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More and More is Less and Less
The Myth of Massive Psychiatric Need

ALEX RICHMAN and ARTHUR BARRY

Summary: The idea of massive unmet need for mental health services is a myth, generated and perpetuated by processes within the system which provides psychiatric care and within society. Diffusion of the traditional boundaries of mental health care, lack of norms and standards, medicalisation and 'healthism', specialoid practice and patient selection, diversion of resources from the long-term mentally ill and their absorption by better-functioning patients, substitution and development of new mental health service providers, and changes in the threshold for help-seeking all affect our assumptions of need. Needs are less massive, if the boundaries of psychiatry are defined so as to include only those disorders which the profession is best able to treat.

There has been a massive growth in mental health services during the past 20 years as psychiatry has extended its boundaries to include an ever-widening array of human problems. Psychiatric manpower, facilities, and programmes have been vastly increased. However, as more resources are provided, more are perceived to be needed: more and more is less and less. Of particular concern are those needs of the long-term mentally ill which have been shuffled aside, despite recent advances in psychiatry.

Although some unmet need for mental health services inevitably exists, this is not as extensive as is generally thought. The idea of *massive* unmet need is a myth, generated and perpetuated by various processes within the system of psychiatric care and within society. This myth seeks to justify the addition of resources to existing services, rather than correction of existing problems in the delivery of care. However, needs are less massive than generally assumed if the boundaries of psychiatry are defined so as to include only those mental disorders which the profession is best able to treat. When the predicaments and problems of living which do not reasonably require psychiatric intervention are excluded, and when alternative sources of psychotherapy are considered, a more finite concept of need emerges. Psychiatry therefore needs to reassess its roles, redefine its functions, and reallocate its resources.

Background

In 1965, Lindemann anticipated the processes which have generated disillusionment with our present systems of mental health care, and predicted that: (1) The demand for mental health services will increase with the available supply of services, (2) Resources will always fail to meet the needs of the population, and (3) The problem cannot be resolved by increase of professional manpower.

It has been repeatedly demonstrated that when psychiatric resources are increased, there is an inevitable increase in the utilisation of those services (Giel, 1980). An increase in the number of psychiatrists, however, does not reduce the service-gap: they rapidly acquire a caseload, and the previous short-fall in services returns. Further, as the number of psychiatrists increases, there develops a marked rise in sub-specialisation (e.g., child psychiatry, family therapy, forensic psychiatry), which produces further need in the area of each sub-specialty, as well as diverting emphasis from the care of the long-term mentally ill.

Need for mental health services: Few have questioned the assumption that there exists a massive level of unmet need for mental health care in the population. Community epidemiological studies have shown that up to 25% of the population may be suffering from any of the major or minor mental illnesses, psychological disturbances, emotional reactions, or demoralisation, while two out of every five persons suffering from psychosis have never received treatment (Dohrenwend *et al*, 1980). There is repeated emphasis on the tremendous gap between the 'call for psychiatric help' and the number of services available (Srole *et al*, 1978). However, assumptions of need have been influenced on two major fronts: by the methods used for identification of the mentally ill and of their needs for treatment, and by changes in the practice of psychiatry. These developments are detailed below.

Development of the myth of massive need

Identification of the mentally ill and needs for treatment: Previous epidemiological surveys provided global estimates of psychiatric disorder, without differentiating diagnostic groups, while more recent studies have purported to establish the number of persons in need of treatment, but without specifying the stage or severity of the disorder, or the type and amount of treatment. Jeffers *et al* (1971) noted that gaps are measured between needs and supplies of medical services, without considering that the quantity needed may differ from the quantity demanded. There are few studies on the interactions between needs and resources or on how resources are used. Regier (1983) has distinguished data on true prevalence from prevalence of need for mental health services. Formulation of a mental health service policy requires knowledge of the interrelationships between presence of a mental disorder and the type and amount of specific treatment needed.

