use and availability of drugs in outlying areas. A few years ago, drugs were obtainable mainly in large cities where the addicts converged, but now drugs are available in every city so that addicts no longer have to go to large cities in order to obtain them.

The "Addiction Career"

Belated requests for assistance from the authorities by the older age groups of addicted and the quasi disappearance of addiction after the age of 45, is due to the "Life Style" which is particular to addicts.

During the first ten years of drug use, addicts tend to deny to themselves cognizance of the fact of their addiction and succeed in attending to their own sustenance and financing of their drug purchases by legal or as in most cases, by illicit means. Later on however, they find difficulty in keeping up with demands due to physical deterioration and emotional exhaustion and are forced into bitter acknowledgment to themselves of the fact that they are "Addicted" and are compelled to turn to the authorities for assistance. For some of the addicts however, turning to the National Insurance Institute is in continued denial of their addiction and they contend that they request assistance because of family pressures for livelihood and not because they need detoxification.

The moment of turning to assistance from the authorities by the "Hard Drug" user is a turning point in the addict's life. Researchers in the field see the addict not as a passive person who has decided to let life pass him by, but rather as someone who exists in a sub-culture that has all the ramifications of an organized society, such as: Clear divisions of function, hierarchy, it's own language [slang], transactions, comportment and ways of coping, group identity and an ethical code [Research Issues, 7, 1975--Norco, 1972 in NIDA]. In this sub-culture, there is continuous involvement around the procurement of drugs- its financing and the accepted methods for its use in that sub-culture. We recognize the phenomena of the "Addiction Career", by the periodical changes that occur in life surrounding drugs. This "Career" has a life span of from one to 35 years with a mean mid-point of 9.5 years [Simpson, Joe et Lehman, 1988 and Caspi, 1993]. After the well organized, surreptitious use of drugs for the first one to three years, come 4 to 6 years during which the user believes that he is in control of usage, not "Addicted" and able to extricate himself from its grip. He is subject to a struggle- defense and evasion- from his family, society and Police. Occasionally during this period, the user turns to various therapy schemes to relieve pressure placed upon him, but mostly, this is not yet an honest and truthful attempt. It is only after this stage, when exhausted by perpetual evasion, that the user admits to himself the fact of his addiction.

This turning point is also connected to the quantity of drugs already absorbed into the body. The amount of drugs used by addicts is not uniform, the addict does not use the same drug every day nor its equivalent in quantities and there may be days when he is "Clean". If at the start of his "Career", an addict requires 1/3 of a gram of "Coke" to obtain the desired effect, then with his career's progress, he may require 2 or 3 grams for the same effect. Larger quantities cannot be absorbed by the body, impair breathing and lead to death [Caspi, 1993].

With the passage of time, a process of "Maturing" takes place [Winick, 1962] with 20% to 30% of the addicted; a reduction and sometimes even cessation in drug consumption takes place towards the end of their 30th. year [depending upon the start age of usage]. Approximately one quarter of the addicts die, generally due to neglect of health while the addict is not fully cognizant and tends to relieve pain by using drugs or by accident due to neglect or drug overdose. After about ten years of using hard drugs, the survivors find themselves at a crossroads: if they are ripe for detoxification, have supportive surroundings and find sufficient emotional strength within themselves, they may be able to extricate and rehabilitate themselves if they request assistance; if not- they become chronic drug users, "One step away from death" [Caspi, 1993].

Table No. 5 depicts time length of usage for "Persian Coke" [heroine mixed with additional material and the most widely spread hard drug in use], until addicts apply for assistance from the National Insurance Institute: 57% used this drug for between 5 to 10 years and they comprise today 61% of the 30-34 year old age group.

Table No.5: Breakdown of "COKE" usage- according to age and time length of drug use [%]

Age	Total Nombers	%	Number of years of drug use 1-2	3-4	5-7	8-10	11-15	16-20	21+	Not Known
Total	3,763	100	5	15	32	25	16	4	2	2
Upto 25	431	100	11	26	46	13	1	0	0	3
25 to 29	796	100	7	18	39	26	8	0	0	1
30 to 34	1,184	100	3	11	33	28	20	2	0	2
35 to 39	751	100	5	9	24	28	22	8	1	2
40 plus	601	100	4	10	20	21	22	10	12	2

