Integrative mental

Can complementary therapies have a role in mental healthcare in the general practice setting? Dr Jennifer Hunter **and psychiatrist** Dr Wai Mun Tang **explain.**

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Integrative mental health (IMH) combines conventional biological psychiatry and psychological interventions with traditional and complementary medicine (CM) to provide holistic patient-centered care. Using non-hierarchical interdisciplinary teamwork, the patient and practitioner are able to explore psychological paradigms involving biological, cultural and spiritual dimensions of health and illness. Beneficence, avoidance of harm and informed consent are core ethical principles of practice. As well as addressing immediate mental-health problems, the patient is encouraged to become actively involved in their own prevention of mental illness and maintenance of mental health.

Benefits of IMH include the possibility of a truly scientific approach to healthcare, with an emphasis on evidence-based medicine that responds to the individual circumstances of the patient.[1] Synergistic, multidimensional therapies are offered; there is active participation from the patients; and a greater focus on primary and secondary prevention. As in other areas of medicine, using a holistic model extends the focus to include better outcomes in all aspects of disease prevention, health and well-being.[2]

As with any emerging new paradigm, there is resistance from the status quo.[3] The IMH practitioner must use a particular cognitive style to ensure the inclusion and integration of the vast array of competing paradigms. Combined with the lack of resources for training and research, it remains a challenging yet potentially rewarding field.

The Australian scene

Many Australians use CM for mental health. Recent ABS statistics found 8.2% of Australians use vitamins, minerals or herbs for their mental well-being [see *JCM* 2009;8(4):8]. In lieu of mapping of integrative services, let alone IMH services, in Australia, we observe a gradual and steady increase in the number and types of IMH services operating in Australia. These range from:

SUMMARY

- Integrative mental health (IMH) aims to use the best available evidence to provide holistic solutions for the management and prevention of mental-health problems
- St John's wort, kava, omega–3 fatty acids have the strongest evidence to support their use
- The patient is included as a central, active participant in the IMH team
- For patients refusing standard psychiatric treatment, IMH offers alternate options
- A holistic approach to management should include the patient's spirituality
- IMH practitioners have honed their clinical skills generally take a heuristic and commonsense approach to treatment
- Psychiatry, with its inherent complexities and comorbidities, lends itself to IMH
- Issues of patient confidentiality, consent and practitioner lack of training in mental illness are specific to IMH

1. Solo practitioners (GPs, psychiatrists, mental healthcare workers) offering IMH care using various combinations of therapies and referring patients to other practitioners in a virtual team
2. Integrative clinics comprising of doctors, psychologists and TCAM practitioners offering mental healthcare as part of their primary-care services
3. Specialised IMH services providing intensive 'in-patient'-like services for mental health and addiction.

health

Assessment and diagnosis

IMH uses orthodox psychiatric diagnostic criteria. The *DSM IV-TR* is most commonly used in Australia. The *DSM IV-TR* is a diagnostic system with five axes: (I) primary psychiatric clinical disorders including psychotic illnesses, mood and anxiety disorders, substance abuse and eating disorders, developmental and learning disorders; (II) personality and mental retardation; (III) medical conditions; (IV) psychosocial and environmental problems; and (V) global assessment of functioning.

Subsequently, depending upon practitioner qualifications and training, the IMH assessment can also include other diagnostic criteria from traditional medicine systems such as Chinese, Ayurvedic and Western naturopathy, as well as emerging nutritional and energetic therapies. Included in these extended views on aetiology and diagnosis is an exploration of the spiritual, energetic and neurobiological dimensions of mental health.

Assessment tools include clinical history, self-report questionnaires such as the Beck's Depression inventory II (BDI II)[4], Hospital Anxiety and Depression Scale (HADS)[5], Depression Anxiety Stress Scale (DASS)[6], Short-form DASS-21[7] and Kessler Psychological Distress Scale (K10)[8,9], and biological screening from physical examination and further investigations as clinically indicated. Depending upon the other therapeutic modalities chosen, extended nutritional and hormonal assessment; more extensive and in-depth psychological interview; and other diagnostic tools, such as iridology, kinesiology, tongue and pulse diagnosis may be incorporated.

