Rethink Mental Illness.

Lethal discrimination

Why people with mental illness are dying needlessly and what needs to change.

September 2013

Who we are

Rethink Mental Illness is a charity that believes a better life is possible for millions of people affected by mental illness. For 40 years we have brought people together to support each other. We run services and support groups across England that change people's lives and we challenge attitudes about mental illness.

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Acknowledgments

We would like to offer our thanks to colleagues from both the Royal College of Psychiatrists and Royal College of Physicians for their reports 'Whole person care: from rhetoric to reality: Achieving parity between mental and physical health' and 'Smoking and Mental Health'. This paper has drawn on their work and we would like to acknowledge this.

Summary

One in three of the 100,000 'avoidable deaths' every year have a mental illness, but this issue is virtually ignored across Government.[1]

This report examines how people with mental illness are being let down and lays out recommendations for change.

OUR KEY FINDINGS

- People with serious mental illnesses like schizophrenia die, on average, 20 years earlier than the rest of the population.
- More than 40% of all tobacco is smoked by people with mental illness, but they are less likely to be given support to quit.
- Fewer than 30% of people with schizophrenia are being given a basic annual physical health check.
- People gain an average of 13lbs in the first two months of taking antipsychotic medication and this continues over the first year. Despite this, in some areas 70% of people in this group are not having their weight monitored.
- Many health professionals are failing to take people with mental illness seriously when they raise concerns about their physical health.

OUR KEY RECOMMENDATIONS

- People with mental illness should be offered tailored support to quit smoking.
- Patients should be told about the side-effects of antipsychotic medication so they can look out for warning signs, and GPs should monitor their physical health closely.
- All mental health professionals should receive basic physical health training as part of their mandatory training.
- Commissioners and service providers need to be clear about the respective responsibilities of primary and secondary care services for monitoring and managing the physical health of people with mental health problems.

1. This figure has been derived using data from the Health Survey for England, Mental Health Minimum Data Set and Russ TC, Stamatakis E, Hamer M, Starr JM, Kivimaki M and Batty GD (2012), Association between psychological distress and mortality: an individual participant pooled analysis of the Health Survey for England prospective cohort studies. BMJ 345: e4933.

Foreword

The fact that people with serious mental illness die an average of 20 years earlier than the rest of the population, the majority from preventable causes, is one of the biggest health scandals of our time, yet it is very rarely talked about.

Imagine for a moment that this chilling statistic applied to any other group of people, such as residents of a particular town. There would be public outcry. Questions would be asked about why these people are being so badly let down by health services and politicians would call for targeted support. But this simply isn't happening for people with mental illness.

The facts are stark and shocking. One in three of the 100,000 people who die avoidably each year have a mental illness. We know that people with mental illness are three times more likely to develop diabetes and twice as likely to die from heart disease. More than 40% of all tobacco is smoked by people with mental health problems.

Despite the indisputable evidence that people with mental illness are one of the most at-risk groups in our society when it comes to avoidable deaths, the Government is failing to take firm action.

The Health Secretary Jeremy Hunt wants to reduce the 100,000 avoidable deaths per year in England by a third. Yet his recent 'call to action' on addressing avoidable premature mortality barely touches on the physical health of people with mental illness, although it does acknowledge the 'shameful inequality' of outcomes related to smoking.

When such stark evidence has been presented for other conditions, such as diabetes, action has followed. The same is not true for mental health. Failure to address this issue amounts to lethal discrimination which is costing lives. We urge the Secretary of State for Health to act now and publish an avoidable deaths strategy that will change this.

A year ago the NHS mandate set a need to achieve change in this area. How progress towards this will be measured, when it will be delivered and how it will be funded has yet to be defined. If this is a Government priority, why are we still waiting?

Some say this issue is simply 'too difficult' to tackle, but in reality there are simple, cost-effective solutions detailed in this report, which could save thousands of lives. They are small things like offering targeted support to give up smoking and ensuring GPs carry out basic physical health checks on patients with mental illness and act on the results.

