

Parity of Esteem between Mental and Physical Health

Final Report (November 2022)



Working in collaboration with:



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Introduction

Parity of esteem is a borrowed phrase from political policy and placed within mental health policy. It aimed 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, questioning whether the concept is of any use.

This study used interviews and discussion groups to identify participant's meanings of parity of esteem, to explore parity between physical and mental health, to ask participants to provide feasible and measurable indicators of parity of esteem 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.

The study identified that healthcare providers and policy developers alike failed to clarify parity of esteem. Furthermore, there was little indication of the constructs of parity of esteem and its measurement. Analysing the interviews brought forward a variety of suggested indicators, some of which were complex, nested within one another and difficult to measure.

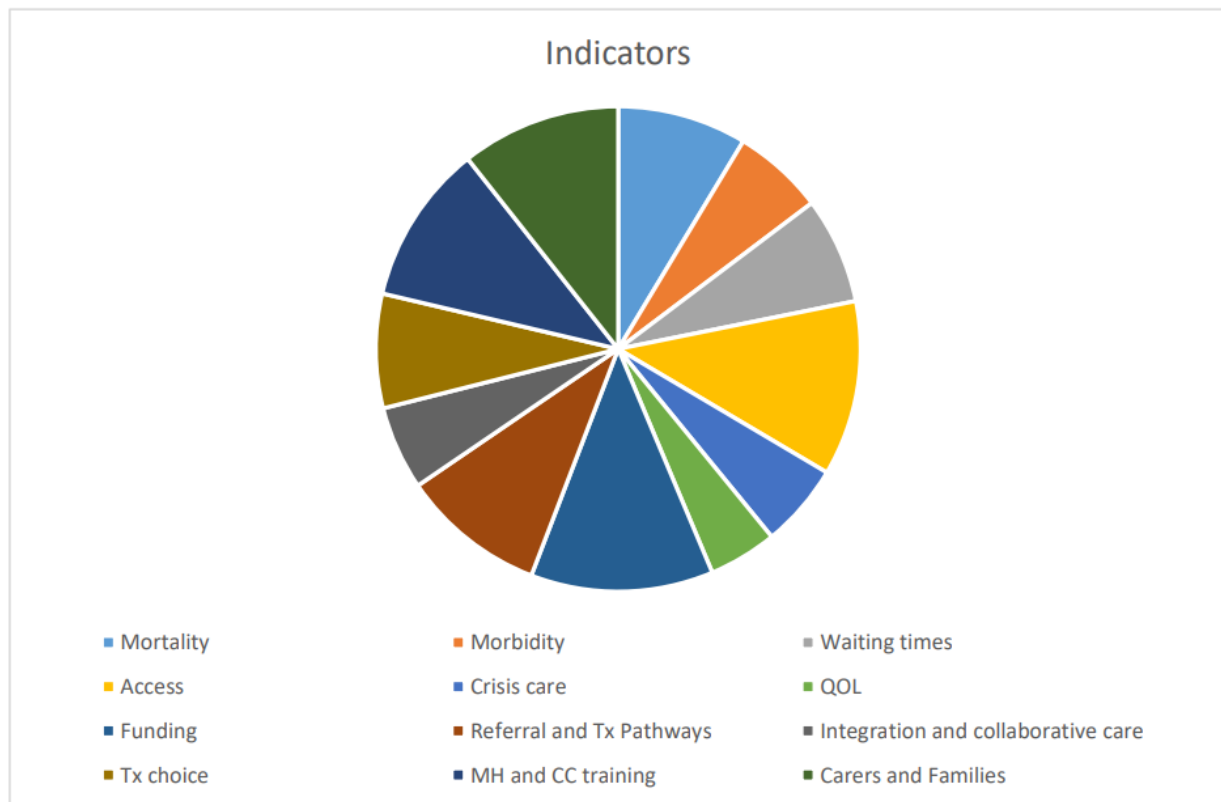


Figure 1: Pie chart of different indicators mentioned in interviews

Legend:Tx- treatment, MH-Mental health, CC-Cultural Competence, QOL- Quality of Life

An inductive thematic analysis of interviews occurred. 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 meant there is confusion about the term parity of esteem and in many cases participants feel it is 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 exhibited 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 means practitioners gaining 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 led 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 meant that discriminatory attitudes of physical health workers drives inequity and reduces 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. It appeared that mental health was a backwater, not a career and only one-step above learning disability. 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 a target and missing treatment pathway stages to achieve targets reduces parity. Participants argued that targets should not become crude indicators of achievement, but 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 of parity. Measuring availability by physical access, not choice reduces parity. Waiting 2 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 little evidence as to what degree 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 defined indicators. 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 are a cost cutting exercise, not one of compassion. With the impact of austerity, Brexit, COVID-19, the reduction of targets and shrinking resources people with mental health problems appear to run the real risk of relegation to a wasteland of nothingness.

Parity of Esteem

In 2011, in its document '*No Health without Mental Health*', the coalition government in the UK introduced the phrase parity of esteem to promote equality between physical and mental health care (Department of Health 2011, p. 64, Para. 7.1). This was driven mostly by economic deficits and the need to make savings. The document recognised the interdependency between physical and mental health. It proposed that services needed to provide better quality and effective care, shift their focus towards health promotion and prevention, alongside earlier interventions for mental health problems to prevent crisis and tackling the social determinants of health and consequences of mental health problems. Quite how this was to occur in practice is vague and lacks the necessary steps to guide service delivery. What it does underline are large inequalities between physical and mental health.

There are a number of reviews arguing that there are large inequalities between the physical health of people with mental health problems compared to people without mental health problems (Mitchell et al. 2009; Lawrence & Kisely 2010; Moore et al. 2015). Moreover, in a recent meta-analysis, it is suggested that people with past or present mental health problems experience accelerated mortality (Walker et al. 2015). This would appear to make parity between physical and mental health a priority.

In the UK, the principle of parity of esteem is enshrined in legislation by the Health & Social Care Act, 2012. This happened because it was felt that mental health did not receive the same level of financial investment alongside staffing resources, as physical health and that this affected access to and quality of services (Bailey 2019). This created further constructs which underpin the phrase.

- Equal access to effective, safe care
- Equal efforts to improve the quality of care
- The allocation of resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users

- Equal status being given to the measurement of health outcomes. (Source Bailey et al. 2013).

Although these principles appear sound, they are in fact loose phrases which are open to interpretation. For example, what is meant by access, does it mean physically entering services, does it mean being offered choice to a range of services, does it mean being treated in an acceptable manner and what does effective and safe care look like? What aspects of quality of care need to be focused upon? What are resources? Are they staffing levels, staff training, or the physical environment? Although the intention means to be helpful, the lack of clarity within the statements appear to confuse the area further.

Rather than focus on clarifying meanings, the All Party Parliamentary Group (2015) identified that there was a lack of parity in three areas

- An unacceptable large premature mortality gap for people with mental illness
- An acute shortage of high-quality mental health crisis care
- Failure to prioritise mental health promotion and prevention in public health strategies

These three areas appear to be a point of focus for service development and provision. Although, some authors argue that we are not looking at inequality between physical and mental health services, but equity of effective services for those in need of mental health care (Timimi 2014). This questions what is actually meant by parity of esteem, how is it defined and how is it used?

Methodology and Methods

This study took place through 3 Phases.

Phase 1: A systematic scoping review of the UK literature around parity of esteem. Countries using a different system to the NHS were excluded because insurance schemes for health added another tier of complexity regarding equity. This study is reported elsewhere.

Phase 2: This study involving interviews and discussion groups

Phase 3: A priority setting meeting involving healthcare providers and service users to identify the key priorities for future work.

Phase 2: used a descriptive qualitative design because it wanted to inform policy and practice and therefore gives more of a practical overview of the research (Sandelowski 2000, 2001, 2004, 2010; Sandelowski & Barroso 2002; Colorafi & Evans 2016). This is in contrast to employing a specific qualitative design, for example ethnography or narrative, which would offer more depth but may not be as useful for policy and practice.

Prior to interviewing, a questionnaire was drawn up which reflected the themes derived from the scoping review (see Appendix 1). The study employed a non- probability sampling strategy, more specifically purposive sampling. This is the process of choosing participants based on their goodness of fit for the study characteristics. Some participants referred researchers to other likely participants, a process known as snowball sampling. This is in contrast to convenience sampling which chooses participants based on their ease of access. An advert on the medical intranet alongside known contacts enabled recruitment. Participants self-selected, agreed to an interview by submitting their details and contacted researchers directly. Two researchers interviewed 27 participants, from mental health care providers, physical health care providers, policy-makers, commissioners, charity workers and political party members.

Interviews employed digital recordings and verbatim transcription through a specialised company. Post-transcription, recordings were destroyed. Four discussion groups took place with a total of 34 service users and two facilitators per group. Digital recording of discussion groups did not occur because of a lack of ethical approval. Instead, journalistic note taking occurred (Denzin 1989) with two separate observers about the perceptions of participants in the groups.

The aim of the research was to explore the meaning of parity of esteem and provide some key indicators to guide future research and policy.

The objectives of the study:

- Identify definitions of parity of esteem
- Explore parity between physical and mental health
- Ask stakeholders to provide feasible and measurable indicators of parity of esteem
- Outline perceived barriers and facilitators to parity.

Ethics

The University of Manchester granted proportional ethics [Ref. no: 2020-8567- 15631]. All participants were assured anonymity and any identifying data masked. Researchers informed participants of the right to withdraw up to writing the report.

Analysis

The study used inductive thematic analysis, which is more bottom-up emerging from a constructionist paradigm (Burr 1995; Frith and Gleeson 2004). This has elements of analysis used by Boyatzis (1998), but differs in that Boyatzis is more top-down and deductive. Thematic analysis offers the opportunity to gain wider insight into an area of focus (Marks & Yardley 2004). Furthermore, a large amount of content is required to generate a theme in order for it to “describe the bulk of the data” (Joffe and Yardley 2004 p.67). This means that even though one statement may be significant, it does not always reflect the full story, or provide a wider picture of a phenomenon. Inductive analysis is generated by raw data and it is a systematic process where the researcher

weaves backwards and forwards through the data, generating codes, which when grouped together for similarity form themes (Silverman 1993; Huberman & Miles 1994). Once themes have been identified, the researcher then develops a coherent narrative in order to tell the story of the data.

