Integrative Mental Health Care White Paper: 
Establishing a New Paradigm through Research, 
Education, and Clinical Guidelines

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Abstract

Mental illness accounts for about one-third of adult disability globally, reflecting marked societal and personal suffering, and enormous social and economic costs. On a global level mental health care has failed to adequately address urgent unmet needs of the mentally ill. These circumstances call for change in the paradigm and practices of mental health care, including fundamental reforms in education, clinician-training, and research priorities. This White Paper outlines current challenges in mental health care, and characterizes the emerging field of integrative mental health (IMH), a critical element in the large-scale changes needed to transform mental healthcare in the 21st century. Strategic recommendations for advancing IMH are outlined including increasing research in key areas, improving clinician training and education, and promoting a public health agenda. The field of IMH adopts the bio-psycho-socio-spiritual model utilizing evidence-based & evidence-guided treatments from both traditional and modern healing practices. IMH incorporates mainstream interventions including the judicious use of psychopharmacology, psychosocial therapies, and evidence-based complementary and alternative (CAM) therapies such as acupuncture, herbal and nutritional medicine, meditation, in addition to health-promoting lifestyle changes. The clinical application of IMH takes into account the range of socio-cultural, economic and spiritual considerations affecting mental healthcare in different countries. To meet the challenges facing mental health care, the International Network of Integrative Mental Health (INIMH: www.INIMH.org) was established in 2010 with the objective of creating an international organization consisting of clinicians, researchers, and public health advocates to advance a global agenda for research, education and the clinical practice of evidence-based integrative mental healthcare. In authoring this White Paper the Board of INIMH is inviting global dialog on critical issues surrounding mental health care in the hope of achieving more compassionate, individualized, person-centered mental healthcare.

Keywords: Integrative Mental Health, White Paper, Integrative Psychiatry, Integrative Medicine, Complementary Medicine, Mental Health

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Framing the Problem

Overview

Mental illness accounts for about one-third of the world’s disability due to all health problems in adults (Anderson and Jane-Lloplis 2011), reflecting marked societal and personal suffering and enormous socioeconomic costs. Critically, mental health care globally does not adequately address this crisis, calling for urgent change in the paradigm and practices of mental health care including basic reforms in education, clinician-training, and research. The purpose of this White Paper is to characterize and advance the new field of Integrative Mental Health (IMH), which provides one potential solution to address the current crisis. From this, a strategic vision is outlined in the areas of research, clinician education and training, and public education and advocacy.

Serious mental health problems, including depression, bipolar disorder, schizophrenia, and drug and alcohol abuse occur in all countries and directly or indirectly affect all age groups. Mental illness is associated with poverty, wars and other humanitarian disasters, and often leads to suicide. It is estimated that 10-20 million people attempt suicide every year, and 1 million complete suicide (The WHO World Mental Health Survey Consortium, 2004). Major depressive disorder affects an estimated 121 million people worldwide and is one of the leading causes of disability on a global scale (The WHO World Mental Health Survey Consortium, 2004). By 2020 depression is expected to be the second leading contributor to all-cause disability worldwide second only to heart disease (WHO, 2012).

Enormous psychological, social and occupational costs are associated with depressed mood (Kessler, 2012). Maladaptive behaviours commonly seen in depression including over eating, smoking, excessive alcohol consumption and sedentary lifestyle, are important risk factors for many chronic physical illnesses that are responsible for approximately 60% of global mortality including cardiovascular disease, diabetes, cancer and respiratory illnesses (The WHO World Mental Health Survey Consortium, 2004). In the case of depression, this condition affects more than 21 million American children, adolescents and adults annually and is the leading cause of disability in the United States for individuals ages 15 to 44 In the U.S. annual losses in productivity related to depression are in excess of $31B (The WHO World Mental Health Survey Consortium, 2004). Depression is the leading cause of approximately 30,000 suicides that take place in the U.S. annually where suicide is the third leading cause of death among individuals aged 15-24 (The WHO World Mental Health Survey Consortium, 2004).

