Chapter 3
Drug Use Among High-Risk People: Resistance and Resilience Factors

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3.1 Introduction

Much progress has been made over the past few decades in understanding basic factors and developmental processes associated with drug use, abuse, and addiction and the best methods of prevention and treatment services. The initiation of illicit drug use is a necessary precursor to abuse and addiction. Illicit drug use tends to develop during the adolescent years, and the behavior is often preceded by biological, psychological, social, and environmental factors that originate as early as the prenatal period. Misuse and use of illicit drugs can interfere with the normal healthy functioning of persons across the life-span—extending well beyond adolescence into adulthood (NIH, 2011). Figure 3.1 provides a view of these general factors affecting mental health and addiction-related behavior.

The life course developmental perspective suggests that individual and environmental factors interact to increase or reduce vulnerability to drug use, abuse, and dependence. Vulnerability can occur at many points along the life course but peaks at critical transition periods … [including] important biological transitions, such as puberty; normative transitions, such as moving from elementary to middle school; social transitions, such as dating; and traumatic transitions, such as the death of a parent. In addition, because vulnerability to drug abuse involves dynamic intrapersonal (e.g., temperament), interpersonal (e.g., family and peer interactions), and environmental (e.g., school environment) influences, prevention intervention … must

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R. Isralowitz, P.A. Findley (eds.), *Mental Health and Addiction Care in the Middle East*, Advances in Mental Health and Addiction,
DOI 10.1007/978-3-319-41556-7_3

Fig. 3.1 Contributing factors to mental health and well-being. Used with permission from World Health Organization (WHO 2012). Risks to mental health: an overview of vulnerabilities and risk factors. http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf Accessed 06 July 2015

target individuals and social systems across the life-span… [and consider co-occurring factors including] delinquency and criminal behavior, interpersonal violence, mental health problems and HIV, other sexually transmitted infections, and reproductive health problems (NIH, 2011).

Underlying this explanation are a host of biomedical, psychological, and/or sociological considerations such as history of drug abuse patterns and the changing population of users; recognition that specific drug abuse patterns are culturally determined as cultures (and subcultures) differ in the availability of drugs and the extent of abuse; awareness that demographic characteristics of abusers vary over time and across location; need to delineate the specific drug (or drugs) of abuse, route of administration, and length of dependence; etiology of social context in which drug abuse begins; influence of major institutions (e.g., family, community, peer group, schools, and media) upon the onset and continuation of drug dependency; drug abuse is more prevalent in certain populations than others; and determination of institutional supports that promote successful treatment and rehabilitation, including consideration of how persistent behavior in subcultures can be changed (Ball et al., 1995; INCB, 2010, p. 2–6).The following issues shape drug use, abuse, and addiction. Also, they determine the nature and scope of resilience and resistance to drug use.

3.1.1 Social Order

People are often referred to as deviant when they do not share the values or adhere to the social norms regarding conduct and personal attributes prescribed by society (Goode, 2007). Although the process of identifying deviance involves the use of normative definitions that may vary over time, the essential nature of deviant behavior is that it reflects a departure from the norms of a particular society.

3.1.2 Social Forces: Physical Environment, Values, and Morals

From research conducted as early as the 1920s in the United States, it has been shown that the environment where a person lives can be an influential factor in the use and abuse of drugs. An environment that is deteriorating and poverty-stricken serves as a breeding ground for problem behavior such as drug use. Living in these conditions are people from the lower end of the social hierarchy, who are often beset with a huge assortment of personal and family problems. In order to exist, norms and values different from those prescribed through explicit and implicit social policies, laws, and methods of enforcement are adopted by these people, enabling them to achieve goals that are readily attainable and concrete.

3.1.3 Ethics, Values, and Morals

Although issues such as values and morals among the lower classes and the disproportionate amount of crime and drug problems found among the poor have been widely covered by sociological research and literature, studies show that such problem behavior is also indigenous to the middle and upper classes. Facts and statistics reveal that drug use and abuse is a problem that transverses all social classes (Isralowitz, 2002; Miller, 1958). However, it is a problem that tends to be more easily rooted among poor people in conditions of poverty and social degradation and the social reality defined by politicians, law enforcement officials, police, and other decision-makers.

3.1.4 Interpersonal Relations

3.1.4.1 Family

The role of the family is a major causal factor in shaping the personality and behavior of children. The family serves as a reference group on personal and normative levels. Family shares responsibilities with social institutions and peers as a major socializing influence. Parents train their children to conform or not to conform to particular moral standards through the examples they provide by their own behavior. Investigators of families with a drug-abusing member have identified some consistent patterns related to adolescent drug use, including the role of mother and/or father to their child. Research shows that family relations; parental roles; divorce; parent and sibling alcohol and drug use; death or absence of a parent; emotional, physical, and/or sexual abuse; mental health; low aspirations; and other factors are linked to drug use (Glynn & Haenlein, 1988).

3.1.4.2 Peers

Peer relations are often linked to drug use (Goode, 2007; Isralowitz, 2002). Such behavior may be learned through association and interaction with others who are already involved with drugs. A person's relationship with peers may serve as a means of escape from other interpersonal dealings such as family, school, or work. Peers tend to have a consistent influence on health-risk behavior and may be better predictors of such behavior than parental influences among young adolescents. Studies show that a high level of adolescent peer activity predicts drug use (Isralowitz & Myers, 2011). The more young people are isolated and alienated from their parents and the more involved they are with peers, the greater the likelihood that they will experiment with drugs. Users tend to be friends of users, and the selective peer-group interaction and socialization constitutes the single-most powerful influence related to drug use among young people regardless of social class (Kandel, 1980; Needle et al., 1986). Strong bonds to family, school, and religion, however, usually decrease the influence of antisocial peers and problem behavior including drug use (Isralowitz, 2002; Isralowitz & Reznik, 2015).

3.1.4.3 Education

School is a major agent of status definition in society and has a critical role in the socialization process. The school labels youth as winners or losers and by so doing frequently determines the directions they take that may involve the use of drugs.

Many studies have shown a strong relationship between a negative school experience and drug use. For example, negative attitudes toward school, low academic aspirations and educational achievement, and disciplinary problems in school often precede the onset of drug use and/or dropping out of school. Furthermore, teenage pregnancies and frequency of school absenteeism are associated with increasing levels of drug use. The educational process, the school, and its personnel are a potent force in terms of shaping the attitudes and behavior of youth. Too often, however, the full impact of the school's resource base is lost. Communications between teachers and parents, particularly in the areas of strengthening and reinforcing the learning processes of youth during nonschool hours, tend not to be emphasized (Isralowitz, 2002; Smith, 1975).

3.1.4.4 Media

Since the 1920s when motion pictures became a major source of mass entertainment, the effects of the media have been subject to scientific inquiry and public concern. The media has an influence on the socialization process and, in turn, on drug use and related problem behavior (Isralowitz, 2002). American children and adolescents spend an average of 3–5 h/day with a variety of media, including television, radio, videos, video games, and the Internet (Strasburger & Donnerstein, 2000).

Behavior such as drug use in the media can have a lasting effect on children and youth if the themes presented are repeated often enough and if the behavior is not clearly contradicted by significant others, such as parents, peers, or teachers.

3.1.4.5 Labeling and the Criminalization Process

The labeling process is a method that determines a person's fate (Becker, 1953). It tends to reinforce problem behavior rather than ameliorate it. Essentially, labeling theories are less interested in a person's problem behavior and characteristics than in the criminalization process—apprehending and punishing law violators and leaving them with a negative status. In terms of drug use, a consistent pattern of events tends to take place, resulting in a feedback cycle involving more deviations, more penalties, and still more deviations (Isralowitz, 2002; Schrag, 1973). Hostilities and resentment are built up and culminate in official reactions that label and stigmatize the drug user, thereby justifying even greater penalties and restricting opportunities for the person to change problem behavior. The roots of the labeling and criminalization process go right to the heart of a major controversy regarding the drug scene—that is, the belief that the judicial and law enforcement decision-making process underlying the drug problem is racially biased. In many city neighborhoods, black men have nearly a one-third chance of being incarcerated at some point in their lives, and the majority without a high school diploma has spent time in prison by the time they reach their mid-30s (Herbert, 2010).

3.2 Biological and Psychological Characteristics

3.2.1 Biological

Research shows genetic factors contribute from 40 to 60 % of a person's vulnerability to addiction, but this includes the contribution of combined genetic-environmental interactions (Dick & Agrawal, 2008). Drug addiction is a brain disease. It is a chronic illness. Although initial drug use might be voluntary, once this addiction develops, control is markedly disrupted. It has been found that genetic influences are stronger for abuse of some drugs than for others and that abusing one category of drugs, such as sedatives, stimulants, opiates, or heroin, is associated with a marked increase in the probability of abusing every other category of drugs. Heroin is the drug with the greatest influence for abuse (Tsuang et al., 1998; Volkow, 2005). Another theory postulates metabolic imbalance as a possible cause of drug abuse—specifically, narcotic addiction. Whether drug users and abusers are at higher risk of suffering some metabolic imbalance is not widely known.

