Chapter 11
Collaborative Approaches to Addressing Mental Health and Addiction Care in the Middle East

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11.1 Introduction

Illicit drug use and trafficking are global issues that are negatively impacting the social, economic, public, and mental health of citizens internationally (Isralowitz et al. 2001; Thomas et al., 2012). Stress resulting from exposure of living in an environment with chronic violence and political unrest can have either a direct and/or indirect impact on an individual's psychological well-being (Thabet, Tawahina, Sarraj, & Vostanis, 2013). In the Middle East, this constant traumatic exposure may lead to serious mental illnesses such as post-traumatic stress disorder (PTSD), depression, anxiety (Thabet et al., 2013), and/or substance abuse (Sweileh, Zyoud, Al-Jabi, & Sawalha, 2014). Furthermore, acculturation is another contributing factor to substance abuse; acculturation can contribute to an increase in alcohol and illicit drug use (Reznik & Isralowitz, 2016; Straussner, 2012). While the focus of this book is on the Middle East, this issue has implications for other regions worldwide dealing with terrorism (Isralowitz, 2002), death (e.g., about a third of European citizens have tried an illicit drug, with overdoses killing at least one individual every hour (European Monitoring Centre for Drugs and Drug Addiction, 2010), and other medical, psychological, and environmental issues (Broyles, Conley, Harding, & Gordon, 2013).

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11.2 Collective Trauma

The Middle East has gone through an extended period of trauma related to ongoing conflicts. Reactions to such repeated traumatization can lead to psychosocial reactions, such as drug and alcohol use, that become viewed as normal parts of everyday life (De Jong, 2002). Progler (2010) found that Palestinians continue to live with psychological reactions to the 2008 conflict with Israel, with many individuals experiencing mental health, addiction, and other chronic illnesses. For many in the Middle East, they suffer from historical trauma and transgenerational trauma whereby they refer to the response to chronic stress among whole groups of people and how this stress gets transmitted across generational lines (Firestone, 2014). Firestone (2014) argues that this ongoing sense of trauma and disruption, even from earlier generations, can lead to disempowerment, anxiety, and anger. Such responses can cause individuals to turn toward alcohol and/or other substance abuse.

As with the development of the collective trauma within the community, Somasundaram (1998) found community-based interventions useful in addressing maladaptive reactions for prevention and mental health recovery purposes. The collective level of response allows for community, village, and family rebuilding in which the community itself can be used as a source of support (Somasundaram, 1996). However, some substance abuse treatments, as stated earlier, do respond better to individual interventions such as a 12-step program (i.e. Alcoholics Anonymous and Drug Addicts Anonymous), detoxification, aversion therapy, rehabilitation, and counseling (De Jong, 2002). These will be discussed later in this chapter.

11.3 Substance Abuse Disorders

The advent of the publication of the new Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) in 2013 has collapsed all categories of substance abuse and substance dependence into a sole category called substance use disorders which are measured on a continuum from mild to severe (APA, 2013). The American Psychological Association (APA, 2013) sees this new collapsed diagnostic category as more reflective of what the patient actually experiences. Therefore, throughout this chapter any form of substance abuse condition will be referred to as a substance abuse disorder.

11.3.1 Substance Use: Prevalence and Cultural Meaning in the Middle Eastern Countries

Attitudes and use do vary among the Middle Eastern countries and cultures about the use and abuse of substances. For example, in the Israeli culture, alcohol consumption for religious reasons is allowed; wine in moderation is “praised for

gladness for the hungry heart" (Loewenthal, 2014, p. 973). In fact, drunkenness is condoned on very rare occasions, such as during the festival of Purim, but overall excessive alcohol use is discouraged. Views by the general Jewish and the rabbinical communities on opiate and other mood-altering substance use and abuse have been evolving as concerns over their use have been rising. Drug use is seen as illegal, particularly drugs that are known to be harmful. Under Jewish law "life and health must be protected and the saving of life prioritized" (Loewenthal, 2014, p. 974). Self-control is promoted with rabbinical endorsement of the 12-step programs.

On the other hand, Islam forbids alcohol and substance use, and addictive behaviors are stigmatized within the community- at- large if they are used. However, despite these views, both the World Health Organization and the United Nations Office on Drugs and Crime have found a consistent rising trend in the use of both illicit and licit substances and Arabic countries (UNODC, 2011; WHO, 2011). The most commonly misused substances in the Arab region include alcohol, heroin, and hashish (Al Ghaferi, Osman, Matheson, Wanigaratne, & Bond, 2013).