Improved Mental Health Care is Urgently Needed in All World Regions

As outlined above, mental illness is the pandemic of the 21st century which is our next global challenge. One current example of deficiency in the present treatment approach is in the area of clinical depression. In spite of the increased availability of antidepressants over the past few decades, questionable efficacy, unresolved safety issues and high treatment costs have resulted in an enormous
unmet need for treatment of depressed mood. On average it takes almost 10 years for a depressed person to obtain treatment after symptoms begin, and over two-thirds of depressed individuals never receive minimally adequate care (Mental Health America, 2012). Despite the magnitude of the impact of mental illness on global health, most countries do not regard mental illness as a high priority.

More than 85% of the world's population lives in 153 low- and middle-income countries (The WHO World Mental Health Survey Consortium, 2004). Poverty is linked to a higher burden of mental illness, with variables such as education, food insecurity, housing, social class, socio-economic status and financial stress exhibiting a strong association (Lund et al., 2010). Most of these countries allocate scarce financial resources to mental health care needs and have grossly inadequate professional mental health services (The WHO World Mental Health Survey Consortium, 2004). In Western countries such as the U.S., the elderly, minorities, low income groups, the uninsured, and residents of rural areas are less likely to receive adequate mental health care and most people with serious mental health problems receive either no treatment or inadequate treatment for their disorders. While data is absent in many jurisdictions, this occurrence no doubt is mirrored in less-developed countries.

In 2009, the last year for which data are available, total costs associated with treating mental illness in the United States including outpatient visits, hospitalizations, and ER treatment were approximately $80B, almost matching total treatment costs associated with heart disease and trauma (AHRQ table) showing costs of mental health care in United States (U.S. Department of Health & Human Services, 2009). Heart disease was the only major medical condition for which total treatment costs significantly surpassed costs associated with mental illness. A recent comprehensive survey of European Union member countries found that 38.2% (approximately 165 million people) met criteria for a psychiatric disorder with fewer than one third receiving any treatment at all (Wittchen et al., 2011). Disorders of the brain, including mental disorder, were found to be the largest contributor to the all cause morbidity burden as measured by disability adjusted life years (DALYs).

Unresolved Efficacy and Safety Issues Limit Current Mental Health Care

While appropriate therapeutic application of pharmacotherapies is a valued and vital aspect of any ethical treatment protocol, unselective over-prescription presents with various problems. In spite of decades of research and billions of dollars of industry funds, the evidence supporting pharmacologic treatments of major psychiatric disorders is respectfully underwhelming (Fournier et al., 2010; Herrmann, Chau, Kircanski, & Lanctot, 2011; Thase, 2007; Velligan et al., 2009). In addition to growing concerns about lack of efficacy, many widely used psychotropic drugs may cause serious adverse effects, including weight gain, increased risk of diabetes and heart disease, neurologic disorders, sudden cardiac death, and may potentially increase suicide risk. Some adverse effects lead to additional medical disorders, which in turn increase psychological burden. Metabolic syndrome is a well-documented
sequella of antipsychotics and other psychotropic agents, associated with weight gain and increased risk of diabetes and coronary heart disease (Henderson, 2008). Furthermore, prescription drugs often result in disappointing outcomes even when recommended treatment protocols are rigorously adhered to. The limited capacity of conventional medications to alleviate serious symptoms of depressed mood, anxiety, psychosis and other psychiatric disorders often results in impaired occupational functioning and losses in productivity. Leading figures in academic psychiatry have raised serious concerns about limitations of the current mainstream model of care including inequalities in the delivery of mental health services, the lack of integration of mental health services into primary care and other medical specialties, and conflicts of interest in relationships between the research community and the pharmaceutical industry (Reynolds et al 2009).

The shortcomings of conventional treatments and established models of mental health care invite urgent open-minded dialog on the range of promising non-conventional treatments as well as innovative concepts in care delivery. In addition to novel pharmacological therapies, accumulating research evidence demonstrates efficacy of other treatment modalities for many common mental health problems, including psychological interventions, select standardized pharmaceutical-grade natural products, as well as non-allopathic whole system approaches such as Traditional Chinese Medicine (TCM) and Ayurveda, and mind-body approaches. Examples of scientifically validated Complementary and Alternative Medicine (CAM) therapies include St John’s wort and S-adenosyl methionine (SAMe) for depression; adjunctive nutrients such as omega-3 fatty acids, folic acid, l-tryptophan, n-acetyl cysteine, and SAMe for mood disorders; acupuncture for acute anxiety or depression; and mindfulness training for negative symptoms of schizophrenia, anxiety and mood disorders (J Lake, 2007). In addition to these CAM therapies, lifestyle modifications such as regular moderate exercise, a healthy diet, and minimization of vices such as alcohol and nicotine, also offer encouraging evidence for improving overall mental health and reducing relapse risk (J Sarris, 2011).