3.2.2 Psychological

Psychological theories associated with drug use may be categorized into two groups—those that emphasize the mechanism of reinforcement and those that stress personality differences between people who use and are dependent on drugs and those who abstain. Research shows that drugs have addicting reinforcement properties independent of personality factors—and this reinforcement can be positive and negative. Positive reinforcement occurs when a person receives a pleasurable sensation and, because of this, is motivated to repeat what caused it. Negative reinforcement occurs when a person does something to seek relief or to avoid pain and to feel normal (Goode, 2007).

Personality pathology, defect, or inadequacy is another theoretical approach (Isralowitz, 2002). The inadequate personality approach posits that the emotional or psychological nature of certain people leads them to drug use. Drugs are used to escape reality and avoid problems. This personality type lacks responsibility, independence, and the ability to defer pleasurable gratification for the sake of achieving long-range goals. Other personal characteristics include low self-esteem and feelings of self-derogation brought about by peer rejection, parental neglect, school failure, impaired sex-role identity, ego deficiencies, low coping abilities, and coping mechanisms that are socially devalued and/or are otherwise self-defeating (Petraitis, Flay, Miller, Torpy, & Greiner, 1998). Other characteristics include being less religious, less attached to parents and family, less achievement oriented, and less cautious as well as having a higher level of sexual activity.

3.3 High-Risk Populations: Israel

3.3.1 Youth: School Dropouts

Drug use, school dropout, and other behavior problems among youth in many countries continue to grow and make headlines (DuPont et al., 2013). The high level of drug use reported by such youth is not surprising since their backgrounds reflect school failure, delinquent and criminal behavior, and other related factors linked to those described above in the theoretical section of this chapter (Cohen-Navot, Ellenbogen-Frankovits, & Reinfeld, 2001; Isralowitz & Reznik, 2007; Isralowitz, Reznik, & Straussner, 2011; Rumberger, 2004). A higher level of alcohol and drug use among females than males is consistent with patterns evidenced in many European countries (EMCDDA, 2005; Isralowitz & Myers, 2011). This detail supports a growing literature on female-specific treatment needs and approaches including early intervention both in school before girls drop out and with their families (Tuchman, 2010).

Information on school dropouts is sparse; in part, this is because most don't receive assistance. For example, in the United States, it has been reported that 21.6

million persons (8.2 % of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. The number in 2013 was similar to the number in each year from 2002 through 2012 (ranging from 21.6 million to 23.6 million) (SAMHSA, 2014). Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs. From these numbers, it is important to note that among the 21.6 million persons needing treatment for an illicit drug or alcohol use problem in 2013, 20.2 million persons (nearly 94 %) did not receive treatment at a … facility in the past year. (SAMHSA, 2014, p. 93–94).

The Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben-Gurion University, conducted a study of Israeli youth who, for the most part, dropped out of school with an addiction problem. These youth, approximately two-thirds male, were referred by probation, social service, and healthcare workers to a residential facility for drug treatment from 2004 to 2013. During their intake interview prior to treatment, the following information was collected[1]:

- Significantly higher level of last 30-day drug use before residential treatment was reported by females.
- Country of origin (i.e. mother's place of birth—Israel and former Soviet Union) was not a factor that differentiated high-risk youth in treatment for drug addiction.
- Significant predictors of last 30-day drug use include ability to access drugs and problem behavior including fighting, stealing, weapon possession, decline in school achievement and interpersonal relations, and unsupervised evening/night activities.
- Over time, there has been downward trend in terms of the ability to access drugs.

3.3.2 Prescription Drug Use Among Young Adults

Prescription drug abuse is a major public health concern and the consequences continue to mount; the cost in human lives lost is tragic and the cost to society growing. One of the most disturbing trends to emerge is the number of young people initiating their drug use with prescription medications containing a controlled substance (EOP, 2012; 2012). The reason for this drug problem and serious public health concern is because prescription medications have become more widely available and easier to obtain; it is an issue of concern worldwide.

Often times, individuals receive prescription drugs from a friend or relative for free. Other methods of obtaining such drugs include making multiple visits to different

[1] Here and below we don't present the results of statistical analysis. For more information about statistical data, please contact Dr. Alexander Reznik, Ben Gurion University (Reznikal@bgu.ac.il).

physicians for the same health claim, visiting physicians or clinics known to be "prescription mills," stealing or forging prescription pads, changing the dosage amount or number of refills indicated internet sales, or purchasing smuggled or stolen drugs (Isralowitz & Myers, 2011).

Prescription drugs are usually used for legitimate medical purposes. However, many physicians are not well educated or experienced about drug use and abuse, and there are physicians who readily prescribe prescription drugs for pain relief without understanding the consequences and harmful effects such use may have on a client's behavior and well-being (Glajchen, 2001).

Opiates and opioids (i.e. narcotic analgesics or pain relievers) are commonly used prescription drugs. These include hydrocodone and oxycodone with brand names such as Vicodin, OxyContin, Percocet, and Percodan. Tramadol, a synthetic opioid developed by a German pharmaceutical company in the late 1970s, is also commonly prescribed for moderate and severe pain relief despite overstated manufacturer claims about the efficacy of the drug and understated information about the serious risks associated with its use that include abuse and addiction. This drug is commonly available in Gaza among Palestinian people (Progler, 2010).

Most information about nonprescription and prescription drug use among youth and young adults is based on school or national surveys and has been previously noted in this chapter. Generally, based on research in Israel, Europe, and the United States, females, especially young adults, tend to have a higher rate of prescription drug use than males (EMCDDA, 2005; Isralowitz et al., 2011; NCADD, 2014).

Most parents are not involved with the prevention and treatment issues of drug abuse and addiction (Isralowitz & Myers, 2011). Research, publication, talks, lectures, and workshop offerings do not prepare oneself for a real-life situation unless that person is directly dealing with the problem. Young adults in Israel, for the most part, are obligated to do military service—for females normally 2 years. The following is the true story of "N" caught up in a cycle of medical mismanagement leading to problematic prescription drug use.

The Story of "N": *A Case Study*. Assigned to a unit with "combat status" and responsible for monitoring security, "N" was injured in a training incident that resulted in dislocated ribs—an injury affecting her breathing, sleep, physical movements, and other personal functions. A sneeze or cough is, understandably, a painful experience. Hours after the accident, and in pain, "N" was advised to travel on buses from an isolated naval base to a regional medical center. There she was examined and provided opioid pain killers. Little did she know about the serious path she was being taken down—a path affecting her physical and mental functioning… she was entering the twilight zone or "zombie land" of personal functioning. Over time, military physicians continued to address her pain with prescribed narcotics. "N" reported that she received enough medications to set up a pharmacy.

Examination after examination, in Haifa, Tel Aviv, Jerusalem, and Beer Sheva, evidenced N's medical problem. Some physicians prescribed more narcotics; others advised her to stay clear of such use because of the harmful effects. Ordered to return to her security monitoring position, a commanding officer reviewing her situation labeled her "an addict, a junkie" in need of getting control over her life and

needing to learn pain management. A young person committed to national service had been put on the path of narcotic prescription use by her physicians.

"N" is not alone for sure. There are many others who are given narcotic prescription drugs by physicians—some exercising care and concern, and others using such drugs as a quick fix and out the door remedy for pain management. Fortunately for "N" she had support and guidance on how to deal with her use of prescription drugs. Others are far less fortunate.

Without proper monitoring and follow-up, well-meaning physicians may be contributing to a growing population of "legitimized" drug abusers in need of medical, psychological, and social work supports in order to maintain a "normal" lifestyle. There is no hiding from this problem, it is serious and intervention measures are needed to prevent its growth as a major issue of concern and cost—cost to the individual, family members, and society.

As a personal note, there are many experienced and well-meaning people able to provide support in such matters. However, from experience, it was the placement of N in national service that provides young adults with an option of military service that helped pull herself together with self-confidence and motivation to move forward with her life. N and her family were the lucky ones… many are not.

3.3.3 Women

Considerable progress has been made toward understanding illicit drug use. However, the problem related to females has been recognized as being sorely neglected (Isralowitz & Myers, 2011). The reasons why drugs are used differ between males and females. Females are more vulnerable to abuse and addiction—they become more dependent on drugs, such as crack cocaine, faster and suffer the consequences sooner than males.

A particular stressful event is often cited by women as a reason for initiating the use of harmful drugs. Studies show that females who abuse drugs have problems related to co-dependency, a history of parental alcohol and drug abuse, incest, and physical and sexual abuse—up to 70 %, victimization, sexuality, and relations with significant others (Isralowitz & Reznik, 2008). Also, many women are faced with the need to deal with serious health and mental problems such as poor nutrition and below-average weight, low self-esteem, depression, preterm labor or early delivery, and medical and infectious diseases such as increased blood pressure and heart rate, sexually transmitted diseases (STDs), and/or HIV/AIDS (NIDA, 2009). Socioeconomic factors are viewed as related both directly or indirectly to drug abuse by women.

Women begin abusing drugs later than men and they are more likely to have a coexisting psychiatric problem such as depression; report a greater history of suicide attempts; and tend to be more hostile. Many women report that their drug-using male sex partners initiated them into drug abuse. In addition, drug-dependent women have great difficulty abstaining from drugs when the lifestyle of their male partner is one that supports drug use (Isralowitz & Reznik, 2013).

