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GUIDED SELF-HELP IN THE TREATMENT OF COMMON MENTAL HEALTH DISORDERS – THE DEVELOPMENT OF THE FINNISH GUIDED SELF-HELP (F-GSH) MODEL

ABSTRACT

Increasing access to short-term, evidence-based psychological therapies in primary care or community-based settings is a key strategy for responding to the rapid increase of demand for mental health services seen in most Western countries. To succeed, it is necessary to maximize effectiveness and resource use by optimizing length, content, process, delivery format and use of technology in therapy. In Finland, guided self-help (GSH) has become one of the principal components of a modified stepped care system, aimed at improving access to treatment and maximizing the cost-effectiveness of the overall treatment system. Self-help (SH) and GSH therapy systems aim to optimize the use of trained therapists' time while retaining the goals and effects of more conventional face-to-face therapies. By employing diverse digital solutions in treatment conceptualization and delivery, the access and flexibility of services can be enhanced. Unfortunately, the terminology and classifications describing: a) the different ways a therapist can interact with clients, and b) the augmentation of these interactions with various digital tools, have not kept pace with the advancements in new technologies. This significantly hinders scientific progress. In general, the effectiveness of SH and GSH for common mental health disorders, especially depression and anxiety, have been well demonstrated. In many cases, meta-analyses have shown no difference in effectiveness between GSH and other treatment formats. Further, SH seems to be superior to no treatment for depression and anxiety. This paper has two aims. First, to present a narrative literature review of meta-analytic evidence regarding SH and GSH, examining terminology and evidence base in both adult and youth services. Second, to describe the rationale, principles, development, key contents and implementation process of a national Finnish Guided Self-Help (F-GSH) service, developed as part of the Finnish First-line Therapies model.

KEYWORDS: SELF-HELP, GUIDED SELF-HELP, PSYCHOTHERAPY, DEPRESSION, ANXIETY, PRIMARY CARE

INTRODUCTION

The burden of mental health disorders has been growing worldwide, and now constitutes the leading cause of years lived with disability. Globally, one in eight people have been estimated to live with a mental disorder. The gap between evidence-based treatments and their timely availability is huge, meaning that most people do not receive adequate treatment. Finding more cost- and resource-effective ways of delivering psychological therapies is essential to meet treatment demand [1].

The proportion of the population receiving sickness absence benefits from Kela (Social Insurance Institution of Finland) for mental health reasons has increased by around 75% between 2016 and 2023. This equates to over 100,000 individuals and approximately 20,000 work years lost, not including full- and part-time disability pensions or short-term sickness absences [2]. Finland has been globally unique in increasing ultra-long rehabilitative psychotherapy (up to three years and 200 sessions) fourfold within the last decade, aiming to preserve the work ability of the population. This form of therapy covers annually over 60,000 people (ca.

2% of eligible population) and incurs costs of ca. 150m€ per year (including out-of-pocket costs) [3]. Interestingly, a recent Finnish study found that less than 20% of people who applied for permanent disability pension had received rehabilitative psychotherapy within the previous five years [4]. These perspectives show that the current Finnish model of heavily investing in ultra-long rehabilitative psychotherapy has not been able to stem the increase of sickness absence due to mental health reasons, highlighting the urgent need to develop alternative models, preferably focusing on wider access to cost-effective, evidence-based psychotherapies.

There is no unequivocal evidence regarding the relationship between the duration of therapy and its effectiveness. For example, a meta-analysis of 176 studies, investigating the predictive value of treatment length on the outcome of psychotherapy for adult depression, concluded that there is no association between the duration of therapy and its outcome [5].

One key reason why mental health systems are failing to meet demand is that traditional face-to-face (f2f) psychotherapy, delivered by highly trained professionals, scales particularly poorly. It is practically impossible to offer long-term f2f therapy to all who could benefit from it. Fortunately, research evidence and technology support various ways of increasing the accessibility and cost-effectiveness of interventions [6,7]. This can be done by optimizing the use of therapist time – for example, by increasing the use of digital self-help (SH) and guided self-help (GSH) interventions.

The goal of these different "augmentation methods" and delivery channels of therapy is to achieve an optimal balance between human contact, professional guidance and the patient's self-directed activities. Unfortunately, as the field is rapidly evolving, even terminology and categorizations in this field need clarification.

In Finland, a full-scale reform of health and social care systems was conducted in 2023. As part of this reform, following the national mental health strategy, primary care mental health services have been strengthened, including delivery of early-onset psychological therapies. The First-line therapies initiative ("Terapiat etulinjaan") is a comprehensive, national model and service package to support increase of early-onset, evidence-based psychological therapies, as part of introducing a resource-efficient, modified stepped care model to Finland. As a part of this initiative, a system for delivering unguided and guided self-help therapies (Finnish Guided Self-Help, F-GSH) based on cognitive behavioural therapy (CBT) has been developed and implemented.

