National Insurance Institute Israel

Research and Planning Administration

Entitlement to Income Support Benefit Among Drug Addicts and Recommendations for their Rehabilitation

by
Tamar Haron

Jerusalem, August 1999

[Translated from the Hebrew original by W. Haron]

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Foreword

The Jaffa Diagnostic Center has been operating for ten years in assisting in the examination of the entitlement of drug addicted persons to receive income support benefits from the National Insurance Institute. During this period of time, a large reservoir of information has accumulated, regarding thousands of drug users unable to earn their own livelihood. These persons required income support from public assistance systems in order to cover their own and their families minimal needs. The National Insurance Institute encouraged the development of the Jaffa Diagnostic Center and the Beer Sheva Center, not only in order to identify and diagnose populations entitled to income support benefits, but also because these Centers can help in developing treatment frameworks for drug addicts.

During this period, a large number of care units for treatment of drug addicts (shortage of which had been sorely felt and duly emphasized in Diagnostic Center publications) were established. As a result, the Diagnostic Centers began providing recommendations for treatment of addicts and their orientation to care units. These recommendations have not always been implemented and because of historical reasons, there is no obligation to do so. In addition, the large amount of data which has accumulated on addicts has been insufficiently exploited. There is no doubt that proper use of the mese data can assist in developing useful research in this field and in improving the diagnostic systems, management and policy for treatment of addicts.

This publication, which is the third and (for the time being) last of the series regarding the activities of the Diagnostic Center, has been prepared and written by Mrs. Tamar Haron, expert researcher in the "Long Term Benefits Dept. of the National Insurance Institute headed by Mrs. Brenda Morgenstin. We are most appreciative of the great efforts invested by Mrs. Haron in researchng this subject over a long period of time and

thank her for the establishment of the data bank, analysis of findings and their presentation.

We also wish to thank the team at the Jaffa Center, especially Dr. Eli Elbaz the Center's director, for their cooperation, assistance and professional guidance in collecting and sorting the data; the staff at the Anti Drug Authority of Israel - the Head Scientist, Dr. Rachel Bar- Hamburger and the librarian, Ms. Yaffa Tsubery for their professional assistance, and Mr.Alexander Gealia of the Research and Planning Administration of the National Insurance Institute who monitored and guided the data processing as well as Mss. Gila Mograby and Dana Rahamim the data processing team under the tutelage of Ms. Rivka Wartman for their dedicated and precise work in assembling and concentrating the data. We also thank Ms. Irah Kahanaman, and Ms.Sarah Gargi for editing and laying-out this publication and last, but not least, Mss. Orly Abutbul and Nira Amir for their excellent typing.

Shlomo Cohen

Deputy Director General
Research and Planning

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Introduction

Eight years have now elapsed since the enactment of the National Insurance Institute regulation entitling persons unable to work because of drug addiction, to receive "Income support benefit" [Income Support Regulations, Amendment 1. 2. 90]. This group of persons onstitutes only 5% of the total population receiving income support benefits but it forms the hard core of dependents remaining within the support system for over three years, while the average dependency period is of two and a half years only [B. Morgenstin, T. Haron, A. Zifkin, 1997].

Since June 1988, when the Diagnostic and Orientation Center in Jaffa commenced diagnosing claimants of income support allowances due to drug addiction [Haron -Surveys No.71, 1990 and No.116, 1994] and until today, over 8,000 men and women have been referred to this Center for diagnosis and appraisal.

Ongoing developments in the fields of diagnosis, classification, orientation, therapy and rehabilitation of the addicted, demand a reexamination of the appraisal and orientation procedures for appropriate handling of claimants of income support benefits due to drug addiction, as well as a reexamination of the dependency period within the system, with regard to update appraisal of policy and regulations of the system.

The determination of policy and the establishment of a system require: "Accumulation of information on actual developments in matters of drug use, data on necessary combat requirements and so forth". This statement was made by the Inter-Ministerial Committee for Comprehensive Action on Drug Addiction, headed by Professor Mann -1983 (Amram 1997). Due to historical and organizational reasons, no system providing comprehensive attention to all stages of diagnosis, therapy and rehabilitation, has yet been established. The system set up by the National Insurance Institute (N.I.I.) deals solely with diagnosis and orientation whereas treatment remains the responsibility of the health and welfare systems. Until now, The N.I.I., has carried out two surveys regarding the activity of the Diagnostic and Orientation Centers, and the present report compares current findings with those of these previous surveys. This report also makes reference to the possibility of changes within the existing work framework and examines the chances for rehabilitation of addicts, based upon professional opinion as well as the appraisal of the addicts themselves.

Appraisal and Orientation for Detoxification and Rehabilitation

General Background

The prevailing opinion in professional circles is that detoxification is doomed to failure unless it is accompanied by emotional, social and mainly employment rehabilitation and that otherwise, the addict will return to the use of drugs. Even when the addict begins to earn his own living, he is most likely to be deep in debt, his family destroyed, holds himself in low self esteem and therefore any crisis, big or small, may revert him to the use of drugs.

A number of years ago, the N.I.I. approached social security services abroad in order to obtain information on authorized benefits to which addicts were entitled in substitution for regular income. Responses received from institutions in various countries (Canada, Finland, Britain, U.S.A., Germany, Austria etc.) indicated that in general, there were no central bodies which attended to proper care and sustenance of addicts who were unable to attend to their own needs. There exist mainly dispersed care units at which addicts arrive after being guided by friends, relatives or other sources. It is to be noted, however, that in 1994, the European Community States established in Lisbon, Portugal the "Monitoring Center for Drugs and Drug Addiction" in order improve collection and spreading of information regarding prevention and care systems for combating drugs within the European Community (EMCDDA 1995).

Addicts do not always receive the therapy they require. Professional literature regarding application of therapy concentrates mostly on such subjects as type of drug in use, geographical proximity or economic feasibility and less upon adaptation of appropriate therapy to suit the characteristics and socio-cultural background of the addict (A. Lowenthal, A. Michael, H. Chasm, 1993; R. Ber-Hamburger, S. Levitt, A. Ben-Levy,1997; M. Betzner, A.E. Reiney, J. Lexenberg, M.G. Christensen, 1996). In Israel, the type of drug in use is governed by market conditions and addicts' preferences. Geographical considerations are not of importance and it is often advisable to distance the addict from his natural surroundings. Success of detoxification and rehabilitation depend mainly on the addict's motivation and persistence in therapy, and these are linked to the socio-demographic factors, personal history and education of which the addict at the time of diagnosis.

Entitlement Procedure for Benefit from the National Insurance Institute

Income support benefit is paid to claimants who are unemployable as a result of addiction to drugs or alcohol. This benefit is allocated to four different groups:

1. Addicts addicted to hard drugs - clause no.17.
2. Addicts to hard drugs undergoing detoxification and rehabilitation - clause no.27.
3. Addicted alcoholics - clause no.18.
4. Addicted alcoholics undergoing detoxification and rehabilitation - clause no.28.

Claimants requesting income support benefit due to addiction to hard drugs (hereinafter "claimants"), who conform to the criteria set for entitlement and "level of income" examination, and who do not participate in any approved detoxification and rehabilitation framework, are referred to Diagnostic Centers for verification of their status in accordance with income support Service regulations (Amendment Clause 1.6.4.dated March 1995, to the Guidelines and Regulations of the income support Service.). Apart from the Haifa and Krayot branches, which refer claimants to the Geffen Home for victims of drug addiction in Haifa, the National Insurance Institute now refers all claimants to the Drug Diagnostic and Orientation Center in Jaffa. In the past, the Beer Sheva branch would refer claimants to this city's S.L.A. Therapy and Rehabilitation Center for diagnosis, but now, this diagnostic facility has been closed and claimants who are unwilling to participate in one of the local detoxification frameworks operating in Beer Sheva are referred to the Jaffa Center.

The diagnostic procedure at the Jaffa Center comprises three urine tests, medical and psychiatric examinations, and interview(s) by a psychologist or social worker. Cases in which claimants refuse to cooperate in diagnosis or drop out before conclusion of this diagnostic procedure are classified as "non cooperative" and their applications for income support benefit are denied. Claimants who persevere in attending diagnosis and are subsequently classified as "addicted" undergo appraisal in order to determine whether they are capable of entering detoxification and rehabilitation frameworks, and what their chances for success are. When a claimant has detoxification and rehabilitation potential, he receives a recommendation referring him to the therapy unit appropriate for his needs and capacities. He then returns to his referring branch with this recommendation and the branch establishes his entitlement by cause of drug addiction (Clause 17). Implementation of the recommendation depends on the claimant's good will and the amount of pressure exerted upon him by the staff of the branch.