A related problem involves traditional assumptions that counts of actual or potential cases of a certain type of psychiatric disorder can readily be translated into specific needs for care. Kendell (1975), however, indicated that a diagnosis does not denote a plan of clinical action, nor does it define the person as needing medical care. Finally, there is little information about the natural history of the minor psychiatric disorders and of symptoms in the population. It is not yet possible to select those conditions which are unlikely to remit without treatment. Feinstein (1967) has demonstrated that a range of factors other than signs and symptoms make up the clinical diagnosis, yet it is generally assumed that untreated individuals exhibiting symptoms of clinical conditions actually *have* these conditions with the same range of severity and stages as treated persons, and that the untreated groups will have the same course, outcome and needs for clinical intervention (Richman, 1980). However, the results of studies by the World Health Organisation (1973) show that it can no longer be assumed that persons with similar symptoms will have similar courses and outcomes for their disorders.

Changes in the practice of psychiatry

Diffusion of the traditional boundaries of mental health care: The vast increase in perceived needs for mental health care has been, to a large extent, a result of the broadening of traditional boundaries. A number of factors have contributed to this expansion. Firstly, psychiatry increasingly directs attention toward conditions which precede acute stages of mental illness. Interventions have become more frequently aimed at the pre-psychotic, or pre-breakdown stage, to forestall deterioration and reduce the need for hospitalisation; they have even aimed at prevention. A second factor has been the broader focus on socio-behavioural problems which were previously excluded or dealt with only tangentially (Arnoff *et al*, 1969). Geller *et al* (1976) point out that psychiatry is now concerned with issues which formerly would have fallen within the scope of other service providers or professionals, such as public health practitioners, theologians, economists, and political organisers.

Lack of norms and standards: Another major factor has been the failure of researchers, clinical practitioners, and service managers to provide norms and standardised criteria for mental health care. Guidelines as to what staff or services are best *vis-a-vis* the structure and diversity of the mental health system have not been delineated. Treatment programmes have often resulted from the ideological perspectives of clinicians, rather than from the needs of patients. Geographical variations persist or even increase, with growing numbers of psychiatrists. The old norm is replaced by a new one: "The amount of shortage depends on the ratio selected as the standard. The standard is in turn a function of the point on the array that is chosen and also the degree of variation in person-to-population ratios that exists among areas. Given this method, it would be surprising if a shortage were not always calculated" (Arnhoff *et al*, 1969).

Medicalisation and 'healthism': Psychiatry has adopted the WHO view of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (Shepherd, 1971). With this expanded view, the psychiatrist sees his role as going beyond the treatment of mental disease, to one which involves offering assistance and advice on a much more extensive range of human issues. Crawford (1980) has termed this process the 'medicalisation' of every-day life; one aspect of it is an expansion of professional power over a wider range of problems, in particular over deviant behaviours such as drug abuse and delinquency. Thus, these kinds of problems have been labelled as illness, and as symptomatic of psychiatric disorder, rather than as problems of social control. Psychiatry has thus assumed responsibility for problems traditionally overseen by legal and religious systems.

The second aspect of medicalisation is 'healthism'. This involves the encroachment of concepts of health and disease on an everwidening

range of problems of living, and a preoccupation with personal health and well-being. Medicalisation expands mental health needs because it "sets boundaries on ways of thinking and channels consciousness and behaviour" (Crawford, 1980), thus increasing the propensity of the population to seek mental health services.

Specialoid practice and patient selection: In North America, psychiatry has become a 'specialoid' rather than a specialist activity; psychiatrists spend less time as consultants to other doctors and assume responsibility for the primary care of patients with mental illness. Despite increasing emphasis on the role of psychiatry in primary care, there are relatively few opportunities for family practitioners to function in the continuing care of the long-term mentally ill. A parallel process is that of patient selection. Psychiatric services tend to be delivered to the 'good' patients, who are more amenable to psychotherapeutic techniques and better suited for the education of students (Levinson, 1969). Link & Milcarek (1980) suggested that the best patients are those who receive the most attention—"instead of selecting patients solely on need, the service delivery system appears to single out for special attention those patients who are the most successful competitors".

