



editorial

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Self-management in mental health: questions for service providers and commissioners

Self-help or self-management approaches may offer a satisfactory solution to several problems associated with traditional mental healthcare: disempowerment, stigma and lack of resources. It has even been hypothesised that the use of self-help strategies by certain groups of people can help to explain the socio-economic gradient in demand for traditional health services (Goldman & Smith, 2002). The terms 'self-management' or 'self-help' are used to refer to three different types of activity: groups; reading/using the internet; and non-traditional, or complementary, therapies.

Organised 'self-help' groups are widely known and have been accepted for specific problem areas for over 25 years. In 1989, Jacobs and Goodman predicted that:

'self-help groups will assume a central role in the nation's mental health delivery system over the next two decades'.

The authors believed that this was because they offered a less costly alternative to mental health services in the USA. However, not all groups play a therapeutic role, some prioritise campaigning activities. In the UK, at a national level, SANE is an example of the latter, whereas MIND and Rethink provide services as well as campaigning. At a local level, also, the function of self-help groups in relation to mental health services ranges from the provision of alternative sources of practical support and group counselling through raising of awareness to a critical appraisal of the *status quo*.

More recently, the term 'self-management' has been used in relation to chronic physical health issues (von Korff *et al*, 1998). This frequently involves giving individuals information to be read and acted upon. They may do this on their own or in a group convened for that purpose, with or without professional input in either case. Imported to the mental health arena, similar approaches are used most frequently to treat anxiety, depression and eating disorders. Use of these self-management strategies is difficult to measure because access to printed material and the internet is unlimited. Where professionals are involved, interventions are more likely to be manualised and monitored. Hence, most evidence is generated from formal, professionally organised self-help programmes.

In addition, quasi-medical interventions using non-traditional approaches, such as aromatherapy and massage, are sometimes referred to as forms of self-help or self-management.

However, there may also be problems associated with self-help, including risk to users, poor consistency of delivery, discontinuity of provision and lack of accountability. By reviewing research in relation to the three main types of self-help (groups, reading, non-traditional therapies), this article raises some issues for consideration by mental health services.

Self-help management

Groups

Organised groups are usually run by non-professionals in a voluntary capacity, although professionals may facilitate groups or contribute when invited to do so. A self help or mutual aid group is defined as a group consisting of people who have personal experience of a similar issue or life situation, either directly or through their family and friends. Sharing experiences enables them to give each other a unique quality of mutual support and to pool practical information and ways of coping. Groups focus on diverse aspects of mental health, including alcohol problems, anxiety, autism, depression, drugs, eating disorders, hearing voices, schizophrenia, sleep problems and tranquillisers.

Judging by published evaluations, groups seem to be most effective in relation to bereavement (Caserta & Lund, 1993), eating disorders (Carter & Fairburn, 1998), substance misuse (Moos *et al*, 2001) and smoking cessation (Lancaster & Stead, 2002). Several studies have investigated self-help groups for substance use problems as an adjunct to mental health interventions (e.g. Noordsy *et al*, 1996). They found participation in self-help groups to be associated with better substance misuse and social functioning outcomes, usually when groups follow a highly structured programme, such as the Alcoholics Anonymous 12-step plan.

As noted by Levy in 1976, the nature of the self-help group is directly affected by the person who joins, and



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groups themselves are altered by the participation of each member. Therefore, an understanding of group processes is required to interpret the impact of self-help groups. Hatzidimitriadou (2002) highlights differences between self-help groups in terms of their political ideologies and presents some evidence of differential outcomes associated with type of group. 'Radical' groups seeking to reform the mental health system appear to generate greater optimism in their members. 'Conservative' groups aim to promote change in their members, so they have a higher rate of expressive group processes.

Reviews by Kyrouz *et al* (2002) and Lewis *et al* (2004) emphasised the need for research into the outcomes of group membership for people with severe mental health problems. It is assumed that group support can take the place of secondary care. Groups may also supplement specialist services by maintaining participants' motivation between appointments. Once formal treatment has ceased, such groups can provide social networks for people whose problems may have long-term implications. These assertions are largely anecdotal.

Reading/accessing the internet

Books and didactic electronic materials may be strictly educational, but they often offer explicit or implicit advice on what a person can do for themselves. A large amount of self-help material is available from frequently used English language mental health websites (Box 1). This includes highly structured materials, such as relaxation guides. The use of these materials is sometimes referred to as 'bibliotherapy'.