The Haifa and until recently, the Beer Sheva diagnostic and rehabilitation centers, referred detoxification potentials to their own internal rehabilitation frameworks. These addicts, like those cared for by the Ministry of Social Affairs or of the Ministry of Health, receive their income support benefit under the detoxification and rehabilitation section (clause 27), while the care unit reports monthly to the branch on continuation of therapy. This benefit, which is granted as a result of rehabilitation, is limited to one year and extension for another one or two years is possible only if approved by the proper supervisors. Should the beneficiary cease to cooperate with the care unit, the benefit is annulled. Addicts are classified as "addicted' (Clause 17) and granted benefit for a full year only in cases of extreme hardship which do not permit the addict to enter any therapy framework.

The Jaffa Center, established later than those in Haifa and Beer Sheva, deals solely with diagnosis and orientation. In its early years this Center refrained from performing appraisals of addicts' detoxification and rehabilitation potentials and from recommending therapy frameworks, due to lack of time and proper tools for in depth studies. Due to the fact that claimants referred to the Center came mainly from distress populations lacking the resources and energy to attempt detoxification and rehabilitation, as well as to the shortage of care units to which the addicts could be recommended, most claimants who completed diagnosis were classified as being unredeemably "Addicted to Hard Drugs" under Clause 17. income support benefit is canceled if claimants fail to appear, to terminate the diagnostic procedure or prove to be "Not Addicted".

In contrast to benefits payable under the Detoxification and Rehabilitation clause, entitlement under the Addiction to Hard Drugs clause are not limited in time and therefore, in order to reconfirm addicts' status, it is customary to send them for updated diagnosis every year or two. This renewed diagnosis enables collection of follow-up data such as socio-demographic changes, changes in the types of drugs used, and history of attempted detoxification and rehabilitation. Again, as with the first initial diagnostic procedure, should the addict fail to appear or to complete this renewed diagnostic procedure or should he be found "Not Addicted", his benefit is immediately canceled. So far, a substantial quantity of data including years of follow-up material has been collected at the Center regarding those "Addicted to Hard Drugs" but insufficient data has so far been collected regarding claimants are entitled to income support benefit due to "Detoxification and Rehabilitation" clause.

Present Appraisal and Orientation Within the Framework of the National Insurance Institute

Claimants of income support benefit due to addiction undergo extensive interviews at the Diagnostic Centers in order to confirm their status as "Addicted". They have to take urine tests the results of which are the main factor in identifying addiction. Since it is relatively easy to achieve the presence of drug traces in urine in "Non Addicted" cases as well, it becomes necessary to examine the claimant's history and demographic background in order to corroborate these with profile characteristics identified as belonging to the "Addicted" group. Should there be suspicion of attempted sham by the claimant (by injection of certain quantities of drugs into his urine - the results of which show up in the tests), the claimant is requested by the Diagnostic Center to undergo additional urine tests, over and above the three compulsory ones. Claimants whose urine tests show few drug traces or seem to be bogus from their "life story", are classified as "Non Addicted" and their claims are rejected.

In cases where claimants have commenced and show motivation in becoming "clean" but still need the income support benefit in order to ensure their sustenance, they are classified as "Non Addicted" but with recommendation to continue their benefit provided that they enter a detoxification framework. At the diagnostic interview, the seriousness of the claimant's problem and the means at his disposal to effect detoxification are appraised, and then the appropriate framework is recommended. So far, data obtained at this interview have not been sufficiently exploited for therapy and rehabilitation purposes and this leads to disappointment of both interviewer and claimant.

Therapists have two different prevailing attitudes regarding the compulsory placement of addicts into care frameworks against their will: Those in favor of making the allocation of income support Benefit or other compensation dependent upon claimants' cooperation and thus enforcing therapy by threat of allocation annulment in cases of non-cooperation; and those who consider coercive therapy, without patient motivation and against their will, to be ineffective as well as a negation of rights. Most requests for assistance take place when addicts run out of material and emotional resources (Shoffman & Co., 1991) This is the predicament in which most addicts find themselves in when they request income support benefit, and this is the opportune time to refer them to therapy. There are the proponents of both attitudes at the N.I.I. and this creates a lack of equality in relating to the claims presented for income support benefit by virtue of addiction.

Mainly due to the increase in number of drug care units operated by the Ministry of Labor & Social Affairs, there have been for the past three years an adequate number of available addresses for referral of addicts to detoxification. This fact, together with the potential of addicts to endeavor detoxification, has prompted the interviewers at the Jaffa Center to make appraisals and recommendations for continuation of treatment together with their diagnoses. As yet, in most cases, adherence to the recommendations is dependent on the policy or initiative of the claims personnel at the branch. There is no obligation to execute recommendations and there is no follow-up after referral to the care units. Entrance into the therapeutic framework is dependent upon the addict's good will and he continues to receive benefits for one to two years without further monitoring or examination of his condition.

Since there is no compelling of addicts to keep regular contact with the Institute, it is possible, to their detriment, that this causes their fallout from therapeutic frameworks. Due to lack of monitoring and follow-up, there now exist numerous additional problems: many questions remain unanswered because there is no way of knowing why specific addicts do not show up at the Center for diagnosis, why others drop out before conclusion of the process and what happens to these after rejection of their claims for benefits. We do not know if addicts attempt to carry out recommendations and if so, what happens to them during that time, and should they not attempt to do so - why not. We do not know whether minor or more substantial assistance would have helped them to enter and remain inside therapy frameworks, nor what happens to them and their families during the year up to the time when they must again present themselves at the branch in order to renew their claim.

Not all those classified as "Addicted" receive benefits over explained periods of time: some leave the country or receive benefits under different criteria such as "seeking employment" or "unemployable", others are imprisoned or have passed away. We know of many addicts who, after attempting detoxification in other frameworks (such as receiving benefits under the "rehabilitation" clause) return and receive benefits under the "addiction" clause because they relapsed into the use of drugs. In the ensuing processing of data, we shall endeavor to follow the "addicted"s trail within our income support benefit system.

Differences rooted in the historical background of the establishment of care units create reporting divergencies in various branches, between entitlement under the "Addicted" and the "Rehabilitaion" clauses, thereby hampering the unision of report and handling required by the N.I.I. for proper allocation of entitlement and follow-up. It is in fact possible that there are beneficiaries who were diagnosed in Jaffa and not compelled to enter into approved care frameworks, therefore resulting in the fact that no one knows what happens to them for a year or two, hence delaying their detoxification

and rehabilitation. In addition to this, even if they do agree to enter into specified care frameworks, lack of monitoring and follow-up on results of this care, whether successful or drop-out, hamper attempts at integration into employment or entrance into alternate frameworks which may be better suited to their condition and characteristics. Lack of professional appraisal and follow-up on the work done at the diagnostic centers, damages first and foremost, the amelioration and efficiency of diagnosis and the chances of addicts who have successfully concluded partial stages in detoxification but have dropped-out because of maladjustment without being given timely referral to alternate or more appropriate frameworks. There is increasing danger that these addicts will return to the use of hard drugs due to lack of supportive frameworks to encourage their integration into the community and employment.

Framework of this Survey

Objectives

This is the third survey to be carried out on the function of the Diagnostic and Orientation Centers of the N.I.I., and continues the examination of trends and orientation of characteristics of the population claiming income support benefit due to addiction. In this survey, we endeavor to appraise this population's strength, its motivation and its potential for detoxification and rehabilitation. The survey displays historic and socio-demographic factors combined with patterns of drug abuse and therapy frameworks, as well as estimations of the interviewers and self-appraisal by the addicted.

The survey also endeavors to examine disparities between these factors and recommendations made by the Centers as well as connection to the beneficiaries' routes within the payment and care systems.

The Survey Population

This survey includes claimants of income support benefit who have undergone diagnosis at the Centers in Jaffa or Beer Sheva by virtue of being addicted to hard drugs, and apart from one examination, does not include persons addicted to alcohol.

Differentiation is made between the following groups:

1. Claimants: All persons who requested income support benefit from the N.I.I. by virtue of being addicted to the use of hard drugs.
2. Referrals: All claimants found to be entitled under the "Income Test" and Civil Rights tests and who were referred to diagnosis to confirm their addiction.
3. Diagnosed: All referrals who arrived at the Diagnostic Centers and underwent diagnosis, even if they dropped out during the process and failed to complete it.
4. Addicted: All referrals who arrived at the Diagnostic Centers and were classified as "Addicted".

