Bridging the Gap

Strategies to Reduce Health Inequalities and Improve Life Expectancy for Individuals with Severe Mental Illness in England

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Introduction

In England, at least 580,000 people are recorded as living with a Serious Mental Illness. The actual number is likely higher, as these figures are based on General Practice registers, which may not fully capture everyone affected.[1] Serious mental illness (SMI) refers to mental health conditions that cause significant functional impairments, disrupting a person's daily life and activities.[2] Examples of SMI include schizophrenia and bipolar affective disorder.

Significant physical health inequalities exist between those with and without SMI in the UK, with those with SMI having significantly worse outcomes and reduced life expectancy. People with a SMI have a life expectancy of between 15-20 years less than for someone without a SMI. NHS data shows that between January 2021 and December 2023, 130,106 adults in England with SMI died prematurely, before reaching the age of 75. This means that you are five times more likely to die prematurely if you have a SMI.[3] Within this population, there are further inequalities for individuals with SMI from more deprived backgrounds and from ethnic minority groups. Those from more deprived backgrounds have a four times higher risk of premature death than for those from more affluent groups.[4] Black women with SMI are significantly more likely to be diagnosed with two or more physical health conditions compared to White British women with SMI.[5]

The mortality gap for individuals with serious mental illness is not due to suicide. The evidence shows that this disparity is largely driven by preventable physical health conditions. Approximately 66% of premature deaths are linked to avoidable physical diseases.[6]

In the UK health policy is devolved. As a result, considerable efforts have been made in England to address and reduce this mortality gap. Improving mental health and addressing premature mortality among people with SMI was identified as one of Public Health England's top ten priorities in its 2020-2025 strategy.[7] In

recent years, enhancing the physical health of individuals with SMI has also been a key focus for the NHS.[8]

Despite action, the data shows an increase in premature deaths for those with SMI due to cancer, cardiovascular disease, liver disease and respiratory disease.[9] More needs to be done to achieve better physical health outcomes for those with SMI and ensure they are not left behind.

Annual Physical Health Checks: A Solution or Just the First Step?

The National Institute for Health and Care Excellence (NICE) recommends that general practices maintain a register of individuals living with SMI and offer them an annual physical health check. The components of the core physical health check should include six key assessments:

- Alcohol consumption status
- Blood glucose or HbA1c test (as clinically appropriate)
- Blood pressure
- Body mass index (BMI)
- Lipid profile
- Smoking status

Annual physical health reviews for individuals with SMI are cost-effective, leading to a reduced likelihood of both A&E visits and hospital admissions specifically related to mental health.[10] Research indicates that receiving an annual health check within the past 12 months is associated with a 20% reduction in the chance of A&E attendance, a 25% lower risk of mental health-related admissions, and a 24% decrease in emergency admissions for preventable conditions.[11] These reviews not only lead to better health outcomes, but they also are likely to reduce stresses on the NHS in the future.

Therefore, there has been a huge focus on improving uptake to an annual physical check, with a target of 390,000 people with SMI receiving an annual physical health review by 2023/24. In the 12 months to 31st March 2024, 361,210 people on the GP SMI registers received all six elements of the health check. This left at least 160,000 people with SMI who did not receive a physical health check during this period.

There are multiple examples of good practice of ways to increase uptake of annual physical health checks which include:

- Creating accessible invitation and information material. Birmingham and Solihull worked alongside people with lived experience to make the material easy to understand by those with SMI.[12]
- People with lived experience of SMI providing training to healthcare workers doing physical health checks.
- Using outreach workers to explain the process and help people to travel to their appointment.
- Home visits where a member of the practice goes to the individual's home to carry out their health check.
- Collaborating with managers of support accommodation where many people with SMI live to arrange time for their residents to come into the practice together.

However, while annual physical health checks are a valuable tool for identifying health risks in individuals with SMI, they should be viewed as just one component of a comprehensive approach to improving health outcomes. These checks risk devolving into a superficial "tick-box exercise," addressing immediate procedural requirements without leading to meaningful improvements in overall health.