While conventional pharmaceuticals may be appropriate and efficacious treatments for some mental health problems in some individuals, the time has come to move beyond a strictly conventional allopathic approach to mental health care, be it the prescription of a pharmaceutical or natural medicine, to a more inclusive integrated model that considers the range of social, psychological and biological causes of mental "illness"; an approach that addresses both preventing and treating mental health problems, and considers the concept of "wellness", as opposed to simply the amelioration of symptoms.

**The Emerging Context of Integrative Mental Health Care**

High prevalence rates and unmet treatment needs of serious mental illness in both developed and less developed countries illustrate the enormous global public health challenges posed by mental illness. Further, this underscores inadequacies of the conventional model of care, and the urgent need for more effective, safer, more affordable and more accessible treatments. As discussed above, CAM is rapidly
developing evidence of comparable efficacy to conventional treatments, with a superior safety profile, and this used in the context of an integrated system of care may provide a potential solution for enhancing the current mental health treatment model.

Increasing acceptance of CAM treatments in developed countries is the result of both scientific advances and social trends. Conventional allopathic medicine is being influenced by increasing openness among conventionally trained physicians to non-Western healing practices in the context of growing patient demands for more meaningful and more personal contact with medical practitioners. This is often difficult to find during brief appointments in managed-care settings. The twin issues of the inadequate therapeutic efficacy of certain treatments available, and a deficit of a time-rich, person-centered, therapeutic relationship with some medical practitioners, have led increasing numbers of individuals who see conventionally-trained physicians to seek concurrent treatment from CAM practitioners. These may include TCM clinicians, naturopaths and herbalists, homeopathic physicians and others (Barnes, Bloom, & Nahin, 2008).

While use of CAM for mental illness can be practiced as a stand-alone modality, it is also a major element of the emerging practice of Integrative Psychiatry. More broadly, this falls under the umbrella of the paradigm of “Integrative Medicine” which has emerged in direct response to patients’ needs and challenges since the 1990s. Integrative medicine reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing (Consortium of Academic Health Centers for Integrative Medicine, 2009). Along the same lines, IMH (as one branch of Integrative Medicine) focuses on treating the “whole person” (i.e. views mind/body and its systems as interrelated), emphasizes the therapeutic relationship between clinician and patient, prioritizes healthy lifestyle, and addresses biological, psychological, cultural, economic and spiritual/religious factors that affect general well-being and mental health. IMH is an evidence-based, research-driven paradigm and model of care that seeks to provide the “best of both worlds” by combining mainstream conventional AND non-conventional treatments. Conventional treatments encompass interventions such as psychopharmacology, psychotherapeutic techniques, and electroconvulsive therapy (ECT). While non-conventional treatments include approaches not presently used or endorsed by medical doctors or approaches practiced by a small minority of conventionally-trained clinicians, such as CAM therapies or medicines, mind-body medicine, dietary and exercise instruction, and lifestyle modification. For a more detailed discussion of the history, conceptual foundations and methods of IMH see Lake, Helgason and Sarris (2012).
Proposed Solutions

Summary
Transforming mental health globally is achievable. After comprehensive discussions between members of the International Network of Integrative Mental Health (INIMH), American Psychiatric Association CAM Caucus, The Bravewell Collaboration, in addition to integrative psychiatrists from several European and Asian countries, various challenges and solutions to advance IMH and better global mental health were identified (Table 1). These are outlined this White Paper, namely:

- The incorporation of evidence-based CAM into treatment models
- Advancement of an IMH research agenda with an emphasis on studying clinically-relevant IMH via rigorous methodology, and translating and disseminating this for the benefit of clinicians and the public;
- The development of model curricula and training programs for clinicians and the creation of a new discipline of “Integrative Psychiatry” or allied-health IMH-specific practice (with potential regional-specific board certification)
- The creation of clinical guidelines for the practice of IMH Care
- The formation and expansion of an international organization for advancing IMH.