We know what the problem is and we know what the solution is. All we need now is for the Government, local authorities, clinical commissioning groups, health and wellbeing boards, service providers and individual clinicians to face this issue head on and take action which will save thousands of people with mental illness from dying too soon.

Professor Sue Bailey
President of the Royal College of Psychiatrists

The problem

There is extensive evidence that people with serious mental illnesses, such as schizophrenia, are at risk of dying on average 20 years prematurely.[2,3] Compared with the general population, they have:

- 2 times the risk of diabetes.[4]
- 2-3 times the risk of hypertension.
- 3 times the risk of dying from coronary heart disease.[5]
- 10-fold increase in deaths from respiratory disease for people with schizophrenia.[6]
- 4.1 times the overall risk of dying prematurely (than the general population aged under 50).

Many of the premature deaths of people with serious mental illness are the result of poor medical care that fails to monitor risk factors such as smoking and obesity. They are avoidable. Yet despite these poor outcomes, the NHS is not providing the care patients need to stay well.

For example, NICE guidelines state that everyone with schizophrenia should have annual physical health checks. Yet the recent National Audit of Schizophrenia found that just 29% of people are receiving this.[7] Even very cheap and basic care is not being provided, such as weighing people and taking their blood pressure.

Just 56% of people with schizophrenia are weighed by health professionals, with some NHS Trusts weighing just 30% of patients.[8] We often hear that psychiatric wards don't even have scales. It's about time they did.

Furthermore, even when health checks are provided and problems are discovered, this does not always result in action. The Audit found that when patients were found to have high blood pressure, just 25% of them were then treated.

The 'inverse care law' is well known, where "*the availability of good medical care tends to vary inversely with the need for it in the population served*".[9] Nowhere is this more evident than in the treatment of the physical health needs of people affected by mental illness.

When such basic care is denied, it is not because of lack of funding or NHS reorganisations. It is because the physical health of these patients is not deemed important. This systemic discrimination is causing thousands of people to die too soon – change is long overdue.

2. Newman SC, Bland RC., 1991. Mortality in a cohort of patients with schizophrenia: a record linkage study. *Can J Psychiatry* 36, pp 239–45.
3. Brown S, Kim M, Mitchell C and Inskip H., 2010. Twenty-five year mortality of a community cohort with schizophrenia. *British Journal of Psychiatry* 196 pp 116–121; Parks J, Svendsen D, Singer P et al., 2006. Morbidity and Mortality in People with Serious Mental Illness. 13th technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.
4. Royal College of Psychiatrists, 2013 '*Whole person care: from rhetoric to reality. Achieving parity between mental and physical health*', Occasional paper OP88.
5. Osborn, DPJ., 2007 Physical activity, dietary habits and coronary heart disease risk factor knowledge amongst people with severe mental illness: a cross sectional comparative study in primary care. *Social Psychiatry Psychiatric Epidemiology* pp 787-93.
6. Mental health and smoking: a position statement (2008), Faculty of Public Health.
7. Royal College of Psychiatrists, 2012. *Report of the National Audit of Schizophrenia (NAS) 2012*. London: Healthcare Quality Improvement Partnership.
8. Royal College of Psychiatrists, 2012. *Report of the National Audit of Schizophrenia (NAS) 2012. London*: Healthcare Quality Improvement Partnership.
9. Hart JT,. 1971 The inverse care law. *Lancet* Feb 27;1(7696) pp 405-12.

Recent policy developments

This Government has made a promise in the NHS Mandate to transform the NHS so that mental and physical health are treated equally, and the NHS Outcomes Framework includes an indicator to reduce the under-75 excess mortality rate in adults with serious mental illness. However, how progress towards this will be measured, when it will be delivered and how it will be funded has yet to be defined. Yet when the Health Secretary published his 'call to action' to reduce avoidable premature mortality,[10] he barely mentioned the widely acknowledged issues about premature mortality in mental health.