There is a lack of consistent follow-up mechanisms and interventions to address health issues identified during these reviews. With current guidelines, such as those outlined by the Quality and Outcomes Framework (QOF), primary care providers are tasked with conducting these annual checks. Yet, there is little clarity or consensus on the interventions to be delivered based on the findings, leaving a gap in continuity of care and long-term health management for individuals with SMI.

Additionally, the format of these health checks may inadvertently overwhelm people with SMI. Individuals with SMI are often presented with a barrage of questions, instructions, and recommendations focused on behaviour change,

which can feel intrusive or unmanageable. This approach risks alienating individuals with SMI and diminishing the effectiveness of the intervention if recommendations are not tailored to the individual's circumstances, readiness, and capacity for change.

To address these issues, a more holistic and person-centred approach is needed, ensuring that annual physical health checks serve as a starting point for ongoing, coordinated care. This includes clear guidance on actionable, evidence-based interventions, regular monitoring of health outcomes between annual reviews, and a focus on delivering health advice in a manner that empowers individuals rather than overwhelming them.

Supporting Healthier Lifestyle Choices

Obesity, smoking, physical inactivity, and harmful alcohol use are widely recognised as major risk factors for numerous physical health conditions, including cardiovascular, liver, and respiratory disease and are the leading causes of preventable illness and premature death in the UK. Among the general population, mortality rates were over 2.3 times higher for individuals with these risk factors compared to those with a healthy BMI, who never smoked, and who were physically active.[13]

Individuals with SMI exhibit higher rates of smoking, obesity, physical inactivity, and harmful alcohol use compared to the general population, factors that may be identified during the annual physical health check.

Amongst those with SMI:

- Smoking prevalence is over 3 times higher than in the general population (41% compared to 12%).[14]
- Obesity is 1.8 times more prevalent than the general population.[15]
- Alcohol dependency is at least 3 times higher than the general population.[16]
- Physical activity is much lower, and more time is spent being sedentary.[17]

The biggest risk factor for reduced life expectancy in individuals with schizophrenia is smoking, whilst for those with bipolar disorder, it is physical inactivity.[3] Modelling indicates that addressing modifiable risk factors could reduce the current mortality gap between those with and without SMI by 24% in men and 28% in women.[18]

Individuals with SMI are interested in making such lifestyle changes.[19] However, they face considerable barriers to start and maintain these changes. Barriers include anxiety, negative symptoms (symptoms that reduce or lead to a loss of function), lack of social support, lack of accessible support, limited knowledge, and financial constraints.[20] Healthcare professionals need to be flexible and patient with their approach to behavioural change, recognising that it needs to be the right

time for the individual to have the conversation and may take several attempts. Support needs to be personalised, such as one-to-one support, to sustain improvements.

The Alarming Reality of Smoking Rates

Smoking accounts for half of deaths among individuals with SMI. Smoking significantly increases the risk of several conditions, including cardiovascular disease, type 2 diabetes, and chronic obstructive pulmonary diseases.[21] While smoking rates in the general population have decreased from around 27% in the mid-1990s to 12% in 2023, the rate for those with SMI has remained relatively stable at approximately 40%.[22] [23] Despite the increased uptake of annual physical health checks, smoking rates among individuals with SMI have not shown significant improvement. Moreover, they tend to smoke a higher amount and exhibit higher levels of nicotine dependency, placing them at greater harm.[24]

Smoking cessation rates for those with SMI are low, despite the evidence showing that people with SMI are just as motivated to stop smoking when they are offered the appropriate support. There are many barriers to accessing mainstream smoking cessation services which contribute to low smoking cessation rates. Healthcare staff are often reluctant to engage in discussions about smoking cessation due to the assumption that those with SMI have a low motivation to quit. Healthcare staff do not receive adequate training on smoking cessation to promote behaviour change. Only 58% of mental health nurses and 43% of psychiatrists reported receiving training on smoking cessation.[25]

Possible evidence-based solutions to increase smoking cessation rates include:

- Tailoring smoking cessation services for individuals with SMI is supported by the Smoking Cessation Intervention for Severe Mental Ill Health Trial which demonstrated higher cessation rates for participants who received

bespoke interventions.[26] Providing longer sessions as well as an extended programme overall has shown to be of benefit.

