



How Can Psychiatry Catch Up with the Wave of the Future During the Current Global Mental Health and Addiction Crises? A Clinician's Perspective

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Abstract

We are experiencing global mental health and addiction crises that have created unprecedented challenges for psychiatrists and other mental health professionals. These crises cannot be dealt with using traditional delivery models of services alone. They have created the need for interventions using new ways of delivering mental healthcare services. This conceptual paper explores how psychiatrists can contribute to alleviating the current crises through the revival of mental health self-help. Coined as 'the wave of the future' over three decades ago, mental health self-help is an umbrella term that encompasses a multiplicity of participatory and collaborative approaches dating back to the 1950s. Integrating extant theoretical and empirical findings, and taking a scientist-practitioner stance, this paper unpacks the therapeutic factors and mechanisms of change embedded in mental health self-help and self-help groups. Their corresponding outcomes and benefits are also highlighted by elucidating the linkages between theory and practice. The paper further discusses how psychiatrists can support the new 2030 Agenda for Sustainable Development in global mental health, beyond what has been traditionally understood. By examining past and present relevant research findings to explore the future of mental health, this paper advances understanding of the need for collaboration between psychiatrists and other mental health professionals, end-users and the community at large, as a way of moving out of the current crises.

Keywords: Global mental health crisis; Addiction; COVID-19; Mental health self-help; Self-help groups; Helper therapy principle; Single-session interventions

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Introduction

We are in the midst of a global mental health crisis [1-3]. Worldwide, most people needing Mental Health (MH) care lack access to quality services due to stigma, fragmented service delivery models, shortages of human resources, and lack of capacity to implement the required policy changes [4]. MH and addictive disorders in high-income and upper-middle-income countries affect a significant amount of the global population, and have increased dramatically in the last decade – mostly due to stigma and lack of treatment [5]. In fact, addiction has become a global threat and, being the most common comorbid disorder in individuals with other mental conditions, is the costliest to treat and the least treated, with catastrophic economic impact, and in desperate need for solutions [6].

The COVID-19 pandemic has skyrocketed the demand for mental health services. As a result, it has become increasingly challenging for individuals to access Mental Health Professionals (MHPs: e.g. psychologists, psychotherapists, psychiatrists) who are available. The negative impacts of these states of affairs on individuals, families, and communities have been astonishing. Even some of the most developed nations in the world are in crisis mode. In the US, for example, "the current mental system is collapsing with a wobbling infrastructure" [7]. In the UK, the Royal College of Psychiatrists reports the MH crisis in England as terrifying, and psychiatrists warn about overrunning the National Health Service (NHS), following a record number of adults and children seeking help during the pandemic [8]. The Australian National Association of Practicing Psychiatrists (NAPP) claims "the Australian Mental Health Crisis" is a system failure in need of repair [9]. These challenges, in turn, have also been impacting MHPs. Psychiatrists, especially many who have never experienced the current working demands and conditions in their lifetime, as a result are experiencing – or are at risk of experiencing – compassion fatigue, secondary traumatic stress, vicarious traumatization, and even Post-Traumatic Stress Disorder (PTSD) -related symptoms [10].

Clearly, the current crises pose unique challenges for the general population and MHPs, cannot be dealt with using traditional delivery of services alone, and require a large-scale response [11]. Psychiatrists need to face their short- and long-term consequences [3,12]. This new response requires collaboration among MHPs, and entails psychiatry shifting from a social and biological paradigm towards a recovery model of mental illness [13]. The historical tension between social and biological psychiatry and the recovery movement [14] can reconcile by considering this as a progressive shift rather than a radical move. This transition can be viewed as a repositioning of perspectives within a dimensional plane of epistemologies, which locates homothetic knowledge (a tendency to generalize; used by the professional-centered model) and idiographic knowledge (a tendency to be specific and focus on subjective phenomena) [15], at each end of the continuum. It thus proposes that psychiatry adopt a more recovery-oriented approach [16]. The essence of the recovery model is the belief that individuals can recover from mental illness, and lead fulfilling and satisfying lives. This approach to MH is holistic and person-centered. Research evidence indicates that self-management strategies are more valuable than models based on physical health [17]. From a stakeholder perspective, the recovery model identifies the following six themes: (1) identity and meaning; (2) the service provision agenda; (3) the social domain- connection and supportive relationships; (4) power and control; (5) hope and optimism; and (6) risk and responsibility [18].