The goals of this article are to:

1. Present a narrative review of the meta-analytic literature regarding SH/GSH, examining terminology and evidence base in adult and adolescent services
2. Describe the rationale, development, structure and implementation process of the Finnish guided self-help (F-GSH) system
3. Describe the content of key F-GSH programmes

PART 1: OVERVIEW OF SH & GSH SYSTEMS AND DIGITALLY AUGMENTED THERAPIES

HISTORY, TERMINOLOGY AND CLASSIFICATION OF SH & GSH

SH and GSH are structured approaches designed to empower individuals to address and manage their mental health and personal development independently, or with some professional input. In GSH, professional guidance can include goal setting, encouragement, progress monitoring and evaluating potential adverse effects. The current terminology for GSH and its relation to other psychological therapies incorporating self-help practices via various channels (e.g. internet or leaflets) is problematic, as there is no consensus on definitions and terminology [8]. For example, does guidance offered by a digital system, e.g. generative artificial intelligence, count as GSH? As both SH and GSH can function like brief psychological therapies, they are often utilized in the creation of low-intensity or stepped care service models.

CBT in its various forms is the most strongly evidence-based therapy framework. In the context of CBT, there has been a surge in low-intensity service formats. Low-intensity CBT refers to practices which increase the availability of CBT by either reducing the amount of time the practitioner is in contact with individual patients, or by widening the provider base to those who do not traditionally offer evidence-based therapy. The goal is to increase the availability, flexibility, capacity and cost-effectiveness of CBT-based therapies. This includes communicating the key principles of CBT in accessible ways with openly available CBT resources (e.g. internet-based or written materials, tasks and tutorials). Therapy and guidance can be provided in a multitude of delivery formats (e.g. f2f, email, group sessions, phone) in order to increase access, ideally guided by patient preference. A focus on low-intensity therapies has been a global approach

to innovate service delivery and democratize access to evidence-based treatment during the last decades [7]. SH and GSH are examples of low-intensity CBT.

Despite recent innovations, driven especially by the development of digital systems, the concept of relying on self-administered and individually conducted learning, exercises or practices to reduce symptoms and mental health conditions, is not new. For example, in 1978, Glasgow and Rosen pooled together studies examining the effectiveness of various self-help manuals, rooted in behavioural therapy in solving problems caused by childhood behavioural problems, addictions, specific phobias and others, concluding self-help as potentially efficacious [9].

The current consensus today in clinical guidelines is that guided self-help is more effective than unguided self-help [6]. However, the results regarding the added positive effect of guidance and the optimal amount of guidance are mixed, and may vary between disorders and problem areas targeted with the programme.

Service models that involve minimal professional guidance and support are also referred to as *minimal contact therapies* in the literature.

There are no universal definitions on what constitutes minimal contact therapy as opposed to low-intensity therapy or guided self-help. For example, in a review conducted by Newman, Szkodny, Llera & Przeworski, minimal contact therapy was defined as a service model which does not involve more than 1.5 hours of a therapist's time [10]. The amount of support provided should be seen as a continuum, so that the significance and added value of amount and type of support can be examined in more detail. It is not clear that more therapist support is always better. For example, a systematic review by Farrand and Woodford (k=38) summarized that, on average, CBT SH results in medium effect sizes, but that this effect varied across different conditions [11]. Interestingly, in treating depression, minimal contact therapy yielded greater effect than SH and GSH with more therapist support. In addition, the effects of minimal contact therapy and GSH were the largest when the therapy was supported by telephone compared to other modalities. The researchers explained that providing therapy over the phone might reduce 'therapeutic drift' which could lead to a less effective mix of therapist-patient interaction and use of self-help materials. The results were congruent with an earlier review which recognized that the ideal amount of support varies by disorder, and that minimal contact therapy can be the most beneficial form in some contexts (k=142) [10].

DIGITALLY AUGMENTED OR DIGITALLY DELIVERED THERAPIES

Referring to the current literature and the way services are organized today, SH and GSH systems cannot be analysed in isolation from technology. The core concept of SH and GSH, which involves promoting individual, self-administered activities addressing mental health problems, remains the same whether using printed or digital materials. In practice, however, development of SH/GSH programmes has become fundamentally entangled with development of digital mental health tools. The technological advancements made in the last 30 years (including, among other things, the internet and mobile phones) have dramatically increased the reach of self-help materials and expanded alternatives for administration of SH, GSH and even f2f therapy. A combination of sensing and feedback technologies powered by machine learning could already help us provide much more personalized, digitally supported care. Future developments, such as artificial intelligence and expanded reality, promise a new wave of technological possibilities [12-14]. Psychological therapies have already become fundamentally entangled with digital technologies and will become increasingly so in the future. Again, the terminological boundaries between *digital therapeutics, digitally augmented or digitally delivered therapie*s are far from clear.

Some commonly used concepts and terminology related to low-intensity and digitally augmented psychological therapies are presented in *Table 1*. The table follows the originally proposed taxonomy by Glasgow and Rosen which was later refined by Newman and colleagues [9,10]. It is by no means exhaustive, but rather aims to show the need for a refined terminology that would better support research and policy debates in the field.