Indices

The variables analyzed were those accumulated within the system such as the socio-demographic factors, appraisal of the addict and the recommendations made for him. The data were gleaned from the first questionnaire filled in at the initial interview with the claimant at the time of diagnosis. We also analyzed the track followed within the system by entitled persons. These data were taken from current data bank files of the income support Service.

1) The socio-demographic variables analyzed were:

1	Gender
2	Age
3	Education
4	Family status
5	Relations within the family of origin
6	Relations within the family nucleus
7	Military service
8	Work experience
9	Characteristics of drugs use
10	History of treatments

2) Appraisal of the addict is carried out during the initial interview on the level of two variables:

1. Willingness to effect detoxification, in terms of motivation and amount of interest expressed by the addict.
2. Strength to effect detoxification, in terms of emotional resources to persist in the process.

These appraisals were made by the addicts themselves as well as by the professionals (psychologists or social workers) who interviewed them.

In addition to the above, the diagnoser makes a basic appraisal of character in the following fields:

1. Cognizance (variables such as intelligence, thought, memory, awareness of time and place etc.);
2. Effect (variables such as veracity of emotions and their suitability, aggressiveness, anxiety, frustration brink, etc.);
3. Motivation (willingness and strength to effect change);
4. Various personality traits (maturity/ childishness, cooperation/negativism);
5. Rehabilitation potential (psycho-social treatment for rehabilitation).

3) Diagnoser's recommendations made at the end of the interview for continuation of treatment based on data collected during the interview.

4) The track followed by entitled addicted persons defined in terms of three possible situations:

1. The addict is entitled to receive income support and has never been within any rehabilitation framework.
2. The entitled addict has participated in a rehabilitation framework but has come back due to addiction.
3. The entitled addict was/is within a rehabilitation framework and has not come back to receive income support due to addiction.

Findings

Characteristics of the System

Differences in methods of diagnosis and appraisal created differences in the rates of entitlement granted by various branches of the N.I.I., and this comes to light in the tables hereunder which show the breakdown of recipients of income support benefit according to branch and cause of entitlement.

Tables Nos. 1 and 2 show the breakdown of recipients of income support benefit caused by addiction in October 1994 and October 1996. On the whole one sees an increase from 3,895 to 4,198 (i.e. 7..9%) in the number recipients of benefit by cause of addiction, whereas the rate of entitlements by cause of addiction to hard drugs fell from 61% to 57%. On the other hand, the rate of entitlement under the detoxification and rehabilitation clause rose by 372 persons (i.e. from 25% to 32%). It must be noted that the increase in the numbers of recipients of benefit was 17% (mainly due to new immigrants, most of whom are unemployable due to age and low income), thereby reducing the percentage of addicts receiving income support benefit from 5.5% to 5%.

Table No.1; Total Recipients of Income Supp. In Oct. 1994, by Cause of Addiction . According to Branch and Entitlement Clause - (in %)

Branch	Recipients		%	Addicted to		Under Rehabilitation from	
	Total	Addicted		Drugs	Alcohol	Drugs	Alcohol
Total	71,260	3,895	100	2,383	2,383	978	105
Percentages	100	5.5	100	61	11	25	3
Tiberius	2,301	73	100	40	44	14	3
Affula	1,819	80	100	49	15	31	5
Nazareth	4,813	126	100	61	24	14	1
Naharya	4,701	181	100	80	2	13	6
Krayot	3,089	34	100	3	9	79	9
Haifa	4,285	82	100	28	9	51	12
Hadera	2,783	93	100	46	3	47	3
Nethanya	3,558	129	100	71	8	20	1
Kfar Sava	1,451	86	100	84	5	8	3
Petah Tikva	2,020	110	100	70	9	20	1
Ramle	2,590	282	100	77	6	15	1
Rehovoth*	10,334	569	100	50	32	17	2
Rishon	1,248	96	100	72	10	17	1
Tel Aviv	2,502	310	100	73	4	21	2
Jaffa	5,508	720	100	86	4	10	0
Ramat Gan	2,581	188	100	89	24	9	1
Jerusalem	4,892	277	100	20	4	68	8
Beer Sheva	10,785	459	100	39	12	52	4

* Includes Ashdod, Ashkelon, Kiryat Gat, Kiryat Malachi and Sderot branches.

Table No.2: Total Recipients of Income Support Benefit In Oct. 1996 by Cause of Addiction According to Branch and Entitlement Clause - (in %)

Branch	Recipients		%	Addicted to		Under Rehabilitation	
	Total	Addicted		Drugs	Alcohol	Drugs	Alcohol
Total No.	83,187	4,198	100	2390	332	1,350	126
Total Percent	100	100	100	57	8	32	3
Tiberius	2,797	62	100	29	16	48	6
Afula	2,003	57	100	51	9	37	4
Nazareth	6,114	197	100	61	4	23	12
Nahariya	5,017	234	100	66	4	26	4
Krayot	3,548	45	100	4	4	84	7
Haifa	5,218	53	100	4	9	77	9
Hadera	3,412	118	100	50	3	44	3
Nethanya	4,148	162	100	61	5	30	4
Kefar Saba	1,555	94	100	80	3	15	2
Petah Tikva	2,332	126	100	67	6	25	2
Ramleh	2,862	302	100	77	4	18	1
Rehovoth	12,565	649	100	52	22	24	2
Rishon	1,387	104	100	62	8	29	2
Tel Aviv	2,778	336	100	70	2	27	1
Jaffa	6,272	744	100	79	2	18	1
Ramat Gan	2,649	168	100	76	2	21	1
Jerusalem	5,652	335	100	15	6	73	6
Beer Sheva	12,878	412	100	28	14	54	4

Tables Nos. 1 and 2 give expression to the difference between the Haifa, Krayot and Beer Sheva branches, which send claimants to rehabilitation centers for diagnosis and the other branches which send claimants solely to the Diagnostic Center in Jaffa. This difference is expressed in the disparity of proportions between recipients of income support benefit by cause of addiction as against recipients by cause of rehabilitation: In October 1994, of the 82 "entitled" persons at the Haifa branch, 28% received entitlement by cause of addiction. At the "Krayot" branch this was the case for only 3% out of the 34 entitled. In October 1996 the percentage of addicted went down to 4% in Haifa. This proportion is low within the small number of recipients classified as "addicted". This is a low proportion out of the general number of "addicted". The proportions of entitlement uder "rehabilitation" were 51% in Haifa and 79% in the "Krayot" branch. The Ramleh and Jaffa branches showed high proportions of "addicted"- 77% and 86% respectively- with only 15% and 10% classified under "rehabilitation". The Jerusalem branch is a special case due to the fact that it was connected with a diagnostic and

rehabilitation center for a number of years and addicts referred by it received income support benefit under the "rehabilitation" clause. This explains the low proportion (19%) entitled by cause of "addiction" in October 1994, and its grading between Haifa and Krayot and the other branches. In October 1996, there was an increase in the proportion under "rehabilitation" due to the increase in the number of available detoxification and rehabilitation units. Like most branches, the Jerusalem branch has been sending claimants to the Diagnostic and Orientation Center in Jaffa since December 1989.

Table No. 3: Sample of "Disabled" who should have been diagnosed "Addicted" by Branch

Branch	Number of Disabled in the Sample	Percentage of Addicted in the Sample
Total Number	1,600	8.7
Tiberius	63	13.4
Afula	66	9.7
Nazareth	91	6 9
Nahariya	68	11.5
Krayot	82	15.6
Haifa	167	19 2
Hadera	71	2.7
Nethanya	71	5.8
Kfar Sava	78	1.1
Petah Tikva	64	2.8
Ramleh	51	4.8
Rehovoth	161	6.9
Tel Aviv	106	11.7
Jaffa	188	6.6
Ramat Gan	92	4.1
Jerusalem	101	3.7
Beer Sheva	80	9.1

* Disabled persons receiving income support benefit and addicted to drugs or alcohol
Internal survey, June 1996, National Insurance Institute.

Table No. 3 tangiblizes the high rate of addicted amongst recipients of "Disability Benefit" at the Haifa and Krayot branches (16% and 19% respectively) in comparison with the national average of approximately 9%. These branches are characterized by the especially low percentage of classified "Addicts" receiving income support benefit. It is difficult to explain the reason for this occurrence other than due to pressure exerted by claimants (upon certain branches) to receive "Disability Benefit" after they have been rejected by the income support Service because of "Failure to Cooperate" with the Haifa Center for Drug Addiction. In other words, at these branches, unless the claimant enters into a treatment framework, it is harder for him to obtain income support benefit by virtue of addiction and he therefore

turns to Disability Insurance for assistance. It would seem that factual conditions create compensatory solutions, when one avenue is sealed off, another is opened.

