

The World Health Organization Calls for a New Paradigm for Mental Health and Residency Training: Do Any of the Newer Alternatives to the Standard Biomedical Model, such as Lifestyle Psychiatry, Meet WHO Requirements?

Cheryl L. Green, M.D., Ph.D.

Abstract:

Background: In its most recent publications, the World Health Organization called for profound change in how mental health care is conceptualized and delivered—for a new paradigm for mental health. The new model will be non-coercive, person-centered, human rights-based, recovery-oriented, readily implementable in the community, and evidence-based and optimizable via ongoing quality studies.

Methods: The author identified eight alternative models for mental health care from one or more of three sources: scientific publications, scientific journals, and/or professional associations. A narrative review was conducted in which the eight different models were reviewed and analyzed qualitatively regarding their potential to meet WHO criteria.

Results: After qualitative analysis of complementary and alternative psychiatry, complementary and integrative psychiatry, energy or mind-body psychiatry, functional psychiatry, holistic psychiatry, lifestyle psychiatry, nutritional psychiatry, and orthomolecular psychiatry, lifestyle psychiatry was found to be the only model for mental health that meets all criteria recently established by the WHO.

Conclusions: Lifestyle Psychiatry meets WHO criteria, and additionally, it is affordable, easy to implement, and effective, either as a standalone treatment or in tandem with the existing model of psychiatry. Lifestyle psychiatry should be widely implemented in community settings and taught in psychiatric residency training programs.

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Background:

In June of 2023, the World Health Organization (WHO) released a 300-page document entitled “Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches” (1) (henceforth called the WHO Guidance document). In it, the authors called for a “paradigm shift” in how mental health care is conceptualized and delivered worldwide. The document includes information about the “WHO QualityRights Initiative” (2) and links to “Seven Supporting Technical Packages on Community Mental Health Services” to advance such a transformation. (3) The new WHO documents are consistent with and draw from numerous other WHO documents put forward since the end of World War II: “The Universal Declaration of Human Rights” (4) of 1948, the “International Covenant on Civil and Political Rights” (5) of 1966, the “International Covenant on Economic, Social and Cultural Rights” (6) of 1966, the “Convention on the Rights of Persons with Disabilities” (7) of 2006, several recent reports by UN Special Rapporteurs (8) (e.g., 2017, 2020), and the “Comprehensive Mental Health Action Plan 2013-2020,” (9) which was extended to 2030 in 2019.

The recent WHO Guidance document criticizes the current global mental health system as “inadequate and outdated” (10) and points to several key problems, giving particular emphasis to two: coercion and discrimination. As to the former, the WHO Guidance document decries forced institutionalization and treatment, restraint, seclusion, and overmedication. It points to the lack of evidence of benefit from such practices and highlights “the damaging effects of institutionalization...and of involuntary hospitalization.” (11) It cites evidence to the effect that “interventions that are undertaken with force have negative outcomes for those subjected to them” (12) and asserts that “coercive practices such as restraint and seclusion cause harm to physical and mental health, and can lead to death.” (13) It also emphasizes “the negative effects of antidepressants, including the serious withdrawal syndrome that can occur when people stop using these drugs.” (14)

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Further, the WHO Guidance document asserts that “Evidence for [antidepressants] efficacy is mixed and even contested” (15)

and advises that “People wishing to come off of psychotropic drugs should also be actively supported to do so.”(16) On its recommended list of civil society organizations for people with psychosocial disabilities, both the World Network of Users and Survivors of Psychiatry (WNUSP) and the European Network of (Ex)Users and Survivors of Psychiatry (ENUSP)(17) are featured. That is to say; the WHO Guidance document appears to support two of the largest anti-psychiatry organizations in the United States and Europe.

As to the latter problem with the global mental health system, discrimination, the WHO Guidance document decries what it calls the global stigmatization of persons with mental health conditions and adds that such persons are often excluded from or discriminated against in employment, education, housing, and matters of social welfare (for example, in some areas persons with mental health disabilities are denied the right to vote, to marry, and/or to bear children). The WHO Guidance document decries the “insufficient and fragmented nature of community mental health services” (18) implemented globally.

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To address these pervasive problems and to chart a more favorable course for global mental health going forward, the WHO Guidance document calls for a new model of mental health that includes several key aspects. The following aspects are not cited in a single list. Instead, these are discussed repeatedly in multiple parts of the WHO Guidance document. For ease of understanding, I am enumerating these as follows. The new model for mental health is to be 1) non-coercive, 2) person-centered, 3) human rights-based, 4) recovery-oriented, 5) readily implementable in the community, and 6) evidence-based and optimizable via ongoing quality studies.