The good news is that this paradigm shift is already in motion. A good recent practical example is the 'Reinventing mental health care' forum, initiated by the Harvard T.H. Chan School of Public Health [19]. In brief, this initiative aims at transforming mental healthcare, and adopts the recovery model, which integrates the above-mentioned themes in three principles, represented by the three Ps: People (social support – family, friends, peers); Place (physical environment); and Purpose (finding purpose from lived experience).

This article explores how psychiatrists can further contribute to the management of the current MH crisis, while simultaneously relieving their own workloads, by supporting the recovery model *via* the revival of Mental Health Self-Help (MHSH), as evidence-based strategies that are in line with the new 2030 Agenda of Global Mental Health (GMH) – an emerging discipline “that seeks to address one of the most neglected global health issues of our time” [20]. Drawing on the extant literature, and taking a scientist-practitioner stance, this qualitative paper examines past and present relevant theoretical and empirical findings to explore the future of MH.

Mental Health Self-help and Self-help Groups – The Wave of the Future

Mental Health Self-Help (MHSH) is an umbrella term that encompasses a multiplicity of approaches and interventions that date back to the 1950s, and were coined as “the wave of the future” over three decades ago [21]. The MHSH movement emphasizes the importance of responsibility and self-actualization in the healthcare sector [22], and focuses on how people with mental illness, and their families, organize multiple self-directed, mutual support-oriented initiatives, including Self-Help Groups (SHGs), and non-profit organizations [23]. MHSH embodies self-directed organizations of people that create social change and facilitate personal transformation. Such strategies constitute evidence-based, low-cost interventions with processes that benefit their users and interface with the MH system. In the US, for example, such initiatives have become increasingly common over the

years and today outnumber traditional MH organizations [24].

SHGs are voluntary, small configurations for the mutual assistance and achievement of specific goals, which enable individuals with a range of concerns to develop a tailored response to their specific needs [25]. SHGs have also been defined as “self-organizing groups where people come together to address a shared health or social issue through mutual support. They are associated with a range of health and social benefits, but remain poorly understood” [26]. The most widely researched type of SHG is Alcoholics Anonymous (AA). This is due to the fact that AA germinated and pioneered a message of recovery for those struggling with alcohol addiction [27]. In 1987 in the US, for example, the Surgeon General C. Everett Koop stated that SHGs such as AA had become a significant alternative to the formal healthcare system. By the 1980s, SHGs were viewed by psychologists as “a major and legitimate format for delivering mental health care” [28]. At its core, the notion of self-help is primarily related to the taking of personal responsibility and accountability by mobilizing and using inner personal resources and the management of solitude. Albeit that the importance of SHGs was neglected by social scientists for many years – mostly due to methodological research challenges and limitations – to date many quantitative and qualitative studies have been conducted in this field and offer meaningful contributions to treatment outcomes and directions for future research [29]. This includes the fact that SHGs are able to promote emotional recovery [29] and assist individuals with severe and long-standing mental illnesses [30], including complicated conditions such as chronic fatigue syndrome [31] and schizophrenia [32]. International examples of these types of SHGs include Recovery Inc., Emotions Anonymous, GROW International [33], Narcotics Anonymous, Cocaine Anonymous (CA), Gamblers Anonymous (GA), SMART Recovery, Overeaters Anonymous (OA), and many other so called 12-Step Programs (12SP) [34].

Why Should Psychiatrists be Confident in Making Referrals to Self-Help Groups?

Previous research suggests that MHPs (e.g. medical practitioners, psychologists, psychiatrists, social workers) may hold certain attitudes that could interfere with their collaboration with SHGs, due to the perceived ‘dangers’ of SHGs [35]. This includes dangers to patients and their families, and to professionals resulting from the differences in the systems of meaning that professionals construct regarding SHGs [36]. However, other research investigating the nature of the relationship between SHGs and MHPs indicates that MHPs: have a certain degree of familiarity with SHGs; believe they could be helpful; hold favorable attitudes toward them; and are prepared to inform about and to make referrals to such groups [37]. The extent to which psychiatrists oppose, or refrain from, making referrals to SHGs precludes collaboration and the formation of valuable alliances; thus, diminishing efforts in the struggle to improve MH care services that are so urgently needed.