Not all the claimants referred to diagnostic centers and classified as being "addicted" receive income support benefit over protracted periods of time. Some of them leave the country or begin receiving income support under such clauses as "seeking employment" or "unemployable"; others are imprisoned or just pass away. We know that many addicts who have attempted detoxification within recognized frameworks and have received the Benefit under the" rehabilitation" clause, have once again received the Benefit under the "addiction" clause when they returned to drug usage. In the following analyses, we shall endeavor to trace the "addicts" path within the "Income support Administration".

Out of 4,263 cases receiving income support benefit due to "addiction" for at least one month during 1992, 2,374 (i.e. 55.7% of the cases) remained as recipients under the following clauses, in 1996:

Table No. 4: Percentages of "Addicted" Recipients of income support benefit under Various Different Clauses

Clause	Numbers	Percentage
Addicted	1,450	52.9
Rehabilitation	480	20.2
Unemployable	287	12.1
Released Prisoner	83	3.5
Seeking Employment	74	3.1
Low Wage "Protected Worker"	62	2.6
Employment Suitability Diagnosis	26	1.1
Mother	26	1.1
Old Age	19	0.8
Illness	19	0.8
Prisoner Performing Outside Work	14	0.6
Alcoholism	7	0.3
Rehabilitation From Alcoholism	7	0.3
Professional Training	5	0.2
Pregnancy	5	0.2

During 1992, only 274 additional men and women entered the income support System under the "Addiction" clause and 46 of these (i.e. 16.8%) remained there until 96, under the following clauses:

Table No.5: Percentages of recipients of income support benefit under various clauses in 1996, who entered the system in 1992 under the "Addiction" clause

Clause	Numbers	Percentage
Addiction	13	28.3
Rehabilitation	23	50.0
Low Wage "Protected Worker"	3	6.5
Prisoner Performing Outside Work	2	4.3
Illness	2	4.3
Seeking Employment	1	2.2
Released Prisoner	1	2.2
Pregnancy	1	2.2

Personal and Social Characteristics

Since the Centers were established in June 1987 and up to the end of 1997, more than 8,000 men and women have been referred to the Centers for diagnosis. 65% of those referred were diagnosed "Addicted" and received income support benefit under the "Addiction" clause.

26% of those referred never showed up for diagnosis and another 6% dropped out before completing the diagnostic procedure, while the remaining 3% were diagnosed "Not Addicted" - all these categories were not granted income support benefit. Table No. 6 shows the breakdown of referrals to centers according to branch and result of diagnosis.

Table No. 6: Diagnosis results of claimants referred to centers (from 6/88 to 9/97) according to Branch

Branch	Total	%	Addicted	Not Add.	Dropped Out	No Show
Total No.	8,173	100	65	3	6	26
Tiberius	142	100	44	2	8	46
Afula	83	100	39	4	5	53
Nazareth	492	100	62	3	7	28
Hadera	174	100	66	2	5	26
Nethanya	361	100	62	5	6	27
Kefar Saba	269	100	64	4	7	25
Petrah Tikva	330	100	69	4	5	23
Ramleh	694	100	68	3	7	22
Rehovoth	1,221	100	642	2	6	27
Rishon	70	100	64	4	6	26
Tel Aviv	779	100	69	3	4	23
Jaffa	1,829	100	74	3	5	18
Ramat Gan	391	100	70	4	5	20
Jerusalem	361	100	46*	14	6	34
Beer Sheva	913	100	57	2	6	36

- See notes to Table No.1.

91% of the referrals to the diagnostic centers are men whereas only 9% are women. The low incidence of women amongst the addicted is a known factor, and the differential between the sexes varies according to the type of drug used. This differential varies from 1 for each 2 up to 1 for each 6. When we refer to recipients of income support benefit, the incidence of women is especially low since women who are mothers of children aged 6 or below are entitled to receive benefit without having to undergo "employability" or "drug addiction" diagnoses.

Most of the persons diagnosed had received 10 years of schooling or less, whereas 27% had not even received Primary School education.

The breakdown of the "diagnosed" according to gender and education is displayed in Table No. 7. Women have a higher level of education: The proportion of those with 9 or more years of education is higher amongst women than amongst men. 53% of the women completed 9 years of schooling as against only 38% amongst the men, 25% of the women completed 11 years of schooling as against only 13% among the men.

Table No. 7: Education of the "Diagnosed", according to gender (percentages)

Gender/Education	Total		Number of years of education					
	Number	Percent	Less than 8	8	9 to 10	11 to 12	13	No Dat
Total	6,03	100	27	30	25	13	1	4
Men	5,51	100	28	31	25	12	1	4
Women	51	100	17	26	28	22	3	4

Study of the age breakdown of the diagnosed reveals that the 30-34 is the largest age group. This factor is constant and is in accordance with the finding that the addicted turn to the N.I.I. after an average of ten years of drug use (Haron,T. 1994). Most of the diagnosed had families: 43% were married and 26% were either separated or divorced. This incidence of rate is higher amongst the recipients of income support benefit than amongst the addict population as a whole, due to the necessity of their having to turn to the Institute in order to support their families, albeit at a minimal level, by using the income support benefit or the Alimony Allocations of the N.I.I. It is also clear that there is a higher rate of singles within the lower age groups, more were married within the higher age groups and even more were separated, divorced or widowed. Table No. 8 gives the breakdown of the diagnosed according to age and family status.

Table No. 8: Ages of the "Diagnosed" according to family status (percentages)

	Total		Ages					
Familly status	Number	%	18-24	25-29	30-34	35-39	40+	No Data
Total	6,237	100	7	22	30	22	15	4
Singles	1,664	100	16	34	29	13	7	0
Married	2,670	100	5	19	33	25	18	0
Separated	402	100	4	17	36	22	20	1
Divorced	1,221	100	2	15	30	30	22	1
Widow/er	32	100	0	3	22	41	34	0
No Data	248	100	0	2	2	4	4	85

In this survey, 73% i.e. most of the diagnosed, were Israel born, 16% were born in North Africa and approximately 5% were born in Eastern Europe. Over 53% of the addicted were born to parents of North African origin, which indicates that there is a continued reduction in the proportion of those emanating from North Africa (previous surveys (Haron, T. 1990) placed North African born at 86% and (Haron, T. 1994) at 70%}. 16% of the diagnosed were born to Israel-born parents and 5% to parents of Eastern European origin.

(Haron, T. 1994) at 70%}. 16% of the diagnosed were born to Israel-born parents and 5% to parents of Eastern European origin.

The diagnosed come mainly from large families with many children: More than 70% are from families with 5 or more children. One may deduce from this that most of the diagnosed emanate from underprivileged sections of the population or have only entered the income support system after all their financial resources were exhausted.

The proportion of Moslems referred for diagnosis stands at 17% and is slightly higher than their proportion within the general population of Israel (14.6%). The proportion of Christians referred stands at 1% as against 0.3% within the general population, whereas it is only 0.3% amongst the Druze who form 2% of the general population. One must bear in mind, however, that we are not in possession of data regarding claimants referred to the Haifa and Krayiot branches, areas in which many Moslems, Christians and Druze live.

Service in the Israel Defense Forces and employment determine, to a great extent, the individual's integration into Israeli society. Enlistment into the army means entrance into the adult world and being accepted by it whereas employment means - ability to earn one's keep and determines independence, standing and level of success, all of which are factors closely linked to the addict's detoxification and rehabilitation potential.

Approximately half the diagnosed enlisted into the army but less than half of these completed their military service as required. 66% of the diagnosed had worked at some form of employment prior to receiving income support benefit: 21% of the diagnosed declared that they had a profession but only 40% out of these had worked at it for more than two years. 37% of the diagnosed stated that they did unskilled work, 32% did odd jobs, 7% were independent (mainly stall owners in the market) and 2% declared that they were white collar workers.

Analysis of employment history, family status and military service created a breakdown of eight groups.

Table No.9: Family status, employment and military service history (percentages)

Employment	Total %	Were Married		Never Married	
		Enlisted	Didn't Enlist	Enlisted	Didn't
Had worked	86	33	30	13	10
Hadn't worked	16	5	5	3	3

Most of the diagnosed (86%) had worked at some time. The largest group within these (33%) had worked, married and enlisted, in second place (30%) came diagnosed who had worked, married but not enlisted. One can note that there is a link mainly between family status and employment as well as a minor connection between military service and employment.

Start Age and Patterns of Drug Use.