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“Non-coercive” is explained to mean free of any forced treatment, whether this be in the form of institutionalization, forced medication, or the necessity of disabled individuals to surrender their most basic human rights to surrogate decision-makers. “Person-centered” means personalized, individualized, and aimed at promoting the dignity and respect of the individual (as opposed to dehumanizing or disempowering). “Human rights-based” means promoting basic human rights such as autonomy (e.g., informed consent), inclusion in the community, and non-discrimination. “Recovery-oriented” is explained to mean that the new model must encourage healing rather than mere symptom reduction and rather than prolonged and/or ever-escalating psychiatric services. As part of the healing, the new model should foster the recovery of identity and a sense of control over an individual’s own life. It should restore hope, optimism, connectedness, meaning, purpose, and empowerment. The new model should also be readily implementable in the community setting (as opposed to exclusively in psychiatric hospitals and other institutional facilities) and should, whenever possible, address the social determinants of mental health (e.g., isolation, unemployment, poverty, and violence). Finally, the model should be evidence-based and capable of ongoing study and research. The new model should “move toward more balanced, person-centered, holistic, and recovery-oriented practices.”(19) The WHO Guidance document then provides examples of individual organizations around the world that are presently providing services of this nature.

Methods:

Existing alternatives to the standard biomedical model of mental health care (i.e., medications and therapy, with hospitalization and/or institutionalization as needed) were identified by the author. Existing alternative models of psychiatry that have associated scientific publications, journals, and/or professional organizations include *at least* the following eight: complementary and alternative psychiatry, complementary and integrative psychiatry, energy or mind-body psychiatry, functional psychiatry, holistic psychiatry, lifestyle psychiatry, nutritional psychiatry, and orthomolecular psychiatry. There may be other models; however, this author could not identify others associated with scientific publications, journals, and/or professional associations (s). Each of these eight was analyzed qualitatively to determine whether any meet the essential characteristics, which are, again, that it be 1) non-coercive, 2) person-centered, 3) human rights-based, 4) recovery-oriented, 5) readily implementable in the community, and 6) evidence-based and optimizable via ongoing quality studies.

Results:

Eight models of psychiatry were reviewed, with results as follows.

Complementary and alternative (CAM) psychiatry

CAM refers to two types of treatments: complementary, which are offered in addition to standard biomedical care, and alternative, which are offered instead of standard care. The American Psychiatric Association has a caucus, or special interest group, on CAM. CAM also has multiple peer-reviewed scientific journals, including the *Journal of Complementary and Alternative Medicine*, *The Journal of Alternative and Complementary Medicine*, the *International Journal of Alternative and Complementary Medicine*, *Evidence-Based Complementary and Alternative Medicine*, and several others. CAM for psychiatry has a textbook, *Complementary*

and *Alternative Treatments in Mental Health Care*,⁽²⁰⁾ published in 2006 by the American Psychiatric Association. The textbook provides information about a range of non-standard treatments, including herbal medicines and homeopathy, that have not yet been accepted within mainstream psychiatry.

“Complementary and alternative (CAM) psychiatry refers to two types of treatments: complementary, which are offered in addition to standard biomedical care, and alternative, which are offered instead of standard care... CAM offers complements or alternatives to drugs (such as certain herbs) and also psychotherapies (such as meditation).”

CAM offers complements or alternatives to drugs (such as certain herbs) and also psychotherapies (such as meditation). It is not incompatible with the first five of the WHO criteria. Its main problem is the sixth principle concerning the need for treatments to be evidence-based. Some CAM treatments, like most of its botanical medicines, have only weak evidence of benefit. Others, like homeopathy, are difficult to prove even in theory (i.e., it would be hard to show the benefit of a vanishingly small quantity of a substance against a placebo). The fact that CAM psychiatry is not consistently grounded in a strong evidence base renders it incompatible with WHO goals.

Complementary and integrative (CIM) psychiatry

Complementary refers to treatments offered in addition to standard biomedical (known as “Western”) care. Integrative usually refers to a blend of Eastern and Western approaches. Ayurvedic medicine is an ancient medical system that originated in India. Its goal is to cleanse the body and restore balance to the body, mind, and spirit through diet, herbs, yoga, and, if necessary, *rasashastra* medicine. This is a type of medicine in which minerals, including gems and metals, sometimes even lead and mercury, are ground into powders and used therapeutically.