Indicators

All 27 participants were asked about indicators of parity of esteem. Table 1 (pp. 14-15) identifies measurable indicators from participants who volunteered them. Participants often struggled with the concept of indicators, relating to the lack of concrete definition of parity of esteem (pp. 9-10). Researchers sometimes suggested indicators to participants and these have not been added to Table 1 because they were not primarily volunteered.

Table 1. Indicators identified by participants

P. no	Mortality	Morbidity	Waiting times	Access to services	Access to Crisis care	QoL	Funding and resources	Referral & Tx Pathway	Integration + Collaborative care	Tx Choice	Training on MH and CC	Including and supporting F and I carers
1.	X	X	X	X	X	X	X	X	X	X	X	X
2.	X		X	X	X	X	X	X	X	X	X	X
3.		X	X	X	X		X	X	X	X	X	X
4.	X	X		X	X	X	X				X	X
5.	X		X	X	X	X	X	X		X	X	
6.	X		X	X			X	X			X	
7.	X		X	X		X	X	X			X	
8.				X		X	X	X	X		X	X
9.		X		X		X	X	X			X	X
10.				X			X		X	X	X	X
11.								X	X		X	
12.	X	X	X	X	X	X	X	X	X	X	X	X
13.				X	X		X	X		X		X
14.	X		X				X			X		X
15.	X	X		X			X	X				X

16.	X							X			X	
17.	X	X	X	X			X	X	X		X	X
18.	X	X		X			X	X		X		X
19.	X	X	X	X			X	X		X	X	X
20.			X	X	X		X	X			X	X
21.	X	X	X	X	X	X	X	X				
22.			X				X			X	X	X
23.				X			X			X	X	X
24.				X	X			X	X	X		X
25.	X	X		X			X			X	X	X
26.	X			X			X		X	X	X	X
27.	X	X	X	X	X		X		X		X	X
N	17	12	14	23	11	9	24	19	11	15	21	21

Text: N- total number, QoL-Quality of Life, Tx-treatment/s, MH-Mental Health, CC- Cultural Competence, P-Participant, No- Number, F-formal (paid and employed health carers), I-informal (families and unpaid carers)

Themes

The following themes were derived inductively from the data and illustrate the complexity of parity of esteem. Moreover, evidence from the data suggests that there is little parity between acute and mental health services.

Rhetoric and resistance

Twenty-four out of twenty-seven participants used the definition, or similar, provided by the Royal College of Psychiatrists, two had to Google the term to find out what it meant. All participants inferred that parity of esteem is a rhetorical term with many different interpretations, causing some to query its utility, whilst others demonstrated confusion.

Participant 1:

“[...] Erm, it was, where Government gave a commitment to give equal weight, erm, and value to mental health as well as physical health. [...] Erm, I, I guess it's, erm, it's a, it's a statement of intent, erm, like a commitment. The challenge will be the rhetoric, whether it's a rhetoric, or whether it's enacted. Erm, but I think it's a, it's a reasonable concept. I'm not sure how well understood it is outside immediate,[...] Erm, so, yeah, basically, it's a set of words[...].”

This participant acknowledges the political definition of the phrase, simultaneously contradicting their original definition by implying it is rhetoric, devoid of meaning and understanding. They further suggest that many people outside the field of mental health may not understand the term.

Participant 2:

“But I think, um, actually very few people, um, understand the full nature and breadth of what parity of esteem means, and I think it means a lot of stuff.”

Participant 2 goes further and implies that although the phrase might create confusion as to what it actually means, it does actually mean many different things, but when questioned failed to identify what these may be, illustrating their own confusion. The problem with a phrase meaning a lot of different things is that it fails to give direction as to how it may be applied to promote improvement.

Participant 3:

“[...] Er, but it's action that you need with it. And as I say, I think the terminology's used sometimes just to, er...er...er, avoid...because it's not measurable, um, that, er...it's an ambition without any targets [...].”

Participant 3 underlines that because parity of esteem means so many different things it makes it difficult to measure or provide any targets for services to assess whether they have achieved parity in a service, or for people.

Participant 4:

“[...] talking about parity of esteem can be very useful cover when people don't want to spend money...because esteem doesn't cost anything.[...] I want you to treat this with the same esteem as you treat that, that's an incredibly individualising – potentially – way of framing the problem [...].”

Participant 4 considers parity of esteem in somewhat cynical terms, suggesting its use is political when government does not wish to spend money on services. They further underline that esteem is not tangible and runs the risk of individualising and constructing the area in negative terms.

In contrast to the other participants, Participant 6 accepts that the term parity of esteem is vague, but then proceeds to suggest that vagueness has benefits.

Participant 6:

“Um, so it’s a...it’s a...I...I think it...it...it has to be accepted that it’s quite a...a vague concept, um. Er, it...it is valuable in that it’s, you know, er, it highlights the importance of fair treatment for mental health [...] it allows campaigners to, um, pressurise Government, er, by, er, sort of, asserting that they’re failing to meet, er, parity. So far as I’m concerned, I would interpret it to encompass all, er, aspects of, um, er, er, of, er, medical treatment [...] within the NHS, [...]”

Participant 6 acknowledges the vagueness of the term but then appears to suggest this is positive because using the term enables advocacy for parity of treatment, for both physical and mental health, when people feel parity does not exist.

Participant 1 also uses the term as a form of advocacy:

Participant 1:

“I suppose the, the opportunity to use the expression, parity of esteem, is really to, to allow people with lived experience to say, look, these are really important issues for us, and we want people to be, to help us to understand them better, and to come up with ideas about how we can deal with these things [...] I think it allows you to create an argument with, erm, for instance, commissioners. I’m more, I’ve got some legitimate way of saying, look, why is, why is x not experiencing whatever it is, why, why should they have to put up with these sorts of things.”

Leaving the phrase deliberately vague opens up the potential for people, particularly those with lived experience of a condition, to use it as a bargaining tool to gain access to and receive what they, or the people they care for need, or want. In this sense, parity of esteem is a tool of political resistance. Resistance itself is a hermeneutic, which enables the undoing of rhetoric, challenging the marginalised positions enforced

by a dominant culture.

Participant 12:

“[...] it's a sort of collective, it's a collective movement. It's registering a dissatisfaction, which you could, which you could define as a health inequality, a social justice. There's a social justice issue, and parity of esteem is a way of engendering a sort of collaborative approach, which requires participation, and responsibilities of different, in different ways to achieve a movement. Because, fundamentally, it's about getting a change of experience.”

Parity of esteem transforms into a social movement for participant 12, moreover it moves more towards social justice and equality of provision. Parity of esteem, in this sense, is about equity and a right to health care equating as either equal access or a decent minimum of care. This exists on a continuum from a negative right (preventing no one from obtaining care) which does not require the government to guarantee equal care for everyone. At the other end of the continuum, government guaranteed equal access to care for all. In the middle is the right to a decent minimum or adequate level of care (Beauchamp and Childress 1994, p.356). Social justice is a way of addressing health inequalities, but to do this effectively there needs to be shared health governance. This means sharing responsibility between national government and institutions, non-government organisations, the private sector, families, service providers and users and communities.

Participant 14:

“[...] conflict resolution [...]. That...that, er...so, you know, where...where people on both sides of a conflict have to feel that they are both...that, you know, that one...that, because they...they, on the...on the whole that historical conflicts are often between groups who both feel that they have been, er, put at a disadvantage [...] So, you have to, in order to resolve conflict, get both...both sides to feel that they are now being viewed, er, positively, with equal regard [...] It does mean that the terms is...is...has this slightly, um, a rather distant history, with nothing to do with mental health except to do with the fact that

people feel done...hard done by [...] And so, the...the...the risk is that it becomes, taken out of its natural context, it becomes are rather meaningless term.”

Even though this participant feels it is a meaningless term, they acknowledge that parity of esteem does originate from political conflict resolution, more specifically from arguing for equality of treatment between Catholics and Protestants in Northern Ireland. This appeared during the Opsahl Commission in its report on Northern Ireland (Pollack 1993). Appropriating the term from political theory has its limitations because it is removed from its original context and it would appear without consideration for the services it intends to represent.

Key points:

- There is confusion about the term parity of esteem
- In many cases people feel it is a rhetorical phrase
- The lack of clarity creates differing interpretations
- This enables its use in advocacy and self-advocacy
- The term derives from political conflict resolution, but it has not been clarified for use in healthcare

Inequality and the Social Determinants of Health

The social determinants of health underline the concept of inequality. Ten participants out of the twenty-seven openly discussed the social determinants of health and the impact they have on health inequalities. A further ten participants touched on social inequalities but did not discuss them in any depth.

Participant 25:

“there isn’t, um, parity between how, um, families and carers are treated, whether in mental or physical health, due to their kind of social circumstances or their cultural background or ethnicity or kind of social class. And I think what, what’s interesting is, even though that’s an aside, what we tend to see is that the people in society who have the worst mental health or the worst physical health are also those people who are living in the kind of more deprived social circumstances.”

Inequalities in health link to cultural background, ethnicity, social class and deprivation. The participant acknowledges that people with worse mental and physical health frequently experience social inequalities.

Participant 14:

“[...] and not just, um, in terms of their, er, symptoms and their experience and, if you like, their predicament. How they feel and how it is affecting their lives, um, but also, um, some quite concrete indicators; things like employment, um, and social, um, outcomes to do with housing and, er, social support and those kind of things [...]”

Other social determinants like employment, housing and social support mentioned by participant 14 appear important for treating the patient as a part of their social context and not engaging in the mind-body dualistic approach present in some services.

Participant 1:

“[...] you’ve got certain knowledge on, say, specific, like with diabetes, say. Erm, but to understand that what generates good diabetic care, is often understanding psychological and social contexts in which people have their difficulties. And often, those are the key things to improving the diabetic care [...] one of the things that was preventing them getting on top of their diabetes was to understand that they were very upset, or they couldn’t sleep, erm, or they were having trouble with their job, or their relationships at home. Erm, so I suppose in a sense, that, you know, parity of esteem would be, actually, just the mechanics of recognising, in general practice, that to deal with a particular physical problem, required a very good understanding of the social context [...]”