Table 1. Commonly used concepts and terminology related to low-intensity and digitally augmented psychological therapies: taxonomy of self-help interventions with varying levels of therapist support (adapted, edited, and enriched from Glasgow & Rosen and from Farrand & Woodford [9,11]

Category	Definition
Low-intensity therapy [7]	Practices which increase the availability of psychological therapies by either reducing the amount of time the practitioner is in contact with individual patients, or by widening the provider base to those who do not traditionally offer evidence-based therapy
Digital therapeutics (DTx) [15]	Refers to the use of technology to deliver, enhance or support mental health treatment and therapeutic interventions. This approach leverages various digital tools and platforms to improve access to therapy, increase engagement and provide innovative therapeutic techniques. Digital therapeutics are patient-facing software applications that help patients treat, prevent or manage a disease and have a proven clinical benefit
Unguided self-help	No specific rationale, overview or support in the use of self-help is provided at any time
Minimal contact therapy	The patient is provided with a rationale for the use of self-help, or the materials overviewed which may also include regular check-ins or automated reminders
Guided self-help	The patient receives an initial support session in which a rationale and overview of the materials is provided, alongside regular scheduled support sessions during which progress is discussed
Internet-delivered therapy [16]	Refers to psychotherapeutic interventions provided through online platforms, including self-directed app-based programmes or therapist supported via delayed chat or even therapy sessions conducted in real-time by a therapist via videoconference

Note: "Low-intensity therapy" and "digital therapeutics" represent a defining characteristic of a form of psychological therapy. The former the organizational intensity when delivering treatment, and the latter the role of technology in treatment. "Unguided self-help", "minimal contact therapy", "guided self-help" and "internet-delivered therapy" refer to specific service models that can represent a low-intensity therapy or digital therapeutics, or both

EFFECTIVENESS OF SH AND GSH FOR COMMON MENTAL HEALTH DISORDERS – META-ANALYTIC LITERATURE

Despite terminological variations, thousands of studies and several meta-analyses have been conducted on different SH and GSH programmes. A recent meta-analysis of 1,390 studies and 145,744 comparisons on the effectiveness of SH interventions in addressing common mental health issues found small to medium effect sizes. Overall, SH interventions were better at improving psychological wellbeing than no interventions. This was especially the case with various therapy-derived SH interventions (including CBT, acceptance and commitment therapy, mindfulness-based interventions, positive psychology interventions and activity-based interventions). SH without professional guidance helped to manage anxiety, depression, stress and subjective wellbeing, but to a lesser extent than more traditional psychological therapy with therapist guidance [17].

GSH has been studied most in the context of depression and anxiety.

A network meta-analysis of 155 randomized clinical trials of CBT-based GSH for depression concluded that, for acute symptoms, GSH has comparable treatment outcomes compared to individual, group-based or telephone-administered CBT and may be considered an alternative to individual therapy. These treatments all demonstrated medium to large effect sizes in comparison to waiting list, treatment as usual and unguided self-help. However, GSH may exhibit slightly lower acceptability compared to other treatment methods [18]. In addition, GSH is not associated with significant risk for harm in the treatment of depression. The risk of symptom deterioration in GSH programmes is significantly lower compared to waiting list and treatment as usual (k=18) [19].

For anxiety symptoms, a meta-analysis of 19 studies conducted in routine care settings indicated that internet-based guided CBT achieved a large effect size in symptom reduction and demonstrated high acceptability. The average

professional guidance time per patient was 133 minutes [20]. More recently, guided self-help and other low-intensity CBT were associated with medium effect sizes in treating generalized anxiety disorder (GAD) (k=12) [21]. For panic disorder, GSH was superior compared to treatment as usual and had comparable effectiveness and acceptability to other CBT delivery formats (k=74) [22]. For obsessive-compulsive disorder (OCD), a meta-analysis of nine trials concluded that internet-delivered GSH-CBT was slightly more effective in ameliorating OCD symptoms compared to active controls (e.g. self-help, treatment as usual), and as effective in addressing symptoms of OCD and comorbid anxiety and depression symptoms post-treatment as CBT [23]. Finally, trauma-focused guided self-help interventions (TF-GSH) with evidence-based components have yielded moderate to large effect sizes compared to treatment as usual, waiting lists, phone monitoring, non-trauma writing, general support and supportive counselling in the treatment of post-traumatic stress disorder (PTSD) (k=17) [24].

For alcohol misuse, both unguided and guided internet-delivered self-help are associated with a small effect size in terms of alcohol consumption (k=16). Participants in various internet interventions consume, on average, 22 grams of ethanol less than control groups (assessment only, waiting list and alcohol information brochure only) and are more likely to adhere to low-risk drinking guidelines after treatment. The authors concluded that despite the small effect size, large scale implementation from the public health viewpoint is warranted [25].

For eating disorders, GSH has been found effective in ameliorating global eating disorder psychopathology and achieving abstinence from binge eating compared to waiting list and other active treatment modalities. GSH is especially effective in addressing the behavioural elements regarding binge-eating (k=30) [26]. However, the results are mixed in the context for young people (k=8) [27].

In the context of insomnia, individual, group, guided self-help and digitally aided CBT for insomnia (CBT-I) formats are more effective compared to treatment as usual, waitlist, placebo and no treatment, in terms of sleep efficiency. CBT-I GSH may be the most effective intervention in terms of sleep efficiency and sleep onset latency, but the acceptability of CBT-I GSH compared to individual and group CBT-I formats is significantly lower (k=61) [28].