The integrative mental health assessment can also include other diagnostic criteria from traditional medicine systems such as Chinese, Ayurvedic and Western naturopathy

The IMH practitioner will then formulate a diagnosis that incorporates orthodox psychiatric models including psychodynamic, social and biological views of mental health, integrating them where appropriate with conceptual models from other paradigms.[10] What at first seem to be a vague or complex psychiatric condition, often with comorbidities, can potentially be more clearly categorised using another diagnostic system, thus expanding management options.

Management options

Management options are guided by the diagnosis, severity and staging of the condition/s. Selection of treatment modalities considers their evidence basis, cost benefits, availability and acceptability to the patient and practitioner. Severe, acute and/or life-threatening conditions are best managed on the basis of evidence with orthodox medical and psychiatric interventions including pharmacotherapy, electroconvulsive therapy and medical treatment where appropriate. Non-pharmacological modalities, such as psychotherapy, meditation and exercise, which are an integral part of treatment and rehabilitation for less severe conditions may be contraindicated in some acute presentations [see table, p 24].

Scientific evidence is strongest for the use of allopathic medicine, particularly psychotropic medication, in the treatment of acute and severe mental illness, specifically schizophrenia and bipolar disorder and, to a lesser degree, depressive/anxiety disorders and personality disorders. In the former, CM modalities have a secondary and adjunctive role unless other evidence emerges, side-effects of pharmaceuticals are intolerable or a patient refuses consent to allopathic medicine and does not fulfill the criteria for involuntary treatment under the *Mental Health Act*.[11,12]

The strongest current scientific **evidence** for CM therapies in mental health are for some of the St John's wort [*Hypericum perforatum;* see *JCM* 2009;8(1):6, 8(4):5][13] and kava [*Piper methysticum*; see *JCM* 2007;6(6):36–9][14] extracts for the treatment of depression and anxiety respectively; and the use of omega–3 fatty-acid supplementation for a range of mental-health problems [see *JCM* 2006;5(6):56–7].[15] Exercise, meditation, acupuncture and other CMs have varying levels of evidence to support their use.[16–24]

Integrating orthodox biomedicine with CM raises concerns about **interactions**.[25,26] Many St John's wort extracts are known to interact with a large number of pharmaceuticals and confer a potential risk of increasing adverse reactions from antidepressants.[27] As is the case with pharmaceutical antidepressants, the use of St John's wort includes the potential risk of switching from depression to mania in bipolar disorder. Conversely, there is increasing evidence for positive interactions with the concurrent use CM (e.g. omega–3, folic acid, S–adenosylmethionine and L–tryptophan with antidepressants).[28]

Aside from a limited number of **psychotherapy** protocols (e.g. interpersonal psychotherapy, cognitive behavioural therapy and possibly long-term psychoanalytic therapy[29]), many of the psychological interventions used by clinical psychologists and psychiatrists also lack clinical trials to support their use.[30,31] New holistic psychotherapeutic models are beginning to integrate CM with orthodox psychological treatments, including the mindfulness movement, positive psychology and body-centered psychotherapies.[32–34]