Parity of esteem for participant 1 is the mechanics of recognising that patients do not exist in a vacuum. Gaining insight into their social context and the ways that work, family and other social factors away from the clinical environment interact and exert an impact on both physical and mental health, may improve care and reduce the number of visits. This is about making care more tailored towards individual and their circumstances and not privileging physical health over mental health.

Participant 12:

“[...] know, we need to be looking at these upstream factors and not just, uh, the differences in kind of levels of investment and prioritisation of, of healthcare; but what’s going on in terms of, you know, socioeconomic inequality and socioeconomic circumstances that people live in, you know, uh, what are, what are the conditions that people live and work and playing and going to school in, and how, how did those play a role in the development of health problems with mental and physical, or, or in positive, uh, health and wellbeing outcomes [...]”

Participant 12 uses the World Health Organisation (WHO) Ottawa Charter definition for health promotion where “Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love” (WHO 1986). This view envisages people as part of their social context, paying attention to the social determinants of health and their impacts on health and wellbeing. It also links firmly to parity or equity within the *‘Health for All’* policy and is enshrined in *‘Health 21’* with 21 targets for improving the health and wellbeing of populations included physical and mental health (WHO 1999a, 1999b). Within *‘Health 21’*, health means ensuring health care professionals are trained, skilled and exhibit appropriate attitudes to be able to promote health and reduce inequalities. The WHO argues for equitable and sustainable funding and resources for health services in order to increase access and promote health for the population at country, regional and local levels.

Key points:

- Parity of esteem exhibits a complex relationship with the social determinants of health
- Gaining insight into the social determinants of health for individuals enables the practitioner to view the patient holistically
- Inequality frequently exhibits an impact on physical and mental health and wellbeing
- Parity of esteem means recognising people are a part of their environment and enables more individualised care

Disabling attitudes and discrimination

Barriers to parity were mentioned by seventeen out of twenty-seven participants who when interviewed voluntarily mentioned stigma and discrimination.

Participant 12:

“[...] stigma on a kind of...in terms of your kind of interactions with, with healthcare professionals, especially if they're not mental healthcare professionals, is probably much worse when it comes to mental healthcare, just because there is so much more stigma and less understanding around mental health. [...] I also think [...] because of the societal stigma and internalised stigma that exists around mental health it's obviously much more difficult for people to talk about a mental health problem with their, their partner or their family or their friends. I mean, obviously this is going to vary from person to person and family to family and, you know, culture to culture. [...]”

Participant 12 discusses stigma, but their way of interpreting the term makes it a problem of the individual; it is something within them and a result of their difference. For example, if something becomes internalised, it originates from society and the individual's belief system is unconsciously shaped and mediated by societal pressure and societal representations change their beliefs, becoming a part of who they are. Internalisation is the deepest level of conformity. Therefore, the correct term is discrimination because people receive unfair treatment and frequently exclusion based on differences constructed by society, rather than society being inclusive and celebrating diversity. The process of unfair discrimination involves disadvantaging certain groups of people, discrimination then becomes a source of oppression. Participant 12 underlines that society and non-mental health professionals more readily accept physical health problems compared to mental health problems and the lack of parity between the two, reinforces disabling attitudes towards mental health.

Participant 23:

“[...] I think there’s been times where I think there’s maybe the wrong attitude had been taken to mental health. If... Um, for example, if somebody... I do not know, somebody, um, self-harmed, sometimes the treatments... I have heard staff say, oh no, this person has self-harmed, I am not going to suture their arm, they can just have Steri-Strips. Or, you know, sometimes the, the treatments have maybe...they’ve not had the same choice in treatment, or they’ve said, you know, I’m not going to Steri-Strip...I’m not going to suture them because, you know, they’ve self-harmed, they’ll probably rip it out and self-harm again, so it’s not really worth it. Whereas, you know, if you came in and you had fallen over and cut your arm, you would be asked [...]. You could have this glued, you could have the Steri-Strips, all three options, or you can have this sutured. The patient would be fully informed [...]. At no point would anybody ever say to somebody, well, actually I’m not going to bother suturing your arm because you fell over. You know, [...] that would be very unacceptable. But I’ve heard that happen with mental health patients [...].”

Participant 23 discusses choice of treatment but also discrimination in the lack of parity between a patient with mental health problems requiring acute care and a patient without mental health problems. Inequality occurs in the type of treatment offered, stemming from negative and discriminatory attitudes of non-mental health professionals about patients with mental health problems. Displaying discriminatory attitudes could contribute towards creating a disabling environment for people with mental health problems and this reinforces their own attitudes towards mental health, simultaneously reducing their sense of self.

Participant 5:

“[...] when you choose to work in mental health, you choose to embrace the complexity and the range of the population. [...] one hopes you are less judgemental, although some of the horror stories I hear from people that are in

contact with mental health services, erm, suggest that that's not always the case. But, you know, I think, you have to be fairly tolerant to work in mental health, and you have to get that people vary, and they come from different perspectives. I have had conversations with excellent paediatricians, who I really respect, who kind of bring you up short by coming out with terms like, well that mother is not normal. When actually, I can see what they're saying, and they're not meaning to be discriminatory, and they're not meaning to be pejorative. They are talking about someone who was quite a tricky customer, but if you knew the back story and you knew what they were dealing with and you understood where their anxieties were coming from. Actually, a lot of that behaviour, you know, it, it's kind of a clash of experience and culture. I think as the staff who work with mental health patients often feel a degree of stigma. There was [...] a conversation going on, erm, from a medical student saying how people ahead of them on their course were, you know, circulating tweets and chats saying, you know, psychiatry is a horrible place, and nobody will give you a history, all the patients are violent. You know, it's starting before people even get trained."

Participant 5 suggests that most people choosing to work in the mental health sector embrace complexity and difference compared to health professionals in other sectors. However, mental health training does not always lead to improved care.

There appears to be a juxtaposition between mental health professionals who lack insight about mental health by identifying who is 'normal', using internalised beliefs about normality to guide their thinking. However, this is sometimes unintentional discrimination because they lack cultural competence and are simply unaware of the effect of language on others. There is also discrimination against staff who work in mental health. Further discrimination occurs through their association with people with mental health problems. The discrimination appears to begin during training and perpetuates, fuelling the lack of parity between mental and physical health.

Participant 27:

"I think physical...physical health professionals find it difficult to adjust their individual behaviour and the behaviour of their institutions to match the needs of

people with mental health problems. We adapt less well. Erm, I...I also think it's undeniably stigmatising to have a significant mental health problem. There are myriad examples of how individual professionals shy away from people with significant mental health problems and avoid interacting. As would anyone and as many people do in society."

This participant indicates that non-mental health professionals exhibit difficulties in changing their attitudes, perceptions and ways of working to accommodate people with mental health problems. Again, they talk of stigma when what they really mean is discrimination. Examples of non-mental health professionals avoiding interacting with people with mental health problems are given and excused by likening them to 'anyone else in society'. This deeply ingrained form of discrimination reinforces difference and reduces parity between physical and mental health.

Participant 4:

"[...] problem with mental illness in general is that it is so connected, for example, with, um, one's environment, one's childhood environment, um, one's employment or housing status,...with one's racial identity, um, with one's gender identity. Um, there are so many really, really broad ways that...that, um, that marginalisation I think I would call it, the way people are marginalised in a culture or in a society can contribute to...to really kind of poor access to mental health, um, treatments, or really poor sort of self- stigmatising attitudes, or the way that other people kind of relate to them. It's so broad..."

Participant 4 considers the marginalisation of certain groups and then the complexity of adding mental health problems when people are already experiencing discrimination because of their socio-economic status and other characteristics. For example, disabled people, black, Asian and ethnic minorities, lesbian, gay, bi-sexual, transsexual, queer plus groups (LGBTQ+), homeless people, amongst other groups in society. When you add mental health problems to a person already experiencing discrimination, they experience double discrimination from their original status and their mental health problem. They can also experience multiple forms of discrimination when they have several characteristics that make-up their identity.

Participant 4 suggests that all these factors exert an impact on access to mental health services.

Key Points:

- Discrimination is a source of oppression for people with mental health problems
- Non-mental health workers more readily accept physical in contrast to mental health problems
- The discriminatory attitudes of physical healthcare workers towards mental health drives inequity and reduces treatment choice, creating inequalities
- Staff working in mental health and with people with mental health problems experience discrimination
- Marginalised groups experience multiple forms of discrimination when they have mental health problems

Training and resources

Training

Staff training is an important area if discrimination can be addressed effectively. 10 participants discussed the imperative of training and education of staff, whilst another 20 mentioned resources as part of achieving parity.

Participant 19:

“[...] the kind of obvious standpoint point is, you know, just education. [...]the five years of medical education, a tiny, tiny proportion of it is dedicated to mental health, um. So from what I remember, on the second year we had some lectures on the brain and kind of neuroscience and mental health. [...] you’ll have maybe a four-week, or six-week placement working in psychiatry. That pretty much accounts for the bulk of your mental health education as a junior doctor. If you happen to get a job working in psychiatry or even working with a GP, then maybe you get exposed to kind of a bit more [...] but, you know, that’s a tiny, tiny portion of your medical education as a doctor, um, even though, you know, it’s going to form such a huge, huge part of your career. [...]. So I think, yeah, even just looking at basic medical education, just the amount of time we dedicate to it...er, not at all. In our exams, how often does it crop up? We might get, er, the odd question here or there but it’s not a priority at all [...].”

Participant 19 reflects on their medical training as a doctor and underlines the small percentage of time spent on mental health. Six weeks out of a five year programme is 1.9% in terms of training for a junior doctor on mental health, even though mental health is probably one area that they will encounter with more frequency than other illnesses. The lack of emphasis appears to reinforce the reduced level of parity attached to mental health within the medical curriculum.

Participant 27:

"I think there...there's...there's inherent bias, erm, in the way that we're trained. Some of that becomes subconscious but it's...it's built in. If I'm trained as a physician I'm trained in physical health. I see physical health problems, I have tools at my disposal to address them. Erm, I...I am...I learn to be blind to mental health problems. "

In contrast, participant 27 suggests that training in medicine focuses more on physical health and provides the tools to diagnose and treat physical health problems, but there is a lack of parity when it comes to mental health problems. This lack of priority in training disables medical practitioners because they are not attuned to signs and symptoms.

Fifteen participants discussed Cartesian dualism within medicine, or splitting body and mind, failing to treat patients holistically and acknowledge the synergy between physical and mental health.