Attitudes of the professionals can also vary by culture, thus impacting the care of individuals. For example, Lev-Ran, Adler, Nitzan, and Fennig (2013) found in Israel that physicians rated individuals' with alcohol dependence as having "weak character" significantly more than individuals who were dependent on cigarettes or marijuana and individuals who were addicted to heroin as having a "weak character" significantly more than those who were dependent on cigarettes, nicotine, alcohol, or marijuana. This has implications for how the physicians provide care and work with a treatment team.

The World Health Organization has reported wide ranges in the prevalence of smoking among younger individuals (i.e. adolescents and college age) in Arab countries overall (Al-Mohamed & Amin, 2010). For example, the range is lowest at 7 % for Oman, 23 % in Iraq, and as high as 53 % in Yemen. Al-Mohamed and Amin (2010) report from their prevalence study of college students in Saudi Arabia that smoking by parents and siblings was a significant initiator for smoking as well as the continuation of the pattern. They also stated that friends' behavior and attitudes toward smoking played a large role in smoking as well. Surprisingly, Al-Haqwi, Tamim, and Asery (2010) found a 25 % rate of smoking among medical students in Riyadh, Saudi Arabia, despite the fact that 90 % of the students would advise their patients not to smoke and 94 % of the samples reported know that smoking could cause serious illness. Twenty percent of the students felt that smoking had a beneficial effect in stress reduction and used smoking as a coping mechanism.

Both alcohol and illicit drug addiction rates have been on the rise in Israel. Isralowitz and Rawson (2006) report in a study of 911 high-risk adolescents who ranged from 12 to 18 years that girls used cigarettes more than boys, boys used all types of alcohol more than girls, and boys used marijuana and hashish more than girls. This study challenged the societal belief that alcohol and drug use is primarily a male issue in Israel.

More recently, Badr, Taha, and Dee (2014) approximate that the percentage of students using illicit substances by sixth grade has tripled over the last decade in the Middle East. They assert that this is seen in both developed and developing

countries with the cause most likely due to the transition to a more Western society. In their study of 68 adolescents between the ages of 13 and 18 years living in Beirut, Lebanon, and Middle Eastern adolescents residing in California, they found that having an attachment to God was a protective factor for both alcohol and substance abuse in both the Muslim and Christian groups. Similarly, they found a negative relationship between attachment to family and substance use in both groups, regardless of religion or where they lived (Badr et al., 2014). The WHO ATLAS reported that in Saudi Arabia, Egypt, and Jordan, the prevalence estimates of alcohol use disorders among individuals 15 years and older were nonexistent among females, yet among males it was 0.44 (12 month %) in Egypt, 0.38 in Saudi Arabia, and 0.32 in Jordan. Drug use disorders' prevalence was estimated at 1.3 (Egypt), 0.63 (Jordan), and 0.01 (Saudi Arabia) among males. Saudi Arabia found no drug use disorders in females (Sweileh et al., 2014; World Health Organization, 2010). However, the bibliometric analysis (i.e. a statistical analysis of books, articles, or other publications) completed by Sweileh et al., (2014) noted that despite the findings for illicit drugs, most of the published research they reviewed from the Arab countries focused on tobacco smoking and water pipe use.

Gaza has also seen increases in risk-taking behaviors, which include a substantial rise in drug addiction (Isralowitz & Afifi, 2016). Most research points to Tramadol as the drug of choice in Gaza. Despite it being illegal without a prescription, it is easily acquired on the black market or through the use of falsified prescriptions (Progler, 2010). The age of the addicts are between 18 and 30 years old, with many more not presenting for treatment because of the stigma related to mental illness and addiction. Progler (2010) reports that the underlying cause of the increase in substance abuse is related to the ongoing conflict with Israel, particularly after the December 2008 war that left Palestinians "feeling insecure and at risk wherever they are" (Progler, 2010, p. 186).

11.3.2 Substance Abuse Treatment

It is clear that "substance-related disorders are not limited to any particular country or world region" (Sweileh et al., 2014, p. 597). The treatment for substance abuse and co-occurring disorders such a mental illness or every physical illness requires coordination. However, in the Arab countries, much like those in other countries in the Middle East, the ongoing political instabilities and general social and physical insecurities within the country can lead to the creation of psychiatric issues (Sweileh et al., 2014).

