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Parity of Esteem between Mental and Physical Health

Executive Summary

Working in collaboration with:

Authors

Owens, J., Lovell, K., Windfuhr, K., Brown, A., Bell, V., and Bee, P., (2021)

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Executive Summary

‘Parity of esteem’ is a borrowed phrase from political policy, placed within mental health policy. It aims to create equity between physical and mental health, but despite policy guidance and recommendations, the lack of clarity surrounding the phrase merely serves to add to the confusion. Furthermore, the gap in funding and resources between mental health care and physical health care indicates that there is an uneven playing field from the outset, bringing into question whether the concept is of any use.

This study used interviews and discussion groups to identify participants’ interpretation of parity of esteem, to explore parity between physical and mental health and to outline perceived barriers and facilitators to parity. We interviewed twenty-seven participants drawn from physical and mental health services, policy development and third sector organisations. Four discussion groups of 36 participants from a range of stakeholder backgrounds (service users and carers) took place.

Analysis of the interviews produced themes. Key points from the analysis suggested that the term derives from political conflict resolution. There is no clarification for its transition and use in healthcare. This means there is confusion about the term ‘parity of esteem’ with participants feeling that it was a rhetorical phrase. However, the lack of clarity created differing interpretations, enabling its use in advocacy and self advocacy in order for people to acquire what they wanted or needed from services.

‘Parity of esteem’ exhibits a complex relationship with the social determinants of health, which are the root cause of inequality. So for example, poverty as a social determinant exhibits an influence over people’s health and well-being. Social deprivation generally, sub-standard education, poor housing, low paid jobs and deprived areas, all exert an effect on health. Viewing the patient holistically implies that practitioners gain insight into the ways the social determinants exhibit an effect on individuals. Inequality exhibits an impact on physical and mental health and

wellbeing. ‘Parity of esteem’ means recognising people are a part of their environment to enable more individualised care.

Disabling attitudes and discrimination lead to inequity, discrimination particularly being a form of oppression for people with mental health problems. Within the interviews, non-mental health workers more readily accepted physical in contrast to mental health problems as a source of distress. This means that discriminatory attitudes of physical health workers sometimes drives inequity because they potentially reduce treatment choice, creating inequalities. Staff working in mental health and with people with mental health problems also experience discrimination from staff working in physical health.

Marginalised groups experience multiple forms of discrimination when they have mental health problems. Any form of difference from the majority population; being black, or any ethnic minority (BAME), disabled, lesbian, gay, bi- sexual, trans-sexual, queer+ (LGBTQ+) is not celebrated and then having mental health problems as well creates numerous intersecting areas of discrimination which becomes difficult to manage.

Resources and training exerted a large impact on parity. Medical education and training, which continued to focus on the mind body divide, perpetuated the lack of holistic care. In contrast, staff training in cultural competence and diversity increased parity between physical and mental health. A reduction of time for mental health on the medical curriculum emphasised and reinforced the lack of parity between physical and mental health, valuing mental health the same as physical health increased parity. The importance of skill-mix in teams creates the potential to increase parity because people learn from each other. Resources appear predetermined, finite and inequitable between physical and mental health services. Although, participants suggested that services need more proactive management to ring-fence and better allocate resources and targets.

Displaying a lack of clarity when setting targets means parity becomes difficult to achieve. Problems with targets indicate that focusing on achieving a target and

missing treatment pathway stages reduces parity. Participants argued that targets should not become crude indicators of achievement, but be formed from complex indicators of improvement to ascertain parity. They also felt that target setting should focus on people most at risk in an effort to reduce inequalities. Different types of payment to achieve targets may affect parity of esteem and much depended on how targets were set and what they aimed to measure.

Dimensions of access to provide quality care appeared in all interviews. Availability of services appears patchy and inconsistent reducing parity between physical and mental health, which begin from different starting points. Measuring availability by physical access, not choice, reduces parity. Waiting two weeks to access mental health services, when in crisis, suggests that parity with other services works against people with severe mental illness. This implies that treating people with mental health problems equally creates inequity because there is no accounting for difference. A lack of patient-centred care meant people with mental health problems became objects of care rather than collaborative and active partners, which led to inequitable treatment.

Collaboration and integration link with one another. Integrated services display different specialities and skill mixes work together to provide quality care. Lack of integration appears to be a barrier to parity, although integration of services may be challenging because of differences in commissioning, referrals, staff training and service organisation. Integration fails to consider existing inequalities as a barrier to parity of esteem. There appears to be little evidence as to what degree of collaborative practice occurs and indeed is possible. Participants felt that collaboration also means including family perspectives to build a more holistic view of the patient, service users particularly felt that the ‘right questions’ needed asking to reduce time spent in services.

The phrase parity of esteem appears to have little effect on developing equitable services because of the lack of clarity and definition. There is uncertainty about developing parity because of existing inequities between physical and mental health care. The discrimination and marginalisation of people with mental health problems

appears to be increasing, because their problems appear to be a cost cutting exercise, not one of compassion. The impact of austerity measures, reduction of targets and shrinking resources suggests people with mental health problems appear to run the real risk of relegation to a wasteland of nothingness.

For more information, please contact Gill Rizzello, Programme Manager: gill.rizzello@manchester.ac.uk
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