Two major characteristics of the addicted are start age and patterns of drug abuse. Most of the addicted who were diagnosed within the framework of this survey commenced using hashish (Canabis) at a relatively early stage: 80% prior to the age of 20 and half of these prior to the age of 16. From this relatively "light" drug they moved on to the use of "hard" drugs. Almost all the addicted (90%) had at some stage in their lives used "Persian Coke", which is heroine mixed with other substances. 36% of the addicted commenced using this drug before the age of twenty. 40% used or are continuing to use heroine and 15% started using it before the age of 21.

Table No. 10 shows the breakdown of "Start Age" of the diagnosed for use of hashish, methadone, persian coke and crystal (Cocaine).

Table No. 10: Types of drug used by the diagnosed, by "Start Age" (%)

Start Age	Total	Hashsish	Methado	Persian	Crystal
Total	5,313	4,007	3,563	4,597	798
Up to 15	37	41	5	3	5
16-20	42	45	24	24	31
21-25	12	9	27	32	33
26-30	5	3	23	24	19
31+	3	1	19	16	8
Unknown	-	2	2	11	4

Patterns of drug usage are most important due to the effect that the form of consumption has on control

and safety of the body as well as on the increase in the level of addiction. The slower the ingestion of the substance into the body (as is the case orally, by mouth), the more the control the addict has over his drug taking and the more slowly and less drastically the drug acts. Heroine has relatively no effect when taken orally and cocaine has no effect when smoked . On the other hand, when a drug such as crystal is inhaled by smoking, and even more so when injected, it penetrates immediately into the blood system and the respiratory passages and then there is no turning back for the addict. This form of ingestion bypasses the body's natural immunization protection and creates health hazards. Smoked drugs cause respiratory difficulties and "sniffing" (ingestion of the drug by inhaling) damage the mucus membrane of the nose. The greatest danger comes from the use of unsterilized hypodermic needles which pass from hand to hand, thereby infecting users mainly with aids and jaundice (Type "B" Hepatitis). It is to be noted, however, that although there is increased use in Israel of injected drugs, the incidence of aids sufferers and carriers has not increased - conceivably due to the low basic inception of aids in Israel. On the other hand, there has been increase in the incidence of jaundice (Type "B" Hepatitis). Table No. 11 displays the methods of use for the two main types of drug.

Table No. 11: Usage patterns for "Coke" and "Crystal", according drug type, (%).

Drug	No.	Smoking	Swallowing	Inhaling	Injecting	Sniffing	Combined	Unanswered
Persian Coke	4,597	23	1	5	11	54	3	3
Crystal	798	7	1	60	14	8	3	7

Analysis of the breakdown of "Start Age" according to patterns of usage showed that the percentage of addicts injecting the drugs became higher in conjunction to the lowering of the "Start Age". The total of those injecting "Persian Coke" was 11%, whereas the percentage for those who had started using this drug after the age of twenty was 9-10% as against 13% for those who had started using this drug at the ages of 16-20. This rate continues to increase to 17% for addicts who commenced usage before the age of 15 and one can well imagine the pitiful physical and mental condition of this group.

Treatments

More than 2,800 persons referred for diagnosis declared that they had undergone various detoxification treatments, including medicinal, psychiatric, self-care, psycho-social care and the taking of

Approximately half of these declared that they had undergone only one type of treatment, 567 two types, 223 three types and another 50 had undergone four different types of treatment.

Examination of the periods of time during which the addict remained "clean" after undergoing treatment showed that approximately two thirds relapsed to drug use after short periods of time not exceeding six months and that only 6%, according to their statements, remained "clean for over two years (Table No.12). One must bear in mind that this datum was obtained from the addicts' statements during diagnosis without confirmation from independent sources and therefore remains to be corroborated. (for example, statements like "I've been clean for over four years").

Table No.12 shows that addicts who were treated with methadone (by regular supply of the synthetic drug "Methadone" in substitution for "Hard Street Drugs") remained "clean" from "street drugs" for longer periods of time. One must bear in mind that treatment by methadone is not really detoxification, but rather an attempt to prevent addicts' deterioration into the use of more potent drugs, the high cost of which invariably lead to crime and create ever increasing dependency and hence the necessity to take ever larger doses of these drugs. Although methadone is synthetic and cheaper, it is in itself a drug which causes addiction even though it does not require ever increasing doses as is the case with "street drugs". On the other hand (except in cases of "black market" methadone which has a relatively early start age), the use of methadone occurs mainly with the relatively advanced age group whose bodies have reached a saturation point of hard drug abuse and are therefore possible candidates for "spontaneous detoxification" either because drugs no longer have any effect on them or due to their knowledge that additional doses may prove fatal. In these cases, turning to methadone just prolongs the state of addiction and prevents this "spontaneous detoxification' which often occurs around the age of forty. It also often happens that when some of the "Methadone Centers" (for official distribution sponsored by the Ministry of Health) note that an addict is close to spontaneous detoxification and only in need of "light" support, the center may then gradually reduce dosage to nil without the addict's knowledge, and subsequently inform him that he has become detoxified. We have no data on how often this occurs, but it may be worthwhile to institute this method at all the Methadone Centers.

A high rate of "cleanliness" over lengthy periods of time is also noted amongst the small number of diagnosed who declared that they had undergone psychiatric treatment. This finding requires more "in depth" investigation into the essence of this treatment and the characteristics of those receiving it

Please note that our data refer only to persons who relapsed into drug usage and have claimed income support benefits after the periods stated in Table No.12. We have no data available on patients who, as a result of non-relapse or other reasons, did not submit claims for such benefit.

Table No. 12: Cleanliness, according to type of treatment (Percentages)

Treatment	Total		Duration of Cleanliness (in months)					
	No	%	Up to 6	6-12 m.	12-24 m.	24-36 m.	36-48 m	No data
Total	2,862	100	64	9	10	4	2	11
Medicinal	478	100	78	7	7	1	1	6
Methadone	100	100	48	8	15	7	6	16
Self treatment	1,104	100	64	10	13	5	2	6
Psycho-Social	545	100	65	11	11	5	2	6
Psychiatric	246	100	49	7	8	2	1	23
Other	389	100	61	8	6	2	2	21

Evaluation of the Addicted

Self-evaluation by the Addicted

At the initial stages of the evaluation, we requested the addicted to grade their willingness to attempt, and their belief in their ability to succeed, in effecting detoxification. Table No. 13 gives the breakdown of their responses. The total figure appearing in the following tables expresses the number of answers received to these questions.

Table No. 13: Belief of the addicted in their ability to effect detoxification, by accordance to willingness (percentages)

Willingness to detoxicate	Total		Belief in ability to detoxicate		
	Numbers	%	Negative	Unsure	Positive
Total	3,149	100	38	34	28
Not interested	1,003	100	74	18	8
Ambivalent	866	100	33	56	11
Interested	1,280	100	13	31	56

The breakdown of the addicts' answers is worthy of study: One third openly declared that they were not interested in detoxification, whereas only 41% were interested and only 28% believed they had any

chance of success. Correlation between willingness to attempt detoxification and belief in ability to succeed is high: 74% of the uninterested do not believe that they have the possibility to succeed ; 56% of those who were unsure also have medium belief in their chances of success, whereas 56% of those interested in detoxification believed that they would succeed.

We again note that we are dealing with a distress population which has low motivation and self esteem (only 56% of those interested in detoxification believed that they would succeed). We assume that enhancing their self esteem and strengthening their belief in their own capability to effect detoxification will heighten their willingness to enter into detoxification frameworks. They are at present in a difficult situation, and according to the evaluation of the professional diagnosers (psychologists and social workers), it is doubtful if there is any possibility of these addicts effecting detoxification. The diagnosers evaluation of the addicts' chances is even lower than that of the self-evaluation by the addicts themselves.

The principal factor necessary for success in detoxification and rehabilitation is strong motivation and emotional strength to persevere in the process. Diagnosers were requested to evaluate the potential strength and level of willingness found in the addicts to carry out detoxification. They discovered motivation in only 20% of the addicts, as against 41% of the addicts who had expressed interest in detoxification, and only in 6% did they find the strong emotional force necessary to commence the detoxification process, let alone persevere in it. (Self-evaluation by the addicts commenced with start of diagnostic procedures at the Center whereas evaluation by the diagnosers was only instituted at a later date). Table No. 14 shows the breakdown of the addicts willingness and level strength, as evaluated by the diagnosers.