Many drug-using women do not seek treatment because they fear not being able to take care of or keep their children, reprisal from their spouses or boyfriends, and punishment from authorities in the community (Isralowitz & Reznik, 2013). Among those in need of treatment, many are faced with addressing a range of issues like life with an alcoholic or addicted male partner, a lack of education, job experience, self-esteem, and assertiveness skills, making it difficult for them to manage the complex treatment and assistance network (Straussner & Brown, 2002).

In many developed countries, drug abuse is no longer a predominately male activity. Among European countries, it has been reported that understanding drug use by women is a critical requirement for effective prevention and treatment responses to their needs (EMCDDA, 2005; Isralowitz & Bar Hamburger, 2002). Among key issues for women are barriers to treatment access. The lack of social and economic support and childcare obligations have been identified as factors that can inhibit women from making use of drug treatment services. Also, women may be disinclined to enter inpatient treatment services, where they often represent an even smaller minority of clients than they do in outpatient services (Isralowitz & Bar Hamburger, 2002).

3.3.3.1 Low-Threshold Facilities for Women

Low-threshold agencies (i.e. agencies or services that help drug addicts with daily survival and help avoid their further deterioration) are available in a number of countries. They usually involve outreach, information and advice particularly about safe sex, provision of sterile injecting equipment, condoms and lubricants, and referrals to further health, social, and treatment services without imposing abstinence from drug use as a condition to service access. Also, this service may include comprehensive healthcare and counseling (EMCDDA, 2005; Gervasoni, Balthasar, Huissoud, Jeannin, & Dubois-Arber, 2012).

3.3.3.2 Focus on Sexual Health and Pregnancy

Outpatient and low-threshold facilities increasingly include basic medical care and have orientated service provision for sexual health, contraception advice, and free infectious disease testing and treatment, as well as pregnancy tests. Pregnant drug users are defined as a priority group and staff members help them to “jump” the drug treatment queue. An approach to pregnant drug users that has gained ground across Europe is to provide integrated quality care. Here, staff members support women in gaining access to a range of appropriate services. It has been reported there may be as many as 60,000 pregnant women using opioids and other drugs. Therefore, the issue of pregnancy and drug use is important to address for the mother, the unborn children and public health reasons (Gyarmathy et al., 2009).

Up to the 1990s, scant information was available on former Soviet Union (FSU) and Israeli origin female addicts (Isralowitz & Borkin, 2002; Isralowitz & Reznik, 2009, 2013). After nearly two decades of research, the following has been found:

- FSU females tend to be younger, less likely to be Jewish (a status that affects government benefits to immigrants), more likely to be married, better prepared for work through specialized training, and employed than their Israeli counterparts.
- Immigrant and native-born women report similar rates of being victims of sexual and physical abuse.
- FSU women report significantly more chronic medical problems including hepatitis C and HIV/AIDS than Israeli origin females.
- Alcohol and opiate use are higher among FSU women; Israeli-born women use more cocaine and sedatives.
- FSU women prefer shorter forms of treatment intervention such as detoxification and are more inclined to use alcohol and other drugs while receiving treatment.
- FSU women have a greater concern about their personal health and maintaining custody of their children (Isralowitz, 2003; Isralowitz & Bar Hamburger, 2002; Isralowitz & Borkin, 2002).

Nika's Story. The following story about "Nika," a former Soviet Union immigrant and drug user, is true. The story reflects the interaction of individual and environmental factors that influenced her vulnerability to drug use, abuse, and dependence. Born in 1978, Nika emigrated from Leningrad (now St. Petersburg) to Israel at the age of 22. The interview was conducted by a senior researcher of the RADAR Center, Ben-Gurion University, with permission and proper safeguard to her confidentiality. The interview has been edited for this chapter.

The Early Years. After many years of trying to became pregnant and give birth, my mother succeeded. I was born after 10 years of trying but believe my parents had no real desire to have a baby. My father was an editor of one of the Leningrad's newspapers and my mother worked as an accountant for a restaurant in one of the train stations … They had a pretty good life and were together for 10 years.

My father wasn't an alcoholic but he loved to drink … He had a good job and a positive outlook toward his career. My mother was always there for him and for him only … she treated him as if he was a big child. When I came into his world all the romance and intimacy of their relationship disappeared and then the problems began. They divorced 2 years after my birth.

My father called me once a year on my birthday but we never met even when I visited Russia. He was making good money but never provided support for my mother and me. My mother went on to marry other men. The first was wonderful who I wanted to be near when I was 4 and 5 years old. Mother was suspicious of our relationship. I remember how we were lying very close and tight to each other once; … in that moment my mother came in. She had a very strange look on her face. I don't know any of the details but soon afterward he was gone. Afterwards, she had 4 other husbands. There was one, a military man, who was strict and who

I did not get along with … after a couple of years he left the house. The third one was a married man; he was in a constant process of leaving his wife but eventually didn't. When my mother understood, after 2–3 years, that he was not going to divorce his wife, she left him. Afterwards, my mother was alone for many years and then remarried again. I lived with my mother in a two bedroom apartment—one room was my mother's, the second was mine and a living room. To be honest, I was sleeping with my mother most of my life when her men were not in the way.

My school life was fine and from the first grade 3 girls remained my closest friends to this day. After I finished the 7th grade I joined a children's choir and was able to travel to many European countries. I studied English but it didn't come easy and I had a hard time getting into the university. Mother saved money and bribed my way in … after 2 years and failing grades, I was expelled. The real reason was that after the first year at age 19, I "messed up" with drugs, then my life began to come apart.

Alcohol and Drug Use: *The Start*. I began to drink when I was 15 years old with girlfriends. We would buy something cheap like port wine. It was a big bottle, more than enough for us to "get wasted" and then go out to the city. When I got drunk it was fun … We didn't drink a lot, it was just for the good mood before going out … I remember drinking a bottle of liquor in the house, getting drunk, and nearly passing out when my mother and her husband went out for a few hours … When I got older, age 17, my mother and I occasionally had a drink together.

My mother smoked so when I was 13, I secretly tried a number of times but I was fooling around not really smoking—you fill your mouth with smoke and then blow it out without breathing in the smoke. I began to really smoke at 17. When I started smoking I decided not to hide it from my mother. I simply asked if I could join her for a cigarette. She was very surprised and tried to change my mind about smoking at first. But then, she got used to it. Besides smoking cigarettes and drinking, I used marijuana after graduating high school—several times a month with friends including guys who were drug addicts my age who I grew up with in the same building.

Friends. Through high school I had only girlfriends, but after graduation when our "grown-up" life began, we all chose different paths. I made friends with boys as well. The first boys I had as friends were three drug-addicted neighbors. I had a friendship with them, nothing more. I spent a lot of time with them, we regularly traveled together, went out of town or swimming. With them I began to smoke marijuana. They didn't keep secrets from me and I was aware that that they didn't smoke only marijuana but also used "cherniah," that is, black opium. They cooked it by themselves and then used it. Several times I came with them to Dybenko Street, the city market to buy supplies. I saw how they cooked it several times. However, they didn't use it when I was around. After a while they began offering me to try it with them.

I held myself for almost a year refusing their offers time after time. Then somehow I threw it all away—they never stopped bugging me so I gave it a try … We took the train to a suburban town where they occasionally bought "cherniah" for themselves. Then we walked for long time until we came to a house where they cooked it and used it in front of me. When I saw the needle I was shaking from fear … they

injected themselves and then began to try to inject me but could not find the vein. Initially they tried to find a vein in my arm but it did not work; then they decided it would be better to try in the leg but it too did not work. I could not stand it anymore and I burst into tears and began to swear at them and they left me alone. For more than a year they heard me say “no,” but when I finally said “yes,” nothing happened. If you meet drug addicts on a daily basis and you’re constantly offered to try it yourself, sooner or later, even if it takes years, you give up and accept the offer to use at least for the sake of being left alone or out of curiosity.

About a week later I went to visit one of them in his house. This time we didn’t go anywhere, it was in our building. He and another friend told me “let’s go,” found my vein and injected. I didn’t feel a thing; I sat with him and the other one for an entire hour. They saw nothing was happening and offered me marijuana to smoke. They told me that after the marijuana it would start. So we smoked and decided to go outside for a walk. When we got to the elevator there was another neighbor of mine from my floor. He looked at me in a very strange way so I understood that something was wrong with me. When we got out of the elevator and went outside I fainted and fell down. Afterwards I felt very sick and told myself enough experimenting. I said to those guys that they should stay away from me with their cherniah and not offer me again.

Soon after that time I met a new guy and we started dating. We developed a more serious relationship. He was a rich kid; we started to go out to nightclubs, discos, and various “hangouts.” My period with the neighboring friends was over but a new period was just beginning, I started sniffing heroin. The first time I was offered to try was by my boyfriend. I knew already what it was and that it was “cool” and popular. Thanks to him I meet many people who also used it. I envied them; near them I felt like a little girl who didn’t know anything about this lifestyle. Therefore, when he offered me I accepted without hesitation. I calmed myself by thinking that to sniff is not the same as to inject; injecting is dangerous, but to sniff a couple of times—why not?