In children and adolescents, a meta-analysis of 50 studies found moderate to large effect sizes for unguided and guided self-help in treating anxiety, depression and disruptive behaviour compared to waiting lists and treatment as usual. GSH was better than no treatment in all situations but slightly worse than conventional f2f treatment formats. Referring to lower costs, improved accessibility and patient acceptability, the researchers supported the notion of GSH as a viable option for treatment of common mental health disorders during childhood [29]. In the context of adolescent depression, a more recent meta-analysis of 68 trials found no significant differences between CBT delivery methods (including individual, group, guided self-help and unguided self-help). In effectiveness rankings, guided self-help (GSH) was the highest rated treatment. However, the studies included only adolescents aged 16-19, and the methods of therapist guidance varied significantly [30].

Overall, the evidence supporting the non-inferiority of CBT-based GSH compared to other formats of CBT, as well as the superiority of self-help over no treatment for common mental health problems, is quite compelling. In general, the evidence is strong for both SH and GSH in adult services, with less evidence for children and adolescents. The evidence base is strongest in the context of adult depression and anxiety. From as early as 2010, researchers have supported large-scale dissemination and implementation of guided self-help in the daily practice of treating adult depression and anxiety [31]. The evidence on the effectiveness of various GSH interventions supports incorporating them into the service system (e.g. within stepped or stratified care models) alongside more intensive psychotherapies, in both adult and youth services.

PART 2: THE DEVELOPMENT AND PROPERTIES OF THE FINNISH GSH SYSTEM

HISTORY AND DEVELOPMENT OF FINNISH GSH/SH SERVICE PLATFORM

The idea of a web-based platform for disseminating mental health-related information and services, including self-help materials, began in Finland in 2006. The first version of a website, Mental Hub (Mielenterveystalo.fi, www.mielenterveystalo.fi/en), was designed for this purpose, developed by Helsinki University Hospital (HUS) and launched in 2008. In 2013, the website expanded into a national service and, since then, has served as a hub for client-centred information on mental health issues, tools and services.

The site offers free access to information related to mental health and mental health disorders. These include tools for

symptom assessment, CBT-based self-help programmes and signposting for necessary services. In addition to digital services aimed at citizens, a separate section within the website provides mental health professionals with information, tools for patient assessment as well as treatment manuals and protocols.

In 2019, a proof-of-concept study was conducted where patients, with mild to moderate depression or symptoms of social anxiety, were to receive either ten sessions of video-mediated psychotherapy or a guided self-help programme supported by three video-based visits [32]. Patients demonstrated significant improvements in perceived functioning and in symptom levels, and satisfaction with treatment, with no discernible differences between the groups. This was in line with earlier research on effectiveness of GSH and supported the feasibility of formulating the basic structure of the F-GSH model around three sessions. Mental Hub had reached an annual user count of over 2 million by 2021, supporting the notion that national digital mental health services could feasibly be delivered using this portal.

FIRST-LINE THERAPIES INITIATIVE: GSH AS A PART OF A STEPPED CARE SYSTEM

As part of the preparation for the Finnish reform of social and health services in 2023, the First-line therapies initiative (FLT, "Terapiat etulinjaan") was launched in 2020. The initiative supports the Finnish Mental Health Strategy and the national primary care reform "Future Health and Social Services centre". The initiative built a modified stepped care framework tailored to the Finnish system, and a comprehensive digital tool and service package to realize this. The services are provided to all 23 wellbeing service counties to assist them in organizing effective early access to mental health services.

The key tools relevant for implementing F-GSH are the Mental Hub website, a digitally supported needs assessment system (the Finnish Therapy Navigator, FTN), a digital e-learning platform and nationwide co-creation networks. These are described here only as far as necessary for understanding the design principles of the F-GSH [33].

Stepped care, the Finnish Therapy Navigator (FTN) and F-GSH

As presented, self-help (SH) and guided self-help (GSH), along with various digitally augmented therapies, have demonstrated effectiveness at a group level for various mental disorders. However, to respond to varying individual needs, a variety of different evidence-based treatment forms and modalities should be offered. Ideally, patient preferences for treatment modality should be respected.

Treatment optimization can, in theory, be done following a stepped care model (trying the least intensive treatments first) or a stratified model (trying to find sufficient treatment directly) [34]. In publicly funded healthcare systems like Finland's, care is optimized based on cost-effectiveness at system level, while ensuring the treatment need of every individual is fulfilled. This naturally leads to a modified stepped care model, where patients are started on the least burdensome treatment likely to be beneficial but can always "skip steps" based on individual-level needs assessment. A key component of success is to simplify processes so that patients get the correct form and intensity of treatment faster [35].

For many patients with common mental health disorders or symptoms, fast access to GSH (Step 1 treatment in Finland) is a natural starting point of treatment. As GSH can be delivered by a workforce not specialized in mental health, and with fewer resources than f2f CBT and other more high-intensity therapies (e.g. interpersonal therapy, IPT) (Step 2), it can be initiated much faster, and provided directly from primary care.

The FTN is a digital tool designed to streamline and systematize the assessment process by collecting anamnestic data and symptom scores. Different versions of the system are developed for adults, adolescents and children. The FTN system includes a training programme that teaches professionals how to use the tool. It is intended as a basis for professional judgement and discussions with the patient about the focus of treatment. Evaluation and treatment decision can be done within a single session.