Table No. 14: Diagnosers' evaluation of strength according to addicts' detoxification willingness (percentages)

Level of Willingness	Total		Evaluation of Strength		
	Numbers	%	None	Medium	Good
Total	1,343	100	61	33	6
No willingness	694	100	88	11	1
Medium	376	100	40	59	1
Willing	273	100	19	55	26

* There are diagnosers evaluations in only 1,343 addict case files.

The diagnosers' pessimism is evident in this Table: More than half the addicts were graded by them as

having no willingness to detoxificate and more than 60% were graded as lacking the emotional strength to carry out the change. Generally, persons in such depressed condition are not candidates for detoxification and rehabilitation, especially when they themselves do not believe in their own capability.

The diagnosers also evaluated the addicts' rehabilitation potential in three areas: detoxification, employability and psycho-social treatment. The results are shown in Table No.15.

Table No. 15: Rehabilitation potential evaluated by diagnosers, according to type of treatment recommended (Percentages) N=1,315

Recommended treatment	Total	Evaluation of rehabilitation potential		
		Low	Medium	Good
Detoxification	100	52	37	11
Employment	100	54	33	13
Psycho-Social treatment	100	52	34	14

Approximately half the addicts are of low rehabilitation potential, slightly more than a third have medium potential, whereas only one eighth have good potential.

The connection between the types of rehabilitation potential is evident: 82% of those graded as having low detoxification potential were also graded as having low employment and psycho-social treatment potential. 49% of those graded as having medium detoxification potential were graded likewise in the two other fields, and 45% of those graded as having good detoxification potential also showed good employment and psycho-social treatment potential.

We constructed a "unified rehabilitation potential index" made up of the average grades for the three types of rehabilitation potential, as evaluated by the diagnosers (1=low, 2=medium and 3= good) and received the following distribution:

53% had low potential,

34% had medium potential and

13% had good potential.

We also constructed an addicts' self evaluation index of detoxification potential, made up of "level of willingness" and "belief in chances of success".

Table No.16 shows the connection between diagnosers' and addicts' evaluations.

Table No. 16: Addicts' self evaluation of rehabilitation potential according, to diagnoser' evaluation (percentages)

Rehabilitation Potential as per Diagnosers	Total		Addicts' Self Evaluation		
	Numbers	Percentage	Low	Medium	High
Total	1,315	100	60	29	11
Low	697	100	45	34	20
Medium	447	100	13	44	43
Good	170	100	2	13	85

- The diagnosers evaluated the rehabilitation potential and the addicts evaluated willingness and chances of success.

Correlation between the evaluations of the diagnosers and those of the addicts is partial because addicts tend to be more optimistic than professional diagnosers: Only 45% of those graded by diagnosers as having low potential thought that they are indeed of low detoxification potential, whereas 20% believed that they had good detoxification potential. 85% of those graded by diagnosers as having good detoxification and rehabilitation potential expressed willingness and belief that they would succeed. Regrettably, these constitute only 11% of the total of diagnosed addicts.

Recommendations and Referrals for the Addict

Diagnosers were requested to recommend appropriate treatment frameworks for the addicts, even if in some cases the appropriate facility was not available within today's frameworks and even if such recommendation was made only after an initial interview. One of the reasons for few recommendations being given was that the diagnosers felt that the persons turning to the diagnostic centers belonged to weak distress populations and lacked the strength, resources and possibilities to effect detoxification. Dr. Eli Elbaz, Head of the Jaffa Diagnostic Center, is of the opinion that such initial interviews are insufficient for thorough diagnosis and the obtaining of the comprehensive personality evaluations required for referring addicts to treatment frameworks. This is especially true with regard to evaluations of addicts' motivation which is the main factor for perseverance within treatment frameworks, and this is also the reason that most recommendations were referrals to local welfare agencies in each community, for further in-depth diagnosis and evaluation of the addict.

Diagnosers were requested to make up to three recommendations out of a list of ten possibilities which included most of the "treatment framework" facilities available in Israel. Recommendation possibilities were as follows: Hospitalization - Methadone Treatment - Communal Support Treatment - Rehabilitation Center - Psychiatric Treatment - Mental Health Station or Psychiatric Hospital - Welfare Office -

Office - Narcotics Anonymous - or the regional "Care Giver" for the addicted. In addition to the aforementioned, there were referral possibilities for finding employment, monitoring by the Diagnostic Center itself - or referral to the division for the "Disabled" at the National Insurance Institute. Diagnosers also were permitted to mark: "no available rehabilitation or treatment facility available for this addict".

Admittance into some of the recommended facilities is difficult to obtain, either due to shortage of facilities or length of waiting lists, or in many other cases, due to the high participation cost which is beyond the means of most addicts. One must bear in mind that diagnosers provided "recommendations" only and that neither the N.I.I. nor the other institutions are bound to act in accordance and accept the addict into the recommended treatment framework.

Diagnosers were also permitted to add to their own recommendations for any such other treatment facilities known to them. Possibility of making more than one recommendation was provided not only as an alternative, but rather in order to enable the combination of more than one type of treatment which is necessary in some special cases. As we know, recommendations to the "Welfare Office" or "Methadone Treatment" are of a general nature and most of the diagnosed (69%) were given only one recommendation. 22% received two recommendations and 4.9% received three recommendations.

The various recommendations were amalgamated into five main treatment possibilities:

1) Methadone treatment
2) Treatment by the welfare services (Regional care-giver and home detoxification)
3) Hospitalization
4) Long term treatment (Communal Support , Rehabilitation Center and Psychiatric treatment)
5) Outpatient clinic treatment (including N.A., employment seeking and monitoring by the Diagnostic Center).

Hereunder is the breakdown of the various types of recommendation made (because more than one type of recommendation was permitted, we received a total of 139%);

32% Methadone treatment
38% Welfare Office / home detoxification
16% Detoxification by hospitalization
19% Long term treatment

7% Other

19% No treatment or rehabilitation facility available.

All told, the addicts received some 3,500 recommendations, whereas, because of various reasons, some 1,800 addicts received no recommendations at all.

Table No. 17: Recommendations given to addicts, according to declared level of detoxification willingness (Percentages)

Recommendation	Total	Low	Medium	High
Total	3,431	1,704	969	629
No facilities available	18	28	10	3
Welfare office	35	30	46	33
Methadone treatment	30	39	23	118
Long term treatment	17	12	19	30
Hospitalization	14	6	18	33
Outpatient treatment	14	10	17	22

We note that there are more "Long term" and "Hospitalization" recommendations made where the level of motivation is higher since these stand a better chance of success for detoxification and rehabilitation. If there is no possibility for success or at low levels of motivation, recommendations for methadone treatment are prevalent since this is, in effect, not detoxification treatment, but rather an attempt to sustain the addict by using the lesser of the evils.

Correlation between Differentials

On the whole, we found no blatant correlation of factors when we studied links between the psycho-social / historical differentials of each individual case and evaluations made by the diagnosers. The population under study is mainly a weak distress population of low socio- economic level meeting the entitlement criteria of income support benefits. We attempted to extract cases which indicated potential for detoxification and which showed the willingness and stamina required to effect the long and difficult treatment. Table No 18 shows the breakdown of cases which were found to have above average motivation for change, according to the addicts' specific differentials.

Table No. 18: Detoxification willingness according to social differentials (%)

Differentials	Total	%	Unwilling	Medium	Willing	No Data
Total	3,431	100	50	28	16	6
Ages 35 to 39	840	100	48	30	19	4
Married	1,750	100	49	28	18	5
1-12 years education	525	100	37	33	24	7
Past professional employed	665	100	34	32	29	5
Completed military service	840	100	41	30	23	6
3-5 years employment	700	100	46	28	19	7
Jewish, N.Africa born	490	100	39	32	211	7
Offspring to N.Africa born	1,785	100	41	31	20	8

Table No. 18 indicates that, unlike cases with no record of professional employment and cases of "odd-job" workers", there is a proportionally high rate of detoxification willingness amongst addicts who were professionally employed in the past. There is also a higher rate of willingness to change amongst addicts who completed military service, as against those who failed to complete their military service or were never inducted at all. This is also true of addicts who completed 11-12 years of education and 3-5 years of employment and are of North African origin. We note that on the whole, no major differences appear and that these range from 19% to 29% willingness to effect detoxification as against the average of only 16%.

We also studied the connection between substance usage patterns indicating severity of addiction and the recommendations made by the diagnosers at the Diagnostic Center.