- Ensuring smoking cessation services are offered to all individuals with SMI who are smokers both during inpatient physical and mental health admissions and in the community.
- Adopting a "cut-down-to-quit" approach and focussing on reducing the amount smoked as well as complete cessation.[27]
- Training smoking cessation practitioners on severe mental illness.
- Offering sessions by a smoking cessation practitioner prior to quitting.
- Offering home visits where a smoking cessation practitioner visits the person's home or virtual sessions to eliminate the barriers of transport and financial stresses.
- Educating healthcare professionals on how they can effectively support smoking cessation. Training should also challenge common misconceptions, such as the belief that smoking alleviates anxiety and depression— a notion that is not supported by evidence. Training should include the impact of smoking on the absorption of antipsychotic drugs, and therefore decreased doses may be needed if smoking cessation is achieved, overall reducing the chance of side effects and potential adverse effects on their physical health.[28]

Unpacking the Rising Rates of Obesity and Physical Inactivity: Opportunities for Change

People with SMI are more likely to have a higher body mass index (BMI) than the general population. Obesity is 1.8 times more likely in those with SMI between the ages of 15-74 and 3 times higher for those between the ages of 15-34.[29] A high BMI can lead to many different physical health conditions, including type 2 diabetes and cardiovascular disease. Historically, weight gain has been viewed as an inevitable side effect of psychiatric medication. However, while these medications

can contribute to an increased BMI, they are not the only factor at play. Other causes of obesity in this population include lifestyle choices, such as higher energy intake together with reduced physical activity, and socio-economic factors. Calorie and salt intake is likely to be higher in people with SMI than those without[30]

Estimates suggest of those referred, there is a 2% uptake of weight management services by those with SMI compared to at least 50% of the general population.[31] Similar barriers to mainstream weight management services exist as smoking cessation services.[32] This includes a lack of a tailored support, social isolation, stigma and discrimination, financial barriers, and limited access to services.

Bespoke programmes designed solely for those with SMI are costly – but cost effective. For example, offering regular contact through a weekly call, further information through handouts and personalised materials, and tailored support (for example, shorter or repeat sessions) increased engagement with services – and lead to effective weight loss.[33]

Additionally, individuals with SMI are more likely to experience a period of admission to an inpatient mental health hospital, at some point in their lives, with many being detained under the mental health act. Not only are service users who are detained more likely to be obese and overweight, but they appear to be more at risk of gaining weight when detained due to a lack of access to physical activity opportunities, high calorie foods and a lack of alternative healthier food options and a ward environment that does not promote healthy behaviours.[34] [35]

The Reality of Unequal Access to Cancer Screening Programmes

Despite rates of cancer being similar, an individual with a SMI under the age of 75 is 2.5 times more likely to die from cancer than an individual without SMI.[36] This stark inequality is caused by a reduced uptake of cancer screening initiatives, delayed cancer diagnoses, difference in treatment choices and adherence to treatment plans. Premature mortality due to cancer in adults with SMI is increasing, with the rates for 2021 to 2023 being 17% higher than between 2015 to 2017.[9]

Cancer screening programmes are an effective way of detecting cancer at an early stage by testing asymptomatic individuals. Early detection can make treatment more effective and improve survival rates. Common screening tests include mammograms for breast cancer, smear tests for cervical cancer, and a stool test which detects non-visible blood for bowel cancer. But participation in cancer screening programmes is low for those with serious mental illness. Public Health England Analysis shows that people with SMI were 31% more likely to not have participated in bowel screening; 20% more likely to not have participated in cervical screening; and 18% more likely to not have participated in breast screening.[37]