Awareness of the existence of the "Addiction Career" which terminates in ripeness for detoxification may lead to the adoption of diagnostic techniques relating to the career's characteristics. The Tel Aviv District "Adult Probation Service" has developed a group "Diagnostic and Sorting System" for addicts referred to them by Law Courts in order to evaluate the potential for rehabilitation instead of punishment. This system which saves time and manpower, is being tested at the Diagnostic Centers and is capable of evaluating an addict's ability and willingness to enter into therapy. In other words, this system brings forth the addict's readiness to rehabilitate physiologically [lack of pleasure from the drug], psychologically [dissatisfaction with self] and sociologically [termination of role within the family] proving that the "Addiction Career" has reached its end [Caspi, 1993].

The Family

Special emphasis on "Family Attitudes" has been inserted into the "Expanded Intake Form": Relationships with parents, brothers and sisters, spouses and children. These areas are important for two reasons:-

1] The addict's relationship with his family determines to a large degree his - willingness and ability to rehabilitate [Lex, 1990-]. Acknowledgment of family - responsibility was a motivating factor in 56% of detoxification cures [Simpson et al- 1988].
2] Addicts' children are the highest "Risk Group" for potential addiction and therefore - require special attention. The likelihood of these children also turning into addicts - is infinitely higher than the likelihood of those whose parents are not addicted.

The Family Nucleus

It is incorrect to claim that all addicts come from broken homes or families. Only 10% of the parents of the interviewed were divorced and 37% of the interviewed declared that relations between their parents were "all right" or "good". 30% of the interviewed declared that they had "good" or "all right" relations with their fathers and 42% declared that they had "good" or "all right" relations with their mothers. As against this, only 24% claimed that they had "good" or "all right" relations with their spouses. This phenomena of better links with the "Family of Origin" than with the "Nucleus Family" is propounded in related literature[Textor, 1987].

Table No.6 shows the breakdown of cases referred to Centers according to gender and family status. 44% of the addicted had families: This proportion was high in comparison to addicted populations worldwide since these do not tend to lead orderly family lives. It is conceivable that this is due to the influence of traditional Jewish life which encourages well regulated family living. Throughout the world, research on the use of hard drugs in relation to family status, shows a higher incidence of usage amongst divorcees, seperated couples and singles [National Household Surveys, 1988]. It is to be noted that the proportion of married persons amongst the Moslems is even higher and the divorce rate especially high: 20% of the Moslems referred were divorced, some even more than once, with the main reason given for divorce being "Use of Drugs" [N.B. The divorce rate for the general population is 4%]. This factor is probably indicative of the strong urge for divorcees to turn to the National Insurance Institution in order to obtain money for self sustenance and for their families as well.. In case of entitlement to under "Income Support", the National Insurance Institute pays alimony to the wife who is unable to work, as well as to the children. In any case, the proportion of children [of addicts] whose homes are broken, is substantially higher than that of other children.

Table No.6: Breakdown of Referrals to Centers according to Gender and Family Status [%].

Gender	Total Numbers	[%]	Singles	Married	Seperated	Divorced	Widow/er
Total in population							
Ages 19-54	2,168,900*	100	24	72	-	4	-
Total Referred	4,445	100	28	44	7	20	1
Males	4,089	100	28	46	7	19	-
Female	356	100	31	18	5	43	3

* Excerpt from the 1993 Annual Report, Central Bureau of Statistics.

Women- Spouses

The subject of this paragraph is "Women- Spouses" [the overwhelming majority of the referrals are men] and focuses on information regarding their first partner, obtained from the men at their first "Intake Interview": In two thirds of the cases the bond was marriage; for 8% the bond was "Living Together" and for another 8% the bond was one of regular visiting. The remainder failed to answer. For half of the interviewed, this bond lasted 6 to 13 years and 8% of the interviewed declared that their partners used drugs. 14% declared having a second partner after the first and 1% declared that they had a third partner. Although the first bond between the diagnosed and their partners lasted an average of 12 years, most of them left their spouses after 1 to 6 years.