Participant 1:

"[...] you know, we're definitely trained in splitting people's bodies and minds. And you can sort of understand how that happens. Erm, but it, but it takes a lot of time to readjust to primary care, then, when you come out of your training, to realise that you've got certain knowledge on, say, specific, like with diabetes, say."

Participant 1 discusses the imperative of training medical staff to consider the impact of mental health on physical health, rather than instilling a biomedical focus on one aspect. Recent adjustments to the undergraduate medical curriculum includes mental health, but perhaps this is not woven into all aspects of the curriculum and separating mental health from physical health further reinforces the divide. Postgraduates would need to enrol on a continuing professional development course (CPD) but this again separates physical and mental health from one another. Nursing training at university divides into mental health nursing or general nursing with separate degrees, this

further emphasises the split in physical and mental health care. Other medical degrees, for example dentistry or physiotherapy focus entirely on biomedical aspects of care and anything non-biomedical appears relegated to a position of little importance.

In contrast, mental health nurses argue that they can sometimes feel under confident providing physical healthcare.

Participant 10:

"[...] don't, as nurses, mental health nurses, feel as confident with physical healthcare as we should, because...or as we could, because we haven't been trained to the level that we need. [...] the reverse is true for, err, adult nurses. Erm, they don't get any mental health training and they're scared [...]."

Lack of confidence in providing physical healthcare for mental health nurses, contrasts with fear for acute care nurses when encountering patients with mental health problems.

Participant 23:

"[...] I just don't know how to deal with a mental health patient. I don't know how to deal with mental health needs, I'm a bit fearful of it. And there's just this real lack of training and understanding of what we need to be doing and we just... I don't know, it's almost like they [nursing staff] just don't understand their needs or they, they feel they don't understand their needs. [...]."

Participant 23 emphasises the lack of training and fear when dealing with people with mental health problems, she reports that her colleagues feel the same way and are at a loss as to what they can offer.

This fear sometimes translates into a lack of empathy for people who self-harm and Participant 8 comments on their observations.

Participant 8:

“[...] the self-harming, uh,[...]. Uh, people who self-harm, you know, they cause it. Th-they bring it on themselves. They don’t deserve our empathy or our...even our kindness. Th-they should, uh, uh, they should just stop doing what they’re doing, uh, then they’d be fine [...].”

Lack of empathy displays poor insight into the feeling of emotional pain someone who self-harms displays. The lack of training about mental health and exposure to people with mental health problems appears to reinforce negative attitudes. This can eventually lead to institutional discrimination and reinforce structural inequalities.

Participant 9:

“[...] it’s the training that we need to give to GPs, whether it’s better tools for identifying depression and I certainly think there is something about the training in terms of talking to people from different backgrounds, some of whom don’t have a word for depression, um, but also, you know, in terms of thinking about, um, the social strata of society, that they’re in a, kind of, very ordinary lay people, some who might be described as, kind of, working class people who might not frame their experiences in a way that would enable GPs to quickly identify that this might be depression [...].”

Participant 9 discusses diversity and the importance of being able to identify the ways people from different backgrounds and cultures conceptualise mental health. For example, in some cultures there are no words for mental ill health and this can be a barrier to diagnosis. *“The use of standardized “Western” assessment instruments poses many risks. It is not simply an issue of language, but rather whether concepts are similar, scales (e.g. True/False) are appropriate, and norms are suitable for other populations. Without this equivalence, there can be many errors in service provision decisions, especially those related to classification, diagnosis, therapy, and medications”* (Marcella 2011, p.6). Training medical practitioners to be culturally competent, instilling the concept of diversity and the myriad of ways people may

present with mental health problems are viewed by participant 9 as an enabler for increasing parity.

Staffing

Increasing the number of staff is a positive example of increasing resources in mental health care. Staff may be said to be the most important resource because they are delivering care.

Participant 20:

“[...] a lot of that stuff knocked around quite badly and how much you had difficulty in recruiting into mental health roles, if you’re really prioritising mental health [...], then you will expect to see people come into mental health as a career [...] I think, er, think some of the, um, while there are big gaps and bits in mental health workforce still, actually it’s a much more buoyant labour market than say, learning disability.”

Gaps in the workforce appear driven by hierarchical attitudes towards working in the mental health sector, viewed as a backwater for a healthcare professional and only slightly better than learning disability. Valuing mental healthcare in the same way as acute services appears to require a complete change of attitude needing leading from the top down and being met bottom up, otherwise disparity will persist.

Participant 10:

“[...] investment in mental health staff being embedded in teams for people with long term mental health conditions. So I can give you an example, X is a mental health nurse working in, erm, err, a renal and dialysis team at Y. X is a fantastic nurse and is embedded in that team, so their job is to look after the mental health needs, well, not...it’s not actually...their job is to consider the...and advocate for the patients within their journey, within...within the renal team. So an incredible measure would be to find out how many [...] physical healthcare teams have started to embed mental health nurses, psychologists, consultant psychiatrists in their teams.”

It is not merely staffing numbers that can increase parity but skill-mix on teams in order for holistic care to be carried out. The example given is the psychological needs of renal patients throughout the treatment pathway and the importance of treating the patient as a whole, with fears, hopes and desires, not merely the biomedical sum of parts.

The mental health estate

Lack of resourcing also affects the physical environment and provision for people with mental health problems.

Participant 6:

"[...] which are often not therapeutic. Um, and often, [...] in facilities that are not fit for purpose. You know, the...we simply haven't had the investment in the, er, physical estate...in mental health, than we...that we've had in much of physical health. It is not to say that the physical health estate is all in good...a good condition, because it is not you know, we still have people on dormitories in mental health. Er, and...and even where they're not in dormitories, um, I mean, [...] we have wards that are not acceptable in this day and age. Um, they are not therapeutic environments. Er, but we can't, er, um, get access to...we...we don't get the permission to invest in new facilities [...]"

Lack of investment often leads to a lack of therapeutic environments to aid people with mental health problems. The lack of therapeutic environments merely reinforces the view that patients with mental health problems are not as worthy as those with physical health problems. In effect, the run down and uninviting physical environment others people with mental health problems, discriminating against them because of their status. This may have an impact on long-term care and recovery and further underlines the lack of parity between physical and mental health.

Funding

Participant 4 saw funding as a resource to improve quality care.

Participant 4:

“(Parity if esteem) is useful in that it draws, it draws attention to the fact that we really need to do something about this massive gap between, uh, between mental healthcare and physical healthcare in the, in the areas of kind of funding and, and quality of care.”

What they also suggest is the gap between acute and mental health funding and the quality of care delivered in each sector. This reflects back to staffing and the physical environment.

Participant 27 argues that the system is constrained in terms of funding.

Participant 27:

“[...] it's very easy to talk the talk but ultimately the resource will continue to go where it always has gone because it's that...in a resource constrained system, if we want to give more to someone else we have to take it from one area and move it to another.”

They also highlight that increasing funding in one area means reducing in another to compensate or balance the books. This suggests that funding for mental health is tight and resources are finite.

Participant 12 reinforces the comments on funding from participant 27.

Participant 12:

“[...] what we focus on (young people) – is so sort of underfunded and under-prioritised compared to, um, uh, you know, the rest of the healthcare system.

Um, and we want to obviously, you know, bring up mental health in relation to the rest of the healthcare system [...]

They also suggest that mental health, particularly for younger people, is not only under-resourced it is also under-prioritised and parity of esteem does not exist. Participant 6 gives more insight into the politics of funding for acute and mental health services and resource allocation.

Participant 6:

[...] each ICS (integrated care system) has a sort of capital spending limit, which has to be shared between its acute hospitals and its mental health trusts. Um, mental health is always, um, a...a relatively small player, er, compared to the enormous expenditure in, er, acute hospitals. [...] So it ends up...it ends up with a tiny, er, er, well, with...with, er, very, er, limited opportunities to be able to get capital projects approved within that spending limit. So again, that's another disadvantage suffered by mental health [...]

Mental health appears to lack the same level of importance as acute services and this limits its ability to gain larger amounts of funding. The funding division between mental health services and acute services further increases the lack of parity between physical and mental health. The prioritisation of acute services, leaves mental health services fighting for any remaining money. Whilst the inability to attain larger levels of funding exists, it appears that the lack of parity of esteem between acute and mental health services perpetuates.

Participant 3 brings in one further issue to do with funding, not suggesting increasing funding but looking at the area differently and managing resources in a more effective way.

Participant 3:

[...] you know, you can keep throwing money at a system, er, but unless you actually, you know, try and manage the system, then it's not going to work [...]

I'm not suggesting more money, just throwing money at it, but it's...it's...but you need to, er...um, you know, see what works locally. ”

Managing systems more effectively may be a more efficient way of conserving finite resources and looking at local provision alongside availability of other community services may be a way forwards. Three participants mentioned working with communities to enable resources and spread the load and one discussed ring-fencing money for service allocation to channel it more effectively. The suggestions both appear to link to the ways management of systems occurs.

Key Points:

- Perpetuating the mind body divide maintains a lack of holistic care
- Training in diversity and cultural competence increases parity between mental and physical health
- Lack of education and training leads to a reduction of parity between physical and mental health care
- Reduced time on the curriculum emphasises a lack of parity between physical and mental health
- Valuing mental healthcare in the same way as acute services increases parity
- Skill-mix on teams creates the potential to increase parity
- Resources appear predetermined and finite
- Resource allocation appears inequitable between acute and mental health services
- Services need more proactive management to ring-fence and better allocate resources

Targets and incentives

Targets serve many purposes; they provide accountability to the government and public, provide a consistent national standard that everyone should work towards, align performance with priorities, improve operational performance and help focus contracts (Berry, Gardner & Anderson 2015, p. 4). Targets are supposed to improve quality of care and there is a large body of evidence that they have made improvements to the English NHS, but simultaneously exert negative and unintended consequences (Bevan & Hood 2006). Nineteen out of the twenty-seven participants interviewed discussed targets and parity of esteem in both positive and negative ways.

Participant 21:

“[...] to focus resources and provision to meet those targets. I think the challenge with it is that you have to have adequate resources to do that, because if you don't, what you're partly doing is you're pulling money away from another part of the system really [...] I think it's helpful to have something that's central and universal. [...] I worry about asking local areas to set their own standards and targets, because, um, my perception is that often, that that will then become, you know, there'll be variation in local determination. Um, and often, the system finds change difficult. So the system generally tends to keep the status quo, and the status quo tends to favour prioritisation in physical health because that's always what we've tended to do.”