Incorporating CAM into an Integrative Model of Care
In addition to the current deficits of conventional mental health care, as discussed above, patient motivation to use evidence-based CAM in an integrative model is another justification for this approach. CAM is widely used to treat or self-treat a range of mental health conditions, with large surveys confirming that consumer use has steadily increased over several decades (Barnes et al, 2008). The use of CAM to treat psychiatric disorders is growing rapidly. Some surveys have found that for specific psychiatric disorders, 43% of patients with anxiety disorder (Bystritsky et al., 2012), and 53% with depression (Wu et al., 2007) use CAM. Seriously mentally ill individuals who use CAM therapies to treat their symptoms perceive such treatments as improving their physical, emotional, cognitive, social, and spiritual functioning, reducing symptom severity and promoting recovery and wellness (Sirois, 2008). Findings of a survey recently published by the Bravewell Collaborative (Horrigan, Lewis, Abrams, & Pechura, 2012) support that integrative care is often beneficial for common medical and psychiatric disorders, and highlights depression and anxiety as among the top five health concerns for which integrative medicine is most beneficial. It is estimated that over half of all individuals diagnosed with a mood or anxiety disorder use CAM therapies to manage their symptoms; however few disclose CAM use to their psychiatrist, family physician or other conventional health care provider (Thomson, Jones, Evans, & Leslie, 2012) leading to potential health risks (Ernst, 2003). Aside from common usage,
burgeoning evidence is emerging for select complementary medicines and therapies for a range of mental health disorders (detailed in next section).

Establishing a Research Agenda for Integrative Mental Health

Psychiatric research in the past 50 years has focused primarily on neurobiological mechanisms, biological medicine, and psychotherapeutic techniques. More recent research has explored lifestyle moderators of mental health, mind-body therapies, and natural products (J Sarris, 2011). At present there is a scarcity of research on real-life, clinically-relevant integrative approaches in medicine and psychiatry (i.e. approaches that combine multiple interventions in a personalized manner), with most studies employing reductive randomized control trial (RCT) designs to examine single interventions. Important advances in research and the clinical practice of psychiatry will take place when formal research methodologies permit the rigorous evaluation of complex interventions involving multiple therapeutic modalities (which mirrors true clinical practice) to treat real-world clinical populations. A truly integrative research focus is urgently needed. While methodologically challenging, this approach may potentially elucidate the relative contributions of social, psychological, biological and spiritual factors in each unique patient’s response to combined treatment modalities. Additionally, it may clarify the roles of genetic and biochemical individuality, ethnicity, family history and culture play in the pathogenesis of mental illness. Along these lines Hoenders et al. (2012) recently reported on the advantages of an innovative research methodology that uses single-subject time series analysis to examine dynamic real-time relationships between symptom and treatment variables and interactions between particular treatment modalities in a patient receiving integrative treatment for anxiety. Findings of this “n-of-1” study revealed complex inter-relationships between the patient’s symptoms and responses to treatment, positive feedback loops between lifestyle behaviors and outcomes, and differential effects of different treatment variables that would potentially have gone unnoticed in conventional group study designs.

Recent findings from economic modeling research suggest that while incorporating CAM into treatment may be costly, down-stream savings can be achieved when integrative strategies yield positive long-term outcomes (Herman, Craig, & Caspi, 2005; Pelletier, Herman, Metz, & Nelson, 2010). Similarly, the findings of economic modeling studies on comparative cost-effectiveness of conventional vs CAM or integrative treatments of common psychiatric disorders including major depressive disorder, bipolar disorder and schizophrenia suggest that higher up-front costs of many CAM or integrative treatment may be offset by improved work productivity and increased future Quality Adjusted Life Years (QALYs) (Herman et al., 2005). A simplistic version of assessing socioeconomic benefits of using certain CAMs for e.g. depression, may involve comparing a standardized evidence-based nutraceutical (such as St John’s wort) versus a synthetic comparator. For example, a recent Australia analysis by Access Economics (Access Economics, 2010) found that if Australians switched from their antidepressant to St John’s wort they could save the country $50 million dollars per annum. While we are not suggesting St John’s wort
be substituted in place of conventional antidepressants at a macro level, this example of economic modeling encourages further exploration of potential cost-savings from use of CAMs that have equivalent efficacy to conventional treatments.