He stated that two thirds (around 103,000) of the deaths among the under 75s are avoidable. As around a third of those deaths are people with mental health problems, we know that the Health Secretary will find it much harder to reduce premature mortality if he does not address the needs of this group.

The Government's promises to tackle avoidable deaths and improve mental healthcare have been welcomed. While the NHS Mandate demands improvements in this area, the NHS Outcomes Framework only measures rates of mortality, not causes of death or co-morbidities.

NHS records tell us when people have died, but do very little to highlight at-risk groups and ensure they are offered targeted support. More must be done – urgently – to prioritise interventions that are known to work, and which can prevent the onset of the poor physical health associated with mental illness.

10. Department of Health, 2013. *Living Well for Longer: A call to action to reduce avoidable premature mortality.*

Why are people with mental illness dying too soon?

The causes of poor physical health will vary from person to person, but there are common factors which contribute to the poor physical health of people affected by mental illness, outlined below.

Smoking

People with mental health problems consume almost half of all tobacco in England (42%),[11] and are 70% more likely to smoke than a person without mental health problems.[12] In mental health units, it is estimated that 70% of patients smoke, with 50% described as heavy smokers.[13]

They also have increased levels of nicotine dependency and are at even greater risk of smoking-related harm.[14] Despite this, only a minority of people with a mental illness receive effective smoking cessation interventions.[15]

People affected by mental health problems have the same desire to quit as everyone else. However, their smoking rate has barely changed in the last 20 years, while the rate in the general population has fallen dramatically from 45% in 1974 to 20% in 2010.[16]

There are a number of barriers to people with mental illness accessing smoking cessation, including staff attitudes and inflexible service targets. In 2012, The Schizophrenia Commission heard evidence that some health professionals do not help patients give up smoking because they believe it is the 'last pleasure they have'.[17] We believe this attitude is unacceptable and is costing lives.

Similarly we are concerned that some services have such rigid performance targets that there is no incentive for them to support someone affected by mental illness, who might take longer to quit. Performance targets should be designed so that services are encouraged to support the people who struggle hardest. Addressing these barriers and offering targeted support should be a priority.

It is essential that smoking cessation services check the mental health status of their clients, as evidence suggests that this is not being routinely undertaken.[18] Alongside this, all smoking cessation staff need to have mental health training to ensure they offer the appropriate level of support.

Targeted support would save money as well as lives. £720m[19] is spent annually treating smoking-related illnesses in people affected by mental health problems through hospital admission, GP consultations and prescriptions. Providing smoking cessation support for this group is one of the most cost effective interventions in the NHS.[20]

The Royal College of Physicians and Royal College of Psychiatrist's report, Smoking and Mental Health, recommends that because smokers with a mental illness are usually more heavily addicted to nicotine, they should be prescribed nicotine replacement therapy products to support attempts to stop smoking.

11. McManus S, Meltzer H, Campion J., 2010. *Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey.* London: National Centre for Social Research.
12. Centers for Disease Control and Prevention, 2013 Adult smoking: focusing on people with mental illness Vital Signs, February.
13. Jochelson J and Majrowski B (2006). Clearing the air: debating smoke-free policies in psychiatric units. King's Fund,as referenced in Mental Health Network, NHS Confederation (2013), 'Smoking and Mental Health briefing', Issue 267.
14. Lawrence D, Mitrou F Zubrick SR., 2009. Smoking and mental illness: results from population surveys in Australia and the United States. *BMC Public Health* 9:285.
15. Royal College of Physicians and Royal College of Psychiatrists, 2013. *Smoking and Mental Health*.
16. Jarvis, M., 2003. Monitoring cigarette smoking prevalence in Britain in a timely fashion. *Addiction*, 98, pp 1569-1574.
17. Schizophrenia Commission, 2012. The Abandoned Illness.
18. McNally L & Ratschen E. (2010), The delivery of stop smoking support to people with mental health conditions: A survey of NHS stop smoking services. BMC Health Services Research; 10: 179.
19. Royal College of Physicians and Royal College of Psychiatrists, 2013. *Smoking and Mental Health*.
20. Royal College of Physicians and Royal College of Psychiatrists, 2013. *Smoking and Mental Health* – £8,000 per quality-adjusted life-year (QALY) gained for lifetime nicotine patch use and £3,600 per QALY for inhalators.