Participant 21 discusses the need for adequate resourcing to meet targets and the imperative of not moving resourcing from another area to meet a target. Central and universal targets are important and local areas thought to be too variable to set their own targets. The focus is primarily on physical health and mental health takes a secondary position. The participant touches on systems theory. One of the positives and at the same time drawbacks of a system is that when a system is exporting more than importing it refers back to itself as a means of protection. This is one structural reason why change in organisations can sometimes be so difficult to effect.

Participant 5:

"[...] targets can be a double-edged sword. And, erm, you know, I, I think it needs careful thought. It's not a bad idea. And it would help measure progress, if we're clear about what we're trying to do, and how we're trying to do it. Erm, but we need to be a bit careful that the tail doesn't wag the dog, if you get my meaning, you know, because sometimes what happens then is people only focus on the targets, rather than the bigger picture."

Participant 5 does not discount the utility of targets but urges caution because in some cases they may have unintended consequences. In terms of measuring progress, targets need to be clear and attainable. The main drawback of targets is that people tend to focus on achieving the target at the cost of perhaps following a treatment pathway and perhaps missing stages in order to achieve an initial target. One example of this would be number of people seen within a certain time scale, but then cancelling procedures that are not part of the target such as aftercare.

Participant 8:

"Targets are...targets are really interesting and targets within healthcare [...] I mean, my...my own feeling is, erm, actually targets are q...are quite a good thing, erm, not necessarily because [...] we will meet them but because they help to galvanise thinking. They help...help to give [...] prominence to an area. [...] the thing with the indicators though is I...I think they need to be refined because [...] the indicators are going to act as this kind of galvanising force, erm, around an area that the targets are going to do that so be...be very specific about, you know, what it is you want change, [...] what's a target for that [...] there's a couple of issues. You know, do you set a...a realistic target or do you set a kind of aspirational target, and that...and that's again, a very tricky [...] fine balancing act really, whether you [...] you really want to, make people strive towards it and there...I think there are problems with the second in that it needs much more careful kind of policing, if you like."

Participant 8 underlines the importance of targets for focusing and galvanising thinking around a certain area. Making it more prominent. They then go on to discuss the problems with setting a target as being realistic or merely aspirational in that it may never be achieved. They then question the utility of target setting and propose that more thought around setting targets and monitoring of outcomes needs to occur, although they are uncertain as to the ways this may occur. What they confuse here are indicators and targets, making them one and the same thing when an indicator is a priority area whereas a target is a more discrete measure of something within a priority area.

Participant 15:

"I think you should start with those who have the poorest outcomes and poorest experience, and so you could say targets are more important in terms of mental illness, and targets are more important for particular groups, people in prison, people from diverse background, um, people who are homeless, [...]...we should prioritise, and of course in terms of those with the greatest need, who...people who are most acutely and severely unwell, so I guess you could say, well, crisis and emergency has got to be also a priority within a priority. [...] I think one way of incentivising people [...]...is to show good practice, that if you invest in mental health services there, you can see a demonstrable improvement [...]"

Participant 15 feels that targets are best served when they prioritise and focus on people most at risk and in need. For example, prioritising crisis and emergency care as indicators and developing targets within these areas to improve parity. Providing incentives and rewarding good practice when demonstrable improvement occurs is perhaps a positive way of using targets, rather than punishing when failing to meet them.

Participant 27:

"[...] so targets are incentives, erm, but medicine is very good at [...] and medics in particular are very good at hitting targets [...] but we miss the goal.

So, if you incentivise GPs to perform a mental health review every three months in someone with a mental health condition they will perform the review. The question is will there be a better outcome as a consequence of it? You can incentivise me to do it and to measure it, the question is does it change the world or not. I've done the behaviour, has it delivered the outcome that it's designed to deliver. So I think we need to be a bit smart. I think targets can be helpful, but...but we need to be smart about what they are and don't default to that which is easy to measure.”

Participant 27 reinforces that targets are positive and an incentive when there is clarity about measurement. What is more important is the outcome of reaching the targets and will physical and mental health improve as a result? Alternatively, will a target be met for the sake of meeting a target? Parity of esteem between physical and mental health may meet the targets, but the outcomes need linking to the targets. Measuring areas that are easy such as mortality rates or access can actually be reductive because they become crude indicators of reaching a target, rather than a complex indicator of improvement.

Participant 13:

“[...] one of the things that would make parity easier to achieve is a process of expected integration. [...] if you think we've got, erm...you've got quite...you've got separate financial rules... [...] So if you think one of the things [...] that contributes to the...the lack of parity, is the fact that, hospital treatment is incentivised...according to a payment for activity model. Er, mental health treatment, primary care treatment, er, social care treatment isn't incentivised... [...] er, because they...they're largely paid on, erm...on...on blocks. Er, so the more people you treat, actually, the only thing you can do is negotiate an uplift in the block.”

Using targets on number of people treated and incentivising, or rewarding meeting a target is not necessarily the answer to achieving parity, according to participant 13. This is because incentivising all types of care occurs in different ways. Payment by activity and payment by block both have benefits and drawbacks. The British Medical

Association [BMA] provides guidance on types of payment (BMA 2020): Payment by activity encourages treatment of more patients and reduces waiting times, but the downside is that it does not facilitate more co-ordinated care and it may encourage practitioners to focus on lower risk patients or certain procedures. Block contracts are based on the Barnett formula (Keep 2020) which makes them predictable and reasonably flexible, but how this is calculated varies. For example, the block could be set on measure of need or on historical spend for a service. Another issue is that payment occurs in advance of service delivery, therefore cannot take into account any change in increased patient demand or cost of care. Moreover, they do not incentivise improved clinical care or efficiency. The differences in incentivising care is another explanation on failure to achieve parity between physical and mental health.

Key Points:

- Lack of clarity when setting targets means parity becomes difficult to achieve
- Focusing on a target and missing treatment pathway stages to achieve targets reduces parity
- Incentivising targets means that parity only occurs through the ways incentives are provided
- Targets should not become crude indicators of achievement, but formed from complex indicators of improvement to ascertain parity
- Target setting should focus on people most at risk in an effort to reduce inequalities
- Types of payment to achieve targets may affect parity of esteem

Access to quality care

Access, similar to parity of esteem, is a complex and multi-layered construct, it is far more than physically gaining physical access to services (Aday and Andersen, 1974, 1975, 1981; Andersen et al., 1983; Andersen et al., 2007). In terms of commissioning services, defining access is not a straightforward task instead it appears to be more usefully and practically employed as degree of fit between patients, their supporters and services (Owens et al. 2011). Penchansky and Thomas's five dimensions of access comprise; availability, accessibility, accommodation, acceptability, and affordability (Penchansky and Thomas 1981). Owens et al. (ibid.) identified that one more dimension from the work of Donabedian (2003) could be used within healthcare and that was the dimension of appropriateness to need. The framework offers 6 non-discrete dimensions that frequently overlap;

- Availability: This the volume and type of services in a local area that enable choice and inclusion
- Accessibility: the physical means (transport etc.,) by which an individual reaches services
- Accommodation (adequacy): How easy it is for the client to negotiate transit through services (appointments, referrals, forms etc.) and whether there is a gatekeeper to access
- Acceptability: the level of satisfaction expressed by the patient
- Appropriate to need: obtaining what the patient needs and requires. This includes continuity of care and whether the service provided is appropriate to the needs of the service user
- Affordability: The costs of the service, and ability to pay

Similarly, applying Maxwell's work (Maxwell 1992) and the dimensions of quality care also includes equity. Within all twenty-seven interviews, there were aspects of access mentioned, apart from affordability because NHS treatment in acute and mental health services is free at the point of delivery. The other dimensions that participants failed to discuss were accessibility and acceptability, possibly because they were not service users themselves.

Availability

Availability of services and choice of treatment was frequently mentioned.

Participant 2:

“[...] access to treatment is really important, um, because we need to make sure, but then the danger with that is we get narrowly focused on how many people are accessing psychological therapies, and, um, you know, or something like that. It's got to be of a more encompassing measure that looks at people who maybe don't want to access psychological therapies, but do still want support.”

Participant 2 reflects back on targets but then moves forwards and considers when services are measured in terms of how many people access a service, but choice is forgotten. It could be that people may not wish to access therapy but still want some form of support and this is unaccounted for in the ways service provision is measured. This appears to make it difficult to set reliable indicators because the decision-making rests on areas of prime importance for individual patients.

Participant 25:

“There are programmes, there are individual areas where we can demonstrate efficacy, erm, but the resources are spread overly thin and not everybody can get them. So...and the early intervention psychosis programmes are really good examples of that. There aren't enough of them and...and people can't get at them and, you know, so they're patchy, it's not uniform.”

Again, lack of resources has an impact on mental health. Intervention services for psychosis lack consistency of provision throughout the UK and reflects what some people perceive as a postcode lottery and whether a variety of services are available in the area they live.

Participant 11:

“[...] I think access to treatment is really important, look at crisis services, how easy it is for people with mental health problems and their families to get support, um, when somebody's in crisis, and how responsive is that service, and benchmark that against kind of physical healthcare standards that might be in existence.”

Gaining access to crisis services appeared in 11 out of 27 professional interviews and in three out of the four discussion groups. The lack of support for people and families when experiencing mental health crisis further reinforces the lack of parity between acute and mental health services. Parity in this sense implies a more holistic approach to health services, with a greater focus on prevention and early intervention to reduce the long term impact for people experiencing mental health problems and their families.

Accommodation

The most frequently mentioned dimension of access was accommodation, mostly in terms of waiting to gain access to services and mentioned by 23 out of 27 participants.

Participant 1:

“NICE set that standard out within equality standards, and then the NHSE, through their commissioning processes, and others, other parts of the NHS, took that standard and said, how do we help support this concept of two week access, two week wait [...] in fact, Norman Lamb, the Health Minister at the time, argued, that people shouldn't have to wait longer than they would wait for, for a cancer service[...] people with psychosis, a psychotic crisis, should expect the equivalent, or parity, if you like, of access, as someone with, with a dangerous disorder like, like cancer [...]”