Table No.7; Breakdown of referrals according to their Age Group and age of spouse [%]

Age of the Referred	Total Numbers	[%]	Age Group of Wife						
			20-24	25-29	30-34	35-39	40-44	45-49	50+
Total	662	100	17	30	24	18	6	2	3
20 to 24	32	100	67	25	3	0	0	0	6
25 to 29	142	100	44	41	10	3	1	0	1
30 to 34	200	100	11	46	33	7	1	1	1
35 to 39	174	100	4	20	32	37	4	1	2
40 to 44	80	100	0	8	19	37	29	6	1
45 to 49	24	100	0	4	13	29	29	17	8
50 plus	10	100	0	0	20	10	10	10	-

Table No.7 shows the age of the interviewed in comparison to the age of their first spouse. While the major portion of the men [30%] belonged to the 30 -34 age group, the major portion of the women [also 30%] belonged to the 25-29 age group. About

47% of the married couples, men and women respectively, belonged to these age groups.

Table No.8 shows the breakdown of number of years of school attendance by the interviewed and their women consorts: 73% of the males interviewed completed 8 years of schooling whereas only 16% had 11 or more years of schooling. The interviewed testified that 88% of their mates completed at least 8 years of school and 41% completed 11 years or more. The table also shows that one quarter of those diagnosed did not complete Secondary School and were married to wives with the same education and that more than half [53%] were married to women who had had 9 years of schooling or more.

Table No.8: Breakdown of Referrals according number of years of schooling of men diagnosed and their consorts

Numbers school Years for women consorts	Total [%]	Number school years of men diagnosed				
		-7	8	9-10	11-12	13+
Total [N]	476	129	150	121	69	7
[%]	100	100	100	100	100	100
Upto 7 years	12	25	7	11	3	0
8 years	25	22	39	14	17	14
9 to 10 years	22	19	19	31	17	0
11 to 12 years	33	29	27	35	54	43
13 years or more	8	5	8	9	9	43

Table No. 9: Breakdown of referrals according to type of spouses' employment and relationship with spouse

Relation between the couple	Total	Employment of spouse								
		Unemployed /Housewife	Unskilled Labour	Professional	Odd jobs	White collar	Disabled	Imprisoned	Independent	Unknown
Total [N]	608	387	70	45	31	42	5	15	7	6
[%]	100	100	100	100	100	100	100	100	100	100
Good	17	18	15	18	23	17	0	13	14	0
Fair	22	23	20	16	29	36	20	0	0	0
Antagonistic	27	39	38	40	26	14	60	27	86	17
Violent	11	9	16	15	6	12	0	20	0	0
Nocontact	10	7	7	11	16	14	20	27	0	83
Other	3	4	2	0	0	7	0	13	0	0

Table No.9 exposed the fact that most of the women [64%] had no employment [i.e. were housewives]; 12% were unskilled labor, 7% were professional workers, 5% took odd jobs, 7% were white collar workers and 3% were criminals.
Due to the use of drugs, antagonistic relations were anticipated between couples and the 645 diagnosed reported having the following relationships:-

Good	19%
Fair	22%
Antagonistic	36%
Violent	0%
No contact	10%
Mixed feelings	2%
Other	1%

Table No.10: Breakdown of referrals according to length of time and quality of relationship %

Length time Inyears	Total Numbers	[%]	Quality of relationship						
			Good	Fair	Antagonistic	Violent	Nocontact	Other	Unanswered
Total	670	100	17	20	34	9	9	3	8
1 to 2	111	100	25	22	21	7	7	1	16
3 to 5	146	100	16	22	22	10	12	1	10
6 to 9	156	100	15	17	37	9	14	4	4
10 to 14	143	100	13	25	41	10	4	5	4
15 plus	114	100	18	15	41	10	10	1	6

Antagonism and violence between couples rises in proportion to the length of time couples live together; from 28% in the first one to two years with up to 51% after 15 years or more of living together [see Table No.10] As is shown in Table No.11, antagonism and violence also increase in proportion to the increase of number of children in the family.

Table No. 11: Breakdown of referrals according to number of children and relationship between the couple [%]

Relationship	Total	Number of Children			
		1	2	3 to 5	6 plus
Total [N]	534	112	162	211	49
[%]	100	100	100	100	100
Good	14	14	12	14	18
Fair	20	28	13	22	14
Antagonistic	41	34	46	40	45
Violent	12	9	14	11	16
No contact	10	11	10	10	6
Other	3	1	2	0	0

It is to be noted that if the interviewed is in a second marriage, the rate of drug addiction increases by up to about one quarter. 23% of the couples terminated their family link by divorce, 18% were seperated and 1% were widowed. 42% of the interviewed declared that drugs were the reason for their seperation. Reasons for seperation are set out hereunder by order of importance:-
Use of drugs = 42% Incompatibility = 23% Family Problems = 10% Criminal Record = 3% Other reasons = 4%.

