Parity begins at home: with you and with me.

Parity – the state or condition of being equal. The Royal College of Psychiatrists describes parity of esteem as ‘valuing mental health equally with physical health’.

Parity in mental health is about many things – reducing stigma within the NHS; putting training, funding and commissioning on a par with physical health services; addressing both the physical and mental health needs of patients; having equal access to crisis care and waiting times for treatment; investment in research and the Government putting in place policies which realise their promise of parity of esteem.

Parity begins at home: with you the profession of psychiatry

Parity begins at home with you, making sure your own house is in order, enabling you to be robust players within the healthcare system.

Dame Sue Bailey said in October, 2013 – ‘achieving parity of esteem between mental and physical health is everybody’s business and responsibility.’

Confidence and identity.

Last July, at the Refocus on Recovery Conference in London, I listened to Professor Mike Slade talking about the challenges that parity bring. I had a conversation with him afterwards about what he had said and he told me that ‘there is an inherent stigma in the medical field and the divide between the discipline of psychiatry and the rest of medicine is becoming bigger. Psychiatry should develop and present the case where its role can evolve and bring other areas of medicine on a forward journey, enabling empowerment as opposed to disempowerment. Psychiatrists could show leadership in driving things forward.’ Dr Glen Roberts at the same conference spoke of ‘the challenge for psychiatry in taking ownership for change.’

In an article entitled ‘Wake-up call for British psychiatry’ a group of psychiatrists commented that ‘British psychiatry faces an identity crisis – a major contributing factor has been the recent trend to downgrade the importance of the core aspects of medical care. The devaluation of medicine is damaging our ability to deliver excellent psychiatric care.’

We know that the continuing advances in molecular biology and neuroscience will enhance understanding considerably and allow for the development of new treatments. People with moderate to severe mental illness should be able to have a referral and access to a psychiatrist for a psychiatric assessment, diagnosis and treatment. The use of evidence-based psychological and social interventions are also important options for the treatment of mental health conditions.

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In my view it is not either/or with these two camps of thought in psychiatry, it is both/and. A range of treatment options should be on the table for each patient which will result in a more sustained recovery outcome.

A robust professional identity enables doctors to take responsibility and leadership in psychiatry as a medical specialty and as an equal player in the spectrum of medical specialties. This boosts confidence and could impact the recruitment and retention of doctors in choosing psychiatry as their specialization.

The current developments in psychological medicine and working within multi-disciplinary teams are evidencing consistency of care, sustainable outcomes and parity at work. Professor Michael Sharpe commented last year on ‘the growing demand from both clinicians and patients for more integrated and patient-centred care. The benefits of such integration of psychiatry into other areas of medicine for both the patients experience of medical care and clinical outcomes are starting to be confirmed by research.’

Recruitment and retention.

Recruitment numbers into psychiatry are not sufficient to meet the growing demand in mental health care. Recruitment, training and retention are key life-lines in psychiatry; they need to be fit for purpose. This should include a selection process based on character and attitude as well as grades.

A study carried out by Curtis-Barton and Eagles highlighted 3 main factors that discourage students from a career in psychiatry; the standing of psychiatrists among the medical profession and the general public; a perceived lack of evidence base for psychiatry; and the prognosis and outcomes for patients in psychiatry.

Experience of psychiatry in the foundation years of training is important. Placements have often only occurred in the last two years of medical school. Kelly, Brown and Carney have shown in a review that doctors who have a psychiatric placement during the foundation years are 8 times more likely to enter psychiatry specialist training than those who do not. The recent Shape of Training Review has highlighted the need for doctors in all specialities to have more training in caring for patients with mental health conditions and also concluded that psychiatrists need more training in medicine. This would help considerably towards achieving parity and mutual respect in the medical profession.

Parity begins at home: with me the patient

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Partnership and responsibility.