Similarly, traditional Chinese medicine aims to balance the chi (energy) along the body’s energy meridians and balance two forces, yin and yang. Again, diet, Chinese herbs, *tai chi*, and other treatments are implemented. This field has at least three major journals: *The Journal of Complementary and Integrative Medicine*, the *Journal of Evidence-Based Integrative Medicine*, and *Integrative Medicine: A Clinician’s Journal*. It also has two major centers, the National Center for Complementary and Integrative Medicine and the George Washington University Center for Integrative Medicine.

Though yoga therapies and Mindfulness-Based Stress Reduction have a large body of evidence supporting their use across a range of psychiatric disorders, many CIM therapies, such as *rasashastra* and yin-yang therapies, lack a strong evidence base. An additional caveat: Some Ayurvedic and some Chinese herbal medicines have been found to contain harmful amounts of toxic substances.

Thus, CIM cannot be accepted as the new model of care.

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Energy medicine or mind-body medicine psychiatry

Energy medicine relies upon the transfer of “energy” (called “prana” in the Indian system and “chi” in the Chinese system) in order to effect healing. For example, in reiki therapy, the therapist places the hands lightly on an individual to guide such energy into that individual to effect a healing. “Therapeutic touch” is a similar practice. “Energy” is a broad term that segues into other mind-body therapies: mindfulness, meditation, biofeedback, hypnosis, yoga, *tai chi*, and healing-directed visualizations. There are several associations for Energy or mind-body medicine, such as The Center for Mind-Body Medicine in Washington, D.C., and several scientific journals, such as *Mind Body Medicine* and *Advances in Mind-Body Medicine*.

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Again, energy or mind-body approaches are not incompatible with the first five of the WHO criteria. The problem is (again) with criterion six: these are not grounded in a solid evidence base. Although many individuals report being sensitive to subtle energy transfers and shifts, these are somewhat difficult to prove objectively. Thus, even when healing appears, it is difficult to connect that with the specific energy intervention applied.

Functional psychiatry

Jeffrey Bland founded functional medicine (FM) in the early 1990s.

It aims to identify the root causes of diseases, such as interactions between the environment and gastrointestinal, endocrine, and immune systems of the body. It seeks to identify “triggers” for disease in a “matrix” of possible causes (e.g., lifestyle dysfunctions, non-optimal genetics, and/or harmful environmental exposures) and then to create an individualized treatment plan that makes use of lifestyle interventions, physiological cures, and spirituality as treatments. There is an *International Journal of Human Nutrition and Functional Medicine* and several functional medicine associations, such as the Institute for Functional Medicine and the Cleveland Center for Functional Medicine. Functional psychiatry is simply functional medicine aimed at identifying the root causes of psychiatric disorders and treating them with this same array of tools.

“...functional medicine...aims to identify the root causes of diseases, such as interactions between the environment and gastrointestinal, endocrine, and immune systems of the body...and then to create an individualized treatment plan that makes use of lifestyle interventions, physiological cures, and spirituality as treatments. Functional psychiatry is simply functional medicine aimed at identifying the root causes of psychiatric disorders and treating them with this same array of tools.”

This approach could be compatible with the first four of the WHO criteria. The fifth WHO criterion, however, requires that the new model be readily implementable within the community. Root cause analyses can be tremendously expensive. Beyond the common tests used in the standard biomedical model, additional allergy, hormonal, and genetic testing are usually required, and it is not unusual for a patient to spend thousands of dollars on such tests before suggestive results are identified. Thus, the functional approach is probably cost-prohibitive on a community-wide or global basis.

Additionally, it is doubtful whether the root cause approach is appropriate for psychiatric disorders. Much of the psyche is unconscious; the mind is quite complex. Determining a root cause for any one psychiatric disorder might not be possible. Also, even if allergy-related, hormonal, and/or endocrine factors were found to be abnormal in a psychiatric disorder, such correlation does not necessarily imply causation. Thus, the sixth criterion is again unmet due to the lack of a sufficiently strong evidence base.

Holistic psychiatry

Holistic medicine and holistic psychiatry use “natural” agents to effect cures. These include light, heat and massage, structured water, herbal products, acupuncture, aromatherapy, and, in

fact, any and all of the treatments discussed thus far except the standard biomedical ones. “Holistic” mental health is perhaps the broadest and most inclusive of any alternative models discussed thus far. There are two holistic associations, the American Holistic Health Association and the American Holistic Medical Association. A board certification is also available from the American Board of Integrative and Holistic Medicine. This holistic approach is very commonly applied to psychiatry.