Integrative mental healthcare options				
Severity	Acute <6wks; severe	Acute <6wks; mild–moderate	Medium 6wks to 12mths; mild–severe	Chronic >6mths; mild–severe
Diagnostic Examples	Acute psychosis Acute Mania Life-threatening depression with medical complications or suicidality	Hypomania Major Depression	Anxiety disorder Major depression	Chronic schizophrenia Personality disorder Dysthymia Chronic pain syndromes
Goals: holistic, integrated, patient-centred, evidence-based	Alleviate acute symptoms, ensure safe environment	Alleviate acute symptoms, avoid further deterioration	Identify & manage underlying triggers and exacerbators	Maintenance, optimise overall health, reduce relapses
Integrative mental-health team	Community mental-health team		Community mental-health team for severe, long-term mental-health problems	
	HEALTHCARE PROFESSIONAL: GP, psychiatrist, CM & allied-health practitioners, psychologist, mental healthcare workers COMMUNITY PROFESSIONAL: social services and housing, pastoral care, occupational health LAY: family, friends, social networks, teachers, employers/colleagues			
Location	Psychiatric hospital admission			
	Community			
Therapeutic interventions	Electroconvulsive Therapy ECT			
	Medical e.g. rehydration			
	Psychotherapy (individual/family), counselling, pharmaceuticals, herbal/nutritional supplements, acupuncture, laser/electro acupuncture*, diet, lifestyle modification*, exercise (general, relaxing e.g. yoga, tai chi, qi gong*), aromatherapy, relaxation techniques*, spiritual practice (may be contraindicated in acute, severe stage) * Application may be limited in severe cases in the acute setting			
		Meditation, mind–body practices		
			Social/occupational rehabilitation	
Medicare	Better Access to Mental Health – Mental Health Care Plan, Psychiatry, Psychotherapy, Counselling			
				Chronic Disease Management Plan, EPC, HMR

A holistic approach to management should include the patient's **spirituality** [see *JCM* 2005;4(5):93–6]. This can be particularly challenging when patients' psychiatric symptoms, such as delusions, involve religious or spiritual themes. Practitioner knowledge of religious and spiritual beliefs within cultural settings is essential in helping differentiate commonly held belief systems from schizotypal or delusional ideation. Clarifying values and beliefs, and identifying previous coping mechanisms, may help direct management.[35,36]

Self-report questionnaires may be used to **monitor outcomes** from interventions, with K10 easy to use in a busy clinical practice.[8,9] Alternate outcome measurement tools that take a patient-centred approach, e.g. the Psychological Outcome Profile (PSYCHLOPS)[37,38], along with the SF-12 and RAND-12 that cover both mental and physical aspects of well-being[39], may be more appropriate in the integrated setting.

Most IMH practitioners who have honed their clinical skills generally take a heuristic and commonsense approach to treatment; the same approach that has led over millennia to the development of traditional medical models and modalities. Interestingly, an integrative model of health is already inherent in most traditional medical systems. For example, in

CASE STUDY

Tom presented at 27 years of age with a history of bipolar disorder with manic episodes from the age of 21. These had a seasonal component, requiring hospitalisation every spring and dysphoric episodes in winter. Although Tom's symptoms would resolve with use of antipsychotics and lithium, he complained of side-effects and was not compliant with pharmacotherapy and psychiatric follow-up between hospitalisations.

Tom sought psychiatric management with non-pharmacological interventions. He began an eclectic combination of psychotherapies including psycho-education, insight-orientated and cognitive behavioural techniques. Tom commenced mindfulness meditation and yoga for stress management; optimised sleep patterns and diet; used St John's wort extracts for his dysphoria; and was referred for acupuncture. His family was enlisted to help in relapse prevention by supporting his self-care and watching for early-warning signs of mania.

Although Tom stayed well on this management for 6 months, he relapsed again in spring, resulting in a two-month involuntary acute psychiatric admission. Following discharge, Tom continued to refuse medication. In addition to his previous management, he was trialled on omega–3 fatty acids in the form of fish oil. Tom noted optimal response at approximately 3g EPA, 2.2g DHA daily, reporting his thoughts speeding up, an early-warning sign of mania, whenever he attempted to reduce the dose.

Two years later, Tom moved to Canada to pursue his career and discontinued all treatment other than regular fish oil, meditation and the use of St John's wort during the Canadian winter. He remained well for 10 years until he changed from fish oil to flaxseed oil because of his vegetarianism. His condition subsequently deteriorated over a three-month period and resulted in readmission for two months. Tom's symptoms resolved again on olanzapine, but he discontinued medication upon discharge and return to Australia. He has since recommenced his usual treatments, including high-dose fish oil, and has been euthymic and well for the last five months.

