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The expectation gap in psychiatry must be reduced

PERSPECTIVES

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If the expectations for psychiatry increase faster than the access to resources, the expectation gap will only continue to grow, leading to a crisis in psychiatry. We can manage this gap by reducing expectations, increasing efficiency or increasing resources.

In an earlier article, we claimed that the crisis in psychiatry is largely a crisis of expectations caused by unrealistic expectations of what psychiatry can accomplish (1). Our claim received broad support, but some pointed out that we did not take sufficient account of the need for resources. The recent debate about the health service's future financial challenges has further highlighted the importance of the resource perspective. Thus, we want to further develop our reasoning by replacing the term *crisis of expectations* with *expectation gap*.

The expectation gap in psychiatry

We are spending more money on mental health care than ever before (2). At the same time, many are experiencing a growing crisis in psychiatry. One explanation may be that society's expectations of what psychiatry can and should accomplish have increased faster than the access to resources; thus widening the expectation gap. The perceived crisis in psychiatry will only worsen if we do not acknowledge this gap (Figure 1).

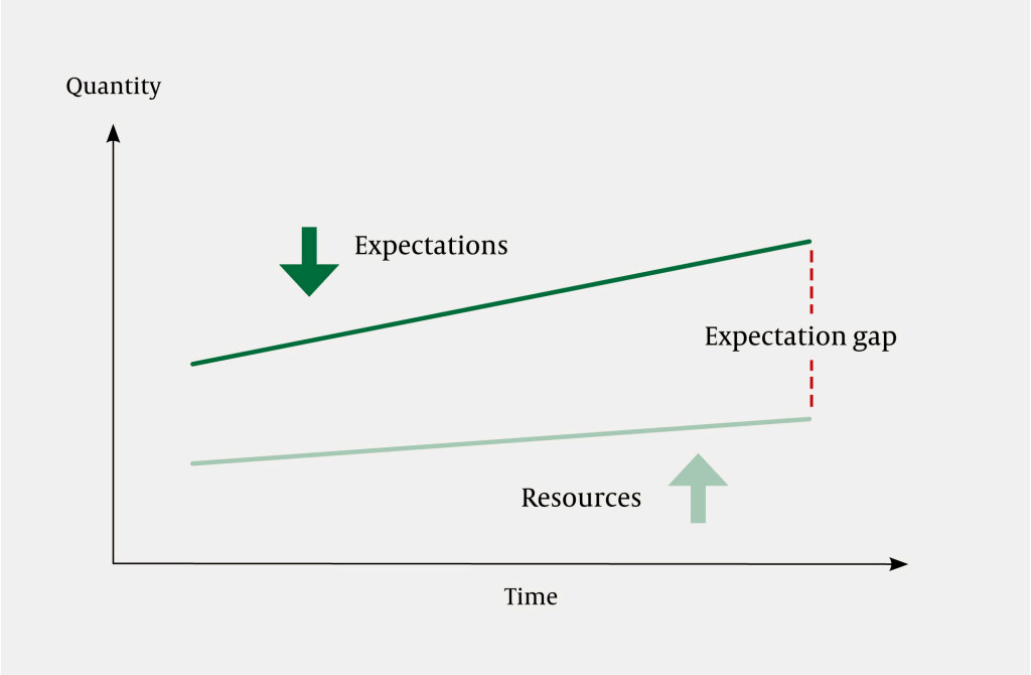

Figure 1 Illustration of the expectation gap in psychiatry. Resource use is increasing over time, but society's expectations of what mental health care can and should accomplish are increasing at a faster pace. The gap between resources and expectations – which we call the expectation gap – is therefore widening. The gap can be reduced by increasing access to resources through prioritisation, increasing efficiency or reducing expectations.

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How can we reduce the gap between resources and expectations? Three overarching strategies stand out. First, we should recognise that good psychiatric treatment requires considerable resources, and there may be good reasons for prioritising psychiatric care over other important areas of society. Second, we should recognise that psychiatry also has an unfulfilled potential for increasing efficiency, including prioritising the most cost-effective treatments and clarifying who should be treated. Finally, we should reduce the expectations of mental health care's role, and we must recognise that we sometimes intervene at the individual level when we should have intervened at the societal level – or at an earlier stage of life.