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The main problem, again, is with the sixth criterion. Holistic psychiatry has a very uneven evidence base, with some therapies having robust evidence of efficacy and others having little to no such evidence. Also, it cannot be assumed that “natural” is necessarily safe. Nature’s pharmacopeia includes many poisons, and even botanicals known to be somewhat beneficial for certain indications, such as lavender essential oil for relaxation, have in some cases been found to contain harmful impurities. Thus, holistic psychiatry cannot be accepted in its entirety.

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Lifestyle psychiatry

Lifestyle psychiatry is an evidence-based field of medicine that offers treatments in six domains: nutrition, detoxification from harmful substances, exercise or movement, sleep hygiene, social and emotional connectedness and meaning, and stress reduction. As of 2007, the field of lifestyle medicine has had its journal, the *American Journal of Lifestyle Medicine*, its professional organization (The American College of Lifestyle Medicine), and as of 2017, it has had its board certification through the American Board of Lifestyle Medicine. Though newer still, the field of lifestyle psychiatry already has two textbooks, (21) and as of 2024, it also has its caucus within the American Psychiatric Association.

Lifestyle psychiatry is entirely free from forced treatment and from coercion in any form. Treatment recommendations are based on patient participation. (Patients choose the top three domains in which they would like to initiate changes; they must

have a confidence level of 7 out of a possible ten that they would be able to make changes in that domain before starting.) Lifestyle psychiatry is also person-centered in that each person engaged with it will help to generate his or her own personalized “SMART” (i.e., specific, measurable, achievable, realistic, and time-bound) treatment plan. A diagnosis, though sometimes helpful for communications among medical providers, can also be stigmatizing and thus is not strictly necessary. It is human rights-based in that the movement is increasingly focused on solutions for community health (e.g., community gardens) and even planetary health for the good of all inhabitants (both human and animal) of the earth. It is recovery-oriented in that it aims not just at temporarily ameliorating symptoms but indeed at preventing, treating, and reversing diseases and disorders. In the domain of social and emotional connectedness, this includes the restoration of hope and optimism, meaning and purpose, and a sense of personal empowerment. Lifestyle psychiatry and lifestyle psychiatry education are implementable in personal homes and community centers such as schools, libraries, religious centers, and other public gathering places. For example, courses in “culinary medicine,” featuring information about the whole food plant-based diet, have sprung up all over the United States and Europe in recent years, wherever there is a kitchen and a willing audience. Finally, lifestyle psychiatry is evidence-based and readily adaptable to ongoing monitoring and continuous improvement. In short, lifestyle psychiatry meets all the criteria in the WHO Guidance document.

“Nutritional medicine and nutritional psychiatry use food and food supplements as alternative treatments. The field of nutritional psychiatry targets at least three mechanisms for healing: healing nutrient deficiencies, such as vitamin D, reducing inflammation throughout the body, and correcting imbalances in the gut microbiome. The field advances the Mediterranean-pattern diet as the mainstay for optimal mental health.”

Nutritional psychiatry

Nutritional medicine and nutritional psychiatry use food and food supplements as alternative treatments. The field of nutritional psychiatry targets at least three mechanisms for healing: healing nutrient deficiencies, such as vitamin D (associated with dementia and Alzheimer’s Disease), reducing inflammation throughout the body (linked with cardiovascular and other diseases), and correcting imbalances in the gut microbiome (linked with depression, schizophrenia, and other mental disorders). The field advances the Mediterranean-pattern diet as the mainstay for optimal mental health. The field has many journals, such as *Nutrition in Clinical Practice*. It has many professional associations,

including one psychiatric one, The International Society for Nutritional Psychiatry Research.

This is an evidence-based field; it meets WHO criterion six of being evidence-based. However, nutrition alone, even if it were to entirely replace our current model of providing psychiatric medications, does not provide any of the psychosocial support elements necessary to create a viable, comprehensive model for mental health. Moreover, though it does address the significant problem of nutritional deficiencies, it does not address any other social determinants of mental health. Specifically, it cannot even theoretically be adapted to address social issues such as isolation, unemployment, poverty, violence, and so on. Thus, this model does not provide the basis for the fifth WHO criterion—i.e., that it be readily implementable in the community—to be met.