Table No. 19: Recommended treatment, according to start age of usage (%)

Drug type	Age	Total		Recommended Treatment					
		No.	%	No Rehabi	Hospital	Methadone	Long Ter care	Out Patient	Welfare
Total		5,313	100	14	11	25	13	6	31
Heroine	Up to 21	292	100	14	15	29	14	4	24
	Over 21	575	100	12	14	25	14	8	26
Persian Coke	Up to 21	779	100	17	11	24	14	5	30
	Over 21	2,156	100	13	11	23	13	6	33
Methadon	Up to 21	217	100	15	9	28	14	6	29
	Over 21	1,296	100	13	9	27	13	7	30

Table No. 20: Recommended treatment, according to usage time length (%)

Drug	Years of usage	Total		Recommmended Treatment					
		No.	%	No Rehab-ilitatio	Hospi-Tal	Metha-Done	Long term care	Out Patient	Welfare
Total		5,313	100	14	11	25	13	6	31
Heroine	Up to 10	455	100	14	11	26	15	6	28
	Over 10	386	100	10	24	25	12	7	21
Persian	Up to 10	99	100	7	8	18	24	14	29
Coke	Over 10	2,863	100	14	11	24	13	6	33
Methadon	Up to 10	490	100	15	11	22	17	7	28
	Over 10	1,019	100	12	8	30	11	1	32

Differences in recommendations according to usage of drug type are most apparent in the high rate of "No rehabilitation possibility" among addicts who began using Persian Coke before the age of 21 as against the low rate of "No rehabilitation possibility" for addicts who have used this drug for less than ten years. Especially high are the percentages of "hospitalization" treatment recommendations made for addicts who used heroine for over ten years, as well as "out patient" treatment recommendations for addicts who have used Persian Coke for less than ten years.

Table No.21: Drug addiction, according to patterns of use and recommendations

Usage Patterns	Total		Recommended Treatment					
	No	%	No Rehabilitation	Possibilit Hospital.	Methadon	Long Ter care	Out Patient	Welfare
Persian Coke								
Total	3,464	100	15	11	25	14	5	30
Smoking	334	100	16	18	17	12	10	26
Sniffing	200	100	13	8	30	16	11	24
Injecting	517	100	13	11	35	12	4	26
Run Inhaling	2,278	100	16	10	23	14	5	32
Injecting +	135	100	11	9	32	19	7	22
Cocaine								
Total	1,014	100	14	13	29	15	6	23
Smoking	88	100	9	15	33	19	5	19
Sniffing	675	100	15	12	29	15	5	24
Injecting	147	100	15	17	30	14	11	14
Run Inhaling	62	100	8	16	26	10	5	35
Injecting +	42	100	19	10	24	21	5	21

*Persian Coke and Cocaine are not ingested orally (by swallowing).

More than 3,400 recommendations were given to some 2,900 users of Persian Coke. As stated before, most of the recommendations were referrals to the Welfare Services (30%) and for Methadone treatment (25%). The 15% " no rehabilitation possibility" means that in the diagnosers' opinion, there are hundreds of hopeless cases. It may be noted that the 19% who inject Persian Coke received a higher rate of referral for Methadone treatment to which addicts in worse condition were referred (about 35%). There are fewer users of Cocaine which is a relatively new drug on the market (only about 1,000), but this number is increasing and is dangerous because addiction to this drug is rapid and very difficult to break. These Cocaine users are also referred to the Welfare Services and in greater proportion to Methadone treatment.

Personal Evaluations

At the close of the interview, the diagnosing professional makes a personal evaluation of the addict in the following fields:

1. Cognizance (including: intelligence, thought process, memory, grasp of time and place, awareness, language and personal outside appearance).
2. Effect (including: emotion and adaptation, belligerence, anxiety, frustration borderline, apathy, depression and euphoria).
3. Motivation (desire for change, activism and strength to effect change).
4. Personal Characteristics (maturity/infantility, cooperation/ negativism, responsibility/ irresponsibility, emotional disruption, manipulativity and focus of internal-external control).
5. Rehabilitation potential (for detoxification, employment and psycho-social treatment).

No substantial connection between personal characteristic differentials and recommendations for rehabilitation was found. However, we noted that biographical details such as completion of military service (not just enlistment), may prove to be an indication of emotional strength and potential for successful detoxification and rehabilitation. Meaningful connection was noted between completion of military service and personal characteristics, especially with regard to such positive characteristics as "focus on internal control' and "detoxification potential"; but this differential was however found to be linked also to "unwillingness to cooperate". Table No. 22 shows the connection between military service and positive personal characteristics (missing data on levels of personal characteristics bring the percentages up to 100%).

Table No. 22: Diagnosers' evaluations of addicts' personal characteristics, according to military service (percentages)

Evaluated Characteristics	Military Service		
	Didn't Enlist	Didn't Complete	Completed Mil. Service
Total (Number)	2,714	1,577	1,242
Willing to change	14	18	25
Has strength to change	3	5	10
Has detoxif. Potential	6	9	17
Has employment potential	8	12	18
Non manipulative	5	4	7
Internal control focus	6	6	9
Interested in detoxification	32	40	47
Belief in success	20	30	37
Has maturity	2	3	3
Has responsibility	3	3	3
Cooperative	35	30	28

It is interesting to note that in general, the salient low rates of positive personal characteristics are: maturity, internal control focus, responsibility and lack of manipulativity. Whereas on the other hand, the addicts are characterized by infantility, connected to need for immediate satisfaction, lack of responsibility, manipulativity and external control focus.

Study of the links between detoxification potential and previous medicinal, psycho-social or mainly Methadone treatments, indicates that previous treatment leads to pessimism and low evaluation of the addicts' strength and motivation, and it would seem that failure of the previous treatment weakens the addicts' resolve. When addicts declare that they are treating themselves (even when this involves remaining "clean " at home even for a few days), he begins showing increased optimism and the diagnoser evaluates his strength as being stronger. This, in certain measure, is also true in cases of psychiatric treatment.

Table No. 23 displays these links.

Table No.23: Evaluation of addicts' characteristics, according to type of previous treatment* (Percentages)

Evaluated characteristic	Total	Type of treatment				
		Medicina	Methadon	Self Detoxification.	Psycho-Soci	Psychiatric
Willing to change	21	17	11	24	22	17
Has strength to change	6	4	4	7	5	3
Has detoxificat. potential	11	5	7	15	11	8
Has employment potential	13	7	6	17	13	7
Has maturity	4	5	3	4	2	3
Has responsibility	3	3	3	4	2	4
Has good personality	3	3	-	3	5	2
Cooperative	33	36	27	28	43	34
Non manipulative	5	4	-	4	8	4
Internal control focus	7	6	2	7	9	8
Interested in detoxificatio	14	10	21	16	11	12
Has belief in success	7	6	9	8	5	4

* It was permissible to note more than one type of treatment, hence the percentages amount to more than 100%.

Continuity of Treatment

Up to mid-1997, over 5,000 persons out of the 8,000 cases referred since the establishment of the diagnostic centers were classified as being addicted, and out of these, over 4,000 of these have been ensconced into the "Income Support System". The major portion of these (55%) were granted entitlement to income support benefit by virtue of their "Addicted" classification. Table No. 24 shows the breakdown of claimants classified by the Center under the initial entitlement clause of "Addicted" and examines the percentages of those who were in rehabilitation at some stage and in what measure they reverted to their addicted status since they were brought into the income support System and up to mid-1997.

Table No. 24: Initial cause for entitlement by recipients of income support benefit classified as "Addicted" (6/88-6/97), according to their entry into rehabilitation*

Initial Cause	Total		Weren't in Rehabilitation	Were in Rehabilitation	
	Number	%	"Addicted" only	Reverted to "Addicted	Didn't re-enter System
Total	4,124	100	82	6	12
Addicted to drugs	55	100	82	5	12
Released prisoner	19	100	86	5	9
Unfit for placement	12	100	85	5	10
Seeking employment	4	100	89	7	5
Employment Diagnosis	3	100	69	10	21
Mother	2	100	74	9	16
Other	6	100	5	10	10

* Initial cause for claim from the System, including causes prior to diagnosis.
. It must be noted that a portion of the "Addicted" in each group remained within the System.

Examination of treatment results during "residence" within the System indicated that 82% of the income support benefit recipients who were classified as "addicted' were identified within the System as "addicted only". The remaining 18% also stayed within the System and were classified as being "Under rehabilitation": At the time of this examination, 12% were placed within various rehabilitation projects and another 6% had fallen out of these projects and had returned to the system as "addicted". In fact, most of the diagnosed (55%), initially entered the system by virtue of addiction. Approximately one fifth of these commenced receiving income support benefitupon their release from prison and another 12% were classified as generally "unfit for placement".