From the first time, at age 20, using heroin made me feel spaced out. I began sniffing and everything went well. I was sniffing only with my boyfriend but we didn’t see each other every day. Because of his job, as a steward on a passenger steamship, we wouldn’t see each other for almost 2 months. During these periods I renewed my relations with my drug-addicted neighbors. It turned out that during the time we weren’t in touch they switched to heroin. When I found out that they were using heroin, I started injecting together with them. That’s the way it continued; when I met my boyfriend I sniffed heroin and when he was away I hooked up with my neighbors and injected with them.

I was still in school, the university, but it was far from being a top priority. I started using a needle on a regular basis. There were withdrawal periods but worst of all was what was after the withdrawals stopped. I had enough strength to deal with the withdrawals but the really hard part was what came after. Everything seemed gray and dull; my legs were taking me to my neighbors for another shot and then it would start all over again.

Thanks to my boyfriend I tried everything—ecstasy, "trip or LSD," and mescaline. I don't even remember what else. But I was craving only for heroin, nothing else, no marijuana, no alcohol, just heroin. In the beginning I was selling my videotapes then it was the gold—4 thin gold necklaces, my mother's and mine.

Addiction, Abortion, and Alcohol. It was a very tough time for me when I was 20–22 years old. At home there were always scandals that ended with my mother in tears. I broke up with my boyfriend, I was tired of "going out" and sniffing heroin was not enough for me anymore. I was expelled from the university in spite of a second chance. I didn't have enough money for heroin so each morning began with visiting and calling my friends, neighbors and relatives to get loans for my drug. The loaned money was returned by my mother. Sometimes she returned the money and sometimes she did not, she wasn't a millionaire you know. Anyway, I did what I could in my situation. My drug-using friends also managed with whatever they had. During the winter we would rob summer houses; we took whatever we could carry and sell even if it was for a few pennies. They were already in the "system," hooked and not able to survive 1 day without the needle. I too was moving in this direction. Mother would give me money for groceries so I would go to the supermarket with one of my friends and steal what was needed to buy. If we didn't manage to steal one thing, we would take something else and tell my mother that it wasn't on sale so I replaced it. Then we would both go and buy heroin.

I tried to get treatment during that time mostly at my mother's urging. The first time was 6 months after I started using. My mother was reaching her own conclusions, but until the very end she refused to believe that I was injecting. The final straw was when she caught me cooking my portion in the kitchen. When she saw the syringe she raised a cry and started telling me stories about drug addicts. I reacted very calmly and told her exactly what I am and that her shouting would not change a thing.

Even after I told her myself, my mother refused to completely believe it. She went to speak with the parents of my neighbor who I was using with. His parents knew for a long time already. Afterwards, she locked me inside the apartment. After 6 h I had such a withdrawal that I can't even put into words. I was aware of what was going to happen but my mother saw it for the first time… she was very scared and called an ambulance. They gave me a painkiller and I felt a little better. The next day my mother invited a narcologist who gave me an IV and I slept for a few days. I woke up feeling empty and confused. I couldn't understand what was happening to me. I had been in this condition for 5 days and felt that I couldn't bear it any more. I had no life without heroin so I went back to my friends and used again. Afterwards, there were seven more attempts to quit and each one ended the same way. I would manage to go through the hard withdrawal but a few days after I would start all over again. The longest time that I was clean was 8 weeks. I realized that I simply didn't want to live without heroin. I wasn't in a state of "I can't quit." I was in the state of "I don't want to quit." I realized that it was my choice and path.

The idea of immigrating and starting over didn't happened instantly. When I turned 21, after another unsuccessful attempt to quit, my mother sent me away to

my relatives in Odessa. I hadn't been there for almost 7 years. I had a 3rd grade cousin there the same age. When I arrived I saw how he had grown and I started living with him. At first, I slept with him in the same bed. They didn't have another place for me and I didn't want to sleep on the floor. Afterwards we started to date; we went out together and he showed me the city. Then after some time I found out that I was pregnant; it was a big surprise for me and for him. Besides that, I didn't have my period from the time I started injecting. I saw that I was gaining weight but thought it was the effect of the vacation in Odessa. I remember I told my mother: "look how Odessa affected me, how well I look." And then, I do not remember for what reason, my mother and I were in the health clinic. We passed by the gynecologist's office so my mom suggested to get in. It turned out that I was 4 months pregnant. I was happy to hear this news and also my mother, but when we arrived home and started to think rationally about what happened and how my lifestyle would affect this unborn child. Nevertheless, after another withdrawal and short break I started to use again. Mother and I decided that the best thing to do was to abort. I regretted this decision and blamed her. From that time we fought a lot and I began using even more heroin. I regret it happened this way. Maybe if I had the child I would have had motivation to quit using. The doctors didn't say anything about drug use and pregnancy but I stated using birth control methods.

I used heroin constantly and drank intensively so there was no place for pregnancy with this type of life. This went on for another year until I heard about a miracle drug that could help me quit without experiencing withdrawal symptoms. It was very expensive but many of my acquaintances started to use it to quit with the needles. I was very tired and exhausted; the abortion left an impact on me. I still can't talk about it calmly. I decided to try this miracle drug and after a week I realized I could stop using without feeling any withdrawal. To prevent my craving I began to drink strong beer. Every time I woke up I would drink a sip of beer and then go back to sleep and that's the way my days went. During that time I met a guy and we together decided to quit using but to prevent the cravings we often got drunk. My mother and his parents were willing to do anything to prevent heroin use. Their approach was it is better to drink.

Immigration, Absorption, and Acculturation. At this time, my father told me about immigration to Israel during our yearly phone call for my birthday. I was a daughter of a Jew and I had the right to immigrate there. I didn't give it much thought at the beginning because I was studying at the university and just began to use drugs. When I decided to quit, I went to a meeting with the Israeli consul. He asked me to come back after a month with all the required documents. When I went to meet him again, he asked me some questions and I filled up some forms. Then someone called from the Jewish Agency and said they found a place for me at some program for young people: I should prepare my documents for departure. To the last moment I wasn't sure whether to go or not. My mother told me to leave since I going nowhere with my heroin and alcohol use. She began to draw a fabulous picture of my future life in Israel—a new country, new friends, no drug use, no alcohol use, and everything was going to be ok. In the end she talked me into. I really didn't know anything

about the country… Little was explained to me by the recruiting agency except for what documents were needed for immigration.

On leaving Russia I told my friends that I would not survive in Israel more than a year so they should not forget me. I got so drunk on the plane going there that I don't remember what happened in the airport. I was sent to a youth program and then to an absorption center in the southern region of the country. I began to learn Hebrew, studied for 2 months and kept on with vodka even though I was told drug and alcohol use was forbidden and a reason for expulsion from the "Ulpan" program. In the end the fairy tale about Israel led me to quite a shock going from a life in St. Petersburg to restrictive conditions in a desert environment. I adjusted quickly enough and visited Beer Sheva with other immigrants a couple times a week. There we bought vodka and under a sweater or in any other way sneaked it to our center. Once a week, after receiving the Sabbath, we would drink intensively. I even had a bottle of vodka in my closet; I would take a drink from it during the day. Of course after that I had to bypass every "Madrich" so he would not notice or smell anything.

After 2 months in the absorption program, I met Dany who visited the program saying he owned a coffee shop. He offered immigrant girls work; easy with good wages. What did I know about this "coffee shop"? I agreed. I was the only one and drove away with him to see my future workplace. We spoke to each other in very basic English.

I soon learned it wasn't a coffee shop when I entered the place. Back then I wasn't an innocent girl, but thought I would be working in a regular "sex shop" as a saleswoman. I couldn't even imagine that the situation was worse and that an immigrant in Israel could be tricked this way. I am not saying that in Russia everything was perfect. There I was also tricked but I understood in what way and for what. But the fact is it happened here in Israel. For me it was a low blow. I just wasn't ready for this kind of thing. When I realized where I was, I immediately wanted to go back to the absorption center. Dany calmed me down by saying it was too late to go back; I should spend the night at his place and return to the center in the morning. The next day I returned to find out I was expelled and no longer living there.

I think if I was visiting friends or relatives no one would have said anything. But they knew what kind of people came from Beer Sheva to invite girls to work at the "coffee shop." When I did not return back on time, everybody thought that I started to work. In addition they remembered all my sins connected to drinking. I think Dany knew that it would end this way and that's why he insisted I spend the night in the city.

Can you imagine my condition—alone in a strange country without knowing the local language, without any relatives, and without a place to sleep? I did not know what to do but I had Dany so I went with him to the: "Sex Shop," "Strip Club," "Mahon" as a striptease dancer only.

For almost a year I began to drink big time. I never imagined that I would end up this way. At the beginning I was scared and embarrassed. To overcome myself I drank a lot and don't remember myself being sober. My first thought when I woke up in the morning was whether I had enough vodka to get myself ready for work.

I forgot about drugs, it was all about alcohol. I wasn't paid much but Dany provided most things. He was making money off of me and only now do I realize that I could have made up to $3,000 a month.