Children of claimants referred to Centers

Data assembled to date* concerning children includes gender, age, current school, grade of the child as well as the sector to which his school is affiliated; home address and educational framework in which the child is placed as well as relationship between the child and the interviewed. Offspring of claimants [including older children] count over 7,000 souls whose emotional, social and economic situation is undoubtedly most critical and gives well founded reason to believe that they are the addicts of the future or to say the least, the upcoming generation of underprivileged [Griffith et al., 1988]. All told, 54% of the interviewed have children and most of them [57% out of the 54%] have one or two children, whereas 3% have 6 children or more.

Table No. 12 displays the age breakdown of the "First Born" child according to the number of children in the family. 11% of the interviewed have a first born child aged between one and two, 15% have their first born aged between 3 and 5 whereas half have their first born of Primary School age [i.e. between 6 and 13]. With 14%, the first born son is aged between 14 and 17 and 12% have another child aged 18 or more.

Table No.12: Breakdown for Fathers as per age of "First Born" and No. of Children in family

No. of Children in the family	Total "First B"		Age of "First Born"					
	Number	[%]	1 to 2	3 to 5	6 to 9	10 to 13	14 to 17	18 Plus
Total	566	100	11	15	24	24	14	12
1	120	100	39	26	18	10	4	3
2	175	100	8	21	31	24	11	6
3 to 5	220	100	1	8	27	31	19	15
6 Plus	51	100	0	0	2	31	24	43

* Data was assembled on first 8 children but only first 4 Data Processed [only 5% have more than 4 children].

Table No.13 shows breakdown regarding relationship of the Diagnosed to his "First Born" in reference to the "Framework" in which his child is living. A major portion of the interviewed [47%] declared that they related well to their children and 35% declared that they had "Correct" relations. It is to be noted that relationship deteriorates with the increase of number of children within the family and relations are worse with the older children and better with the younger ones. Only 1% told of antagonism in the relationship and none declared use of violence towards children although it probably exists. 63% of "First Born" children of school age i.e. 6 to 17 are, according to the Diagnosed, living at home. It is imperative to investigate and find out what is happening to these children.

Table No.13: Breakdown of referrals to Centers as per "First Born's" place of living [Framework] and the Father's relationship [Attitude] to his "First Born"

Relationship to First Born	Total Number	First Born's Framework					
		At Home	School	Army	Working	None / Addicted	Unknown
Total [N]	488	143	283	15	38	3	5
[%]	100	100	100	100	100	100	100
Good	47	57	41	40	61	67	40
Correct	35	29	41	27	16	0	20
Antagonistic	1	2	1	0	3	0	0
No Contact	15	10	15	33	21	33	10
Other	2	2	2	0	0	0	0

The following results were obtained by investigation in order to ascertain "Place of Residence" of the "First Born":-

At Home	68%
With Spouse	18%
With Relatives	2%
Protective Institution	1%
Boarding School	5%
Foster Home	3%
Independent	3%

In other words, two thirds of the "First Born"s of the interviewed lived at home with their parents, indicating that although the father is addicted to drugs and unable to feed his family, most of the families make the effort to raise their children by themselves and only 11% sent their children out to relatives, institutions or foster homes.

Employment

It is to be borne in mind that drug addicts do not turn for assistance from the National Insurance Institute because of family problems, but rather because they are unable to provide for their own sustenance. The prevailing opinion is that the higher the status and the longer the period of employment of a person who previously earned his own living, the better are his chances of rehabilitation and return to productive employment [National Household Surveys, 1988]. The interviewed were asked for details of their employment history in order to evaluate their potential for rehabilitation and the feasibility of returning them to employment. 44% declared that they had been employed in the past and 46% of these had held an additional previous job and out of these, 15% had even previously held a third place of employment. 6% of the interviewed had had professional training in the past, in addition to which approximately one quarter of the interviewed who had not been employed, had also undergone professional training, about half of these received training twice and out of these 20% for a third time.

42% of those who declared that they had worked in the past were unskilled laborers, 28% reported that they had done odd jobs, 23% were skilled laborers, 5% were self employed [generally hawkers and owners of stands in the market] and 1% had held office jobs.