An important future research challenge will entail targeting specific integrative treatment strategies to discrete psychiatric disorders in the context of a broad-based bio-psycho-socio-spiritual model of care. Pragmatic trials comparing integrative models of treatment could be compared to conventional treatments to examine effectiveness, cost, and safety aspects. Studies could involve studying individually tailored multiple-component interventions with both quantitative outcome measures (e.g. using laboratory tests and validated psychometric scales) and qualitative experiences (e.g. subjective perceptions of improved functioning, placebo and nocebo effects). For example, a potential study could involve a clinical sample of people with diagnosed major depressive disorder, comparing conventional practice i.e. “treatment as usual” to a complex treatment process using a decision tree algorithm employing specific evidence-based intervention combinations. Such studies would be conducted following accepted protocols including comparisons of treatment as usual (e.g. cognitive therapy or described pharmacologic interventions) and established research methods including random allocation of matched patients to treatment arms, use of placebos or “sham” treatment in a “control” arm, validated symptom rating scales, blinded raters and validated statistical methods. Studies employing non-conventional treatments (e.g. natural products, mind-body practices, etc) would be advised to use standardized forms of natural products prepared using good manufacturing practices (GMP), or other therapies for which there is extensive data on both safety and efficacy (e.g. mindfulness, yoga, bright light exposure, biofeedback etc.) (J Lake, 2007).

Aside from integrative models, other priority research areas that need to be addressed within IMH include: use of pharmacogenomic, epigenetic, and neuroimaging technologies to elucidate mechanisms of action; exploration of the impact of lifestyle modification (e.g. diet, exercise, stress management) on mental health as both preventatives and treatments; and the interactions between specific pharmaceuticals and CAM therapies and medicines (especially with respect to potentially beneficial synergistic effects or potentially dangerous adverse effects or toxic interactions). Certain challenges however exist, that may potentially delay or interfere with research progress in IMH. These include:

1) Difficulty obtaining research funding for research of integrative models and RCTs utilizing an adequate patient sample size (potentially costing US $500,000 to $1.5 million dollars per study)

2) Need for consensus on how to standardize treatments, including botanicals and nutrient-based nutraceuticals, mind-body approaches, and somatic therapies

3) Need to develop research methodologies that permit replication of significant findings (this may pose complex challenges in view of enormous variability in CAM treatment modalities and clinical IMH practices)
4) Need to achieve a professional and respectable image of IMH research that is accepted within the mainstream biomedical research community and avoids or corrects negative perceptions and stigma sometimes associated with research in CAM or integrative medicine.

Creating Clinical Guidelines for the Practice of Integrative Mental Health Care

At present the practice of integrative medicine, including IMH, is highly idiosyncratic and varied depending on the personal philosophies, values and clinical perspectives of its practitioners, and the goals of diverse training programs, clinics or hospitals where integrative treatment approaches are employed. However a recent survey (Horrigan et al., 2012) of integrative clinics and training programs suggests that integrative medicine is beginning to “mature” into a coherent set of values, model of care delivery, and clinical therapeutics as evidenced by: strong affiliations of integrative centers to hospitals, healthcare systems, and medical and nursing schools; the practice of integrative medicine in diverse sites in the U.S. with high levels of concordance of interventions for specific medical or mental health conditions; integrative medicine centers often embracing core values that inform medical practice and interactions with patients. IMH is fundamentally a collaborative enterprise fostering cooperation between patients and practitioners, and also among clinicians themselves.

According to the Horrigan et al. survey, the most widely used model of integrative medicine in the U.S. is consultative care in which integrative clinicians work closely with the patient’s primary care physician to develop individualized treatment plans. The next most frequently used integrative care model (in centers surveyed) is comprehensive care in which an expert clinician manages a specific medical condition throughout the course of treatment. Finally, increasing numbers of integrative centers are using a primary care model in which family physicians, internists and nurses provide medical and mental health care as needed throughout the patient’s life span (Horrigan et al., 2012). In each of these models, a flexible patient-centered approach is one of the major strengths of integrative medicine and mental healthcare. In this context rigorous clinical assessment of the patient is always the crucial first step needed to ensure a comprehensive diagnostic formulation. All therapeutic interventions considered should be predicated on a thorough review of published research evidence supporting their use for a specific medical or psychiatric condition while taking into account risks of adverse effects, cost and availability. Hoenders et al (2011) have developed such an integrative mental health guideline using an algorithm depicting the judicious safety-conscious application of CAM within psychiatry.