After I saved some money I rented an apartment. I paid 3 months in advance. Then Dany suggested I live at his house but not with him. In one part of the house he and his wife lived and at the other, my room. I had a difficult relationship with Dany. When I was expelled from the absorption center, I realized that I didn't have a choice and I needed to work. I told Dany that I couldn't do it without vodka. He decided to monitor my alcohol use and buy my vodka. I remember getting drunk 1 day and taking off my clothes in front of him. I drank more and by morning realized we had sex that night. On the Sabbath, we didn't work but he would get me drunk and take advantage of me. In his home if he had any problems with his wife, he knew that with a liter of vodka his night with me was guaranteed. After 6 months of this he kicked me out and deducted the cost of living at his place from my money. Again, I was helpless.

After this experience, I decided to go to back to Russia for a short visit. There, my mother had remarried again. It was the fifth time. I had an additional stepfather—Misha, another Jew and a drunk. I told my mother that the main reason for my return was to get alcohol treatment. After a week in Saint Petersburg, she began reminding me why I came in the first place. We went to a narcologist and he prescribed me a medicine—"Espiral"—a medical preparation used for the treatment of alcoholism. I took it for a while but then I met my old buddies who never stopped injecting. After a break for almost a year, I began to use heroin again with them.

When my mother saw what was happening to me she said that I needed to go back to Israel. There I just drank and here I started to use drugs again. I had no choice so I returned to Israel and back to Dany. I lived at his place for a week and thanks to him I met his brother Asher. He also owned "sex shop," "peep show," and "mahon" all under the same roof. Then I started to work at his place. After I returned to Israel I began to drink again. All that mattered for Asher was that I could stand on my feet and perform my striptease number. I was in such a condition that I didn't care about money. Everything that was to do with money was handled by Asher; he talked to the clients and all the money went to him. Vodka was important for me and a lot of it. I was sleeping at the workplace.

Since no one was controlling me, I drank enormous amounts when I returned from Russia and when I worked for Asher. I remember fragments of my life then, walking in the street, drunk, and constantly falling. I would get up, walk some steps, and fall again. Eventually, I found myself at Soroka Hospital because I had terrible abdominal pain; I do not remember how I got there but a couple of hours later I ran out of there going from pub to pub for a drink.

On one evening I met an Arab; he invited me for a drink at his place and promised he would not touch me but there he beat me badly and raped me. After that I remember being in the hospital again; how I got there I do not know. They were treating my wounds and asking me who did this to me. So I told them Asher did it. I received treatment and returned to my workplace to spend the night only to find the place was closed for 3 days. I didn't know where Asher lived and I had no place

to go. I spent 3 days on the streets. I was lucky that it was summer at that time. Afterwards I found out that he was arrested for rape and beating; he had to spend the day in jail until they figured out it was not him.

When we met I asked for his forgiveness in every way I knew. But he could not understand how I could have done such a thing—to tell such a lie. I didn't understand either, I was drunk. He didn't forgive me and kicked me out. I spent a couple of days on the streets, I don't remember from where I got the money for alcohol and food. I had to go somewhere so I decided to go to Dany, his brother. I told him everything and that I was in no condition to work; he saw my terrible bruises. If I was able to do something it was to drink vodka.

Dany let me stay at his place. He locked me up during the day at the "mahon." I was without a drink for almost 12 h; I was shaking and shivering so Dany called for an ambulance and I was taken to Soroka Hospital again. There I had my first epileptic seizure. I lost all control over my body; I was thrown from side to side, bent, and twisted to arches. They immediately gave me an injection of medication and brought me to a patient ward where I spent a couple of days. In the hospital I had a couple of more seizures but they were weaker and I began to realize that I could not keep drinking the way I do. After Soroka, I began to work for Dany, again for pennies. I didn't quit drinking but I tried not to get drunk till unconsciousness because Dany, as before, had me under his control. But even that proved not to be enough when I was offered local heroin by some of the clients. I was now sniffing and smoking… forgetting about alcohol. My salvation was heroin, not alcohol. In spite of it all, I was going back and forth using heroin and alcohol, binge drinking for 5–6 days, then going back to smoking heroin. I had a double dependence—when I used heroin I didn't want to drink; when I was drinking alcohol I didn't crave heroin. During the first 2 and half years in Israel I was half of the time drunk and the other half high from heroin. I used cocaine but only a few times.

After I finished with Dany I returned to Asher as a prostitute to earn enough money for heroin—5 or 6 "manot" every day. Before then I worked only as a striptease dancer. Asher did not have a lot of clients so we focused on quality and not quantity. I had regular clients. On several occasions they invited me to their home. I was not greedy for money. If I came across a client that would pay additional money for some special service, I preferred to turn the offer down. I could have earned more money this way but I just didn't need to and I was concerned about my health.

After my time in Russia and return to Israel my mother came to visit me a couple of times. She would come and see what was going on with me, cry, and leave. Then she and my stepfather immigrated; rather my stepfather did and my mother came as a tourist because she was denied a visa. With my mother in Israel, life became easier for me; she insisted that I quit my job and move in with them. I received government disability support and for the first time in years began to take care of my health—cirrhosis of the liver at a very serious stage.

Life with my stepfather in Israel was bad from the start. I told my mother right away: "Mother, he is shit." We fought regularly except when I drank with him. My mother also has a hard time with him but she tried to hold on because she didn't

have Israeli citizenship. He could say all sorts of stuff and my mother would be deported from the country. He didn't like living in Israel and began to drink more often; we were forced to live together. He couldn't leave—he didn't have the money to go back to Russia; mother was trapped with him because she didn't have citizenship. Both worked in menial laundry and cleaning-related jobs. I also couldn't leave because my path out was only with Dany or Asher.

I have continued to live with my mother and step father but I took methadone for treatment. I didn't use heroin and occasionally I had a drink. I smoked "grass" very often. It's not heroin or vodka and you got to have something for the soul. All my plans were now linked to my health. I totally ruined my liver and needed to start treatment with interferon. If the treatment helped I can talk about the future. If not, in 5 years I was going to be dead. With this kind of diagnosis you don't live long. Also, I planned to keep going with methadone.

Epilogue. Nika was able to stop the use of methadone and alcohol when she decided to have healthy children. She passed through successful treatment of liver cirrhosis, continued to smoke marijuana, and had two children out of marriage from two different men. After stopping heroin and alcohol use and the birth of two children, she voluntarily entered an outpatient psychiatric treatment program to address unresolved issues related to the events she experienced. Nika took antidepressants on a regular basis and did not work, but lived with her children and mother who received Israeli citizenship. Her Jewish stepfather returned to Russia and her mother's apartment in Saint Petersburg was rented serving as an additional source of income.

The case of Nika is one of many women who, in search of a new life in Israel, find themselves trapped in conditions of being used, abused, and discarded. Her story, linked to many drug abuse causal factors discussed at the beginning of this chapter (e.g., relations with family and friends, living conditions, school problems, and exploitation), is sadly common in many countries throughout the world.

3.3.4 Males

3.3.4.1 Heroin Use in Perspective

The value of the global opiate market is estimated at US$ 65 billion per year. Afghanistan alone accounts for more than 90 % of global opium production. Every year, the equivalent of some 3,500 tons of opium flows from Afghanistan to the rest of the world through its neighboring countries: 40 % through the Islamic Republic of Iran, 30 % through Pakistan, and the rest through Central Asia (Tajikistan, Uzbekistan, and Turkmenistan). The potential gross export value of Afghanistan's opiates was $2.8 billion in 2009—the equivalent of about a quarter of the country's gross domestic product (GDP) (UNODC, 2009).

Thomas Schweich (2008), who served the Bush administration as the ambassador for counternarcotics and justice reform in Afghanistan, provides a revealing expose

of conditions in Afghanistan. The following excerpt is drawn from his article published in the New York Times Magazine (Schweich, 2008):

> I took to heart Karzai's (Afghan President) strong statements against the Afghan drug trade. That was my first mistake…Over the next two years I would discover how deeply the Afghan government was involved in protecting the opium trade—by shielding it from American-designed policies…The trouble is that the fighting is unlikely to end as long as the Taliban can finance themselves through drugs—and as long as the Kabul government is dependent on opium to sustain its own hold on power…[T]he Afghans congratulated themselves on their tremendous success in fighting drugs even as everyone knew the problem was worse than ever…Less than 1 percent of the opium produced in Afghanistan was being seized there. There was no coherent strategy to resolve these issues among the U.S. agencies and the Afghan government…despite some successes, poppy cultivation over all would grow by about 17 percent in 2007. Opium cultivation in Afghanistan is no longer associated with poverty—quite the opposite.