It is important to ensure that all people with SM are being offered screening tests and reasonable adjustments are made where necessary to ensure screening programme services are accessible with minimal barriers. Alarmingly women with SMI were approximately 70% more likely to be marked as being inappropriate for having cervical screening on their health records meaning the person will be removed from QOF reporting.[37] We need to ensure people with SMI are educated about what screening tests are and why it is important to participate. People with SMI can be nervous about attending cancer screening due to previous negative experiences with healthcare services and may worry about the

stigmatisation they may face. Individuals may also feel nervous about attending screening appointments in unfamiliar environments, having to wait in busy reception areas and may struggle to access transport to attend appointments.[38] Services working together so that they know a person has SMI may help to allow for reasonable adjustments such as longer appointment times to build rapport and the individual's trust to lead to a positive experience, meaning that person is more likely to participate in the screening programme again in the future.

Integrating physical and mental health services

People with SMI face significant barriers when accessing secondary care physical health services, resulting in missed diagnoses, inadequate treatment, and poorly managed physical health conditions. A key concern is the fragmented nature of NHS services, which poses substantial risks to individuals with SMI who are also managing long-term health conditions, such as Type 2 diabetes.

Barriers to Accessing Secondary Care for Individuals with Serious Mental Illness

While long-term physical health conditions may initially be managed in primary care, more complex cases often require referrals to secondary care, necessitating appointments across different hospital sites. This process can be daunting for individuals with SMI, involving unfamiliar settings, interactions with new healthcare professionals, and the burden of coordinating multiple appointments. These challenges are compounded by the fact that individuals with SMI are more likely to have multiple long-term conditions, further increasing their reliance on secondary care. Each condition is typically managed by a separate team with its own treatment plan, which can sometimes lead to conflicting approaches.

The disjointed nature of NHS services often leaves individuals with SMI vulnerable to gaps in care. A "one strike and you're out" policy is often used, where missed appointments frequently lead to service users being discharged, creating additional barriers to accessing essential treatments. Moreover, stigma within secondary care services remains a pervasive issue, negatively affecting engagement and trust in healthcare systems.[39] This stigma can manifest as diagnostic overshadowing, where physical health symptoms are incorrectly attributed to mental illness, delaying proper diagnosis and treatment.

The Importance of Holistic and Coordinated Care

To address these systemic issues, healthcare workers in any role, including clinicians and administrative staff, must receive training on severe mental illness and the reasonable adjustments needed to ensure equitable access to care. Training should focus on reducing stigma, enhancing understanding of mental illness, and fostering a holistic approach to managing both physical and mental health.

Individuals with SMI often highlight a lack of communication between professionals managing their long-term physical health conditions and those addressing their mental health needs. This divide is further exacerbated by limited collaboration between physical and mental health trusts, with inconsistent multidisciplinary cooperation. Compounding this issue, differences in computer systems often prevent the seamless sharing of care plans, hindering the delivery of coordinated care.

Care coordinators assigned to individuals with SMI play a vital role in providing mental health support, managing appointments, and acting as liaisons between mental health services and patients. However, many care coordinators face challenges in addressing physical health needs due to limited confidence, time constraints, and unclear role boundaries.[40]

Empowering Mental Health Professionals

Experts highlight the need for mental health professionals and services to take a more proactive role in addressing their service user's physical health needs. In the UK, psychiatrists have a medical degree and must complete a two-year foundation programme that includes rotations across physical health, mental health, and community specialities before specialising in psychiatry. However, mental health nurses often train specifically in mental health nursing at the undergraduate level,

which can result in a lack of understanding and confidence in managing their service users' physical health.[41]

It is essential to empower mental health professionals to educate individuals with SMI and their carers about the implications of psychiatric medications and their potential physical health complications. This education should be ongoing and complemented by practical support to help individuals manage these risks effectively. A more integrated, collaborative approach across physical and mental health services is critical to addressing the disparities faced by individuals with SMI and ensuring they receive comprehensive, high-quality care.