Structure of F-GSH programmes

The aim of F-GSH was to create an effective Step 1 treatment based on available literature that would complement the therapy modalities and delivery formats already available or in the process of implementation in Finland. In addition to F-GSH, the First-line therapies initiative also supports the dissemination of conventional f2f psychological therapies (such as CBT, IPT and interpersonal counselling) and internet CBT programmes as Step 2 treatments, with more intensive psychotherapy (ca. 20 sessions) offered as Step 3 treatments [36,37]. As the key intent was to increase access and speed of treatment initiation, F-GSH and the treatment manual was designed to be feasible in primary

care, occupational care and most social care settings. This contrasts with Step 2 and 3 treatments requiring more specialized settings.

The F-GSH programmes are structured around the three process-related phases of therapy: the beginning, middle and termination phases. Correspondingly, the patient materials are often structured around three themes:

1. Assessment and psychoeducation
2. CBT-based assignments and tools (e.g. cognitive restructuring, mindfulness and behavioural exercises)
3. Consolidating the skills and practices learned during the programme to enhance daily functioning post-therapy, establishing healthy behaviours, while also providing guidance on managing persistent or recurring symptoms

As there is no unequivocal evidence to state the optimal amount of therapist guidance in GSH for each individual, the exact number of sessions is not strictly fixed. Rather, the starting assumption is 1-3 sessions, that can be increased up to five depending on individual needs.

To exemplify the aforementioned problems in terminology, the F-GSH could also be called digitally augmented, low-intensity CBT with up to five visits, or a minimal contact intervention with as little as one visit.

Training of F-GSH via e-learning

Ensuring the widespread benefits of F-GSH requires a substantial educational effort to train thousands of professionals effectively. Thus, the training for F-GSH is delivered as a hybrid training programme, consisting of a national e-learning course plus local skills training and support. E-learning has been associated with comparable training outcomes in terms of knowledge acquisition, skills acquisition and implementation of trained methods in therapist training [38].

The training begins with a meeting between the trainer and the group, explaining the rationale and the contents of the course. There are three versions the training: for adults and adolescent patients, school-aged children and for small children and parents. The content of the e-learning modules of the adult/adolescent training is presented in *Table 2*.

In total, the training takes around 5-10 hours to complete. A multiple-choice exam must be passed at the end of the course to gain certification. The training can be enhanced locally by skills workshops, to refine abilities, discuss specific GSH programmes and patient groups, or to address local implementation issues.

Table 2. The module structure of the e-learning segment of the adults and adolescents F-GSH training programme, a description of the learning objectives, and key contents of each module

Category	Definition
Introduction	The student is introduced to the GSH intervention and the e-learning programme's objectives: defining GSH, understanding its application, knowing its contents for anxiety, depression and insomnia, understanding its stages, implementing it in practice, considering adolescent-specific factors, involving parents in adolescent GSH and assessing GSH effectiveness
What is GSH?	The student is provided with a rationale for GSH as a low-intensity CBT intervention for common mental health issues. The text covers the structure of GSH, its effectiveness, the differences between SH and GSH and the appropriate applications of GSH
GSH programmes for anxiety, depression, insomnia	The student is given an overview of adult anxiety, depression and insomnia, and adolescent anxiety and depression. The CBT treatment rationale of these disorders/symptoms, and how it is applied in the different stages of GSH are presented
Considerations in adolescent GSH	The student learns about involving parents in the treatment: why and when it is important, different ways it can be done, and how to take into consideration patient age and their stage of development. The student is presented with considerations regarding working alliance with adolescents and discontinuation of treatment. The possibilities of adapting the intervention structure flexibly to different circumstances are discussed
First session	The student is introduced to the core goals of the first session: to bring mental health into discussion, to set the ground for cooperation and agreeing on a concrete, realistic and measurable goal for the GSH intervention, and to begin practicing the exercises with the patient
Second session	The core goals of the second session: to review the patient's situation, discussing the GSH programme materials and working through some of them together with the patient, and assessing the need for the final/further session(s)
Final meeting	The core goals of the final session: to rehearse and reinforce positive treatment experiences, evaluating the progress made and challenges encountered with regards to the treatment goal, and making a continuation plan together with the patient
Tips for the GSH provider	The student is presented with experiences, tips and lessons from clinicians adopting GSH. The student learns that GSH has been found an effective tool from a clinician's perspective, and what usually contributes to its successful implementation; how to manage patient wishes and reactions with regards to time-limited, goal-oriented treatments like GSH; that GSH may be surprisingly effective despite initial doubts relating to patient presentation or history; when and how to adapt the intervention structure to individual needs; and how to effectively manage GSH endings
E-learning programme completion	The training learning objectives are reviewed, and the student is provided with supporting materials for the intervention. The e-learning training segment concludes with a multiple-choice quiz

Abbreviations: F-GSH – Finnish guided self-help; GSH – guided self-help; SH – self-help; CBT – cognitive behavioural therapy

Implementation, support and quality assurance of F-GSH

The F-GSH system was piloted in adult services in Southern Finland in 2020. The feasibility of the pilot system was good, professional satisfaction high, and the outcome results congruent with existing literature. National dissemination began in 2022.

The implementation of GSH is based on the Normalization Process Theory, which focuses on the embedding and normalization of new practices in the work environment, as well as the EPIS model of implementation processes [39,40].