Orthomolecular psychiatry

Orthomolecular psychiatry was founded in the 1950s by Abram Hoffer and Humphrey Osmond, then continued by Carl Pfeiffer. Molecular biologist Linus Pauling named the field in a 1968 article, “Orthomolecular Psychiatry,” published in *Science*. The premise of the field is that bodily and psychiatric diseases can be prevented and treated with optimal amounts of substances normal to the body. The root causes of symptoms are assumed to be biochemical, the result of deficiencies due to poor diet, infections, drug and alcohol use, disorders of metabolism, and the like. The treatments are vitamins (including “megavitamins”), minerals, amino acids, enzymes, botanicals, and other natural supplements. “Pfeiffer’s law” states, “For every drug that benefits a patient, there is a natural substance that can achieve the same effect.” (22) The movement has a journal, the *Journal of Orthomolecular Medicine*, and a society, the International Society for Orthomolecular Medicine.

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Criticisms of this field are the same as those for Nutritional Psychiatry. Though evidence-based, it does not include any psychosocial treatments, and it does not attempt to address or help mitigate the social issues that could be at the root of some individuals’ mental health problems. Thus, the fifth WHO criterion is not met.

Conclusions:

After qualitative review and analysis in light of WHO criteria of

complementary and alternative psychiatry, complementary and integrative psychiatry, energy or mind-body psychiatry, functional psychiatry, holistic psychiatry, lifestyle psychiatry, nutritional psychiatry, and orthomolecular psychiatry, lifestyle psychiatry was found to be the only model for mental health that meets all of the criteria for the new paradigm for mental health recently called for by the WHO. Lifestyle psychiatry is by nature non-coercive, person-centered, human rights-based, recovery-oriented, readily implementable in the community, and evidence-based and optimizable via ongoing quality research. In contrast, each of the other models fails to meet at least one or more of these criteria, notably the criterion of being evidence-based and suitable for ongoing research. Moreover, while most models either meet or could readily be adapted to meet most of the required elements, lifestyle psychiatry already meets all of these.

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Additionally, the lifestyle psychiatry model can be implemented at all stages of life. It is suitable for infant, child, adolescent, adult, and geriatric psychiatry. Moreover, lifestyle psychiatry is safe, affordable, and effective, either as a standalone treatment or in tandem with the existing model of psychiatry. It is also easy to teach and implement; a Lifestyle Medicine Residency Curriculum (23) was approved in 2018 and rolled out in 2019 to dozens of medical schools and hospitals throughout the United States.

Particularly in the domain of infant psychiatry, which spans the period zero to three in which few to no FDA-approved psychiatric treatments exist, lifestyle psychiatry holds great promise. During these years, psychiatric medications are sometimes prescribed, particularly as a child approaches three. For example, at present, medical professionals commonly prescribe as follows: for insomnia, melatonin or diphenhydramine; for posttraumatic stress (PTSD), fluoxetine or escitalopram; for attention-deficit hyperactivity disorder (ADHD), mixed amphetamine salts, guanfacine, or clonidine; and irritability associated with autism spectrum disorder (ASD), aripiprazole or risperidone. It should be noted that the infant cannot consent nor even assent during these years, yet such prescribing can lead to adverse long-term consequences for his or her developing brain.

A lifestyle psychiatry approach would look very different. It would yield no adverse side effects yet would be comparable in efficacy.

For insomnia, the prescription might be optimal sunlight exposure by day, avoidance of blue light at night, and several other sleep hygiene recommendations. For PTSD, the prescription might be corrective emotional experiences with a foster caregiver and ideally with other family members, perhaps including therapeutic touch, regular and predictable routines, exposure to calmly spoken language, and the reduction of stress (e.g., loud noises). For ADHD, which has been linked to cigarette smoke and lead exposures in utero, the prescription would be keeping the child away from those and other common toxic exposures (e.g., pesticides, strong cleaning chemicals, heated plastics, and other heavy metals, like mercury in dental fillings). For irritability associated with ASD, the lifestyle prescription would be enrichment in early social, emotional, and linguistic experiences in tandem with appropriate psychotherapies, such as Applied Behavioral Analysis.

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In short, while several other potential models for health care fall short, lifestyle psychiatry meets all of the criteria in the WHO Guidance document and thus is suitable to become the new model for global mental health for people of all ages. Lifestyle psychiatry should be widely taught and implemented worldwide in psychiatric residency training programs.

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Corresponding Author



Cheryl L. Green, M.D., Ph.D
 Ph: 909-558-9552
 Fx: 909-558-9252
 Department of Psychiatry
 Loma Linda University School of Medicine
 1686 Barton Rd., Box D
 Redlands, CA 92373
 Email: CLGreen@LLU.edu