Diversion of resources from the long-term mentally ill; and resource absorption by better-functioning patients: The diversion of resources from the long-term mentally ill has continued over many decades (Morrissey *et al*, 1980). Ryan (1969) concluded that: "the larger group of less severely disordered persons constitutes the daily catch of the mental health waters. And these persons fall outside the realm of any rigorously defined categories of mental diseases. The logical error we make is in dealing with such non-diseased persons in the same settings and with the same conceptual terminology that we have constructed for the truly diseased persons". Gerhard & Marks (1980) have pointed out that the mental health system perpetuates the needs of those who enter it, so that it is difficult to exit from the system: patients are transferred from one compartment to the next, with little effort being directed toward developing a functional independency. On the contrary "we have used processes which have produced a population of socially incompetent, socially isolated, totally dependent individuals. As a result, tremendous resources are spent today to serve the product of yesterday's services". Herz (1979) described the "tendency for staff on psychiatric units to hold on to well-functioning patients because of the increased gratification in treating individuals who are well integrated enough to share their thoughts and feelings". The result is a 'heaping up' of services on the most capable clients, to the exclusion of the more severely disordered (Rudolph & Cumming, 1962). Thus, the needs of this latter group persist or even increase, despite increasing allocation of resources.

Substitution and development of new Mental Health Service providers: Along with the broadening of the domain of mental health care, has been the development of a diverse group of mental health professionals and service providers. The psychiatrist is no longer the sole provider of many types of treatment. Clinical psychologists, social workers, psychiatric nurses, and pastoral counsellors are among the many providers who have, over the past 25 years, started to offer services. In turn, much of the psychotherapeutic treatment formerly provided only by the most highly trained professional groups is being delivered by newer types of mental health worker. Yet as the numbers of new mental health professionals and para-professionals increase, there is no accompanying shift in the role and function of psychiatrists.

Changes in the threshold for help-seeking: There have been changes in attitudes and self-perceptions which make people more likely to respond to personal difficulties, worries, and unhappiness, to seek professional help, and to seek help from multiple sources (Veroff *et al*, 1981).

Discussion

Today, psychiatrists are faced with the reality that the mental health system is not working: despite greater availability and diversity of resources, some needs are still not being met satisfactorily. Of particular importance are those needs of the long-term severely mentally ill (those in 'absolute' need who definitely require a specific form of treatment) in contrast with those who have a relative need for treatment, which is determined by the availability of resources (Logan *et al*, 1972). As the World Health Organisation (1972) has noted: "increasing funds or manpower will increase the total resources available, but can never increase them to a level such that all the potential demands can be met. It is thus always necessary to ask two questions. First, what total resources can be made available for health? Second, how should those resources be allocated to various competing needs?"

Inevitably, the broader the scope of psychiatric treatment and of other mental health care, the

greater the care needs of the population, but need must be defined in relation to essential resources, focussing on priority or target groups, e.g. on psychosis rather than neurosis, as Giel & Harding (1976) recommended for developing countries. Needs are less massive than is generally assumed if one constricts the 'panacea' concept of mental health care. When the boundaries of psychiatry are defined so as to include only the range of major mental disorders which psychiatrists are trained to treat, to exclude the predicaments and problems of living which do not reasonably require psychiatric intervention, and to reaffirm the specialist role of psychiatrists as consultants to primary care practitioners, a more finite concept of need emerges. As early as 1969, Ryan suggested that two actions were needed: firstly, a declaration that the great majority of persons with mental health *problems* but no mental disease are out of bounds, and, secondly, a direction that a substantial proportion of psychiatrists should return to the problems for which they are best equipped to deal. Similarly, Arnhoff *et al* (1969) recognised "a need both for a contraction in the scope of endeavour and for specification of subgoals". It is time such proposals were heeded by mental health professionals and planners alike.

Psychiatry needs to re-define its boundaries, roles, and functions, to move closer to other branches of medicine, and to define *which* kinds of patients must be seen by the psychiatrist, for *which* functions and for *which* goals. New concepts of care delivery and of reallocation of resources are required. Better definitions of clinical disorders must be developed, e.g. differentiating demoralisation from depression. Psychiatry must clarify the areas where it's expertise overlaps with other mental health disciplines (Lowy, 1976) and take the initiative in reallocating resources so that the paradox of increasing resources creating additional need can be overcome.

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Alex Richman, MD. *Professor*

Arthur Barry, BA. *Research Assistant*

Departments of Psychiatry and Community Health & Epidemiology, Dalhousie University, 5849 University Avenue, Halifax, Nova Scotia, B3H 4H7 Canada

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