Bower *et al* (2001) systematically reviewed eight self-help intervention studies for anxiety and depression. They concluded that: '... self-help treatments may have the potential to improve the overall cost-effectiveness of mental health service provision. However, the available evidence is limited in quantity and quality and more rigorous trials are required. . . . A meta-analysis by denBoer *et al* (2004) strongly endorsed bibliotherapy for emotional disorders, finding a mean effect size of

Box 1. The relevant, most-frequented English language websites pertaining to mental health

<http://www.psychcentral.com>
<http://www.mentalhelp.net>
<http://www.mentalhealth.com>
<http://www.intelihealth.com>
<http://www.helping.apa.org>
http://www.bbc.co.uk/health/conditions/mental_health
<http://www.mentalhealth.org.uk> (Mental Health Foundation)
<http://www.rethink.org>
<http://www.mentalhealth.org> (SAMHSA)
<http://www.healthyplace.com>
<http://www.emental-health.com> (UK-based)
<http://www.helpguide.org>

0.84 for this intervention compared with a control intervention, and no difference between bibliotherapy and brief psychiatric treatment.

Non-traditional therapies

'Alternative therapies', complementary or non-traditional treatments, are also sometimes referred to as 'self-help'. They are not routinely available on the National Health Service. They include Chinese medicine and acupuncture, homeopathy and herbal remedies, massage and aromatherapy.

With such treatments there is the possibility of placebo effects, so the design of evaluations is important for their interpretation. In a review of alternative treatments for depression, Jorm *et al* (2002) concluded:

'The treatments with the best evidence of effectiveness are St John's wort, exercise, bibliotherapy involving cognitive-behavioural therapy and light therapy (for winter depression). There is some limited evidence to support the effectiveness of acupuncture, light therapy (for non-seasonal depression), massage therapy, negative air ionisation (for winter depression), relaxation therapy, S-adenosylmethionine, folate and yoga breathing exercises'.

Even where effectiveness is demonstrated, the effect size is important, and the cost-effectiveness of alternative therapies should be compared with that of traditional treatments. In the case of depression, Jorm *et al* (2002) judged that alternative therapies did not perform as well as conventional interventions.

Implications for mental healthcare

Providers and commissioners need to satisfy themselves in relation to the following questions.

- (a) Would an audit of waiting lists identify people whose distress could be alleviated by appropriate self-help measures?
This is the key question for managers. Can self-help interventions reduce the demand for secondary services by treating people before they get to them? Might they be used as an interim measure for people on waiting lists? To implement this approach, referrers and clinicians would have to be fully informed of what the advantages and disadvantages of self-management might be for specific diagnoses.
- (b) What are the risks of referring people to self-management, in each of its three forms?
Should we compare the risks of self-help with the risks of no intervention or with the risks of psychiatric service use, which may include stigma, unemployment and low self-esteem? Perhaps it would be better to consider what safeguards would be desirable to ensure that people do not come to harm through self-help. For example, providers might offer clinical supervision for group facilitators, occasional consultations from professionals for people undertaking bibliotherapy, and the licensing of alternative therapists.
- (c) For bereavement, eating disorders and addiction problems, and for carers under stress, are self-help



groups the first resort of primary care referrers? Since there is evidence in favour of these types of groups and given the long-term nature of the problems, self-help groups for addictions, bereavement and carers under stress should form part of primary mental healthcare provision. They will not suit everyone, but the availability of groups as a 'first resort' is likely to increase the efficiency of secondary services.

- (d) What reading material (bibliotherapy) is currently in use, and is it being evaluated? How do clinicians rate the available paper and electronic resources?
In a rapidly developing field such as self-management, it is difficult to keep pace with the new approaches and their impact. Clinicians with experience of using bibliotherapy might be called upon to pool their knowledge of what appears to work and to evaluate these approaches consistently and systematically.
- (e) What alternative therapies are currently in use, and are they being evaluated?
The availability of alternative therapies is patchy. Although they do not appear to have comparable effectiveness to conventional treatment for depression, we need to know how they perform in relation to other common problems. Alternative therapists and groups with an interest in a particular area could be guided to create networks to generate evidence where this is lacking.
- (f) What clinical and cash support is available to self-help groups working with trust service users and carers?
There is no clear dividing line between formal provision and self-management. If commissioners and providers aim to make more use of groups, they will also need to support them. Typically, self-help enterprises have no cash reserves and run largely on goodwill. Small contributions in cash and in kind can make a large difference to self-help organisations. A commitment to local self-help provision can be seen as an investment in preventive mental healthcare.
- (g) How do users and carers rate local self-help provision?
Perhaps the most important question is what users think about self-help, and this is also relatively easy to answer. It ought to be reasonably straightforward to survey service users and carers, both those who embrace self-management approaches and those who eschew them.

Conclusion

Mental healthcare is constantly seeking means to become more effective and more user-friendly. Self-management methodologies offer opportunities to meet many people's needs appropriately, quickly and without stigma.

The answers to the above seven questions would put commissioners and providers in a position to make full use of the potential improvements in mental healthcare afforded by self-management approaches.

Declaration of interest

None.

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