The United Nations estimates that in 2010 between 153 and 300 million people aged 15–64 (about 5 % of the world's population for that age group) had used an illicit substance at least once in the previous year (UNODC, 2012). By far, the most common substance used is cannabis (i.e. marijuana or hashish) compared to opioid use (mainly heroin, morphine, and nonmedical use of prescription opioids) that is used by about 0.7 % of the population. In terms of harm to health including the spread of infectious disease such as Hepatitis C and HIV/AIDS, opioids (particularly heroin) are reported as the main type of drug that is injected and as a major cause of drug-related deaths. For this reason, opiates are the main problem drug throughout the world—about 16.5 million people use opium, heroin, and morphine annually. Those who use and abuse opiates make up about two-thirds to three quarters of the people in need of treatment. About 4 million, or 22 %, of users are in Europe, mainly the central and eastern subregions (e.g., the Russian Federation and the Ukraine), where about 1.2–1.3 % of the population aged 15–64 years have used opiates at least once in the previous year. Presently, Russia is the largest single market for Afghan-origin heroin. There are 2.5 million drug addicts and over 5.1 million drug users, and HIV infection rates are up to 61 % among drug users in some regions of the country. Officials estimate that there are 80,000 new drug users each year; more than 30,000 people die annually of drug overdoses and another 70,000 deaths per year are drug-related in Russia (RIA Novosti, 2012; UNODC, 2011).

It is widely acknowledged that the spread of HIV/AIDS as well as hepatitis B and C and other blood-borne viruses is linked, in part, to injecting drugs—mostly heroin. Eastern Europe and Central Asia is the only region where HIV prevalence clearly remains on the rise; HIV has almost tripled since 2000 and reached an estimated 1.4 million people in 2009. The epidemic in the region is concentrated mainly among drug users, sex workers and their sexual partners, and, to a much lesser extent, men who have sex with men (UNODC, 2011).

Among infectious diseases, after HIV/AIDS, tuberculosis (TB) is the second leading killer in the world. HIV and TB are closely linked and up to 50 % of those people living with HIV can expect to develop TB. About 2 billion people are thought to be infected with TB and about 1.3 million die from the disease each year (Mohajan, 2014). TB is most prevalent in crowded low-income areas with substandard health

conditions, and it is linked to drug users and alcoholics who have a history of crime, imprisonment, and unemployment (Migliori & Ambrosetti, 1998). Drug users are two to six times more likely to contract TB than nonusers (NIDA, 1999). Reported TB rates for correctional system populations have been 10–100 times higher than rates for the local civilian populations, and TB outbreaks with a high number of TB multidrug-resistant cases have been documented. Prisons, heavily populated with drug offenders, are known as social and sanitary pathology reservoirs in which TB is often associated with chronic infectious diseases caused by HIV, hepatitis B virus (HBV), or hepatitis C virus (HCV). HCV prevalence among inmates is 30–40 %, which is higher than that in the general population and is related to injection drug use (CDC, 2012).

In the former Soviet Union, deteriorating conditions including poverty, unemployment, inadequate hygiene and heath care, a lack of preventive health education, and poorly ventilated prisons where inmates fall ill have provided fertile ground for the rise of injecting drug use, the spread of HIV, and tuberculosis referred to as "Ebola with wings" (Isralowitz, 2004; Malinowska-Sempruch, Hoover, & Alexandrova, 2003). Many of these drug users found their way to Israel in the 1990s claiming eligibility for citizenship (Isralowitz & Myers, 2011; UNODC, 2012).

3.3.4.2 Former Soviet Union Immigrants

"A person's cultural affiliation often determines the person's values and attitudes about health issues, responses to messages, and even the use of alcohol, tobacco and other drugs" (Wright, 1994, p. 1). From 1989 to 1998, the Israeli population of 4.5 million rose about 20 % primarily from the nearly one million Soviet immigrants, mostly from Russia and the Ukraine, who entered the country (Isralowitz & Reznik, 2013). A large proportion of the Russian-speaking immigrants had training and education in a variety of technical and professional fields; success was an important component of their worldview and culture (Philippov, 2010). However, there were immigrants who arrived in Israel with drug abuse problems and others became addicted during the absorption process (Isralowitz, Reznik, Spear, Brecht, & Rawson, 2007). Presently, Russian-speaking immigrants are 13 % of the Israel population but about 25 % of the heroin drug users in the country (Isralowitz et al., 2007).

3.3.4.3 Heroin-Using Immigrants from Russia, Ukraine, and the Caucasus Region

Most studies of FSU immigrants have aggregated data that fails to capture racial/ethnic differences that may exist within the broad FSU population. This issue is becoming increasingly important to policy and treatment (SAMHSA, 2007). In response, the RADAR Center, Ben-Gurion University, compared drug use patterns and severity among male immigrants from Russia, the Ukraine, and the Caucasus mountain region (Kavkaz people) residing in Israel and profiled their psychosocial

needs. Such information has contributed to developing clinical interventions to effectively treat drug abuse disorders. Among the key findings from Isralowitz & Reznik, 2014 and Isralowitz, Reznik, Rawson, & Hasson, 2009 are here:

- Kavkaz drug users were significantly older, have less education, higher unemployment, and more Jewish religion identity than those from the Russia or the Ukraine.
- Kavkaz males have a longer history of drug use likely attributed to their older age.
- Kavkaz males report a higher percentage of last 30-day cannabis and cocaine use.
- Ukrainian males report a higher percentage of lifetime opium users.
- All three groups (i.e. Russians, Ukrainians, and Kavkaz) have high levels of employment, legal, family/social, medical, and psychiatric problems.
- No significant differences between groups exist in terms of rates of chronic medical problems, hepatitis C, HIV/AIDS, and tuberculosis.

3.3.4.4 Heroin Use in Israel: A Comparison Between Israeli and FSU Immigrants

Expectations of severe health problems and high-risk drug behaviors abound for the FSU immigrant population in Israel. However, there was not any systematic study of such trends compared to the native Israeli population until 2006. Based on data collected by the RADAR Center, the following has been found:

- FSU drug users tend to be significantly younger than the native Israeli drug users.
- FSU and native Israeli addicts have similar educational backgrounds.
- FSU addicts are more likely to be employed.
- Identification with the Jewish religion is less common among the FSU addicts.
- Native Israeli addicts reveal more years of heroin use than those from the FSU.
- FSU addicts' lifetime opiate use, namely, opium, is more extensive than what the native Israelis report.
- FSU addicts report more lifetime alcohol, polydrug use, and cannabis use than their native-born counterparts (Isralowitz, Reznik, Spear, Brecht & Rawson 2007).

Gender Status Differences: *FSU Men and Women.* A comparison of FSU female and male drug users treatment shows (Isralowitz & Reznik, 2013):

- Females tend to be: younger, married, or living with a partner; not Jewish; less likely to have a criminal record resulting in a conviction, incarceration, and/or parole, and more sexually abused.
- Females report more chronic illness; however, their level of HIV/HCV/TB infection is similar to males.
- Patterns of heroin, alcohol, and other drug use are similar among females and males; cannabis use is higher among males and cocaine use higher among females.
- Females are more likely than males to prefer short-term detoxification (only) as a treatment intervention.
- Females have more employment-related problems than males.

3.4 Older Adults: Prescription Use

Benzodiazepines are a commonly prescribed psychotropic drug often used by elderly persons for anxiety and insomnia (Longo & Johnson, 2000). Epidemiology of benzodiazepines is controversial because prolonged use may lead to dependence (Gonzales, Stern, Emmerich, & Rauch, 1992). Risk factors associated with long-term use include increased age, female gender status, emotional distress, depression, poor health, memory impairment, and falls (Roberts et al., 1998). Inappropriate use of benzodiazepines among older people, like other psychotropic drugs including alcohol, is a major public health problem that leads to mortality, morbidity, and related health costs (Moos, Brennan, Schutte, & Moos, 2004). Studies have documented that the level of potentially inappropriate medication use among nursing home residents may be as much as 40 % and 14–37 % for elderly people in community-based care facilities (Fialová et al., 2005; Ma, Lum, Dai, Kwok, & Woo, 2007).

Little is known about psychotropic drug use among older Israeli adults including immigrants caught up in acculturation processes (Isralowitz, Reznik, & Borkin, 2006). Israel, a country built on the large waves of immigrants from multiple countries, now faces an increasing percentage of its population as older adults. Research shows older adults, especially women who tend to live longer, use harmful prescription drugs like benzodiazepines. Benzodiazepine use was reported by 69 %; among them 45 % use the drug on a daily basis (Isralowitz et al., 2006) for insomnia as well as stress and anxiety, sadness and loneliness, and adjustment difficulties.

Fialová et al. (2005) have noted that the possible abuse of psychotropic drugs among community-dwelling older adults appears to be a common problem with variations reflective of country-specific drug policies, care provisions, socioeconomic and health conditions, as well as other reasons. Large-scale immigration of older people with adjustment problems to a new environment in countries like Israel is another potential cause of inappropriate drug use. Statements among late-life women attributing daily benzodiazepine include: “It is difficult for me to get used to life in Israel. My husband died, my children visit very seldom … I do not know Hebrew and all day I sit at home and watch TV in Russian … bad news about events in Israel frightens me. I very strongly miss my former life in the Ukraine.” “I cannot adjust to life in Israel. My Hebrew (speaking) is bad and I must ask others to help me with translation … I was once helped by my children and husband. My husband died a few years ago and my children returned to Russia … I am in Israel absolutely alone … it is hard for me to continue life here and I feel like a foreigner.” “We came to Israel because we have many relatives here … my daughter and her husband are musicians, she now washes floors and he works as a simple laborer in a factory. Their financial situation is very bad with lots of debts. I hurt very much because I cannot help them” (Isralowitz et al., 2006, p. 679).