Increasing resources

We will start with the most topical strategy first: increasing resources in psychiatry. The scarce resources in psychiatry can, in practice, be divided into two categories: staffing of inpatient wards, and outpatient consultations with a psychologist, psychiatrist, social worker or nurse. In recent years, a deliberate political shift has taken place in mental health care, with a reduction in the number of inpatient beds and an increase in outpatient treatments. In South-Eastern Norway Regional Health Authority, the number of inpatient beds has been reduced by 811 in the last ten years. Correspondingly, the number of outpatient consultations has more than doubled – to 1.5 million – in 2021 (3). These figures show that the price of one inpatient bed equates to numerous outpatient consultations. These changes have inflamed the conflict surrounding two questions: How many inpatient beds and outpatient psychiatric consultations *should* we have? How many inpatient beds and consultations *do* we have? The distance between these forms part of the expectation gap in psychiatry.

There are good arguments for both outpatient and inpatient treatment of mental disorders. What is the right level primarily depends on which treatment studies you choose to place the most emphasis on. One example is the treatment of emotionally unstable personality disorder (borderline personality disorder). Treatment with basal exposure therapy is based on inpatient care over several weeks, while in dialectical behaviour therapy, patients are treated as outpatients. How many inpatient beds we need therefore depends on the treatment we choose to prioritise. Which health and welfare services are otherwise available in society also plays a large role, and it is consequently difficult to draw comparisons between different countries. There is therefore no simple answer to how many inpatient beds we need.

What we do know, however, is that Norway spends more resources on substance use disorders and mental health than most other countries – an important piece of information for those who think that psychiatry is underfunded (2). At the same time, a population survey from 2019 showed that 71 % of the Norwegian population wanted more funding for the Norwegian public health service (4). However, there is less agreement on where these resources should be taken from; either the tax rate must be increased, the oil fund must be used to a greater extent, or resources must be transferred from other public sectors to give more priority to health. All parts of the health service have a natural desire to benefit from these increased resources. Is there a special justification for psychiatry's demand for resources?

Anyone who does not value their own life, or wishes they were dead, also takes little pleasure from the other joys of life. Our state of mind affects our understanding of reality and colours our entire universe. As such, it could be argued that good mental health is fundamental to our well-being and should therefore be prioritised. However, we encourage everyone who wants more resources to reflect on the alternative cost of their proposals – i.e. where these resources should be taken from. After all, any doctor who works in mental health care could also spend their time improving public mental health somewhere else, for example by working as a GP. It may be that the Norwegian GP crisis is just as big a problem for public mental health as the recruitment crisis in psychiatry, given that most mental disorders are treated in the primary health service.

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Conversely, some would argue that treating mental disorders is challenging and should be done by specialists. During the teachers' strikes, several teachers said they would not take responsibility for children and young people's mental health. This may be a symptom of a trend in which a growing number of public bodies think that mental health is not their responsibility (5). This reluctance to share responsibility may be one of the disadvantages of psychiatry becoming more specialised. Mental health care faces a dilemma here. On the one hand, psychiatrists must cite their unique competence in order to receive more resources. On the other hand, this can create the impression that psychological help is something that can only be provided by professionals. Many are critical of this specialisation of spiritual care (6).

Increasing efficiency

Another strategy for dealing with the psychiatric expectation gap is to *improve* the use of resources – by increasing efficiency. At an overarching level, increasing efficiency is about making something more effective without increasing resources. This can be done, for example, by prioritising the most effective treatment first, or by reducing overtreatment. The Wise Choice (*Kloke valg*) campaign of the Norwegian Medical Association can, for instance, increase efficiency by reducing the amount of unnecessary treatment. Reducing overtreatment will free up resources for better and more effective interventions in psychiatry. So how should we prioritise the work within psychiatry to make treatment more efficient?

Norway's specialist health service has three priority-setting criteria: health benefit, resource use and severity. The health 'benefit' criterion entails the most beneficial interventions taking precedence over those that are less beneficial. The 'resource' criterion entails interventions that use few resources being prioritised over those that use a lot of resources. These two criteria combined constitute the concept of *cost-effectiveness* – a concept with an unwarranted bad reputation (7).