The relative majority [40%] persevered for a year or two at their last place of employment, 23% had stayed at their last place of work for periods ranging from 3 to 5 years whereas 25% had even persevered at work for periods ranging from 6 to 13 years.

The interviewed gave the following as reasons for cessation of their employment or professional training:-

Drugs	49%
Lack of motivation	26%
Inability to adapt	8%
Being over age	6%
Criminal record	5%
Other reasons	6%

During the past year, 11% out of 870 interviewed were diagnosed as having potential for detoxification, 13% as having potential for rehabilitation and an additional 13% were recommended for Psycho- Social therapy. As against these, some 34% were diagnosed as being hopeless cases or having only minimal chances of extricating themselves from their predicament and entering into any therapeutic- rehabilitative framework whatsoever. It may be possible to make granting the "Income Support Benefit" conditional upon entry into a therapeutic framework, but it is not at all sure that this will bring about the entry of such hopeless cases into such frameworks. On the other hand, there is no doubt that such action will leave these hopeless cases and their families without any means of sustenance.

Since 1993, persons interviewed have been receiving referrals to therapeutic and detoxification frameworks. 580 out of the 870 interviewed received 1 to 3 referrals.
38% to Welfare Services in general, or through them to "Home Detoxification".
31% to Methadone treatment.
20% to Hospitalization.
13% to a Care and Treatment "Community".
11% to a Rehabilitation Center.
7% to Finding employment.
7% to Mental Health Stations.
3% to Psychiatric Treatment.
3% to Narcotics Anonymous.
5% to the District "Drug Officer" [on behalf of the Authority for Combat Against the Use of Drugs].
2% to the Disability Branch of the National Insurance Institute.
2% For "Follow Up" by the Diagnostic Center for Drug Addiction.
6% Sundry recommendations.

"Follow Up" [Monitoring]

Over 5,300 claimants [out of a total of over 6,000 -veterans and new- who together with spouses were referred to Centers since these were established] were "Diagnosed" as being "Addicted" due to sundry reasons and therefore entitled to receive allocations under "Income Support" for various lengths of time.

Table No.14; shows Breakdown of all referrals to the Centers according to results of diagnosis and reasons for entitlement to allocations for December 1993

Reason for allocation	Total	Results of Diagnosis			
		Addicted	Not Addicted	Dropped Out	No Show
Total Numbers	6,037	4,175	203	402	1,257
In[%]	100	100	100	100	100
Addiction	34	44	13	18	9
In Rehabilitation	7	7	4	8	8
Discharged Prisoners	3	2	1	5	5
Unemployable	2	2	11	2	2
Seeking Employment	2	2	5	3	3
Mother	1	1	2	1	1
Other	2	1	8	3	3
Not Entitled	49	41	56	60	69

Table No. 14 gives the figures of a "Control Check" effected in December 1993, on claimants and/or spouses who that month received allocations under "Income Support" entitlement, due to drug addiction and related causes. 3,098 [i.e.2,278 "Diagnosed Addicts" plus 820 spouses] amounting to 51% of the total number of claimants sent by the local branches for diagnosis, received such allocations.

The above table shows that not all referrals diagnosed as being "Addicted" receive allocations under "Income Support": Only 44% amongst the "Addicted" received allocations because of this reason, an additional 7% were entitled as a result of participation in various therapy and rehabilitation "Frameworks", 3% were discharged prisoners who are entitled to receive allocations for the first three months following their release from prison, 2% proved employable but no employment was found for them, 2% were totally unemployable, 1% were mothers with children up to the age of 7 and another one percent due to sundry reasons. The identity of the 41% "Addicted" who did not receive allocations, remains an open question.

Amongst the referrals who were classified as "Not Addicted" and therefor not entitled to allocations under drug addiction or who failed to appear [i.e. were "No Show"] at the Centers or "Dropped Out" during the course of diagnosis, there were 36% who received allocations for a variety of other reasons including 11% of them under the narcotics "Addiction" clause. The reason for this aberration is possibly connected to the judgment of "Claims Officers", and this still remains to be investigated.

Payment of allocation is made to the family [the couple] when both members are entitled. Table No.15 shows the breakdown of "claimants only" within the referrals, in correlation to the results of diagnosis and reasons for entitlement, together with inclusion of "Disability Allowance".