Service provider and client miscommunication, especially if it involves use of a foreign language, is another reason for possible improper drug use among elderly people. In a report on the prevention of drug abuse and misuse, Carlson (1994) points out that older adults often have sensory and cognitive deficits that make

understanding medication instructions difficult. Also, an older person may play a role in medication misuse by failing to report symptoms, underusing medications to avoid side effects or save money, or using them in combination with alcohol that heightens the risk of adverse effects.

Finally, it is important to point out that Russian-speaking elderly people in Israel are not a homogeneous population and there appears to be variability in biological, psychological, social, and illness factors that may influence inappropriate drug use (Isralowitz, Shpiegel, Reznik, Borkin, & Snir, 2009). Older women especially have health problems including those of a gynecological nature that are often neglected leading to opiate and benzodiazepine prescription drug treatment. This suggests that the management of age-related problems including improper psychotropic drug use will require specific tailoring of treatments and services to address quality of life needs of older adults (Isralowitz et al., 2006; Patterson, Lacro, & Jeste, 1999).

3.5 Discussion and Conclusion

Treatment of drug users is a difficult process and it has been noted by Sullivan and Fleming (1997) that researchers have not confirmed that separate programs for special populations such as Russian-speaking immigrants from the former Soviet Union are superior to mainstream efforts with respect to outcomes. Experts question the cost-effectiveness of such special programs and clinicians must be wary of defining any patient in relation only to age, gender, racial group membership, or functional characteristics. One study has found that effort focused on specific problem histories of drug users may not improve the long-term effectiveness of drug treatment or the lives of those who have been subject to such conditions (Fiorentine, Pilati, & Hillhouse, 1999). However, some experts believe treatment of special populations may be enhanced if their particular needs are considered and met (American Psychiatric Association, 1995; Institute of Medicine, 1990; Kauffman & Woody, 1995; Landry, 1996; Sullivan & Fleming, 1997). Such program activities should be part of a treatment environment that integrates all clients regardless of their personal attributes and background characteristics (e.g., country of origin and gender status).

3.6 Future Directions

It is clear that the interrelationships between male and female drug users with native-born/immigrant status are undoubtedly complex. The information presented here and from other research suggests that high-risk behaviors may cluster, and therefore detailed analyses are needed to delineate the nature of such interrelationships. Second, the interviews of the participants were collected at one point in time and from those receiving some form of ambulatory day care treatment for their

addiction; therefore, caution should be exercised in generalizing the results provided in this chapter.

References

American Psychiatric Association. (1995). *Practice guide for treatment of patients with substance use disorders: Alcohol, cocaine, opioids*. Washington, DC: American Psychiatric Association.

Ball, J., Nurco, D., Clayton, R., Lerner, M., Hagan, T., & Groves. G. (1995). Etiology, epidemiology and natural history of heroin addiction: A social science approach. In L. Harris (Ed.) *Problems of Drug Dependence, 1994: Proceedings of the 56th Annual Meeting* (Vol. 1, pp. 74–78). Rockville, MD: The College on Problems of Drug Dependence.

Becker, H. (1953). Becoming a marijuana user. *American Journal of Sociology, 59*, 235–242.

Carlson, K. (1994). *The prevention of substance abuse and misuse among the elderly: Review of literature and strategies for prevention*. Seattle: Alcohol and Drug Abuse Institute, University of Washington.

Centers for Disease Control and Prevention (CDC). (2012). *Emerging infectious diseases: Tuberculosis screening before anti-hepatitis C virus therapy in prisons*. Retrieved September 25, 2014, from http://wwwnc.cdc.gov/eid/article/18/4/11-1016_article

Cohen-Navot, M., Ellenbogen-Frankovits, S., & Reinfeld, T. (2001). *School dropouts and school disengagement*. Jerusalem: The JDC-Brookdale Center for Children and Youth.

Dick. D., & Agrawal, A. (2008). The genetics of alcohol and other drug dependence. *Alcohol Research & Health, 31*(2). Retrieved December 10, 2015, from http://pubs.niaaa.nih.gov/publications/arh312/111-118.pdf

DuPont, R. L., Caldeira, K. M., DuPont, H. S., Vincent, K. B., Shea, C. L., & Arria, A. (2013). *America's dropout crisis: The unrecognized connection to adolescent substance use*. Rockville, MD: Institute for Behavior and Health.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2005). *Differences in patterns of drug use between men and women*. Retrieved September 25, 2014, from http://www.emcdda.europa.eu/attachements.cfm/att_34281_EN_TDS_gender.pdf

Executive Office of the President of the United States (EOP). (2012). *US National drug control strategy*. Retrieved September 25, 2014, from http://www.whitehouse.gov/sites/default/files/ondcp/2012_ndcs.pdf

Fialová, D., Topinková, E., Gambassi, G., Finne-Soveri, H., Jonsson, P., Carpenter, I., et al. (2005). Potentially inappropriate medication use among elderly home care patients in Europe. *Journal of the American Medical Association, 293*(11), 1348–1358.

Fiorentine, R., Pilati, M., & Hillhouse, M. (1999). Drug treatment outcomes: Investigating the long-term effects of sexual and physical abuse histories. *Journal of Psychoactive Drugs, 31*(4), 363–372.

Gervasoni, J. P., Balthasar, H., Huissoud, T., Jeannin, A., & Dubois-Arber, F. (2012). A high proportion of users of low-threshold facilities with needle exchange programmes in Switzerland are currently on methadone treatment: Implications for new approaches in harm reduction and care. *International Journal of Drug Policy, 23*(1), 33–36.

Glajchen, M. (2001). Chronic pain: Treatment barriers and strategies for clinical practice. *Journal of the American Board of Family Practice, 14*(3), 211–218.

Glynn, T., & Haenlein, M. (1988). Family theory and research on adolescent drug use: A review. *Journal of Chemical Dependency Treatment, 1*(2), 39–56.

Gonzales, J., Stern, T., Emmerich, A., & Rauch, S. (1992). Recognition and management of benzodiazepine dependence. *American Family Physician, 45*(5), 2269–2276.

Goode, E. (2007). *Drugs in American society* (7th ed.). New York: McGraw-Hill.

Gyarmathy, V., Giraudon, I., Hedrich, D., Montanari, L., Guarita, B., & Wiessing, L. (2009). Drug use and pregnancy—Challenges for public health. *Eurosurveillance, 14*(9), 33–36.

Herbert, B. (2010). America's black men continue to face a crisis. *The Daily Advertiser*. Retrieved September 3, 2010, from http://www.theadvertiser.com/article/20100829/OPINION/8290327/America-s-black-men-continue-to-face-a-crisis

Institute of Medicine. (1990). *Broadening the base of treatment for alcohol problems*. Washington, DC: National Academy Press.

International Narcotics Control Board (INCB). (2010). *Report of the International Narcotics Control Board for 2009*. New York: United Nations.

Isralowitz, R. (2002). *Drug use, policy and management* (2nd ed.). Westport: Auburn House.

Isralowitz, R. (2003). Female heroin addicts in Israel. *Psychiatric Times*, Global Watch Special Edition, *11*, 25–27.

Isralowitz, R. (2004). *Drug use: A resources handbook*. Denver, CO: ABC-CLIO.

Isralowitz, R. (2012). Prescription drug use among young adults: Blaming the victim. *Journal of Social Work Practice in the Addictions, 12*(4), 446–448.

Isralowitz, R., & Bar Hamburger, R. (2002). Characteristics of heroin using immigrant and native born women: Implications for policy and program development. *Journal of Psychoactive Drugs, 34*(1), 97–103.

Isralowitz, R., & Reznik, A. (2009). Problem severity profiles of substance abusing women in therapeutic treatment facilities. *International Journal of Mental Health and Addiction, 7*(2), 368–375.

Isralowitz, R., & Borkin, S. (2002). Russian immigrant heroin addiction. In R. Isralowitz, M. Afifi, & R. Rawson (Eds.), *Drug problems: Cross-cultural policy and program development* (pp. 89–112). Westport, CT: Auburn House.

Isralowitz, R., & Reznik, A. (2007). Former soviet union immigrant and native-born adolescents in Israel: Substance use and related problem behavior. *Journal of Ethnicity in Substance Abuse, 6*(1), 131–138.

Isralowitz, R., & Reznik, A. (2008). Problem severity profiles of substance abusing women in therapeutic treatment facilities. *International Journal of Mental Health and Addiction, 7*(2), 368–375.

Isralowitz, R., & Reznik, A. (2013). Former Soviet Union immigrant women: Drug use profiles and special needs. In *Promoting a gender responsive approach to drug addiction*. DAWN Drug Alcohol Woman Network, United Nations Interregional Crime and Justice Research Initiative (UNICRI).

Isralowitz, R., & Reznik, A. (2014). Russian speaking immigrants: Drug use, infectious disease and related health behavior. *Journal of Immigrant and Minority Health, 16*(6), 1311–1315.