"It's so sad when one has cared for an 18-year-old at the time of their first psychotic illness and then one doesn't recognise them when one meets them again five years later because they are 10Kg heavier. Psychiatrists need to take more responsibility for the physical health of their patients because some GPs and hospital physicians don't like treating people with psychosis."

Professor Sir Robin Murray, Chair of the Schizophrenia Commission

Tailored support is also important because medications, such as clozapine, are affected by nicotine intake. Medication dosages may therefore need to change in parallel to smoking cessation. However, NHS Stop Smoking services do not currently record whether someone is using medication for a mental health condition. This needs to be recorded if prescribing clinicians and smoking cessation services are to work together to do this safely. Equally, GP records should record the smoking status of people with mental illness so that they are offered the appropriate support to give up. The NHS Quality Outcome Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) payments could be used more widely and effectively to incentivise healthcare professionals to provide targeted, effective support for this group.[21]

Obesity

People with a serious mental illness are at much greater risk of obesity. This is because some of the medications they use are associated with weight gain.[22] This has recently been described as an '*epidemic within an epidemic*'[23] as young people with emerging psychosis are quickly gaining weight when using medication. Often there is so much focus on managing their mental illness, that people's physical health needs are ignored.

By the time they are considered, people have gained significant weight and are at great risk of cardiovascular problems and dying prematurely. It is therefore essential that physical health monitoring is prioritised at the onset of illness. Mental health providers should promote the use of clinical tools to support the physical health needs of people with mental illness on antipsychotic medication, such as the Lester UK Adaptation – Positive Cardiometabolic Health Resource.[24]

Given that medication plays such a significant role in weight gain, it is important that people are given accessible information about medication and potential side-effects before medication is prescribed. This would allow people to be more aware of the risks and what they should be looking out for, and how their physical health will be monitored alongside their mental health. However this is currently not the case. A recent CQC survey[25] of community mental health services found that only 44% of people felt the side effects of medication had been fully explained to them. If people aren't equipped with the appropriate knowledge, they and their carers cannot make informed decisions about their care and treatment. They also cannot take steps to mitigate the side-effects of their medication and physical health complications can develop.

21. Royal College of Psychiatrists, 'Whole person care: from rhetoric to reality. Achieving parity between mental and physical health', Occasional paper OP88, 2013
22. McElroy, SL, 2009. Obesity in patients with severe mental illness: overview and management, *Journal of Clinical Psychiatry*, 70, Supplement 3:12-21.
23. Bailey, Gerada, Lester and Shiers, 2012. The cardiovascular health of young people with severe mental illness: addressing an epidemic within an epidemic *The Psychiatrist Online* October (36) pp 375-378. Available at: www.rcpsych.ac.uk/quality/NAS/resources.
24. Lester H, Shiers DE, Rafi I, Cooper SJ, Holt RIG., 2012. *Positive Cardiometabolic Health Resource: an intervention framework for patients with psychosis on antipsychotic medication*. Royal College of Psychiatrists: London.
25. Care Quality Commission, 2011. *Community mental health survey 2011.*

"My son was a fit and active teenager who enjoyed many sports at school and would walk 15 miles easily. He was over 5ft 10in and weighed less than ten stone. At 19, he was admitted to a psychiatric unit and given haloperidol which increased his appetite. He was then diagnosed with schizophrenia, and given olanzapine, after which the weight piled on. Now, at the age of 33, my son has diabetes and has been prescribed statins. We all wish we had known the potential side-effects of olanzapine and that another drug with less drastic drawbacks could have been available."