Table No.15: Breakdown of claimants referred to Centers in correlation to diagnosis results and - reason for entitlement during December 1993

Reason of Allocation	Total	Results of Diagnosis			
		Addicted	Not Addicted	Dropped Out	No Show
Tota lNumber	5,230	3,630	181	362	1,057
[%]	100	100	100	100	100
Addicted	30	39	11	16	7
Rehabilitation	7	7	4	8	7
Discharged Prisoner	1	1	-	2	2
Unemployable	2	2	12	1	2
Seeking Employment	2	1	4	2	2
Mother	1	-	2	-	1
Other	1	2	6	1	-
Not Entitled	52	44	54	66	73
Disability Allowance	4	4	7	4	6

Table No. 16 shows the breakdown according to diagnostic results and principal disability entitlement clause for 225 referrals to the Centers who received "Disability Allowance" after having applied or reinstituted claims in December 1993.

Table No.16: Breakdown of referrals receiving Disability Allocation for December 1993 According to diagnostic results and disability clause

Disability Clause	Diagnostic Results				
	Total	Addicted	Not Addicted	Dropped Out	No Show
Total Number	225	154	12	13	50
Percentage	100	100	100	100	100
Internal Diseases	13	11	17	23	17
Uro-Genic	1	1	-	-	2
Neurological	3	1	17	-	1
Psychotic	11	14	-	-	10
Psycho-Neurotic	47	44	50	62	50
Locomotoric	7	8	8	8	-
Ophthalmic	2	3	-	-	-
Epidermic	11	12	8	7	9
Mental Retardation	3	4	-	-	-
Other	2	2	-	-	-

More than half the recipients [58%[receive the Disability Allowance due to mental disturbances, some of which are acute. Although the link between drug abuse and mental disturbance is a known factor, it is difficult to establish which of these two factors affects the other more. Other prevalent disorders are;- Internal [mainly lungs with respiratory difficulties 13%], Epidermic[11%], Paralysis of the limbs[7%].

As mentioned, recipients of Income Support return for "Control" checkups after periods ranging from between one to three years. These "checkups" Permit the Institute to ascertain recipients' rights to continued allocations, to monitor their lives and establish if any demographic changes have taken place [i.e. such as in family status, number of children, address] as well as changes in "Life Style", drug consumption, referrals to therapy and criminal record etc..

Most of today's referrals to the Centers are veteran recipients of Income Support under the "Drug Addiction" clause. An additional section referred for "checkups" is those claimants previously referred but who failed to cooperate, dropped out or failed to complete the Diagnostic Procedure or failed to show up at all at the Centers.

Generally, when these claimants realize that their allocations were canceled due to their own failure to cooperate with the Institute, they exert their right to re-apply and are therefore again referred to Centers for diagnosis. In this chapter of the survey, we limited our study to referrals who were, at some previous stage, initially diagnosed at

the Centers as being "Addicted" and were subsequently recalled for "Checkups". Time elapse between initial diagnosis and subsequent "Checkup" is between one and two years, is conditional upon the Center's capacity to "Intake" additional referrals and decision by claims personnel at local branches to resend claimants for renewed diagnosis. To date, about one quarter of all the persons initially diagnosed as being "Addicted" have undergone this subsequent "Check Up". 10% have done this twice and 1% have done it for a third time.

At the start, we analyzed referrals according to the emanating branches, with each branch sending referrals in accordance to a preset order of priority. At a later stage, branches sent recipients of Income Support as the necessity arose. Table No.17 shows the breakdown of referrals for "Check Up" according to branch and resulting "Subsequent Diagnosis". This table shows a reduction in the number of "Addicted"

Table No.17: Breakdown of "Addicted" referred to Centers for "Check Up", according to Branch and result of "Subsequent Diagnosis" [%]