In psychiatry, we still have some way to go when it comes to prioritising the forms of treatment that are the most cost-effective. Psychoanalytic psychotherapy, which often requires considerable resources and is best suited for less severe disorders, is one of many examples of treatment that may be threatened by the efficiency requirement (8). Debate is needed on the types of treatment that should be prioritised in Norwegian psychiatry, and what role cost-effectiveness should play. Many interventions prove to be of some benefit to patients with mental health problems, but this does not mean that 'everything' should be offered to them. If psychiatry is to stretch its scarce resources further, the treatment provision should perhaps be limited to the intervention that has the best evidence base and is the most cost-effective. This also requires not skimping to the point that opportunities are reduced for conducting clinical treatment research that can provide such a knowledge base (9).

In addition, the prioritisation regulations also have a 'severity' criterion that takes into account how many good years of life a patient loses as a result of their illness (7). For disease groups that deprive patients of many good years of life – such as schizophrenia – the 'severity' criterion will also be relevant when the treatment is not cost-effective. We believe that this is particularly important for psychiatry. Unfortunately, the sickest patients in mental health care are also those with the least potential for recovery and the greatest potential loss of quality-adjusted life years due to their condition. These patients should still be prioritised due to the severity of the condition, which surpasses most of what is found in somatic health.

Reducing expectations

Expectations for both the effectiveness of and access to psychiatric care seem to be increasing. Many believe this is due to a general psychologisation of society as a whole. Some even claim that we live in a 'therapeutic culture' (10). Perhaps this psychologisation can explain why the expectations for psychiatry seem to be increasing more than the expectations for somatic health care. Politicians, clinicians, the media and commercial actors are now all contributing to this increase.

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The zero vision for suicide is a good example of the role that political rhetoric plays in increasing the expectation gap. If the political goals for psychiatric treatment are based on such unrealistic expectations, sustainable management of the expectation gap will be impossible. Political leadership is about setting challenging priorities. With laws such as the 'golden rule', where psychiatry was to have a higher priority than somatic health, the expectations for psychiatry were escalated with the stroke of a pen. However, the resources have not been commensurate with the laws, thus widening the expectation gap (11).

Clinicians can also raise expectations by overselling their own treatment. The private market for mental health services is growing, which is seeing providers try to outdo each other with promises about the efficacy of their particular methods. This can also lead to overinflated expectations of the efficacy of the treatment. Inflated expectations of treatment efficacy are also found in the public health service. A study of patients with negative experiences after treatment with basal exposure therapy highlighted the harmful effects of such an 'expectations crash' (12). This study only serves to support our earlier claim: that patients are best served when they have realistic expectations of psychiatric treatment.

> ***«Patients are best served when they have realistic expectations of psychiatric treatment»***

The significant increase in the number of referrals to the specialist health service for issues relating to ADHD highlights our shared responsibility for the growing pressure on psychiatry. Treating the individual can be a short-term solution to complicated structural problems. Several claim, for example, that the increased incidence of ADHD is due to the high performance demands on children and young people and that more people are feeling pressured into taking medication in order to perform better (13). This tendency also prevails when 'more coercion' becomes the solution to the growing number of people committing murder in a drug-induced psychosis (14). Should we prioritise measures that can change society rather than allocating the funds to treat those who become mentally ill due to society's demands and expectations?

Three strategies at once

We believe there is insufficient discussion on these three strategies (increasing resources, increasing efficiency, reducing expectations) as complementary solutions in the discourse on mental health care. All too often, they are pitted against each other as opposing strategies. We believe it will be impossible to reduce the perceived crisis in psychiatry if we do not bear in mind all three strategies at once.

There are many good reasons why we should try to narrow the expectation gap. A large expectation gap could give Norwegian psychiatry an undeserved bad reputation, which could increase the recruitment challenges. Even more important is that patients will get the wrong impression that psychiatry is unable to help patients. Many severe mental disorders affect people at a young age, leading to significant health deficits and limitations over the life course. As a society, we all have an interest in improving mental health care, but such attempts should be constructive rather than constantly drawing new dystopias of one of our most important public services.

We are in no way suggesting that we are presenting the solution to all of psychiatry's challenges here, but we have tried to listen to the constructive criticism we have received. We think many of those involved in the discourse on Norwegian psychiatry would benefit from doing the same.

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