Anonymous, Rethink Mental Illness supporter

Accessing physical health care

There are a number of barriers for people affected by mental illness when accessing physical health care and monitoring.

Although GPs are obliged to offer people certain physical health checks annually as part of the Quality Outcomes Framework (QOF), this is not a flawless system. Some of the tests in the QOF are only offered to people over 40 years old, meaning there could be significant delays in addressing physical health concerns if people have been taking antipsychotic medication since their 20s.

Practices can also 'exception report' or omit people from their QOF results in certain cases. Exception reporting for mental health is particularly high compared with other health conditions. In 2011/12 the exception reporting rate was 11.8%, compared to 0.5% for cancer.[26]

These high exception rates are sometimes put down to a perceived reluctance of people with mental illness to engage with GPs. However, people can find it very difficult to access GP surgeries. They might be anxious about attending or might struggle with the early morning booking system because of medication side-effects. GP practices need to make sure reasonable adjustments are in place so that people are not missing out on crucial care.

When people do access health services, their physical health needs are often ignored or seen as a manifestation of their mental health condition, rather than a separate health issue. This 'diagnostic overshadowing' is well documented[27] and leads to physical conditions being undiagnosed and untreated, which can prove fatal. Concerns raised by carers can also be ignored.

This lethal discrimination helps to explain why people with severe and enduring mental illness appear to access significantly lower quantities of several common medications for physical health conditions.[28]

"It seems that once you have a mental health diagnosis any physical symptoms you experience are instantly assumed to be part of your diagnosis. Once that assumption is made it is difficult to get anyone to attempt to disprove it."

Anonymous Rethink Mental Illness member

26 NHS Information Centre, 2012. *Quality and Outcomes Framework Achievement, prevalence and exceptions data 2011/12*.

27. Thornicroft, G, Rose, D, Kassam, A., 2007. Discrimination in health care against people with mental illness. *International Review of Psychiatry*, April 19(2), pp 113-22

28. As highlighted in Royal College of Psychiatrists, 'Whole person care: from rhetoric to reality. Achieving parity between mental and physical health', Occasional paper OP88, 2013, referring to Mitchell AJ, Lord O, Malone D. Differences in the prescribing of medication for physical disorders in individuals with v. without mental illness: meta-analysis. *Br J Psychiatry* 2012; 201: 435–43.

Poor physical health monitoring

People with serious mental illness need comprehensive physical health monitoring at least once a year to help with risk factors, such as weight gain associated with antipsychotic medication. However, the recent National Audit of Schizophrenia (NAS) revealed that, on average, only 29% of people had received a full check of Body Mass Index (BMI), smoking, blood pressure, blood glucose and lipids in the previous 12 months. In some Trusts, this number was below 15%. We would like to see more training in physical health care and health promotion for all mental health practitioners. Mental health nurses should be able to provide basic physical health care and progression through training should depend upon this.

This large variation in results shows that there is an inconsistent approach across the country and that physical health is not being properly prioritised. Certain aspects of physical health care, including weight or BMI, were only checked in around half of cases, with some NHS Trusts weighing just 30% of patients.[29] This is particularly worrying given the link between medication, weight gain and health problems, such as heart disease. Even where problems are identified, action is often not taken to address these. The National Audit of Schizophrenia showed that only one in five people with raised lipid levels and one in four people with high blood pressure were offered the necessary intervention.

Rethink Mental Illness has been holding summits across England to discuss these issues with hundreds of people affected by mental illness and with health professionals. Again and again, we have heard that the physical health care of people affected by mental illness is falling through the gaps between GP services and secondary mental health care. It is often unclear, both to professionals and people affected by mental illness, who is responsible for coordinating this support. As a result, no support is offered. This responsibility needs to be clarified so that people's physical health isn't overlooked. Tools like the Integrated Physical Health Pathway could support professionals to agree processes locally so checks are not missed.[30]

Evidence also shows that practice nurses consulted with people affected by mental illness only once a year, compared with the general practice population rate of almost twice a year.[31] Practice nurses have a crucial role to play in health promotion and prevention and, given the higher risk of a range of physical health problems, this is a matter of concern.