Branch	Total		Result of "Subsequent Diagnosis"			
	Number	[%]	Addicted	Not Addicted	Dropped Out	No Show
Total [%]	1,600	100	88	5	3	4
Tiberius	3	100	0	0	0	0
Tsefat	2	100	50	50	0	0
Nazareth	11	100	100	0	0	0
Naharya	51	100	80	12	6	2
Hadera	10	100	90	0	10	0
Netanya	40	100	97	3	0	0
Kfar Saba	16	100	81	6	13	0
Herzlia	25	100	88	4	4	4
Petah Tikva	60	100	81	12	2	5
Ramleh	160	100	88	6	3	3
Rehovot	58	100	91	3	2	4
Rishon le Zion	45	100	87	4	4	4
Ashdod	46	100	89	7	2	2
Kiryat Malachi	12	100	82	0	19	19
Kiryat Gat	22	100	86	0	10	4
Ashkelon	46	100	93	2	2	3
Tel Aviv	265	100	85	5	2	8
Jaffa	411	100	87	5	2	5
Holon	78	100	90	6	3	2
Ramat Gan	49	100	84	8	6	2
Or Yehuda	23	100	96	4	0	0
Beer Sheva	133	100	80	4	8	8
Ofakim	5	100	60	0	20	20
Netivot	3	100	100	0	0	0
Dimona	15	100	80	7	7	7
Arad	6	100	67	0	16	16

since only 88% were now classified as being entitled to allocations, 5% were now diagnosed as being "Not Addicted" [as against only 3% at the initial diagnosis], and 7% were denied allocation because of refusal to cooperate.

Analysis of demographic variables showed that there were no major changes in the family status of most of the diagnosed [Approx. 70%]--Of the married couples, 10% seperated, 3% divorced and three quarters of those "Check Up Diagnosed" declared no change in the number of children.

Drug Abuse

Our "drug using" population has been monitored for only the past three years during which time MEDICAT centers were closed and Methadone became hard to find in comparison with the two preceding years. It is therefore interesting to appraise changes in patterns of drug use by comparing urine tests showing only traces of Morphine, Codeine, Methadone and Valium. Answers given by the interviewed about drug usage have proved inaccurate and not dependable. Disparities were noted between declarations at initial interviews and declarations at the subsequent "Check Ups". It is an established fact that addicts tend to conceal or embellish information when they believe this is to be to their advantage. Morphine was detected in urine tests of 69% of the interviewed at their "Initial Diagnoses" and similar results [morphine presence in 71% of the tests] were detected at the subsequent "Check Ups". Codeine was detected in 67% of tests at "Initial Diagnoses" and in 69% of the subsequent "Check Ups". Methadone was detected in 77% of tests at "Initial Diagnosis" whereas only 27% were using this drug at the time of "Check Up"-- this is obviously due to closure of the MEDICAT stations. Valium traces were detected in 57% of the "Initial Diagnosis" tests of this population and in 52% of the "Check Up" tests.

Most of the "Addicted" use combinations of more than one drug at a time and their urine tests disclose various drugs, generally such drugs as are available on the open market at that specific time. Most commonly used are combinations comprising the following substances: Methadone, Morphine, Valium and Codeine. Two of these four, Methadone and Morphine are "Hard" drugs whereas the other two, Valium and Codeine are sedatives. Morphine is the substance derived by distilling Opium extracted from Poppy Flower seeds whereas Methadone is a synthetic laboratory derived drug substitute which is legally sold to addicts at a price very much lower than that of Morphine in order to distance users from crimes made necessary in order to pay for the purchase of drugs. Methadone was in the past sold in Israel by an organization called MEDICAT which had undertaken responsibility to sell and provide users with only daily Methadone doses and to ensure that recipients did not use drugs bought on the street. MEDICAT proved unable to fulfill this function satisfactorily and two years ago, the Ministry of Health canceled MEDICAT's operating license and started distributing Methadone on its' own by establishing three distribution centers in Tel Aviv, Jerusalem and Haifa. Quantities distributed now by these centers reach only about 10-20% of the volume distributed by MEDICAT conceivably because of users reticence to use official organized frameworks.

An important field to be analyzed is patterns for use of various drugs; whether addicts change the types of drugs used and quantities imbibed or whether they persist in the use of the same drugs. Addicts in Israel are known to be inconsistent with regard to the types of drug used by them and they generally consume the cheapest or such drugs as are available on the market at that specific time [Ben-Yehuda 1979]. As a result of the 'progress' made in methods of drug trafficking in the world, addicts in Europe and North America also vary in types of drug used, in accordance with the

Table No.18: Breakdown of Referrals according to test results of "Initial Diagnosis" and Subsequent "Check Up" [%]