One of the 3 main principles of the current Prudent Healthcare Government policy in Wales is to promote equity between professionals and patients.9 ‘Doing with, not doing to.’

Parity involves partnership and co-production between the psychiatrist and the patient, a shared ethos and a shift in balance and perspective. It requires a greater degree of ownership and responsibility on the part of the patient in the journey towards recovery from illness. The psychiatrist is an expert with knowledge and training, the patient is an expert by experience. Some of the time, the patient is the clinician as a result of very little clinician contact time. The patient must also be a provider, taking responsibility and discovering what they can do for themselves towards recovery from illness and long term maintenance of good mental health.

Stigma and resilience.

Stigma goes hand in hand with mental illness. I have often encountered it over the 40 years of living with a chronic mental illness. I try to use these occurrences as opportunities to address the stigma as I have experienced it. At my first Committee meeting with a group of psychiatrists recently, I experienced a ‘highbrow’ form of stigma. I had prepared thoroughly for the meeting and contributed to the discussions during the morning. After lunch, the psychiatrist sitting beside me, we had not yet been introduced, turned and said to me in a patronising tone ‘you are very well read’

Why is the phrase ‘a mental health problem’ the one frequently chosen when referring to mental illness and mental health issues? We do not refer to physical illnesses and conditions in this way. “I have Crohn’s disease” not “I have a Crohn’s problem”; “I have ovarian cancer” not “I have a cancer problem”; “I have a diabetic condition” not “I have a diabetic problem”. In mental illness, people suffer with a specific illness; they have lived experience of mental and emotional distress. They have mental health issues; they deal with mental health conditions, disabilities and disorders. We are not people or patients with ‘a mental health problem.’10 The phrase is used regularly in mental health policy and service delivery, and this terminology needs to change if parity is to be achieved within the language used in healthcare.

Paying attention to what builds resilience which enables good mental health and wellbeing is a key component for me as a patient. I strongly believe that building resilient communities and promoting wellbeing should be a priority with accompanying resources, not just in mental health policy but in all aspects of public health policy and layers of service provision.

Conclusion

10Richards, V., 2013.Respect and dignity through the use of language, Mental Health Today, July/August, p.7.
We are all familiar with the statement in the Bridging the Gap Report: ‘Almost one in four British adults and one in ten children experience a diagnosable mental health problem at any given time’\textsuperscript{11}(note the use of the phrase—a mental health problem) This is a large section of the population.

I think that the contribution you make as a profession to the health of the nation is often underestimated and under-valued. Psychiatry is the medical speciality best skilled to enable recovery from mental illness and it has a major input and influence over the quality of care and outcomes for patients. It is a key participant in the health and wellbeing of our society.

Professor Kamaldeep Bhui summarised this point well in a recent British Journal of Psychiatry ‘The profession of psychiatry requires the brightest and the best, the most ethical and the most progressive to continue a journey towards the most humane and hopeful ways to recovery, while also helping the wider population to better understand the mind and how to look after ourselves, our families and our communities.’\textsuperscript{12}

The NHS will increasingly be faced with making choices that will influence its sustainability. You and I are both key stakeholders in this healthcare system. This will bring challenges, opportunities, potential, ownership and responsibilities.

What will our engagement and commitment be in this process of moving towards achieving parity of esteem?

Do we need to refresh our vision?

Parity begins at home: with you and with me.

Veryan Richards
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veryanrichards@aol.com

This paper will be presented at a plenary session entitled ‘Parity of Esteem’ at the International Psychiatry Congress in Birmingham, June 2015. Dame Sue Bailey is to Chair the session which will be addressed by 4 members of the Royal College of Psychiatrists Service User and Carer Fora in London.

\textsuperscript{11}RCPsych, 2013. Bridging the Gap: The financial case for a reasonable rebalancing of health and care resources. London: RCPsych

\textsuperscript{12}Bhui, K., 2014. From the Editor’s desk.205(5), pp.421-422.