With a view to dispel any doubts among the psychiatric community in relation to the potential benefits of SHGs, I next outline the main research findings in relation to their therapeutic outcomes and factors, mechanisms of change, and other related benefits – including financial and economic benefits. In doing so, in the main, I draw on 12SP in the treatment of addiction, as this represents their genesis and historical development and the fact that they have been the most researched types of SHGs.

Therapeutic Outcomes

Multiple studies consider AA and other 12SP as one of the few approaches to derive positive outcomes, including motivation to refrain from drinking, increased active coping strategies, and sustained self-efficacy. Thus, they claim that 12SP produce equivalent outcomes to some evidence-based treatments such as Cognitive Behavioral Therapy (CBT) [38]. Further, various meta-analytic studies report that AA attendance: predicts complete abstinence and reduction of alcohol consumption; enhances self-efficacy; quenches the urge to drink; increases interest in others; increases abstinence; and enhances social functioning and purpose in life and psychosocial behavior [39].

Mechanisms of Change

Extensive studies provide empirical support for the mechanisms of change of 12SP. The positive relationship between participation in 12SP and abstinence has been reported to be partially mediated by inter-related factors such as enhanced motivation for abstinence, positive social networks with less pro-drinking influences, more friendships supportive of abstinence, and psychological and spiritual mechanisms – including finding meaning in life. The mechanisms of action for behavior change in AA and related 12SP fall into three categories: (1) common processes; (2) AA-specific practices; and (3) social and spiritual processes. Their main strength, however, lies in the fact that they offer long-term, free, and easy access exposure to recovery-related common therapeutic factors that can be accessed according to users' recognized needs [39]. Reported mechanisms of change linked to NA participation, for example, include: reconstruction of social support and network; sponsorship or personal mentoring; increased motivation for abstinence; transformations of identity and worldview; increased confidence in one's recovery; enhanced self-esteem and self-efficacy; improved coping strategies; therapeutic effects of helping others; spiritual renewal (life meaning and purpose); and decreased stress, anxiety, depression, and shame [40].

Therapeutic Factors

The three chief therapeutic factors of 12SP include spirituality, therapeutic group factors, and sponsorship.

Spirituality

In the context of 12SP, spirituality relates to members' search for meaning and belief in a higher power that is apart from and greater than themselves. Hence, albeit spirituality may include religion, within the 12SP context, it is different than religion and is expressed uniquely through each individual [41]. While religion relates to an organized entity and involves practices and rituals about a specifically defined God, spirituality is a subjective, intangible, and multidimensional construct, which relates to an individual's search for meaning in life [39]. Spirituality has also been defined as an expression of the transcendent ways in which to fulfill human potential, and as a synonym of constructs such as hope, meaning, wholeness, harmony, and transcendence [42]. Spirituality has been identified as the most central and unique change mechanism in 12SP [43]. This is not surprising when considering that spirituality has been identified as a universal quality of human experience [41], an important feature of the therapeutic process, and a contributor to improving life satisfaction, well-being, and reduced antisocial behavior, substance abuse, and suicide rates [44]. Addiction research

has found statistically significant greater levels of spirituality among individuals maintaining recovery than those continuing to relapse [45].

Therapeutic group factors

The therapeutic group factors that underlie 12SP, and act as mechanisms of change, relate to the processes or curative factors emerging from group therapy research [46]. Such factors are known to be powerful therapeutic agents in helping individuals with a range of mental health problems, and are namely: instillation of hope; universality; information giving; altruism; corrective recapitulation of the primary family; improved social skills; imitative behavior; interpersonal learning; group cohesiveness; catharsis, and existential factors. These therapeutic factors are particularly relevant for individuals experiencing Alcohol Use Disorder (AUD), or Substance Use Disorder (SUD), given that the prevalence of comorbidities (e.g. anxiety, depression, bipolar disorder, personality disorders) in such populations is the norm rather than the exception, and they require integrated treatment [47]. In essence, 12SP offer therapeutic strategies that address treatment for populations with co-existing mental disorders along with addiction, and extend to disenfranchised and vulnerable groups.