Enhancing Psychiatric Care to Improve Physical Health Outcomes

Improving mental health care for individuals with SMI can significantly enhance their ability to manage physical health conditions, leading to better overall health outcomes. Effective management of mental health symptoms often results in increased motivation and energy, enabling individuals to engage more actively in health-promoting behaviours and attend necessary medical appointments. Therefore, continued investment in mental health services and treatment is crucial to ensure high-quality care for those with SMI.

Public concern underscores the need for such investment. Pre-election polling indicates that two-thirds of the public are "very" or "somewhat concerned" about NHS mental health services.[42] Additionally, recent figures reveal that 40% of mental health providers were rated as "inadequate" or "requires improvement" for safety in 2024.[43] And inpatient psychiatric hospitals are often older than the NHS itself and no longer meet modern healthcare standards, rendering them unfit for purpose.[44] Compounding these challenges, the mental health sector faces a high vacancy rate of 12%, the highest among NHS sectors.[45] This understaffing undoubtedly affects service users, affecting the quality of care they receive, and potentially leads to suboptimal management of their mental health conditions.[46] The NHS Long Tern Workforce Plan, expected to be announced in the summer of 2025, will need to focus on increasing staffing and retaining healthcare workers in mental health services.

Antipsychotic medications, while essential for managing many mental health conditions, are associated with side effects such as weight gain, impaired glucose regulation, and elevated cholesterol levels. These adverse effects contribute to an increased risk of cardiovascular diseases and metabolic disorders such as diabetes. There is a need for increased investment on mental health research to find medications and treatments for SMI with fewer adverse effects on physical health.

Recommendations

1. Increase the number of adults with SMI having an annual physical health check by improving access to these reviews. Work with people with lived experience to create invitation material and accessible services. Provide funding for outreach services so checks can be done in an individual's home environment, or a peer support worker can accompany a person to their check.

2. Ensure healthcare staff including administrative staff booking physical health checks for individuals with SMI and those carrying out the checks are trained on serious mental illness.

3. NICE should set guidelines for what services should be offered to people following the physical health check leading to an 'intervene, not just screen' model.

4. Improve access to smoking cessation and weight management services by tailoring current services for people with SMI. Offer longer sessions, an extended programme and have practitioners who have received training on severe mental illness.

5. Data from smoking cessation services should not just be collected on the number of smokers who achieve complete cessation of smoking but also on the reduction of the amount that is smoked.

6. Offer smoking cessation in all inpatient psychiatric settings and signpost individuals to community follow-up services on discharge. Increase opportunities for healthy eating and physical activity during inpatient psychiatric admissions. In this way admissions to mental health hospitals should be seen as there to improve the physical health as well as mental

health of service users.

7. Ensure that all people with SMI are offered cancer screening and minimise the number of people being marked as inappropriate for screening.

8. Focus on providing accessible and tailored cancer screening services. Work with stakeholders, including people with lived experience, to identify and address the unique barriers faced by individuals with SMI in accessing cancer screenings. Tailored solutions, such as offering home visits, telemedicine consultations, or mobile screening units, should be explored. Offer flexible appointment scheduling and provide clear, understandable information about the screening process.

9. Implement tracking and reporting systems within healthcare services to monitor the uptake of cancer screenings among individuals with SMI. This data should be used to identify gaps in care and improve service delivery.

10. Enhance the physical health training for professionals working in mental health services to equip them with the knowledge and confidence to address the physical health impacts of SMI. Incorporate mandatory training on physical health in SMI populations into NHS workforce development plans. This includes supporting lifestyle changes, such as providing effective pharmacological and psychological smoking cessation interventions.

11. Invest in mental health services and workforce to ensure all individuals with SMI receive high-quality care. Invest in mental health research exploring novel medications with better side effect profiles, particularly regarding metabolic and weight gain side effects.

12. Mandate the integration of mental and physical healthcare systems to improve the physical health outcomes of individuals with SMI. Foster collaboration between primary care, secondary care, and mental health services by implementing co-located services, shared electronic health records, and multidisciplinary team-based approaches.

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