This case highlights the common and difficult issue of consent in mental illness, and balancing paternalistic and patient-directed approaches within the IMH model of care, depending on illness severity. It exemplifies the combined use of a range of CM modalities and raises questions about the 'active ingredients' in an IMH treatment regime.

traditional Chinese and Ayurvedic medicine, meridians and *dosha* states correspond to, maintain and integrate all aspects of a individuals' structural, physiological, emotional, intellectual, lifestyle and spiritual characteristics. Corresponding treatments for imbalances in these areas are therefore implicitly multidimensional.

There is a danger for the modern practitioner that, in simply abstracting and prescribing the 'best' of the CM therapies without including the conceptual model from which it arose, may potentially reduce effectiveness.[40–42] The evidence basis for the CM therapies must arise from research that takes into account the underlying models rather than simply assessing singular modalities outside of their theoretical context. Using a team approach can help integrate these concepts to create a cohesive management plan.

The IMH team

Conventional mental-health services commonly operate using a hierarchical structure. Community mental-health teams and case managers are used to help coordinate care for people with severe, chronic mental-health problems.[43,44] This approach is most clearly appropriate in severe, life-threatening illness and where the patient meets the criteria for involuntary treatment. However, their effectiveness continues to be challenged in the context of less acute illnesses and broader diagnosis.[45,46] A tiered approach with a shift to an IMH approach may be more appropriate in the latter context and also in the former as patients improve and leave the acute setting.

The evidence basis for CM must arise from research that takes into account the underlying models rather than simply assessing singular modalities outside of their theoretical context

The IMH practitioner utilises a broader base of knowledge and clinical experience to provide optimal care. Best practice involves a diverse and qualified clinical team with mental-health experience or expertise. As well as conventional mental healthcare providers, CM and allied-health practitioners, the team may also include key people from the patient's family and social networks.

Perhaps the greatest challenge to any team approach is creating a seamless and flexible dynamic that meets patients' needs. Team members will have different skills and levels of training. They may use different systems and ideologies to explain mental illness and guide their management.[47] Adding lay people to the team creates further complexities, most impor-

tantly in mental health, issues of patient confidentiality and lack of professional training with mental illness.

In integrative medicine, the patient is optimally placed in the centre of a hub–spoke arrangement with patient autonomy, active participation and shared responsibility encouraged.[48] The patient is encouraged to activate different members of the team according to need, and engage in shared decision-making.[49] This is complicated in mental illness where, depending upon the patient's mental state and capacity and the complexity of the team and management context, one or two key members may be needed to formally act as case manager, guardian and/or patient advocate. Such a role is particularly important with acute psychotic illness and life-threatening situations of reduced self-care or suicidality.

There are only a handful of primary-care clinics in Australia offering IMH care, so for the majority of patients and GPs seeking integrative services, the IMH team will need to use a virtual model. However, as the integrative approach to mental healthcare becomes more popular, we anticipate more primary- and secondary-care services housing IMH practitioners. Aside from the obvious logistical benefits to patients and practitioners, IMH clinics may also support the development of closer working relationships with clearer decision-making criteria between the team members (including the patient). Similar to psychological interventions provided by on-site mental-health workers, there is the potential for IMH clinics to demonstrate reduced visits to doctors, fewer specialist referrals and lower prescription rates.[50]

Medicare item numbers

Two new sets of MBS item numbers were introduced over the last few years; the first was designed for patients with chronic illness and complex care needs[51] [see *JCM* 2008;7(4):21–3, 67, 7(5):24–8]_and the other, for mental healthcare. Many patients with mental-health problems experience concurrent physical illness and vice versa.[52] Patients with either acute or chronic mental-health problems can use the Mental Health Care item numbers. Patient with complex care needs who have chronic mental-health problems or other long-term comorbidities are also eligible to use the Chronic Disease Management Plan item numbers.

Conclusion

The successful practice of IMH requires knowledge of the multilayered aetiology of mental illness sourced from the many paradigms of mental health in orthodox psychiatry and CM, along with the ability to integrate the treatment modalities. Of all the medical specialties, psychiatry — with its inherent complexities and comorbidities — perhaps most lends itself to a truly integrative approach. ◗

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