It is essential that GSH is implemented within the framework of a broader stepped care model. In practice, successful implementation of GSH includes: 1) regional therapy coordinator activities, 2) utilizing the FTN as part of the clients' initial needs assessment and signposting, 3) supporting management in reorganization of work, 4) systematic data collection.

The regional therapy coordinator is an expert in both the national stepped care model and the local characteristics and needs of each region. Utilizing the FTN and systematic symptom assessment are necessary for quick and standardized identification of individuals for whom GSH may be suitable and sufficient. As F-GSH is such a short treatment, the needs assessment should be done within a single contact to ensure swift treatment initiation. Managerial support, particularly from line managers, is crucial in the adoption and integration of GSH. National support in implementation and benchmarking networks are available for managers and regional coordinators.

Routine outcome monitoring is an integral part of implementation. Clinical effectiveness is followed through average symptom change, percentages of clients who demonstrate reliable improvement or percentage of reliable recovery during treatment. The recommended measures include waiting times, length of interventions, depression symptom assessment (PHQ-9 Patient Health Questionnaire [41]) on all patients plus another symptom-specific instrument based on main focus of treatment, the need for further treatment or service and client experience. For legal reasons, no national data collection is possible in Finland, so the regions must collect the data using their own ICT systems. Benchmarking is conducted within a national network structure with aggregated data.

PART 3: THE CORE THERAPEUTIC ELEMENTS OF KEY F-GSH PROGRAMMES

As described, most of the SH programmes in the Mental Hub-platform are divided into three segments: 1) assessment and psychoeducation, 2) CBT-based assignments and tools, and 3) consolidating skills and healthy behaviours for the future. Each programme can be used unguided or guided. Programmes are age-specific; children's programmes are obviously aimed for the caregiver.

The Mental Hub platform includes SH/GSH programmes for common mental health disorders or symptoms (the topic of this paper), as well as for more severe psychiatric disorders (e.g. psychotic disorders) and different stressful life situations (e.g. divorce-related crisis). The programmes for severe mental disorders are aimed to be used within psychiatric specialty care, whereas the programmes for stressful life situations can be used outside a healthcare setting.

Manualized psychological therapies necessarily consist of (more or less) well-defined elements and components. F-GSH programmes make these components transparent by presenting them clearly to the patients in the SH materials. The specific therapeutic elements (e.g. psychoeducation, techniques, assignments) in F-GSH are adapted from widely used CBT manuals. Following Beck, they can be classified into six categories: psychoeducation, relaxation and mindfulness, skills training, cognitive techniques, behavioural techniques and exposure [42].

The core therapeutic elements of F-GSH programmes for anxiety, depression, panic, social anxiety, obsessive-compulsive disorder, insomnia and binge eating are presented in *Table 3*.

In sum, the therapeutic elements present in F-GSH follow well-established manuals of CBT. In addition, F-GSH and the associated training include aspects common to all psychotherapy, e.g. therapeutic alliance and establishment of healthy behaviours [43].

Table 3. The contents of key F-GSH programmes (anxiety, depression, panic, social anxiety, obsessive-compulsive disorder, insomnia and binge eating) are divided into the following core therapeutic elements and CBT-based tools, indicated in parentheses: psychoeducation (P); relaxation and mindfulness (R&M); skills training (ST); cognitive techniques (CT); behavioural techniques (BT); and exposure (E)

Self-help programme	Components of the SH/GSH programmes and their associated core CBT element
Generalized anxiety, anxiety symptoms	• Psychoeducation of worrying and anxiety (P) • Diaphragmatic breathing exercises (R&M, ST) • Progressive muscle relaxation (R&M, ST) • Mindfulness (R&M, ST) • Assessing benefits and drawbacks of change (CT) • Exposure to images/worries (E, BT) • Worry postponement and scheduling a worry time (ST) • Evaluating the likelihood of worries coming true (CT) • Breaking away and challenging from established thoughts (CT) • Problem solving (ST)
Depression	• Psychoeducation of low mood and depression (P) • Daily activities (ST, BT) • Diary keeping (BT, CT) • Relaxation exercises (R&M, ST) • Diaphragmatic breathing exercises (R&M, ST) • Monitoring of feelings and thoughts (CT) • Identifying judgmental thoughts (CT) • Challenging thoughts (CT) • Recognizing and naming own values (CT) • Increasing pleasant activities in life (BT) • Increasing meaningful activities in life (BT) • Recognizing early warning signs (CT, ST)
Panic disorder	• Psychoeducation of panic attacks and panic disorder (P) • Replacing avoidance with alternative strategies during a panic attack (BT) • Diaphragmatic breathing exercises (R&M, ST) • Relaxation exercises (R&M, ST) • Focused attention (R&M, ST) • Diary keeping of panic symptoms and exposure exercises (BT, CT) • Exposure to symptoms of panic (E, BT) • Exposure to panic-inducing situations (E, BT)
Social anxiety	• Psychoeducation of social anxiety (P) • Relaxation exercises (e.g. progressive muscle relaxation) (R&M, ST) • Diaphragmatic breathing exercises (R&M) • Mindfulness (R&M, ST) • Chain analysis (CT) • Recognizing social situations which induce anxiety (CT) • Identifying and modifying cognitive distortions (CT) • Recognizing and modifying thoughts regarding social situations (CT) • Exposure (E, ST) • Establishing an exposure hierarchy and exposure to social situations (E, ST) • Diary keeping of exposure exercises (BT, CT, ST) • Enhancing interpersonal skills (P, ST)