ACTIONS FOR THE NHS

- Commissioners and service providers need to be clear about the respective responsibilities of primary and secondary care services for monitoring and managing the physical health of people with mental health problems.
- Everyone being prescribed antipsychotic medication should be given clear and accessible information about the risks and benefits so they can make an informed choice about medication. Physical health monitoring should start from the very beginning of treatment with identified health needs quickly acted upon.
- Each CCG and mental health provider should work with the local Director of Public Health to ensure that targeted smoking cessation services and support are both available and promoted to smokers with schizophrenia and psychosis.
- All smoking cessation services must check the mental health status of their clients. Their staff need to have mental health training to ensure they offer the appropriate level of support. They should also record whether someone is taking mental health medication, to ensure dosages are changed as necessary.
- All mental health professionals should receive basic physical health training as part of their mandatory training. Mental health nurses should be trained to carry out simple physical health checks.
- Rates of people accessing interventions included in the Quality and Outcomes Framework (QOF) to be in line with predicted prevalence of the illness.

ACTIONS FOR GOVERNMENT

The Government says mental health is one of its top priorities, but this has not translated into action on the ground.

The Department of Health and Public Health England need to:

- Prioritise the needs of people affected by mental illness in the Health Secretary's forthcoming strategy on premature mortality. A significant proportion of avoidable deaths are linked to mental ill health. This must be recognised and acted upon.
- Hold NHS England to account for delivering progress on reducing the premature mortality of people with mental illness in line with the NHS Outcomes Framework and the commitment in the NHS Mandate. Define the progress to be made, how long it will take and how it will be measured.
- Take action to ensure that every smoker affected by mental illness is offered tailored 'quit smoking' support and interventions in line with NICE guidance.
- Amend NHS and CCG outcomes indicators to measure access to proven interventions, not just physical health checks and rates of death (e.g. proportion of people with mental illness accessing smoking cessation services, proportion of eligible individuals accessing Early Intervention for Psychosis services).
- Amend the Quality Outcomes Framework (QOF) to ensure that physical health screening is available for people as soon as they take certain medications, not just at the age of 40.
- NHS England and CCGs should consider an annual mortality review being included as part of their contract for mental health trusts. Commit to sustaining the National Audit of Schizophrenia for a minimum of a further five years to monitor impact, and extend the remit of the audit to include all inpatient settings.

29. Royal College of Psychiatrists, 2012. *Report of the National Audit of Schizophrenia (NAS) 2012*. London: Healthcare Quality Improvement Partnership.
30. Rethink Mental Illness, 2012. *Integrated Physical Health Pathway*.
31. Reilly S, Planner C, Hann M, Reeves D, Nazareth I, Lester H., 2012. The role of primary care in service provision for people with severe mental illness in the United Kingdom. *PLoS One* (7).

Case study: Tracey Butler (39), Hampshire

Tracey developed type 2 diabetes when she was just 22 years old after her GP failed to properly monitor the side-effects of her antipsychotic medication. She thinks medical professionals do not take her physical health concerns seriously because of her mental illness.

"I have schizoaffective disorder and borderline personality disorder, and was first prescribed antipsychotics in my early twenties. After I'd been taking them for around 18 months, I started to notice the impact it was having on my physical health. I felt completely exhausted all the time, thirsty and dehydrated and I constantly had to run to the toilet. I went to my GP because I was convinced something was wrong. But he dismissed my concerns, he wouldn't entertain the idea that there might be something serious going on.