We believe that the clinical practice of integrative mental healthcare will rapidly evolve to a very high standard following establishment of consensus-driven clinical guidelines that provide a template for deriving safe and effective assessment and treatment approaches on an individualized basis of the best available research evidence on efficacy and safety for both conventional and CAM therapies. These guidelines should ideally cover:
• Structure and content of a rigorous integrative clinical evaluation
• Selection and interpretation of diagnostic modalities
• Overarching treatment protocols that address efficacy, safety and ethical concerns
• Selection and prescription (or recommendations) of multi-modal therapeutic interventions
• Assessment of therapeutic efficacy using standardized outcome measures
• Structure of the therapeutic relationship and appropriate follow-up

While diagnostic formulations based upon the Diagnostic and Statistical Manual (DSM) approach clearly have serious limitations when approaching patient care from an integrative perspective, clinical practice guidelines based on DSM diagnostic categories will have immediate clinical utility and provide a practical template for establishing well coordinated inter-disciplinary collaborative methods in assessment and treatment planning. Importantly, clinical guidelines congruent with DSM categories and methods will also provide a framework for developing economic models that can be used to evaluate the cost-effectiveness of integrative approaches. However it is also recognized that the individual manifestations of mental disorders can be viewed as occurring along a spectrum (Cassano et al., 2002), and comorbidity is the rule, not the exception (Gadermann, Alonso, Vilagut, Zaslavsky, & Kessler, 2012). Thus, development of IMH clinical guidelines, which is a high-priority within the field, should take into account discrete and spectrum approaches to diagnosis and treatment.

Developing Model Curricula and Training Programs for Clinicians

In the U.S. and other developed countries there are essentially two parallel systems of education as well as clinical care: conventional training programs in mental health disciplines; and CAM related fields such as naturopathy, herbal medicine, and TCM. Conventional medical training programs include limited coverage of the CAM or integrative approaches outlined above. Similarly, CAM training programs generally minimize opportunities for education and research in the “basic sciences” emphasized in conventional allopathic medical training including biochemistry, psychology, pathophysiology, pharmacology and neuroanatomy (although this is not the case for naturopathic medicine, which provides rigorous education in these areas.) Successful implementation of interdisciplinary education and training programs will require a high level of collaboration between relevant academic centers, professional societies and clinicians from a range of disciplines. Aside from university-based education, web-based education is an emerging application that may provide global education of IMH. Web-based education programs, lectures and discussion forums can facilitate collaborative planning.

To advance the formation and application of IMH curricula we propose three strategic initiatives:

- Develop model curricula integrated into pre-existing programs for students enrolled in medical, allied health, psychology degree programs
Provide post-graduate level education and training for qualified medical and allied health clinicians

Provide venues and mentorship opportunities for IMH practitioners and trainees to learn and develop clinical skills

* Curricula would be modified depending on the specific discipline’s licensing to prescribe certain interventions.

Given the diversity of the emerging field of IMH and the broad range of interests and perspectives of post-graduate training programs in psychiatry, psychology and allied fields, it is likely that programs will emphasize selected areas of specialization. Currently, on completion of formal training, clinicians often seek out continuing education and mentorship opportunities in mind-body medicine including mindfulness-based stress reduction, biofeedback or hypnotherapy; or in training on the prescription of nutraceuticals (botanicals and nutrients). In the same way that conventional post-graduate training programs (i.e., residency) in psychiatry incorporate training in advanced psychopharmacology, psychodynamic or cognitive-behavioral therapy, we envision that post-graduate training programs in integrative mental health care will increasingly add validated CAM approaches.