Waiting two weeks when a patient is in crisis is seen as somehow acceptable and equal to having cancer. This appears to be one instance when parity of esteem actually works against people in mental health crisis, it is unclear where the evidence

of waiting 2 weeks when in the throes of psychosis is somehow comparable to having cancer and waiting for a diagnosis or beginning treatment. The 2 week wait appears to reduce mental health into one homogenous mass and pays little attention to diversity of mental health. This hints at a one size fits all approach to mental health, rather than treating on a case-by-case basis.

Participant 3:

"[...] it's no criticism of GPs, but Access Point, which we're...relies heavily on people going through GPs and access in to the system. What you've got to do is have multiple...multiple access points in to the...in to the mental health system, er, which I think at the moment over-medicalises some...some things that perhaps don't need to be medicalised. Um, so, you know, I think, um, advice and support for example, some...you know, some people could perhaps not get pulled in to the system. What you need to do is a triage system whereby the most serious cases where you do need medical intervention and proper, you know, pathways of care put in place...need to get in to the system."

Participant 3 discusses the GP being gatekeeper to mental health care when perhaps there could be multiple points of access. The GP as sole gatekeeper leaves them responsible for possessing knowledge of mental health and recognising when to refer. The participant also appear to be suggesting community support for milder mental health problems away from mainstream mental health services in order to reduce the medicalisation of mental health. This appears to be more about mental wellness than mental ill health. Creating community supports, in theory, could reduce the load on services and effective triaging may mean that only people most in need of mental health services would be referred. Others would be offered alternative support within the community, for example social prescribing or specific support groups. These depend on availability within each area, but Participant 3 argues that more transparent treatment pathways with multiple staging points may help with decision-making over where best to allocate patients with mental health problems.

Participant 5:

"[...] If you have a child who is anxious and depressed, to the point it's getting in the way of their development, and they are ten years old, being on a waiting list for a year, is a tenth of their lifespan...that they've not been functioning for and they pay a very heavy developmental price. That becomes even more so in the teenage years. So, you know, these waiting lists for, erm, psychological therapy, that are kind of six months to get seen for an assessment, and then another internal waiting list of, often, six to twelve months, it's just not acceptable. As it's equally not acceptable for someone with crippling hip pain..."

Participant 5 argues that treating all patients with mental health problems equally actually creates more inequality. They give the example of young people who can experience developmental delay if they require support with their mental health and the pathway to assessment, diagnosis and treatment is too long to offer immediate relief from distress. This then has a long term impact on the young person. They compare this with someone experiencing debilitating hip pain and hint that physical health would be given more priority.

Participant 27:

"[...] there needs to be equity of access to that once you pass the threshold. And therein lies the problem because access for someone with a mental health problem, even to a...a service which has parity of resource, has to be different to someone with a physical health problem. Erm, we need the equivalent of putting a ramp on the staircase to help someone into the building. What's the equivalent for someone who can't get out the house, can't speak on the telephone, whose first language isn't English and has difficulty getting their needs met because they have interpersonal difficulties? Well, they need a ramp as well and they need the door widened, erm, and we don't invest a lot of time and effort in doing that."

Participant 27 suggests discusses treatment thresholds wherein an individual is assessed according to an agreed standard as to a further referral and the type of

treatment that they may or may not receive. When thinking about parity, there is little consideration for individual difference for people with mental health problems when accessing health services. For example, someone with mental health problems who may be unable to leave their home, have a conversation on a telephone, may not speak English as a first language, or who may struggle with interpersonal interactions. However, these barriers all place the problem of access within the person. Using the analogy of putting a 'ramp instead of steps into a building' does not solve the problem of access because once inside a building there are still attitudes to negotiate and the layout inside a building. What the participant is saying, is that services fail to consider diversity and mental health comes in many forms needing different treatment approaches. Similarly, there are multiple forms of bone breaks and different treatment for say a comminuted fracture compared to a greenstick fracture. There also appears to be a suggestion that people with physical health problems can access services far easier than those with mental health problems and rather than link this to individual mental health status, this may link back to discrimination.

Participant 17:

"[...] about two weeks ago, we asked for a CT scan for a patient, which was fine. They went, they had their CT scan. We've now spent a week chasing the team around to try and get the result. So, they have a system within the main hospital where all the CT scans are reported and actually held electronically, but we don't have access to that, we can't actually see that system. We've tried to get access and we've failed. [...] the radiologists are telling us, well we can't give you access to the system, we can't email you the result, and you have to physically come. So, we have to leave our building, walk across the hospital site, go to another building and get the scan result, which they basically printed out. When my junior doctor arrived there they said, oh no, we're not giving it to you. So, they can't email it to us, they can't physically give it to us, they can't put it on the system, so I'm not really sure how we're supposed to access it."

Accommodation can also apply to staff attempting to support patients with their treatment when they are in-patients for mental health care. The issue of confidentiality frequently appeared when staff were refused access to scans and appointments sent

to the patient's home address, even though they were in-patients in a mental health unit. The inflexibility of the systems and the misinterpretation of confidentiality in these cases had an impact on parity of care. If the person had been on an acute ward and scans had been carried out we can question whether there would have been the same response to staff enquiries for the results.

Appropriate to need

Ensuring services are appropriate to need overlaps with accommodation. Participant 26:

"[...] we got better at treating their heart attacks, then we got better at seeing their heart attacks coming and then we got better at having things in place to prevent them having a heart attack. Erm, yet we still have people with psychoses presenting with full-blown psychotic episodes and we need to ask have we invested the same effort in recognising it early, intervening early, or even preventing psychosis by intervening with the factors that we know actually are involved in predicting them. And the answer is, no, we don't."

Progress over time with physical health problems such as heart attacks and strokes using early interventions, health prevention and promotion appears not to be reflected in the treatment of people with mental health problems, particularly people experiencing psychosis and in crisis. This indicates a lack of parity between physical and mental health services.

Participant 25:

"[...] someone presents to the emergency department with, uh, a kind of mental health emergency or mental health crisis and they're treated differently. [...] So, often in emergency departments there will be a particular area or a particular room where someone who is experiencing a mental health crisis, or is presenting with a primary mental health need, will be placed. Often those places aren't very kind of well looked after; they're not very welcoming, they're not very therapeutic."

Appropriate to need is not merely about type of services, it can be the physical environment that can trigger or worsen existing mental health problems. For example, acoustics, lighting, furnishings and patterns on the floor can all affect mental health (Cooper et al. 2008).

Participant 16:

“ [...] inclusivity is just so fundamental to, um, good health and wellbeing, um, so making sure that the patient’s part of that process, and I think they would, um, be able to tell you, um, more about the, um, their needs than, um, than, um, anything else in terms of what they think is, um, affecting them at that time.”

The process of including the patient and making them the centre of the process, which is fundamental to patient-centred care, is viewed as the best way of addressing needs for participant 16. Patient-centred care fails to be mentioned in 25 out of 27 interviews and many participants focused on the barriers to treating people with mental health problems, seeing them as objects of care rather than involved partners. Patient centred-care developed from the 1980s and positive impacts of this type of care is discussed in medicine (Stewart et al. 2003). Despite the move towards patient-centred care, getting to know the patient as a person is only mentioned in four interviews.

Key Points:

- Availability of Services appears patchy and inconsistent
- Availability is measured by physical access, not choice
- Waiting 2 weeks to access mental health services when in crisis suggests parity of esteem works against people with psychosis
- Treating people with mental health problems equally creates inequity
- Lack of parity emergencies when individual differences fail to be considered
- People with mental health problems appear to be viewed as objects of care rather than active partners which can lead to inequitable treatment

Integration and collaboration

Integration

Integrated care is a somewhat benign concept and means that care should be joined up and carefully planned around individual patients. The Five Year Forward View [5YFV] (NHS England 2014) promotes integrated care and proposes new models of care. The main models were the Multispecialty Community Provider (MCP) model, in which GPs and other community based health practitioners (e.g. district nurses, pharmacists) form an organisation that provides most out-of-hospital care for a registered list of patients. There is also the Primary and Acute Care System (PACS), where a single organisation provides GP and hospital services, together with specialisms such as mental health and community care. This is similar to the model in the USA. Some positive examples of integrated care which addressed physical and mental health were given by healthcare providers.

Participant 17:

“[...] they do simple things like do they access a dietician, do they get to the optician, do they see the podiatrist, do they go for their regular physical health checks. They should have an ECG and bloods taken at regular intervals at least once a year. People with bipolar disorder and schizophrenia should have that in general practice. And, and there was a QoF around that, but that’s been removed. So, the drive from GPs to do that has disappeared, so we’re having to push them now to do that.”

The focus on physical and mental health was incentivised by the introduction of yearly health checks, particularly for people with ongoing mental health problems. Removing parts of the Quality Outcomes Framework (QoF) that address this area hints that GP’s anecdotally are less inclined to carry out routine checks because there is no incentive. Whether this reduces the importance of parity and whether all GPs cease to focus on an area because of removal of an incentive, or whether GPs acknowledge the importance of yearly health checks and continue without incentives is unknown. The

importance of yearly health checks enables prevention of health conditions from worsening or reaching crisis. The importance of prevention and health promotion was mentioned by 17 out of 27 participants, but few had any suggestions as to how this may progress.

Participant 1:

"[...] I think the issues often are for the Health Service, so you know, Health Service, here, I'm looking at a combination of integration between dental services, primary care, for instance, social care [...]"

Integration between services can often be problematic when they are all commissioned and funded differently. However, it is not only funding, it is care pathways and consideration of holistic treatment and assessment. For example, dental care is frequently omitted from any assessment, unless it forms part of an oral cancer pathway. Salaried services in dentistry could, in theory, be part of the assessment pathways but commissioning of services, funding, referrals, waiting lists, staff training and service organisation may prove to be barriers to parity. There is also the issue for general dental services which are becoming increasingly privatised and are no longer free at the point of access, unless patients are referred for secondary care at a dental school. People who experience social inequalities are less likely to access dental services because they cannot afford them.

Participant 7:

"[...] the very concept of parity assumes that two things are like mutually exclusive opposites or like separate categories and the whole point about trying to achieve more integration between mental and physical health is that we want to try and breakdown that dichotomy between mental and physical health [...]"

The dichotomy between mind and body and the way healthcare providers are educated to think in these terms is seen as a contributory factor to the lack of integration between acute and mental health care. The term parity of esteem in this case becomes a barrier itself because for parity to exist there needs to be a lack of

parity.