Given this background, it is worthwhile to examine the model which was implemented in the city of Beer-Sheva. There is an established an organization whose members come from all the groups dealing with addiction victims - the Ministry of Health, the Ministry of Labour and Social Affairs and the Municipality. This organization operates a center which includes a diagnostic and treatment unit and various types of monitoring and it monitors most of the addicted in the city and its surroundings. This model permits the economizing not only of renewed diagnosis and appraisal each time the addict moves

between the various treatment units, but also enables constant monitoring of all the addicted, i.e. which new addicts have been added, which ones dropped out of treatment, the condition of which ones deteriorated etc..

Under the Beer-Sheva model, it makes no difference through which unit the addict entered the system and they all have to fulfill the same conditions of cooperation with their care-givers, in accordance with their physical and emotional state.

In general, uniform unification and regularization of the system enables:

- Choice of the most suitable type of treatment in accordance with the addict's needs and capabilities;
- Attached monitoring and care of the addict;
- Support in times of crisis before deterioration of the addict's condition and prevention of dropping out from treatment;
- Updated appraisal and referral to appropriate treatment units in accordance with the addict's condition and needs;
- Referral of addicts to the various units in accordance with number of places available and waiting lists;
- Long term examination by professionals of questions connected with efficiency of the various rehabilitation systems, diagnostic methods, adaptation of addicts' profiles to various frameworks etc..

Computerization of the system is a necessary prerequisite for sustaining the system and its functions. Should similar systems be established in other cities, these will no doubt enhance the efficiency and quality of addict treatment.

Conclusion

The group receiving income support benefit under the "addicted" clause comprises 5% of the total number of recipients of this benefit. This group constitutes the "hard-core" of recipients remaining within the system over long periods of time; and whereas the general average time within the system stands at two and a half years, the average tenure for the "addicted" is for over three years.

Between 1994 and 1996, the number of recipients of income support benefit under the "addicted" clause increased by 7.9% (the general increase for all recipients was 17%) and the proportion of those within detoxification or rehabilitation frameworks increased from 25% to 32%. There is diversity between various N.I.I. branches in the proportions of addicted found within rehabilitation frameworks, and this diversity reflects the different work patterns of these branches. For instance, Haifa and Beer Sheva show an "in rehabilitation" rate almost twice as high as that of the other branches due to the fact that these branches compel the "entitled" to enter into rehabilitation frameworks. In the other branches however, "entitled" addicts claim that they were diagnosed and classified as "addicted" by the Jaffa Diagnostic and Orientation Center, and that they are therefore not compelled to enter any rehabilitation framework whatsoever. Against this background of diversity in "under rehabilitation" figures, it was decided that the Jaffa center examine the rehabilitation potentials of diagnosed addicts, both by self appraisal by the addicts themselves as well as by as by the center's professional staff responsible for the claimants' diagnosis. In light of the findings, it is possible to examine policy at the branches with intent to set uniform standards.

A high proportion of the addicts do not succeed and mostly do not even try to attempt detoxification. On the whole this is considered by professionals as being a distress population and in their judgement, only 11% have good detoxification potential; 33% have some strength for detoxification and rehabilitation and only 6% really have the required strength for this.

Upon examination of the characteristics of the "addicted" population, we note a high proportion of uneducated or with only up to 8 years of schooling (57%); a high rate of singles or divorcees (58%); 73% are Israeli born and 70% come from families with many children. Approximately half the addicted were drafted into the Israel Defence Forces but only half of these managed to complete their military service. 66% of the diagnosed worked prior to receiving income support benefit but only 21% declared that they had been professionally employed (as against odd jobs or unskilled labour).

A higher detoxification potential was indicated in addicts who had one or more of the following characteristics: had 11-12 years of education; were second generation Israelis of North African stock (as against those who were of European or Asian extraction), were married, were aged 35-39, had completed their military service, had been employed in a profession for 3-5 years. These groups had a higher rate of attempted detoxification and entry into rehabilitation without relapse into drug abuse (up to the date of this study). It is also to be noted that addicts with fewer years of drug usage tended to be readier to accept recommendations for detoxification and rehabilitation.

An important positive connection was found between level of motivation and recommendations for extended treatment and hospitalization, which shows greater promise of success for detoxification than does psycho-social treatment on its own. We also found that at low motivation levels, rehabilitation recommendations were not made, either because of institutional shortage or because of recommendations for Methadone treatment (which as a rule, is the lesser of the evils).

Most of the addicts commenced taking drugs at an early age (before 20). Of those who at some stage had used Hashish (Marijuana), 41% had commenced before they were 15 and another 45% had commenced between the ages of 16 and 20 (i.e. 86% had started taking Hashish before 20). Of those who had used Methadone, P. Coke or Crystal, 30% had commenced usage before they were aged 20.

Approximately half the addicted reported that they had undergone in the past various types of detoxification treatment inclusive of medicinal, psycho-social, psychiatric or Methadone treatments and in most cases, what they termed "self-treatment". Half of these had attempted only one form of treatment whereas the remainder had attempted between two to four different types. Most of them had remained "clean" for periods of up to six months whereas only 6% managed to remain "clean" for over two years. (It must be noted that Methadone treatment enabled longer periods of non usage of drugs).

The professional diagnosers were requested to make recommendations for referrals to appropriate treatment frameworks: only 19% of the addicted were classified as unfit for any rehabilitation treatment whatsoever and one third of the total addicted diagnosed were, for a variety of reasons, not given any referrals whatsoever. Addicts who expressed interest in detoxification were given proportionately more referrals for lengthier treatment periods or hospitalization.

The Jaffa Diagnostic and Orientation Center, which is responsible for addicts' diagnosis, has gathered over the past eight years, a huge quantity of data concerning claimants: psycho-social and medical characteristics, personal case histories, appraisals and treatment recommendations. As a whole, this data has been insufficiently exploited for the benefit of addicts' detoxification and rehabilitation and their exit from the support system. It has also been insufficiently used for policy determination, planning of treatment units or proper manpower channeling to the various sections of the National Insurance Institute.

It would seem that there is need for greater coordination and integration of diagnostic and rehabilitation data concerning the addicted and although the N.I.I.'s role is limited to provision of sustenance for the entitled and does not provide treatment to entitled addicts, the Diagnostic and Orientation Center could be used as a central orientation and monitoring unit and the data accumulated over the years (inclusive of all steps and procedures persons have to go through for entitlement either by cause of addiction or rehabilitation), could assist in the planning of detoxification and rehabilitation projects. In order to attain this, it is necessary to obtain the cooperation of the treatment units of the "Health" and "Social Affairs" Ministries and to have swift transmittal of appraisal and treatment referral information regarding the entitled, as close as possible to their entrance into the income support system.

Under such conditions, the Center could provide an over-all picture of the addicts' condition, on available resources and vacancies within treatment units, on waiting lists, on adequacy and adaptability to various types of addiction as well as operate as an appraisal and monitoring center for patients as well as for treatment units. This formula was also recommended by the European Drug Addiction Center, which states in its 1995 annual report that each country should establish a central body for coordinating operations between the various Governmental and Local Authority agencies. The purpose of such a body will be to assemble data on a country-wide scale in order to assist in treatment of the addicted: for combating viral and contagious infections, for adapting treatments to requisite types and quantities as well as for prophylactic prevention etc. all this as part of the continuous war against drugs and in order to help those afflicted by these drugs.

Summary

Groups of recipients of income support benefits due to Drug Addiction amount to 5% out of the total number of recipients of the benefit. This group forms part of the "Hard Core" recipients who remain within the system for lengthy periods of time.

The major portion of addicts does not succeed - and in the main does not even attempt detoxification; and therefor the frame of reference is that of a "distress population" with a low rehabilitation potential: Expert professional opinion has it that only 11% have high Detoxification potential, 33% have some willingness for detoxification and rehabilitation but only 6% are endowed with sufficient necessary strength to effect this.

The Diagnostic Center in Jaffa which is responsible classifying claimants to income support benefits as being "Addicted" has, for more than the past eight years assembled a great amount of information on the claimants: Psycho- social characteristics, medical data, personal case histories, appraisals and recommendations for treatment. In the main, this material is insufficiently exploited for the advantage of the addicted - their detoxification, rehabilitation and removal from within the system - and is also insufficiently utilized in assisting in policy formation and the planning of therapy units and the correct channeling of personnel in the various branches of the system.

This publication presents processed data emanating from the great amount of information assembled at the Diagnostic Center, proposes the exploitation of this knowledge by the creation of cooperation between the various organizations dealing with and as part of the continuous battle against drug addiction in order to assist the addicted to extricate themselves.

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