Treatment for those with substance use disorders has advanced over the years. It has been found that cognitive behavioral therapy, community reinforcement and contingency management approaches, the 12-step program, family treatment, and motivational therapy are the most effective forms of treatment (Finney, Wilbourne, & Moos, 2007). The underlying value of these treatment strategies is that they focus

Specific Group	Problems	Intervention
1. Children	Learning disorder	Play therapy, art therapy
	Conduct disorder	Family therapy
	Trauma	Referred for child therapy
	Child soldier	Rehabilitation
	Child abuse	
2. Women	Somatization	Find out the social cause
	Anxiety neurosis	Counseling, relaxation
	Depression	Social case work
3. Alcoholics	Chronic alcoholism	AA, Medical therapy
	Acute alcoholism	Detoxification, aversion therapy
4. War victims	PTSD	Medication, rehabilitation, relaxation exercises, counseling
5. Drug Abuse	Addiction	Withdrawal, behaviour therapy & counselling
Neuropsychiatric problems		
1. Children	Epilepsy	Antiepileptic drugs + play therapy
	Mental retardation	Advice to go to school, counselling, referral to ARK
2. Schizophrenia	1. Acute emotional problems	Psychotropic medication, & ECT
	2.Chronic illness	Maintenance medication, observe for side-effects, dose titration, compliance, reduce expressed emotions at home
	3. Social problems	Social case work
	a. Economic	Occupational therapy, employment
	b. Marriage	Marital counselling
	c. Security	Yellow ID card
	d. Social stigma	Mass media propaganda

Fig. 11.1 Common psychosocial problems and interventions (Reproduced from Somasundaram and Jamunanantha (2002), with acknowledgement of the National Institute of Mental Health)

not only on the addictive behavior but also on the context in which the client lives while reinforcing self-efficacy and the promotion of behavior change. Figure 11.1 outlines common psychosocial problems and interventions (Somasundaram & Jamunanantha, 2002).

For individuals with co-occurring substance abuse and psychiatric disorders, their care is much more complex with research data supporting an intensive integrated case management team-based type of model as most effective, particularly since dual diagnosis, based on epidemiological data, should be expected as the norm and not the exception (Minkoff, 2001). In fact, Minkoff (2001) asserts that better outcomes are attached to more systems-level changes which can establish inter-program collaboration.

11.4 Integrated and Collaborative Care

Much attention has been given to develop more integrated (i.e. treatment for mental health in primary care settings) and interprofessional (i.e. simultaneous and collaborative treatment by two or more professionals) care in the past decade. The United Kingdom saw a rise in these types of care models starting in the 1980s (Bailey & Dfapa, 2013) and the stabilization of the models with financial infrastructures coming from the National Health Service and Local Authorities. Other countries have been slow to follow the shift in models, with the latest to join being the United States that received a boost from the implementation of the Patient Protection and Affordable Care Act (P.L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), collectively referred to as the Affordable Care Act (Patient Protection and Affordable Care Act, 2010). Collaborative Care models have been shown to be effective for treating individuals with chronic illnesses as well as mental illnesses (Thota et al., 2012). Collaborative Care models have evolved from Wagner's Chronic Care Model (Wagner, Austin, & Von Korff, 1996). The Collaborative Care model, much like the Chronic Care model, involves multiple levels and specialists in the delivery of care. This approach uses case managers to link primary care providers (i.e. physicians), patients, and mental health specialists with other mental health specialists (i.e. psychiatrists and psychologists) for possible services needed. Thota et al., (2012) found that for mental illness:

> This collaboration is designed to: (1) improve routine screening and diagnosis of depressive disorders; (2) increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders; and (3) improve clinical and community support for active client/patient engagement in treatment goal-setting and self-management. (p. 526)

Working in an interprofessional collaborative manner does take practice as well as self-awareness of one's professional role on the team. Loxely (1997) contends that power and culture are two salient themes that professionals use when they are assimilating into job roles. Varying value systems of different professions can also influence the care provided and the manner in which it is communicated to the patient. For example, a social worker may see the individual suffering from addiction as being caught with an environment where drugs are readily available and part of the culture and seek to shift the individual out of the harmful environment. On the other hand, a psychiatrist may treat the patient with medications and refer for psychotherapy to get at the root of the addictive behavior. Either approach is credible, but if the professionals cannot come together on a decision for a strategy, the patient can become lost at the mercy of the power struggles over perspectives.

The Department of Health in the United Kingdom sets forth 10 Essential Shared Capabilities (ESC) that all staff in their mental health workforce, both professional and paraprofessionals, are required to follow (Brabban, McGonagle, & Brooker, 2006). The intent of the capabilities is to help the disciplines and other key personnel to keep their focus on ideals for the patient while achieving their own occupational standards. These capabilities are to be at the core of mental health practice that supports effective implementation of integrated programming (Brabban et al., 2006). These 10 Essential Shared Capabilities are listed in Fig. 11.2.