Participant 8:

“I mean, to me the positive change that needs to take place, um, that would improve mental health would be, um, better integration with the community. That actually that applies to all long-term conditions. Long-term conditions, including mental health conditions, occur in the community that the individual lives in and in many ways, you know, respond to the quality of interpersonal relations that the individual has with the people that surround them. Then I would say this more a, a place based...what’s called place based care, is a step towards that.”

Integrating health services within the community is linked to developing a supportive environment for all individuals and making more cohesive communities. The concept of place based care is suggested in order for people to receive care where they live and be surrounded by families and friends to extend that supportive and caring environment. This reflects the neoliberal aims of the Conservative government’s ‘Big Society’, where social solidarity became based on hierarchy and voluntarism. This placed the basis of societal organisation firmly in the hands of community, the family and voluntary groups, viewed as buffers against the power of the state. The problem with this positioning is that it pays insufficient attention to existing inequalities such as wealth, free time and social power. The reduction in public funding further compounds the situation. Furthermore, the illusion that there is a zero-sum relationship between society and the state, as evidenced through the reduction and sometimes removal of state funding. That this will spontaneously create more community participation and integration of health, may actually contribute towards greater inequalities. Therefore, the notion of integration requires careful thought as to both its meaning and implications of any actions in order to democratically promote and sustain the well-being of communities.

Participant 25:

"[...] of micro level kind of at an individual team or professional kind of level where again I think the, the, the focus on integration intensifies even more I believe. So, how are we kind of equipping the current workforce to, to understand that when we're treating people we're treating them as a whole, even though we might have been trained in a particular way [...]"

Treating people holistically and using a team approach appears to be an ethos requiring a change of thinking and organisation in the ways health services are delivered. Multi-disciplinary teams are not a new concept, but the ways they work in terms of being more integrated may perhaps need some adjustment. This may prove to be challenging in today's climate of austerity.

Collaboration

Definitions of collaboration in healthcare differ, but common themes are that it is an integration of activities and knowledge requiring partnerships sharing authority and responsibility (Morley & Cashell 2017). This can be about inter-professional collaboration where ideally care is delivered by a multifunctional team who work together as a compete unit to provide quality care for patients.

Participant 5:

"[...] work collaboratively, and you know, with, with mental health practitioners, and really, really see it as, it's important. And there are others who, you know, keep on investigating, erm, youngsters with medically unexplained symptoms, or persistent symptoms that, symptoms that they don't understand, in the kind of hope they'll go away because, you know, they just don't quite know what to do."

Lack of parity occurs when healthcare practitioners fail to include different perspectives from other specialities, particularly young people, by acknowledging the limits of their practice. Building collaborative teams is highly complex and perhaps not without its challenges, there is little evidence as to what degree collaborative practice is possible.

Collaboration is not merely about healthcare providers, it is about including everyone possible in the life of a patient to gain a holistic view of their circumstances. It is about choice and shared decision-making. Families and their importance were mentioned by 21 out of 27 participants. They were also mentioned in three out of the 4 discussion groups. One particular discussion group emphasised that the 'right questions' need to be asked and this could only occur when service providers requested the input of immediate family members in order to build a clearer picture of an individual. This triangulated with comments from some of the healthcare providers.

Participant 13:

"[...] if it's going to be meaningful then, erm, you...you know, I think you've got to start with the, er, you know, with the service users, their families, er, and the professionals that are directly that are directly involved in the, erm, you know, sort of, coordination and delivery of their care and support."

Collaboration here appears to be important in order to effect service co-ordination and delivery. Without the support of families, professionals may struggle to deliver effective care.

Participant 1:

"[...] family members are a really important part of navigating the health systems, advocating for the health systems, reminding the health systems, they alert if there's a problem going on, we often supervise the treatments. So it's kind of collaborative. I mean, obviously it has to be whoever's going to be funding the service as well needs to be involved with...and other key

stakeholders, but I think sometimes we get it wrong, because we don't ask the right people. Um, or, um kind of, um...someone within the healthcare system might have a view that actually, you know, they might think they understand say the needs of somebody with anxiety, but they don't really fully get it, and they might have missed something really important. So it's so...it's so critical to actually speak to the...the people who have the conditions."

The importance of collaboration with family members is apparent and the issue that sometimes a wrong diagnosis is made because of assumptions about an individual. Gaining a more holistic view, as well as including the voice of the patient in diagnosis means enforcing what it means to collaborate and take different perspectives into consideration. The initial time invested in exploration may eventually save time and money in the long-term.

Key Points:

- Lack of integration appears to be a barrier to parity
- 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
- Collaboration and integration are linked
- There is little evidence as to what degree collaborative practice occurs and indeed is possible
- Collaboration also means including family perspectives to build a more holistic view of the patient

Discussion

The aim of this study was to explore parity between physical and mental health, whilst providing insight into some of the barriers to its development. The first area to be explored were healthcare professional insights around the term parity of esteem. What this study identified was that although many healthcare providers used the definition supplied by Royal College of Psychiatrists, in reality they found the term to be confusing, vague and lacking in clarity. The multiple constructions of its meaning makes it difficult to enforce and fails to indicate how parity may be achieved in practice (Millard & Wessley 2014). In contrast, others felt the lack of clarity was useful because it meant the phrase could be used to challenge services and advocate in terms of more equitable provision.

The main issue is that the term parity of esteem has been appropriated from political theory, it is about the vertical relationship between citizens and the state (Ruane and Todd 1999). This is where the state assumes responsibility and citizens can hold the state to account, but to do so they must be aware of their rights and choices. In essence, it is a political ideology, belonging to a particular context, mainly about the treatment of Irish Catholics and British Protestants living in Northern Ireland and the struggle for recognition (Thompson 2002). It is about identity, or the politics of recognition in that the traditions of the two groups need respecting and protecting, this focus made the relationship a horizontal (or mutual) one between citizens which the state would monitor, but not be held accountable. The phrase parity of esteem appears in paragraph 1 section v in the Belfast, (or Good Friday) 1998 Agreement in that the British and Irish governments:

“affirm that whatever choice is freely exercised by a majority of the people of Northern Ireland, the power of the sovereign government with jurisdiction there shall be exercised with rigorous impartiality on behalf of all the people in the diversity of their identities and traditions and shall be founded on the principles of full respect for, and equality of, civil, political, social and cultural rights, of freedom from discrimination for all citizens, and of parity of esteem

and of just and equal treatment for the identity, ethos and aspirations of both communities” ([The Belfast Agreement - GOV.UK \(www.gov.uk\)](http://www.gov.uk))

Within the Belfast Agreement, parity is placed side by side with other principles; freedom from discrimination, equality of rights and equality of opportunity. Gay Rights campaigners later used the phrase and education used it for parity between universities and technical colleges and between academic and vocational qualifications. This meant a shift in meaning from equal consideration of Catholics and Protestants to equal rights for people of different sexual orientation to equal treatment of different types of educational institution and courses.

Using parity of esteem for healthcare we could argue that whilst it is a worthy goal, it is merely political rhetoric given that there has been little consideration of its origins and whether it is about vertical or horizontal relationships. Furthermore, we need to consider the state’s increasing focus on the marketisation of healthcare (Cribb 2008), the reduction in funding for essential services and increasing fragmentation of the NHS. If we perceive parity of esteem as a horizontal relationship, whereby the state monitors but no longer becomes accountable, then the cynical views of some participants, in that it is a way to avoid spending money, appear to ring true.

Over a decade ago within the discipline of education, the Nuffield Review suggested dropping the term and instead of attempting to apply it to academic and vocational qualifications, more focus placed on inequality.

“Perhaps the search for parity of esteem [. . .] is not so much a false as a meaningless aim. There are different kinds of learning experience, different kinds of courses. [. . .] rather than pursue parity of esteem in a highly divided system (with all the fabricated equivalences which that entails), the basic structure of the qualifications system has to be addressed.” (Pring et al. 2009 pp. 7–8)

Within health, there are a multitude of experiences of services and no 2 conditions are the same. Given the lack of consideration for its origins and that there is confusion around parity of esteem, it may be pertinent to suggest that it is given less policy space

and instead more focus is placed on addressing inequity and the inequalities which contribute towards ill health. This, of course may be a double edged sword because parity of esteem keeps the focus on services and their lack of resources, whilst simultaneously individualising mental health. Only a small proportion of mental health problems are genetic and mental health is often couched in terms of illness, not wellness making parity of esteem and mental health the problem of the individual, not an issue of wider society and socio-economic issues such as poverty, deprivation and lack of support amongst other determinants of health.

The social determinants of health are about inequality, these were discussed by participants and given that these may be addressed by political means this indicates that health itself is profoundly political. Marmot amongst others, have already laid the precedent for socio-economic inequality and the social gradient as being the root cause of physical and mental ill health (Marmot, 2016; 2015; World Health Organisation 2014; Wilkinson and Pickett 2009; Marmot & Wilkinson 2006; Marmot & Siegrist 2006; Marmot 2005; Wilkinson & Marmot 2003). Although Greater Manchester declared itself to be a Marmot Region in 2019 and pledged to reduce inequalities, these still appear to exert an effect on resident's health and wellbeing with an increase in mortality for age groups below 50 (Marmot et al. 2020). This figure suggests that an indicator of parity may be a decrease in mortality rates for people below 50 years of age. Participants in this study recognise that taking a more holistic approach with patients, viewing them as a part of their social environment and the ways that this exerts an effect on them, increases parity. Service users said they were at a disadvantage because they sometimes lacked the educational background to assist in accessing services. Other service users and carers explained that characteristics they possessed, or competing identities, often led to multiple forms of discrimination.