*It should be clearly noted that the practice of IMH is not just the prescription of products or utilization of CAM techniques; it involves a fundamental paradigm shift, moving away from a conventional focus of treating solely a person’s acute symptoms, to addressing the physical, mental and environmental determinants of suffering, and ultimately transforming a person’s life (within economic, cultural and spiritual/religious constraints) towards a life of fulfillment, wellness and health.*

As IMH is an emerging field, there remain a number of important future goals of curricula and training projects, these include:

- The creation of curricula with solid evidence-based foundations of scientifically-validated approaches involving both CAM and conventional treatments
- Developing highly interactive models that permit interpersonal contact between clinicians from diverse backgrounds using sophisticated web-based media tools
- Incorporating web-based tools that enhance therapeutic interactions and the potential to evolve IMH-focused “telepsychiatry”
- Coordinating approaches from diverse practitioners with specialized skill sets and fostering openness to diverse perspectives among trainees
- Emphasizing interpersonal aspects of therapeutic interactions that will foster increased “connectedness, humanism and self-awareness” in clinical settings
- Developing training tools that foster increased partnership between clinicians and patients when considering CAM or integrative therapies
Establishing and validating clinical practice guidelines for truly integrative mental health clinics and in-patient services, including use of clinical algorithms and logic models to better understand parameters of integrative practice and evaluative measures to predict outcomes

Creation of an International Network for Advancing Integrative Mental Health Care

The alarming statistics reviewed in this paper suggest that the majority of people suffering from mental illness in all world regions probably receive inadequate or no care, while many widely used conventional and non-conventional treatments are supported by limited evidence of safety or efficacy. Survey findings support that integrative mental health care is already the de facto model of care practiced by some mental health professionals and pursued by the public at large (Barnes et al., 2008). However, while momentum is building, the emerging paradigm of IMH is limited by the absence of clear directions on priorities for research initiatives, education curricula, clinical practice guidelines, dissemination of knowledge to the public, and interfacing with government agencies to assist in shaping health policy.

In response to urgent and increasing needs for improved mental health care globally, the marked limitations of conventional treatments and the conventional model of care, and growing evidence for the benefits of an integrated model of health care incorporating CAM therapies, in March, 2010, the International Network of Integrative Mental Health (INIMH) was established to advance an agenda for transforming mental health care into a more effective, more cost-effective and more compassionate model of care. A non-profit organization, INIMH provides a framework for international networking and collaboration aimed at advancing an agenda of “whole-person” care based on a prevention and wellness model, using both mainstream and CAM approaches.

The concept of a wellness-focused model of mental health care gained momentum in 2011 with publication of the UK Public Health White Paper emphasizing the fundamental importance of prevention and health improvement through lifestyle changes (Bhui & Sokratis, 2011). Findings of a recent survey of 29 integrative medicine centers and programs support that integrative approaches are perceived as successful when used to treat both medical and mental health conditions. The survey, published in February, 2012, was commissioned by the Bravewell Collaborative (Horrigan et al., 2012), a philanthropic organization that works to improve healthcare standards in general and a thought leader in integrative medicine. Of note, 55% of survey respondents reported that depression and anxiety were successfully treated at their clinics using integrative therapies.

The founding board members of INIMH agreed that education, early intervention and developing models of care that address economic and social equality are essential for the success of a broad-based agenda aimed at transforming mental health care globally. An important priority of INIMH is developing advisory relationships with academic centers of excellence and government agencies in all world regions with the goal of facilitating dialog in the private and public sectors that will foster progressive
reforms in mental healthcare policy on a global level and lead to increased uses of evidence-based IMH practices in psychiatric hospitals, outpatient mental health clinics, and primary care clinics. To achieve these broad goals several strategic initiatives will be pursued (Figure 1). Phase 1 (a consensus definition of IMH) and phase 2 (establishment of an international IMH organization) are now complete and we are now entering into phase 3. The final phase advocated in this White Paper (phase 4), concerns four key aspirational goals.

The present formative phase of our work involves greater clinician and public engagement to further develop INIMH membership and increase global awareness and education of IMH. Vehicles through which this can be achieved include increased interaction with the media, universities and educators, like-minded organizations and websites, seminars and conferences, as well as researcher and academic networking. Another key element of this growth phase involves raising revenues needed to promote IMH globally. Following successful outreach and growth of IMH globally, a final phase will be required to solidify the field. This may involve the creation of a specialized journal on either integrative psychiatry or IMH. Currently, while CAM and psychiatry journals exist and integrative medicine journals are on the rise, no dedicated IMH journal has been established. Another key platform of urgently needed change in mental healthcare is region-specific board certification of integrative psychiatrists and IMH practitioners. These boards can set high education and training standards for fellowships and build a membership of highly-educated and trained integrative psychiatrists and allied health practitioners.