The 10 Essential Shared Capabilities	
Working in partnership	**Identifying people's needs and strengths**
Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.	Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.
Respecting diversity	**Providing service user centered care**
Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.	Negotiating achievable and meaningful goals; primarily from the perspective of service users and thier families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is need, including systematically evaluating outcomes and achievements.
Practising ethically	**Making a difference**
Recognizing the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users, carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.	Facilitating access to and delivering the best quality, evidence-based and value-based health and social care interventions to meet the needs and aspirations of service users, their families and carers.
Challenging inequality	**Promoting safety and positive risk taking**
Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in communities they come from.	Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.
Promoting recovery	**Personal development and learning**
Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health system.	Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

Fig. 11.2 The 10 Essential Shared Capabilities (Used with permission from Brabban, A., McGonagle, I., & Brooker, C. (2006). The 10 Essential Shared Capabilities: A framework for mental health practice. *The Journal of Mental Health Training, Education and Practice*, *1*(3), 4–15)

Integrated care models (i.e. the co-location of mental health and medical professionals within primary care settings) have become more prominent in healthcare settings in various parts of the world. It has become an important component of a healthcare delivery system that has better coordination and can be more cost-effective (Kodner & Spreeuwenberg, 2002). Integrated care has been embraced by the World Health Organization Study Group that views the integration as a way to deliver more holistic and individualized care to a patient with multidimensional care needs (WHO, 1996). Thus, integrated care goes beyond just developing an interdisciplinary team, it is delivering mental healthcare that is "consistent with the goals, strategies and culture of primary care" (p. 109)—and not just adding mental health services to primary care, the services need to work in concert with one another (Bailey & Dfapa, 2013). This includes the involvement of the patient's community and all who care for those with addiction and mental health services as well

as a commitment to providing treatment in a way that does not stigmatize them and is holistic in nature that views the mental health and addiction issues as undifferentiated from the patient's physical health (Bailey & Dfapa, 2013). This is critical, when mental illness and a substance use disorder are comorbid (i.e. when two disorders or illnesses occur in the same person, simultaneously or sequentially). Minkoff (2001, p. 598) notes "each disorder should be considered as primary, and integrated dual primary treatment should be provided."

Despite the evidence base for integrated care, Kodner and Spreeuwenberg (2002) argue that sometimes achieving the integrated care goal falls short in many, if not most, countries. The coordination of such multiple services to address mental and physical health in the context of the psychosocial needs can be daunting; the funding and administration of two types of care may be different sources. This is evidenced in work by Courser et al., (2013) agreeing that drug addiction is well documented in Afghanistan, but organized substance abuse treatment has been slow to follow, until very recently. Isralowitz and Reznik (2014) point to a similar issue in Israel where the majority of drug users do not receive care directed at the individual and the society level programming seen as beneficial to enhance overall well-being??. Likewise, a study conducted in Syria only used behavior cessation intervention provided only by physicians that showed poor outcomes with a 16 % cessation rate in the brief intervention arm of the study and 4 % in the intensive arm (Asfar et al., 2008). Thus, despite efforts to support more integrated and collaborative care, that goal is not being realized in the Middle East.

11.5 Conclusion

As stated earlier, Sweileh et al., (2014) made it clear that substance abuse disorders are not limited to a particular region of the world, yet the focus of this chapter has been on the countries in the Middle East. It is evident that much work is needed in the treatment of individuals with substance abuse and/or comorbid mental health issues in those countries. There appears to be consensus on the fact that the treatment needs to be culturally sensitive and relevant offered in a collaborative or integrated manner that will promote evidence-based practice (Hafeiz, 1995; Isralowitz & Reznik, 2014; Nakash, Razon, & Levav, 2015; Shawahin & Çiftçi, 2012).

11.6 Future Directions

Prevention programming is an area of emphasis for the mental health community of psychological practitioners in Israel. However, the education of other professionals including medical students is limited in mental health prevention. In fact, Nakash et al., (2015) point out that a significant amount of the available resources for mental health services is directed toward treatment or rehabilitation rather than prevention.

These researchers feel that the most important action steps include creating partnerships with relevant stakeholders, capacity building and training to develop expertise in prevention programming for those with mental health issues, program development, and the actual delivery of care in a collaborative team/public health model rather than individualized care.

Sweileh et al. (2014) argue that the Arab countries should invest in more international collaboration to heighten the visibility of substance abuse among its people for policy makers and international agencies. Isralowitz et al., (2001) concur on the importance of international expert involvement as it adds legitimacy, encourages participation in discussions, and supports the spirit of cooperation; these findings came from work between Israelis and Palestinians to create prevention and treatment programs in the region. Sweileh et al., (2014) also suggest that policy makers need to be more observant of the misuse of substances and create policies to limit the potential abuse.

There has been some progress in the region toward substance abuse and mental health treatment, yet much more is needed to promote evidence-based treatment delivered in an interdisciplinary and integrated manner. Partnering with Western providers and researchers, as well as policy makers, could help advance the efforts more quickly. The struggle to address addiction on a global scale is an issue for all countries of the world to embrace, and working together cooperatively and collaboratively is the only way to address this significant and detrimental issue to the world at large.

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