Discrimination and disabling environments were mentioned by healthcare providers, service users and carers. Discrimination is preferred to stigma because stigma implies that there is something wrong with the person, whereas discrimination allocates the term to individuals, groups and society where it is practised (Sayce 1998). Examples of discriminatory practice were given by participants ranging from withholding of treatment choice because of assumptions about mental health status, non-mental health workers being more ready to accept physical in contrast to mental

health problems, staff experiencing discrimination because they worked in mental health and with people with mental health problems and lastly, people from marginalised groups with mental health problems experiencing multiple forms of discrimination as different aspects of their identities intersected. Previous research suggests that being black, female and lesbian constructs multiple identities at the macro level which then link with structural level inequalities such as poverty, racism and sexism (Bowleg 2008; 2012). Intersectionality has been used as a framework to explore the social determinants of health and in research exploring disparities or differences in a variety of health beliefs, behaviours, and outcomes, including mental health (Seng et al. 2012; Rosenfield 2012). Discrimination plays a role in explaining health inequity between dominant and marginalised groups (Grollman 2012). In other studies, discrimination intersected with race and sex to create multiple forms of discrimination, exerting an impact on mental health (Vu et al. 2019).

In England, most mental health funding is not ring-fenced. Local Clinical Commissioning Groups (CCGs) must determine their own budgets for mental health from the overall funding allocation received from the government. CCGs are expected to meet the 'mental health investment standard'. This means that their mental health budgets must grow each year by at least the same percentage as their overall funding allocation. The Marmot Review of Health Inequalities suggests that, as a result of the localisation of health spending, service cuts have been most severe in regions of the UK that have also experienced the highest levels of socioeconomic deprivation (Marmot et al. 2010). The follow-up review ten years later suggests that this has worsened, particularly for areas that experience higher deprivation, with Austerity measures taking their toll on the health of the population (Marmot et al. 2020).

Participants in this study all mentioned training and resourcing as barriers to effective care. Compartmentalised staff training on both mental and physical health increased inequity and the potential for discrimination. Acute care staff needed training in cultural competence and mental health awareness in order to reduce discrimination and increase diagnostic efficiency. Mental health staff needed general training in physical health care in order to improve the holistic health of patients and knowledge of when to refer to other specialities.

A lack of investment in environments, particularly for mental health, reinforces the view that people with mental health problems are somehow less worthy than people with physical health problems. This increases the potential for discrimination because it reduces the status of a person with a mental health problem. It also provides environments that have little therapeutic value and can actually add to people's problems. A reported lack of funding in children's and young people's services suggests the creation of long-term problems for the future. Inequitable resource allocation between acute and mental health services merely widens the inequality gap and some participants felt that existing resources could be better managed to improve service delivery.

Resources are linked to targets and incentives set by the state and although they can be useful, this study supports existing research in suggesting that they can also have unintended challenges. For example, over-focusing on the target at the detriment of other areas, or targets being hit, staff performance improving but with little improvement for the patient (Berry, Gardner & Anderson 2015). Incentivising areas can also be problematic when incentives are offered for practitioners to carry out something they do not believe in. Participants in this study echoed previous research in their observations and felt that targets were crude indicators in many cases, lacking in clarity. They also felt that targets needed to be more complex indicators of improvement in order to ascertain parity. Targets for accessing services were mentioned by most of the participants, but varying aspects of access, outlined in quality care, appeared in their narratives which questioned the notion of parity.

One problem with equal access is that the same medical condition may require different provision of health resources to achieve the same health outcomes (Ruger 2010). This takes us to horizontal and vertical equity. Horizontal equity requires equal treatment for people with equal needs, whereas vertical equity requires different amounts and levels of services for people with different needs. Under the NHS, health care is subject to medical necessity and appropriateness as determined by doctors and patients. This means people are entitled to the same sets of treatment, rather than a variety of treatment offered. People in discussion groups offered narratives of remaining within services for up to four years, with declining mental health, before acquiring a treatment that worked. They reflected as to whether offering a more

expensive treatment from the outset would have saved four years of treatment. Others said that having enough information and being able to weigh up the benefits and risks, in order to make an informed choice, was often a problem. Even though guidance is available for service commissioners and providers about improving access to psychological therapies (IAPT), this was originally published in 2018 and updated in 2020 (National Collaborating Centre for Mental Health 2020). With COVID-19 and the population of the UK being in lockdown for nearly 18 months from March 2020, it may be a little disingenuous to say this area lacks equity. Being able to vary what is offered to patients and working with them to provide acceptable and appropriate treatment may assist in the provision of equitable quality care.

Access in terms of waiting times was mentioned by participants and although some services are subject to maximum waiting time standards and targets such as psychological therapies and early intervention for psychosis, with a maximum wait of two weeks from referral to start of treatment (NHS England 2016). This does not cover all services, for example Accident and Emergency. Another problem with a two-week wait for treatment of psychosis is that the condition can escalate to crisis level in that period. This is where parity becomes a barrier to effective care. The two week wait has been paralleled with cancer services, but the evidence behind making people with cancer and people with psychosis wait an equivalent length of time before treatment begins is non-existent. There appears to be no comprehensive evidence of how long people wait to access mental health services and the ways this may vary across the UK. Furthermore, length of time waiting for a bed for mental health care appears longer than for physical care. This indicates a lack of parity between acute and mental health services in terms of waiting times.

Access is also about accommodation and considering diversity with mental health patients. For example, staff were unable to obtain scans for a patient in the same hospital grounds because the patient was a mental health in-patient and confidentiality and governance of information became a barrier. Configuring data sharing between healthcare professionals about patients offers the potential to deliver equitable care. Appropriate to need also appeared in interviews about the physical environment not being therapeutic for patients with mental health problems. Viewing patients as recipients of care, instead of partners in care, particularly when they had a mental

health problem led to inequity. Part of the problem was training; the other part was a lack of commitment to collaboration.

Integrated care involves physically co-located mental health and primary care providers working as a team from a shared treatment plan (Peek 2013). Arguably, this improves equitable access because it makes services available in nearby primary care clinics, whilst improving cultural access by providing mental health treatment during the primary care encounter (Fortney et al. 2015). It can also occur through inter-professional collaboration, where practitioners pool a range of skills and training to provide quality care for patients (Meredith & Mantel 2012; Parker et al. 2012). Integrated care in this study appeared patchy and lacking in enough resources (staff, funding etc.) to increase parity of access and treatment.

Collaborative care can also occur through discussions with families and people of importance in the life of the patient, it is about partnerships and people working together to achieve the same goal (Morley & Cashell 2017). In this study, discussion group members said healthcare professionals frequently failed to 'ask the right questions'. Healthcare professionals were unsure as to the degree of achievement for collaborative practice. All of these areas together suggest parity may be challenging to achieve.

Summary

Parity of esteem is a confusing concept, lacking in clarity, rhetorical and highly political. The lack of clear definition appears to hamper the ability of services to move forwards and offer equitable provision. Participants in this study were unsure as to what could be reliable indicators and ways of applying and measuring them. Various themes emerged from the interviews; each theme indicated that there was a widening gap in equality for mental health in particular. Despite policy guidance, there was limited evidence of achieving parity. The disparity in funding between mental and physical health services, reduced staffing levels, lack of therapeutic environments, inadequate training and patchy availability of services all reinforced the challenges of parity between physical and mental health.

Limitations of the study

The issues raised in this study could have been influenced by the interview schedule, which may have limited the exploration of other areas participants felt to be important. Although the study attempted to be as inclusive as possible, the voices of people with learning disabilities were completely absent. This partly resulted from the study taking place during the COVID-19 pandemic alongside lockdown in 2020-2021 and its associated restrictions. Although some people with learning disabilities can use media such as Zoom, when approached they did not feel happy with this medium to take part in a discussion forum. Many articulated they would prefer one-to-one discussions, but ethical approval for the study did not cover this method for service users.

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Appendix 1

Topic guide

Tick when discussed	
<input type="checkbox"/>	Purpose of the interview
<input type="checkbox"/>	Duration
<input type="checkbox"/>	Audio-recording (or 'Zoom Recording')
<input type="checkbox"/>	Confidentiality
<input type="checkbox"/>	Consent form
<input type="checkbox"/>	Questions (including review results)
<input type="checkbox"/>	Priority Setting Event

Section A: Definitions		
	Are you familiar with the term 'Parity of Esteem'? <i>Follow up:</i> How often have you heard or used the term 'Parity of Esteem'?	

	What does the term Parity of Esteem mean to you?	
	Is there a definition of Parity of Esteem that you typically use/ refer to?	- Do you think this definition works well? If so, why? If not, why?
Section B: Views on the concept of POE		

	What do you think about the concept of Parity of Esteem? Follow up: Do you think there should be parity between mental and physical health?	- If considered useful, why - If not, why not? If not, why not? Which should take precedence?
	Do you think that mental and physical health are given the same priority in [add interviewees profession?]	- If not, why not?
	Do you think there are any circumstances in which mental and physical health may be treated differently?	- Why? -Do you think this is important? Why/why not?
	Do you think there are any disadvantages to applying the concept of Parity of Esteem to our NHS services?	- What are the advantages?
	In regards to current policy, is there an alternative approach that could be used to improve the quality of mental health services?	
Section C: Indicators		
	What would Parity look like in a patient's day-to- day interactions with the NHS?	-Mental health services, primary care, other services
	What does a lack of Parity looks like in day-to-day interactions with the NHS?	
	Do you think there is parity in how families and carers are treated between physical and mental health?	-If not, why not?
	Based on what you have described, what indicators do you think can be used to measure progress towards achieving Parity of Esteem?	-Health outcomes, healthcare service outcomes, process outcomes)
	Are there any indicators which you think should be prioritised (are more important)?	- If so, which ones and why? How easy would these be to monitor?
	What are you views on attaching specific targets to these indicators? Follow up: Who should set these targets?	- -If useful, why? If not, why not?

Section D: Review

We have conducted a systematic scoping review of Parity of Esteem in the context of healthcare and have identified a number of indicators from the publications included in the review which we would like to get your views on

	List Indicators not already mentioned by interviewee (or use indicators table to ask about indicators not mentioned) A B C D E F G H	-If considered a useful indicator, why? -If not considered useful, why? - How do you think this should be measured?
Section E: Implementation and accountability		
	Who needs to decide and review what the indicators are/ should be?	
	Should indicators be prioritised the same for all services/health conditions?	-Is parity absolute or relative?
	What are the challenges to implementation?	
	Whose responsibility is it to measure progress towards achieving parity?	
	Whose responsibility is it overall to deliver on parity?	-How best to incentivise progress towards parity/ or punish lack of progress
	Can parity be achieved within existing legislation/guidance?	- Or is something else needed?
Section F: Sampling		
	Is there anyone else (or organisation) that you think we should be talking to?	

Thank for their time and ask whether they would be interested in attending the Priority Setting Event.

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