Initial Diagnosis	Total Nos.	Subsequent Check Up Results in Percentages								
		Not Diagnosed	Morphine	Morphine + Codeine	Methadone	Met + Mor + Codeine	Valium	Val + Mor + Codeine	Valium + Met	Met + Mor + Cod. + Val
Total	1,076	20	2	18	3	5	1	32	5	14
Diagnosed	104	39	2	11	0	6	0	31	4	9
Morphine	17	29	18	35	0	0	0	18	0	0
Mor. + Cod.	56	13	0	43	0	4	0	39	0	2
Methadone	88	25	2	10	18	11	3	16	6	8
Met. + Mor. + Cod.	195	17	2	32	3	7	1	30	2	6
Valium	15	20	7	0	0	0	13	47	0	7
Val. + Mor. + Cod.	50	16	2	26	2	2	0	42	0	10
Val. + Met.	131	18	2	6	5	5	3	23	18	21
Mor. + Codeine	418	17	3	14	1	3	1	36	4	22

types offered on the market at the time. At present, there is still lack of information regarding causes connected with patterns of drug usage and the Simpson et al., survey of 1988 showed Socio-Psychological and environmental causes as being linked to changes in patterns of drug use. All told, with over half of the addicted, no significant changes occurred between the sixth and twelfth year of drug use.

Table No.18 shows combinations of the most common drugs used by the addicts at time of "Initial Diagnosis" and then, at subsequent "Check Up". Urine tests at "Initial Diagnoses" disclosed combinations of all four drugs together in 39% of the cases but those combinations were reduced to only 14% at "Check Ups". 10% were "Clean" at times of "Initial Diagnoses" whereas 20% were "Clean" at "Check Ups". All told, no significant changes occurred between combinations of drugs used at both these control periods, except for reduction in use of Methadone, probably resulting from the closure of MEDICAT.

Conclusion

Increase in the number of recipients of "Income Assurance" through the National Insurance Institute under the drug addiction clause is drawing the attention of the authorities, especially that of the National Insurance Institute which deals with this population. The principal aim in this field, as delineated by the objectives of this survey, is to provide an "In Depth" study of characteristics of this population, since these characteristics govern in great measure the potential of its members to extricate themselves from their predicament, attain greater economic independence, social standing and emotional well being, by channeling members into the appropriate therapeutic frameworks.

Claimants who arrived at the two Centers in Jaffa and Beer Sheva belonged to the low socio- economic class [38% were lacking elementary education and 27% had only eight years of schooling]. 21% were born in Afro-Asian countries and 70% were offspring of parents born in those countries. 10% were children of divorced parents [i.e. about three times the average number for the general population], 10% of their fathers had never been employed and 30% of their fathers were unskilled laborers. 34% of the claimants were unemployed, 42% had never done any military service and 57% had been imprisoned.

Even under the shadow of these most difficult conditions and the destructive influence of hard drugs used to escape from the realities of life, from responsibilities and from daily burdens; approximately half of the claimants have homes and families, endeavor to raise their children, hold the family unit together and cope with the economic, social and emotional dilemma created by their affliction.

It is important to point out that the addicted generally turn to the Institute for assistance only after about ten years of drug usage which has turned into addiction over the course of time. As a rule they make bombastic statements about willingness and readiness to undergo detoxification but simultaneously exhibit insecurity in their ability to do so after numerous past failures and repeated relapses.

The question always arises as to which of the addicted are capable of extricating themselves from their predicament, return anew to organized normative lives within and not on the fringes or outside of the community? Addicts show amazing capability to manipulate their therapists --denials, half truths, outright lies and even completely ignoring the therapist. These of course greatly impair correct understanding and the knowledge required in order to provide assistance and therapy for the addicted. This study of diagnostic results pertaining to claimants of "Income Suport" was prompted by the necessity to increase knowledge about the causes and background of drug addiction and the factors connected with potential to bring about detoxification and rehabilitation.

The National Insurance Institute is compelled by law to grant benefits to addicts addicted to hard drugs but does not wish to end its role by solely providing moneys

[which could be misused for the purchase of additional drugs]. With the establishment of the Diagnostic and Orientation Centers, the Institute considers its function to be that of orientation of the addicted, each according to his own specific requirements, to the appropriate therapeutic and rehabilitation frameworks to be established by the Welfare Authorities for this purpose. In order to forestall the birth of a new additional "Distress" generation bent on self- destruction, the Institute also considers itself obligated to propagate and encourage the use the large amount of data regarding drug addiction, which has amassed at the Diagnostic Centers and other units of the National Insurance Institute dealing with this curse.

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