About a year passed and the symptoms continued to get worse, before I was finally diagnosed with type 2 diabetes. My diabetes consultant told me that the symptoms I had gone to my GP about were clear early signs of the condition. He also said that it was the antipsychotics that had caused my diabetes. Seventeen years later, I still have to go regularly to the diabetes consultant.

When I'm unwell, I'm not great at looking after myself. It can be quite a big undertaking to go to see my GP, and I really do need them to take me seriously. As soon as a medical professional looks at my records, they see 'borderline personality disorder' flashing up on the screen and it feels like they stop listening to me. They just think I'm neurotic or paranoid.

There also doesn't seem to be any communication between my GP and my psychiatrist. I think it would make a big difference if there was.

In my experience, GPs rarely know much about mental illness. One time, my GP called me after a routine blood test, saying that I might have a tumour in my brain because there was an unusually high level of prolactin in my blood. This sent me into a state of great distress and I had a panic attack. But when I called my community psychiatric nurse, he told me the prolactin level in my blood was probably caused by the antipsychotics. That turned out to be the case – there was no tumour, it was just a side-effect of my medication. A great deal of worry and anxiety could have been avoided if the GP had known more about the side-effects of the medication I was on."

Change is possible

There is reluctance from some to tackle this problem, due to a belief that it's 'too difficult'. However, some Trusts are getting it right and are proving that it can be done. Here are some best practice examples:

Lancashire Care Trust

Lancashire Care Trust has taken a proactive, holistic approach to improving physical health outcomes. By trialling and adopting the Physical Health Check tool from Rethink Mental Illness and embedding it across the Trust, they have drastically improved physical health monitoring and intervention.

The Trust first piloted the Physical Health Check in its recovery team. The results were startling and included identifying undiagnosed high blood pressure, diabetes and cancer. The Trust then decided to implement the Check and set it as a service improvement standard across a wider range of services.

The Trust therefore committed to offering everyone using their mental health services a Physical Health Check. To support this, the Trust offered training, support, awareness raising activities and involved all staff, not just nurses. It developed formal guidance on the Check for social care staff and appointed local physical health leads across the Trust.

The completed Physical Health Check is worked into the person's care plan so that both physical health and mental health needs can be treated holistically. Where issues are identified, Trust staff proactively ensure that these are followed up and liaise with primary care where necessary. Staff members at the Trust have highlighted the role the Physical Health Check has played in identifying serious, and possibly fatal, health conditions. The Trust collected data from the physical health checks it undertook in 2011/12 and 2012/13. These showed a 30% decrease in previously unidentified health needs in the latest round of checks. This suggests the Trust is successfully catching things early and taking action.

Lancashire's focus on physical health continues to grow. From April 2013, the Physical Health Check has been incorporated into the Trust's electronic records. This allows for better recording of and reporting on physical health needs and outcomes. There is ongoing work and communication with GPs and other primary care professionals and the Trust continues to drive improvements in the physical health services it provides.

Solent NHS Trust

Solent NHS Trust adult mental health services are improving their management of diabetic patients and developing close links with the diabetes clinic at the local hospital to improve care. This includes introducing the same diabetic pathway on admission as the general hospital. The unit is also arranging for staff from the diabetes clinic to audit the diabetes care it offers on mental health wards.

The trust is also looking at what food is offered to people on mental health wards. A traffic light system outlining the nutritional content of foods has been introduced so people can make informed choices about their meals. Vending machines are also being stocked with healthier options.

This work is facilitated by the Clinical Matron for Health and Wellbeing, who has both RGN and RMN training. By being able to take more of a teaching and advisory role on the ward, other staff feel better supported to address physical health concerns and key working relationships can be built up with other services.

Barnet, Enfield and Haringey: Early Intervention in Psychosis Service

In this service, physical health is given high priority. It has a clear protocol around physical health monitoring right from when people first come to the service. Information is initially requested from the GP for the preceding 12 months and these requests are proactively followed up. If someone is not registered with a GP or refuses to attend an appointment, there are procedures in place for ensuring crucial monitoring and assessment still takes place. Once these assessments have taken place, relevant information is shared with the appropriate parties.