Finally, a major long term goal is the integration of IMH practices into public and private hospitals in the form of IMH-trained clinicians or allied health practitioners, moving towards a prevention and wellness model. This can be achieved only if IMH has a powerful lobbying presence with relevant government agencies to influence public health policy and promote a paradigm shift towards improvements in mental healthcare. The foundations of this strategic initiative to transform mental health care rest on a foundation of rigorous research, high-quality education, and a large vocal group of IMH clinicians and public supporters.

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**Summary and Future Direction**

As detailed in this White Paper, there is an urgent unmet need for better solutions to mental illness on a global level. Mounting research evidence supports that psychosocial programs, lifestyle modification, mindfulness meditation and relaxation techniques, and select natural products are beneficial, safe and affordable interventions for common mental health problems that could easily be incorporated into existing mainstream mental health care models. This should result in improved outcomes and more compassionate and long-term cost-effective care. Contemporary treatments and models of care do not
adequately address the complex biological, social, cultural and spiritual dimensions of mental illness, and there is urgent need for preventive, integrative model of care that will lead to true healing and wellness.

While this White Paper is oriented more towards developed Western countries, the new IMH paradigm will become relevant on a global scale only by taking into account the diverse socio-cultural, economic and spiritual issues that affect mental health in less developed countries. Less developed world regions have limited access to many conventional treatments widely used in more prosperous nations. By the same token, cultural or ideological barriers may impede acceptance of an IMH model in less developed countries even when cost-effective integrative treatments become available. While it has not been our objective to discuss in detail, we believe that truly integrative models of care incorporating both traditional practices and allopathic therapies are now widely used in many countries suggesting that IMH is rapidly emerging on a global scale.

The first step in transforming mental health care is to clearly define the new paradigm of “Integrative Mental Health Care” that is rapidly changing the way clinicians practice and patients seek care. We intend that the present White Paper, and previous work by Lake, Helgason & Sarris (2012) have achieved this essential goal. This White Paper is envisioned as a “working document” intended to invite open dialog, debate and consensus on conceptual foundations, research issues and clinical methods of IMH among mental health professionals. This paper is offered as a guide for future healthcare policy discussions in the hope of stimulating urgently needed advances in research and the day-to-day practical clinical work of mental health care. INIMH will provide a catalyst for the development of innovative programs for both graduate level and postgraduate education and training in integrative mental health care and the establishment of institution-sponsored fellowships in specialized clinical and research areas. Outside financial support will be required to achieve these important goals, initially to gather data on IMH practices in current use and to examine health and economic outcomes when IMH protocols are employed. Through networking and collaborative partnerships with institutions, clinicians, patients and advocates who share our vision in the coming decades, and for the benefit of all people who suffer with mental illness, INIMH will promote an agenda for transforming mental health care globally.
References


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<td>Clinical Guidelines</td>
<td>Focus on long-term medication and removal of symptoms; neglect of lifestyle and CAM</td>
<td>Increase awareness of prevention, evidence-based CAM, psychosocial and spiritual issues, lifestyle modification; including them in clinical guidelines</td>
</tr>
<tr>
<td>Public Policy</td>
<td>Focus on treating acute problems; lack of awareness of evidence-based CAM and IMH model, and the impact of lifestyle modification on mental health</td>
<td>Engage policy makers to frame better health care decisions, shift focus towards an integrative “wellness” and prevention model</td>
</tr>
</tbody>
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IMH = Integrative Mental Health; CAM = Complementary and Alternative Medicine; EB = Evidence-Based
Figure 1. Agenda to Advance Integrative Mental Health

Phase 1
- Creating via consensus a unified definition of the Integrative Mental Health paradigm

Phase 2
- Establishing an independent collaborative global network for all mental health professionals (medical, allied health, and CAM clinicians, researchers, health advocates) with a strong public interface

Phase 3
- Educating the public & clinicians on the IMH paradigm
- Public promotion of IMH via media, seminars, supportive organizations, and web sites
- Establishing model curricula and professional certification programs & training
- Raising revenues for Integrative Psychiatry Fellowships, research, & conferences
- Developing evidence-guided educational and clinical guidelines & mentorship

Phase 4
- Country-specific board certification of “Integrative Psychiatrists”
- Government interaction to shape IMH policy & promote an IMH care model
- Utilization of IMH as standard practice in clinical settings—including public & private hospitals
- Creation of an IMH-specific journal