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Self-help programme	Components of the SH/GSH programmes and their associated core CBT element
Obsessive-compulsive disorder	• Psychoeducation of compulsions, obsessions and OCD (P) • Thought appraisal (CT) • Distinguishing rituals from caution (CT) • Diary keeping of OCD symptoms (BT, CT, ST) • Establishing an exposure hierarchy (E, BT) • Exposure to images (E, BT) • Exposure according to the established exposure hierarchy (E, BT, ST) • Ceasing reassurance seeking (BT, ST) • Engaging family members or other close persons (BT, P) • Chain analysis (CT) • Challenging existing thoughts and establishing alternatives (CT) • Focused attention (R&M, ST)
Insomnia	• Psychoeducation of sleep, healthy sleep patterns and insomnia (P) • Establishing a regular daily routine (ST, BT) • Establishing good sleeping conditions (BT) • Keeping a sleep diary (BT, CT) • Worry postponement and scheduling a worry time (ST, CT) • Identifying cognitive distortions and developing alternative thoughts regarding sleep and sleeping (BT, CT) • Articulatory suppression (ST, BT) • Paradoxical intention (ST, BT) • Increasing emotional awareness regarding sleep and insomnia (R&M, CT) • Diaphragmatic breathing exercises (R&M, ST, BT) • Relaxation exercises (R&M, ST) • The 15-minute rule (ST, BT) • Limiting the amount of time spent in bed (BT) • Self-compassion and acting according to one's own values (CT, BT)
Binge eating	• Psychoeducation of binge eating (P) • Keeping a food diary (BT, CT, ST) • Examining emotions with the help of the food diary (CT) • Establishing goals regarding eating (ST) • Mindful eating (R&M, BT) • Finding meaningful activities when the urge to binge arises (ST, BT) • Engaging family members or other close persons (BT) • Relaxation exercises (R&M, ST) • Emotional regulation exercise (ST, CT) • Challenging existing thoughts and establishing alternatives (CT) • Problem solving (ST) • Mindfulness (R&M) • Increasing self-compassion (R&M, CT) • Establishing a healthy body image (CT) • Preparing for slip-ups and establishing tools to overcome them (CT, ST)

Abbreviations: CBT – cognitive behavioural therapy; F-GSH – Finnish guided self-help; GSH – guided self-help; OCD – obsessive-compulsive disorder; SH – self-help

DISCUSSION

This paper provides a narrative review of self-help and guided self-help, addressing related terminological issues, meta-analytic evidence of effectiveness, and detailing the development, structure and contents of Finnish SH/GSH systems.

TERMINOLOGICAL CONSIDERATIONS

Currently, the terminology and classification of different ways to augment psychological therapies (e.g. patient-therapist matching, personalization, assessment and monitoring) with technology as well as related terminology and classifications to describe different delivery methods are both in flux. For example, the term "guided self-help" is used to describe a multitude of different services with varying amounts of therapist support and very different digital components.

This makes pooling the results of scientific studies difficult and hinders progress in the field. A shared terminology and classification system is sorely needed. From an implementation perspective, a clear terminology would also aid in the recognition of interventions that would best complement already existing services. In practice, there are several dimensions over which different therapeutic interventions could be described and classified simultaneously. These may include organizational intensity, forms of patient interaction and variety of technologies used.

TECHNOLOGICAL CONSIDERATIONS

The role of technology in the classification, development and delivery of psychological therapies cannot be overstated. The advances of technology have created new frontiers within the fields of research and mental health services. For example, the use of different exercises and homework as part of CBT is well established, whereas digital tools offer infinitely more possibilities over traditional paper and pen approaches.

AI holds significant promise in data-driven research (e.g. outcome prediction) and in treatment personalization as well as making mental health services more diverse. With regard to SH/GSH, especially the development in AI is likely to significantly blur boundaries and challenge terminology. Is AI-delivered therapy SH, GSH – or just therapy delivered by AI therapist? Or how should we call AI-enhanced therapy, where the therapist uses AI, for example, to revise chat? In addition, various mobile and wearable devices can make self-help available to people irrespective of time and place, and offer more tools for routine outcome monitoring of the effects of psychological therapies in real-world settings [44-46]. Extended reality solutions (virtual reality, augmented reality and mixed reality) will further diminish the last remaining distinction between face-to-face therapy and therapy conducted remotely [47].

This rapid advance of technology creates both opportunities and challenges in evaluating the effectiveness of SH/GSH programmes. Ideally, routine outcome measurement should be included in all psychological therapies, not only in technologically augmented care, and the effectiveness of various interventions confirmed and iteratively developed using real-world data [49]. On the other hand, traditional long-term effectiveness studies of digitally aided interventions are practically impossible to conduct if the technology itself is not stable in the long-term, but rather constantly evolving, as with AI. In practice, health technology assessment methodologies must adjust to technology, and not the other way around, if progress is to be encouraged. For example, the UK National Institute for Health and Care Excellence has a novel evidence standards framework for digital health technologies. The framework includes early deployment standards that allow technologies to be deployed early, as long as real-world evidence is simultaneously generated [49].