Several staff within the service have completed a specialist undergraduate training, focusing on practical skills and the research and knowledge underpinning identified interventions. There is also a dedicated staff member who has responsibility for keeping a record of physical health monitoring and any outstanding checks. The programme has been well received by the Trust and there are hopes that it might be adopted by other teams across the Trust.

The Northampton Physical Health and Wellbeing Project

Sheila Hardy, Nurse Consultant and Visiting Fellow at the University of Northamptonshire, has developed training for practice nurses and carried out research on the physical health needs of mental health patients.

She has found that contrary to popular belief, patients with serious mental illness will attend health checks, and proper training in this area for practice nurses increases the level of screening and lifestyle advice given.

The necessary guidance and tools needed for setting up a nurse-led clinic and carrying out a health check for people with serious mental illness are available online (http://physicalsmi.webeden.co.uk/). This allows nurses to follow best practice guidance even if they have no access to formal training in this area.

"The barriers to better physical health care for people with serious mental illness are related as much to communication and knowledge as the obstacles we are already aware of, i.e. diagnostic overshadowing, inflexible GP services, medication side effects and motivational problems. In respect of knowledge, there seems to be a consensus that mental health nurses lack both the training and the confidence to manage common physical health problems. However, we're nearly there.... we know what the issues are, let's work out a way to tackle them. Let's enable our service users to get the physical health care they deserve."

Sue Blakely, Supporting Health Nurse, Manchester Mental Health and Social Care Trust

How Rethink Mental Illness is tackling this

For many years the seriously neglected physical health needs of people with mental health problems has been a priority for Rethink Mental Illness. We have been shouting about this shocking inequality for as long as we can remember. We know that change only happens when solutions are identified along with naming problems. In our efforts to overcome the hurdles that people face in accessing appropriate and timely physical health care, we have spent the last decade in partnership with professional bodies to tackle this issue in practical ways.

We developed tools to help professionals assess and identify key physical health concerns. We created accessible online physical health resources and training, to raise awareness and build confidence around supporting people's physical health needs. We wrote guides for health practitioners. We created a Physical Health Check tool which enables professionals and people affected by mental illness to develop plans together so that they can address any unmet physical health needs.

Working with people with lived experience, we produced guides to help individuals get support for their physical health. We developed tools to help people speak out and campaign for change. We run advice and information services. We help as many people as we come into contact with and spend the little resource we have spreading the word about the importance of physical health.

We want those who commission and deliver local services to get an insight into the physical health issues that people affected by mental health experience so we facilitate discussion between commissioners, professionals and those affected. We create opportunities for decision makers and people affected by mental illness to work together to develop policies and practice that can lead to improvements in their areas. And we have tirelessly promoted these tools and resources to anyone and everyone we encounter.

We have realised much more is needed. To enable the significant change that is urgently required in the NHS and beyond, we have this month launched a country-wide Innovation Network. In partnership with mental health provider organisations, we are working to embed excellent physical healthcare across the system.

It is time for the Government to do its part.

Conclusion

While there are some pockets of good practice in the system, most people with mental illness are being badly let down when it comes to their physical health. This means many thousands of people are dying needlessly every year and many more are left struggling with long term conditions such as diabetes. Many factors contribute to this state of affairs, creating one of the biggest hidden health scandals of our time.

By not acting, the Government and the NHS are allowing some of the most vulnerable people in our society to be treated as second class citizens. We would never accept this state of affairs for other patient groups, and we shouldn't accept it for people with mental illness. We know what the solutions are and they are not complex or expensive. All we need now is the political will, at both national and local level, to make change happen.

For more information on our wide range of physical health resources, please visit www.rethink.org/phc.

Rethink Mental Illness.

Leading the way to a better quality of life for everyone affected by severe mental illness.

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