Sponsorship – The therapeutic alliance and the helper therapy principle

Two additional unique interwoven factors embedded in 12SP, which have been found to predict program participation and abstinence, are sponsor contact – a concept equivalent to the therapeutic alliance [48] – and the Helper Therapy Principle (HTP) [49]. Within the 12SP recovery context, sponsorship relates to the tradition of sober and more experienced members of the program (sponsors) supporting or mentoring newcomers to the program (sponsees). This entails forming a strong personal and intimate ongoing relationship through which sponsors share their experience, strength, and hope with their sponsees. This factor was supported by the findings of Project MATCH, which revealed that recovering alcoholics who help other alcoholics maintain sobriety were significantly less likely to relapse themselves [50]. Research using a rigorous methodological design, which isolated the specific effects of AA sponsorship, found an overall reduction in use of alcohol, marijuana, and cocaine over 12 months, and lagged analyses indicated that AA attendance significantly predicted increased abstinence [51]. The same study also found that having an AA sponsor predicted increased alcohol abstinence, and abstinence from marijuana and cocaine, after controlling for a host of AA-related treatment and motivational measures associated with AA exposure or that are generally prognostic of outcome. The sponsor-sponsee relationship is comparable to the concept of a therapeutic or Working Alliance (WA) between client and psychotherapist. The WA comprises an agreement on goals, assignment of tasks, and the development of bond, and has long been recognized as the major factor in achieving change through psychotherapy [52].

The above findings can also be linked to the HTP, which suggests that those who help others help themselves [49]. The HTP postulates that helpers' MH benefits are derived from helping others with a shared condition. The HTP, therefore, is embodied by a 12SP, such as AA, NA, CA, and others. This principle also extends to populations with chronic conditions beyond addiction [53]. As an example, a study of GROW – a mutual-help group for individuals with mental illness that promotes hope, mutual help, and recovery for good

MH – found that giving help to others predicted improvements in psychosocial adjustment [54].

Benefits Derived from the Ubiquitousness of SHGs

The ubiquitousness of SHGs relates to the fact that such groups are everywhere and easy to access, as they operate around the globe, and offer flexible daily schedules. Currently, for example, AA operates in 180 nations, has an estimated worldwide membership of over two million, runs approximately 1,23,000 groups around the world, and the AA literature has been translated into over 100 languages [55]. Similarly, in 2018 there were more than 70,000 NA meetings in 144 countries [56]. This means that users can access support 24/7 and several times per day. This unparalleled global presence and accessibility offer unique direct benefits to end-users themselves and by default to MHPs – including psychiatrists, who can use SHGs as adjunct or integrated treatment by referring their clients/patients to such groups.

Financial and Economic Benefits

Finally, SHGs also offer financial and economic benefits. Both perspectives attempt to estimate the net-benefits of treatment investment based on the difference between use in SHGs and use of more traditional approaches. However, while financial analyses compare the costs or savings to users, enterprises or the community; economic analyses compare costs or savings to the entire economy. Due to methodological and practical challenges involved in calculating such estimates, research in this area is scarce. Nonetheless, the low-cost strategy of SHGs has been found to foster post-treatment remission maintenance [57], and is a good strategy to extend treatment benefits, by promoting post-treatment outcomes while reducing the costs of continuing care, thus generating substantial long-term savings [58]. The strongest research findings in this area derive from randomized trials demonstrating that the outcomes of mutual-help groups are equivalent to those of significantly more costly professional interventions [59].

Discussion

Based on the foregoing review, the collaboration between psychiatrists and SHGs seems plausible, and a highly desirable, integrated, cost-effective, and sustainable delivery model to deal with the current MH crisis. Hence, more psychiatrists should seriously consider the benefits of referring patients to SHGs, as a way to broaden their repertoire of clinical strategies and unburden their own workloads. This approach is in line with the view that integration maintenance therapy and psychosocial interventions are likely to be the most effective to treat SUD and underlying psychological issues [60]. It is also consistent with state-of-the-art clinical psychiatry, which aims to provide successful treatment using a comprehensive approach that integrates biological, psychological, social, and spiritual perspectives [61]. The results of rigorous research involving a controlled study of Recovery Inc. – a self-help program for people with psychiatric problems [62] – are a good example of this. This study reported that subjects with psychiatric problems reduced both their symptoms and complementary psychiatric treatment following attendance to SHGs. It concluded that SHG attendance is a valuable adjunct strategy to psychiatric treatment. Another example is a study that examined psychiatrists' referrals to, and support for, participation in SHGs for patients with mood disorders [63]. In this study, about 75 percent of psychiatrists reported that they believed they were

knowledgeable of, and had made referrals to, SHGs. Nonetheless, less than half of the sample had SHG literature available or discussed such options with their patients. Not surprisingly, an effort to improve the curricula related to SHGs offered at universities has already been suggested [64], as a compelling evidence-based perspective for the efficacy of 12SP interventions has been provided [65].