Isralowitz, R., & Reznik, A. (2015). Impact of religious education and religiosity on adolescent alcohol use and risk taking behavior. *Religious Education, 110*(3), 303–310.

Isralowitz, R., Reznik, A., Rawson, R., & Hasson, A. (2009). Immigrants from Russia, Ukraine and the Caucasus Region: Differential drug use, infectious disease and related outcomes. *International Journal of Mental Health and Addiction, 7*(3), 450–457.

Isralowitz, R., Reznik, A., Spear, S., Brecht, M., & Rawson, R. (2007). Severity of heroin use in Israel: Comparisons between Native Israelis and Former Soviet Union immigrants. *Addiction, 102*(4), 630–637.

Isralowitz, R., Reznik, A., & Borkin, S. (2006). Late life benzodiazepine use among Russian speaking immigrants in Israel. *The Gerontologist, 46*(5), 677–679.

Isralowitz, R., Reznik, A., & Straussner, S. (2011). Prescription drug use trends among Israeli school dropouts: An analysis of gender and country of origin. *Journal of Social Work Practice in the Addictions, 11*(1), 75–86.

Isralowitz, R., Shpiegel, S., Reznik, A., Borkin, S., & Snir, Y. (2009). Late life alcohol use and gender differences among Former Soviet Union immigrants. *Journal of Ethnicity in Substance Abuse, 8*(2), 201–205.

Kandel, D. (1980). Drug and drinking behavior among youth. *Annual Review of Sociology, 6*, 235–285.

Kauffman, J., & Woody, G. (1995). *Matching treatment to patient needs in opioid substitution therapy* (DHHS Publication No. SMA 95-3049). Rockville, MD: U.S. Department of Health and Human Services.

Landry, M. (1996). *Overview of addiction treatment effectiveness* (DHHS Publication No. SMA 96-3081). Washington, DC: U.S. Department of Health and Human Services.

Longo, L., & Johnson, B. (2000). Addiction: Part I. benzodiazepines—Side effects, abuse risk and alternatives. *American Family Physician, 61*(7), 2121–2128.

Ma, H. M., Lum, C. M., Dai, L. R., Kwok, C. Y. T., & Woo, J. (2007). Potentially inappropriate medication in elderly patients in outpatient clinics. *Asian Journal of Gerontology & Geriatrics, 3*(1), 27–33.

Malinowska-Sempruch, K., Hoover, J., & Alexandrova, A. (2003). *Unintended consequences: Drug policies fuel the HIV epidemic in Russia and Ukraine*. New York: Open Society Institute.

Migliori, G., & Ambrosetti, M. (1998). Epidemiology of tuberculosis in Europe. *Modali Archives of Chest Diseases, 53*(6), 681–687.

Miller, W. (1958). Lower class culture as a generating milieu of gang delinquency. *Journal of Social Issues, 14*(3), 5–19.

Mohajan, H. (2014). *Tuberculosis is a fatal disease among some developing countries of the world*. Retrieved December 10, 2015, from http://pubs.sciepub.com/ajidm/3/1/4/

Moos, R., Brennan, P., Schutte, K., & Moos, B. (2004). High-risk alcohol consumption and late-life alcohol use problems. *American Journal of Public Health, 94*(11), 1985–1991.

National Council on Alcoholism and Drug Dependence (NCADD). (2014). *Prescription drugs*. Retrieved September 25, 2014, from http://ncadd.org/index.php/learn-about-drugs/prescription-drugs

National Institute on Drug Abuse (NIDA). (1999). *NIDA Notes: Infectious diseases and drug abuse*. Retrieved September 25, 2014, from http://archives.drugabuse.gov/NIDA_Notes/NNVol14N2/Tearoff.html

National Institute on Drug Abuse (NIDA). (2009). *NIDA InfoFacts: Treatment approaches or drug addiction*. Retrieved September 25, 2014, from http://www.drugabuse.gov/sites/default/files/if_treatment_approaches_2009_to_nida_92209.pdf

National Institutes of Health (NIH). (2011). *Drug abuse prevention intervention research*. Retrieved March 9, 2016, from http://grants.nih.gov/grants/guide/pa-files/PA-11-313.html

Needle, R., McCubbin, H., Wilson, M., Reineck, R., Lazar, A., & Mederer, H. (1986). Interpersonal influences in adolescent drug use—The role of older siblings, parents, and peers. *Substance Use and Misuse, 21*(7), 739–766.

Patterson, T., Lacro, J., & Jeste, D. (1999). Abuse and misuse of medications in the elderly. *Psychiatric Times, 16*(4), 54–55.

Petraitis, J., Flay, B., Miller, T., Torpy, E., & Greiner, B. (1998). Illicit substance use among adolescents: A matrix of prospective predictors. *Substance Use & Misuse, 33*(13), 2561–2564.

Philippov, M. (2010). *Ex-Soviets in the Israeli political space: Values, attitudes, and elective behavior*. University of Maryland, Gildenhorn Institute of Israel Studies. Retrieved September 25, 2014, from http://www.israelstudies.umd.edu/articles/research-paper-3.pdf

Progler, Y. (2010). Drug addiction in Gaza and the illicit trafficking of tramadol. *Journal of Research in Medical Sciences, 15*(3), 185–188. Retrieved December 12, 2015, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3082799

RIA Novosti. (2012). *Russia hopes to halve number of drug addicts by 2014*. Retrieved September 25, 2014, from http://en.rian.ru/russia/20110525/164213137.html

Roberts, M., King, M., Stokes, J., Lynne, T., Bonner, S., McCarthy, A., et al. (1998). Medication prescribing and administration in nursing homes. *Age and Ageing, 27*(3), 385–392.

Rumberger, R. (2004). Why students drop out in school. In G. Orfield (Ed.), *Dropouts in America: Confronting the graduation rate crisis* (pp. 131–135). Cambridge, MA: Harvard Education Press.

Schrag, C. (1973). *Crime and justice: American style* (pp. 71–80). Rockville, MD: National Institute of Mental Health.

Schweich, T. (2008, July 27). Is Afghanistan a Narco-State? *New York Times Magazine*. Retrieved September 25, 2014, from http://www.nytimes.com/2008/07/27/magazine/27AFGHAN-t.html?ex=1217822400&en=b293a2810d8ad3ff&ei=5070&emc=eta1&_r=0

Smith, G. (1975). Teenage drug use: A search for cause and consequences. In D. Lettieri (Ed.) *Predicting adolescent drug use: A review of issues, methods and correlates* (DHEW Pub. No. (ADM) 276-299). Washington, DC: National Institute on Drug Abuse.

Strasburger, V., & Donnerstein, F. (2000). Children, adolescents and the media in the 21st Century. *Adolescent Medicine, 11*(1), 51–68.

Straussner, S., & Brown, S. (Eds.). (2002). *The handbook of addiction treatment for women: Theory and practice*. New York: Guilford.

Substance Abuse Mental Health Service Administration (SAMHSA). (2007). *Report on the prevalence of substance use among racial & ethnic subgroups in the U.S*. Retrieved September 25, 2014, from http://www.oas.samhsa.gov/NHSDA/Ethnic/ethn1006.htm

Substance Abuse Mental Health Service Administration (SAMHSA). (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*. December 2015.

Sullivan, E., & Fleming, M. (1997). *A guide to substance abuse services for primary care clinicians* (DHHS Publication No. (SMA) 97-3139). Washington, DC: U.S. Department of Health and Human Services.

Tsuang, M., Lyons, M., Meyer, J., Doyle, T., Eisen, S., Goldberg, J., et al. (1998). Co-occurrence of abuse of different drugs in men. *Archives of General Psychiatry, 55*(11), 967–972.

Tuchman, E. (2010). Women and addiction: The importance of gender issues in substance use treatment. *Journal of Addictive Diseases, 29*(2), 127–138.

United Nations Office on Drugs and Crime (UNODC). (2009). *Addiction, crime and insurgency: The transnational threat of Afghan opium*. Retrieved September 25, 2014, from http://www.unodc.org/documents/data-and-analysis/Afghanistan/Afghan_Opium_Trade_2009_web.pdf

United Nations Office on Drugs and Crime (UNODC) (2011). *World Drug Report, 2011*. Retrieved September 9, 2015, from https://www.unodc.org/documents/data-and-analysis/WDR2011/World_Drug_Report_2011_ebook.pdf

United Nations Office on Drugs and Crime (UNODC). (2012). *World Drug Report, 2012*. Retrieved September 25, 2014, from http://www.unodc.org/documents/data- andnalysis/WDR2012/WDR_2012_web_small.pdf

Volkow, N. (2005). What so we know about drug addiction? *The American Journal of Psychiatry, 162*(8), 1401–1402.

World Health Organization (WHO). (2012). *Risks to mental health: an overview of vulnerabilities and risk factors*. Retrieved July 6, 2015, from http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf

Wright, P. (Ed.). (1994). *The National Clearinghouse for Alcohol and Drug Information Technical Assistance Bulletin: Following specific guidelines will help you assess cultural competence in program design, application and management*. Rockville, MD: National Clearinghouse for Alcohol and Drug Information.