CONSIDERATIONS ABOUT EFFECTIVENESS

This narrative review with available meta-analytic research demonstrates that GSH programmes can achieve clinically relevant outcomes in the treatment of various mental disorders, including depression, anxiety disorders, alcohol misuse, insomnia and post-traumatic stress disorder. These outcomes are often comparable with other forms of therapy.

It is evident that, especially among adults, GSH is a suitable treatment option for numerous common mental health disorders. It holds great promise regarding cost-effectiveness due to the low-intensity nature. This can be critically important from an organizational perspective, as resources are always limited. However, it is apparent that GSH is not an acceptable treatment option in every situation. Stepped care should always begin with a comprehensive assessment of the clients' needs to match the least intrusive treatment option with the person's individual needs. If the patients are correctly selected and the treatment process streamlined, adapting GSH as a part of a comprehensive service package is likely to increase access to effective therapy.

FINNISH GSH AND FUTURE DEVELOPMENTS

The implementation of F-GSH has generally fared well in terms of staff trained, interventions conducted and the level of integration of guided self-help in local stepped care systems across Finland. It remains to be seen how the newly formed regions develop in general.

The unique feature of the F-GSH system is that it is deployed on the Mental Hub website, being freely available to all users. The website and the e-learning platform continue to develop, based on outcome data monitoring and cooperation between different stakeholders. The contents of the programmes are updated by experts in CBT for different clinical issues.

Based on clinicians' feedback, we are looking into protocols which would allow more flexibility in terms of delivery of F-GSH. There is clear interest in expanding the forms of delivery to include phone, chat and group GSH.

A NOTE ON TERMINOLOGY USED IN FINLAND

In developing F-GSH, the international terminology of SH/GSH were used both in Finnish and Swedish ("omahoito", "egenvård"; "ohjattu omahoito", "assisterad egenvård"). However, the current Finnish Healthcare Vocabulary (13.2.2024) uses the term "itsehoito" to refer to self-help and "omahoito" to refer to guided self-help, translating these terms to "egenvård" and "assisterad egenvård" in Swedish, and "self-help" and "guided self-help" in English. The Institute for the Languages of Finland (Kotus) has issued a recommendation to the Finnish Institute for Health and Welfare to change the terminology (Lausunto: Ohjattu omahoito -termi, 21.6.2023). Kotus notes, that "itsehoito" and "omahoito" are synonymous in Finnish, and trying to make a difference between these terms in healthcare classifications is potentially confusing. Kotus supports using "omahoito" and "ohjattu omahoito". Usually, in Finland, public institutions have followed Kotus's recommendations.

STRENGTHS AND LIMITATIONS

This examination of F-GSH has both strengths and limitations. The strengths include: 1) an emphasis on terminology of guided self-help and related concepts which is often overlooked, 2) utilizing only meta-analytic evidence when assessing the potential effectiveness of GSH systems, 3) describing the structure and implementation F-GSH from multiple viewpoints, including the therapy structure, therapeutic content, training and implementation. The clear limitation of this article is that it does not discuss the clinical outcomes of F-GSH, as these are outside the scope of this article. Furthermore, using a systematic literature review as a method of pooling would have provided a more comprehensive evaluation of the available evidence.

CONCLUSIONS

The massive increase in demand for mental health services, especially for depression, anxiety and other mild to moderate disorders, has increased the gap between treatment needs and current availability to unsustainable levels. Mental health issues have become not only a central public health burden, but also a huge economic burden due to lost productivity. Although attempts to prevent this increase are also necessary, prevention cannot substitute the urgent need to increase availability of evidence-based treatments. Low-intensity, early-onset psychological therapies offer one solution to this problem.

F-GSH is an example of low-intensity, digitally augmented CBT, which provides feasible tools to massively increase access to treatment. It is not intended as a standalone solution but rather should be seen as an essential element of a holistic stepped care approach. F-GSH is intended as Step 1 treatment in the Finnish stepped care model and should always be accompanied by services with Step 2 and Step 3 as treatment alternatives. The Finnish First-line therapies system supports an improvement framework that provides models and services for holistic enhancement of primary care mental health systems. This contrasts to a model that tries to implement single treatment methods without considering the whole system and patient process. Implementing a single treatment form rarely succeeds, as it usually requires too many extra resources, does not cater for all patients, and often only moves system bottlenecks from one place to another.

Equally important is that F-GSH programmes are openly available to all who want to use them as unguided SH programmes. This caters for those who do not seek professional help – a vast majority of people with mental health issues. Even a small effect size for benefit can translate into significant public health gain, if the number of users is large enough and the price of intervention low.

The F-GSH system is a low-intensity psychological therapy that utilizes the well-documented contents of common CBT programmes. There exists compelling meta-

analytic literature supporting the effectiveness of this kind of GSH programme in addressing common mental health disorders. It is necessary to be realistic and assume that mental health resources are unlikely to increase on a par with the pace of increasing demand. Thus, providing GSH and other digitally augmented therapies as part of a holistic stepped care system, as done in Finland, is one of the few truly realistic ways of increasing access to evidence-based psychological treatments.

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