At a macro-level, MSHS and SHGs support GMH, which seeks to address one of the most contemporary neglected global health issues. Informed by multiple disciplines, such as neuroscience, epidemiology, health services research, social sciences, and psychology in particular, GMH is an evolving area of research and practice that aims to alleviate the mental suffering of individuals and communities around the globe through prevention, care, and treatment [66]. More specifically, MSHS supports the four pillars of the new 2030 Agenda for Sustainable Development [67]: first, the recognition that as a global public good, MH requires actions beyond the health sector; second, adoption of a multidimensional approach that conceptualizes MH as a continuum from wellness to illness, thus enabling equal emphasis on prevention and treatment of mental disorders along with the promotion and maintenance of MH; third, emphasis on the convergence effects of the environmental context and socio-cultural experience, neurodevelopment, and psychology on brain biology to create subjective experiences of MH; fourth, the premise that GMH action is linked to human rights by emphasizing the essential role played by people with lived experiences of MH conditions in shaping research, prevention, and care. From this perspective, MSHS and SHGs improve access to MH care services and reduce inequalities in MH outcomes.

At a micro-level, SHGs are peer-based practices that facilitate a grass-roots process, and their programs are run as participatory democracies where members make significant organizational decisions. The benefits of using SHGs are twofold. First, they empower individuals by enhancing their self-efficacy, self-concept, and reducing the stigma associated with mental illness. Second, they relieve psychiatrists and other MHPs from the pressure of excessive workloads, the impact on poor work-life balance and emotional exhaustion, which in turn are putting their patients' care at risk.

Moreover, MSHS and SHGs support Single-Session Interventions (SSIs) [68-70]. Such interventions promote little treatment with promising effects, and were developed to address the fact that up to 75 percent of youths with MH conditions never receive care services. SSIs can be conceptualized as psychological first aid. Hence, an SSI provides assistance to people who need it, when they need it. SSIs aim at assisting individuals to manage everyday stress and MH (e.g. anxiety and depression) by using psychological principles and components of evidence-based therapy within a single session. Using this approach, psychiatrists can provide patients what they need by squeezing the most useful strategies into one optimized session. The assumption behind SSIs is that they provide individuals with what they need to help themselves develop and grow, without assuming they'll come back for more. Clearly, SSIs are in line with the MSHS philosophy, and for psychiatrists could entail providing information related to, and/or referrals to, SHGs.

Limitations and Recommendations

This paper is not free of limitations. The main limitation is that, being a conceptual paper, this qualitative study is a perspective-based method of research, which is interpretative in nature. Like most qualitative studies, it did not involve the collection and analysis of

empirical data or the use of control groups. Hence, the future viability of the proposed ideas waits to be seen. To this end, future testing of the propositions outlined in this paper is recommended. Notwithstanding its limitations, this paper offers relevant and pragmatic opportunities for psychiatrists, and other MHPs, to consider ubiquitously in their practice and as a contribution to the current global mental health and addiction crises.

Conclusion

This paper has explored how psychiatrists could contribute to the revival of mental health self-help, as evidence-based participatory and collaborative approaches and interventions, to address the current mental health and addiction crises. This has included discussing the contextual factors and conditions that have exacerbated these crises, as well as the main challenges currently faced by psychiatrists. The paper has further explored how it is in the psychiatrists' best interest to use self-help groups as an adjunct to psychiatric treatment, by moving from the traditional professional-centered model towards a more holistic, person-centered, and collaborative approach with self-help groups. In doing so, the paper has dispelled any concerns or reservations psychiatrists may have about the effectiveness, clinical value, and benefits of self-help groups, by discussing their therapeutic outcomes and factors, embedded mechanisms of change, and unique practical, financial and economic benefits. Hopefully, this documented and compelling evidence for the efficacy of self-help groups will re-assure psychiatrists to consider making more referrals, not only to improve the current global mental health and addiction crises, but also to relieve a profession under scrutiny and pressure.

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