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their GPs and the CMHT, and that the alternative would be for a valuable opportunity to improve the physical health of this group of patients to be missed completely.

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Declaration of interest

None.

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Falling between the cracks. Invited commentary on . . . Service innovation: the first year of lifestyle clinics for psychiatric outpatients†

SUMMARY

Hamilton's paper describes a thorough and pragmatic approach to the introduction of physical health checks in people registered with mental health services. This is a moral and political priority, but translating this into day-to-day practice in already stretched community mental health teams requires leadership and vision. Pivotal in Hamilton's success was the establishment of good channels of communication between the mental and physical healthcare teams. Hearing about good practice and positive experiences in other teams should help in the widespread introduction of reliable systems to improve physical health in mental health service users.

†See original paper, pp. 445–448, this issue.

By now, it is well accepted by clinicians and policy-makers alike that the physical health of people with severe mental illness is very poor, with a greatly shortened life expectancy.[1] Much of this excess mortality is due to diseases that are common in the general population[2] and which health services are well versed in treating. The main challenges faced by physicians lie in actually identifying the physical health problems of people with severe


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mental illness, and adapting the system to improve the uptake of treatment.

Hamilton *et al* describe the development and introduction of annual physical health checks for people with severe mental illness in two rural catchment areas.[3] In line with previous studies,[4,5] a systematic approach to screening revealed high numbers of previously undiagnosed physical health problems, the identification of which should improve patient outcome and quality of life.

The substantial effect of staff enthusiasm on uptake is a striking finding of Hamilton *et al*'s study.[3] The team with high uptake seemed to have embraced the initiative of annual screenings, whereas the misgivings of the other team were associated with a lower uptake. This variation in attitude and enthusiasm between teams is not uncommon, despite the recent policy priority given to physical health in individuals with severe mental illness.

Government position

Improving the physical health of people with severe mental illness is now enshrined in UK government doctrine.[6–8] All healthcare organisations must now run systematic disease prevention and health promotion programmes.[9] Mental health trusts are still working on translating this fully into clinical practice; Hamilton *et al*'s initiative provides a useful model.

In the meantime, it is still the case that any past experiences of stigmatising behaviour from health professionals that people with severe mental illness may have had may prevent them coming forward to seek physical healthcare. Mental health service users report 'diagnostic overshadowing' where clinicians interpret physical symptoms as part of the mental health problem.[10]

What is holding patients back?

Barriers to services

People with severe mental illness face real barriers in accessing services. For example, rates of non-treatment for diabetes, hypertension and dyslipidemia in severe mental illness are high, especially in women from Black and minority ethnic communities;[11] and although the use of cardioprotective medications in individuals with type 2 diabetes and severe mental illness is increasing, many are still inadequately treated despite being at considerable cardiac risk.[12] A shift in approach is called for to eliminate unequal treatment, allowing these groups to be healthier and to participate fully in society, and to prevent the extra costs of serious ill health being passed on to other parts of the National Health Service.[10]

Illness-related factors

Factors related to the patient or their illness such as impaired cognitive or organisational skills, poor concordance, compromised communication and lack of motivation, as well as previous bad experiences, reduce the likelihood of successful identification and management of physical health problems in those with severe mental illness.[10,13] These can all be addressed on an individual level by motivated clinicians and there are plenty of examples of such good practice. However, to uniformly improve care we must address the organisational problems such as conflicts over centre of responsibility, inadequate time and resources, and diagnostic overshadowing, neatly quoted by Lambert *et al* as 'falling between the cracks'.[13]

Necessary changes in service provision

It is important to be clear what is asked; we do not expect mental health professionals to become general practitioners (GPs) themselves, but all mental health staff should understand what screening tests are necessary and facilitate communication with the appropriate team to arrange this and any ongoing care. This is a change. Change in any system is fraught with difficulties and requires a shared sense of urgency, an understanding that the problem cannot be ignored, and leadership to overcome the fear of failure.[14] Day-to-day clinical communication must start to include the 'new improved' physical health message routinely.

Conclusions from Hamilton's study

Hamilton's community mental health teams (CMHTs) took responsibility for making things happen such as blood tests, communication and follow-up of results and clinic appointments, as well as adopting a pragmatic approach to transport. This approach is key to the management of physical health in severe mental illness, first because primary care traditionally operates a less assertive model of care, and second, because it allows a consistent approach, less subject to variation between GP practices.

Government initiatives

Physical health in people with severe mental illness is everyone's problem. The National Service Framework and National Institute for Health and Clinical Excellence encouraged primary and secondary services to collaborate to improve physical outcomes in severe mental illness.[6,7] Linking with primary care and hospital consultants undoubtedly improved the success of this programme and serves as a model for other services to adapt to their local needs. That old stalwart clinical audit can boost health screening rates once a start has been made.[15]

Staff training

Training for staff to improve confidence and effectiveness is important. Mental health nurses are expected to have the skills and opportunities to improve the physical well-being of people with mental health problems.[16]

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However, many care coordinators are not nurses and may feel under-equipped for this role and so require support.

Lifestyle changes

The CATIE study concluded that smoking cessation, nutrition counselling and exercise programmes would help to reduce cardiovascular mortality in people with severe mental illness.[17] Hamilton *et al* demonstrate the feasibility, sustainability and acceptability of lifestyle advice and interventions. They were also innovative in that they addressed a range of needs, including substance use which further increases physical morbidity in people with severe mental illness.[18,19]

Resources

Resources are important. The Hamilton team was lucky to have a community dietician and a mental health-specific smoking cessation specialist. However, the required changes cannot wait to see whether the current recession is v-shaped, u-shaped or w-shaped until more money is allocated to improving physical health in severe mental illness. In the meantime, CMHTs should identify local resources and encourage service users to participate as much as possible in community-based activities, if necessary providing support and training for staff to support service users. This will increase community integration and reduce stigma.

Conclusions

The criteria to effect change are now in place; it is clear that the physical health in people with mental illness as a problem can no longer be ignored, and there is a commitment to change at senior levels of the health service. Let us follow Hamilton's team in making it happen on the ground.

Declaration of interest

F.G. is lead investigator in a study looking at interventions in physical health and substance use in severe mental illness.

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