
Physical Health in Patients with Mental Illness

Position Paper

Approved by CPsychI
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Executive Summary

This position paper examines the urgent need to enhance physical health monitoring and intervention for individuals with mental illness, who experience significantly reduced life expectancy—often 10 to 20 years shorter than the general population—primarily due to preventable physical illnesses. Untreated comorbid conditions result in an estimated 15 percent increase in hospital admissions for this population, imposing substantial financial burden on healthcare systems annually. The association between mental illness and physical multimorbidity is both complex and bidirectional; however, individuals with mental illness frequently receive substandard physical care, with physical symptoms being often misattributed or overlooked. Coordinated social and clinical interventions are essential to challenge and reduce the stigma surrounding mental health conditions.

The current framework for physical health monitoring and intervention of individuals with mental illness is inadequate, contributing to a widening health disparity. Physical health monitoring is defined for the purposes of this position paper as the systematic, proactive, and ongoing assessment, documentation, and review of physical health status, risk factors, and comorbid conditions in individuals with mental illness, undertaken across the lifespan and integrated within routine mental healthcare, with the aim of enabling early detection, timely intervention, and coordinated management in collaboration with primary care and relevant specialist services. The complexity of multimorbidity and its increasing burden necessitates a coordinated and integrated management approach that mental health services alone cannot effectively deliver.

This paper does not solely prescribe specific operational recommendations for physical health monitoring, but emphasises the critical need for investment in infrastructure, service development, and workforce training to elevate standards of care. The establishment of robust partnerships between mental health services, primary care and other specialist services is essential to improving health outcomes and addressing the unacceptable disparities experienced by individuals with mental illness.

1. Introduction

Individuals with mental illness experience a 10–20 year reduction in life expectancy compared with the general population. The majority of this excess mortality is attributable to preventable physical health conditions, including cardiovascular disease, diabetes, respiratory disease, and cancer, rather than suicide (Firth et al., 2019; WHO, 2018; Chan et al., 2023). Younger adults (aged 15–34) in particular are more likely to experience multimorbidity including being five times more likely to have three or more chronic conditions before age 35 (HRA THIN, 2018); severe psychiatric illness is associated with increased risk of dementia in later life (Stevenson -Hoare et al., 2024).

This inequity results from a confluence of factors including biological vulnerability, lifestyle-related risk factors, treatment side-effects and socioeconomic disadvantage - including reduced access to healthy nutritious food, safe housing, and opportunities for physical activity—all of which are essential determinants of physical health (DeHert, 2011). Disadvantage is further compounded by structural barriers within healthcare systems and across social systems. (Thornicroft, 2007; Mitchell et al., 2017). Furthermore, the stigma associated with mental illness exacerbates social exclusion and reduces the likelihood of seeking and receiving appropriate healthcare (Clement, 2015).

Mental illness should therefore be understood not only as a psychiatric condition but also as a significant indicator of elevated physical health risk, necessitating systematic, proactive, and integrated care approaches across the lifespan.

Burden and scale

Inequity and parity of esteem represent significant systemic challenges in healthcare provision for individuals with mental illness. Despite well-documented disparities in treatment outcomes and life expectancy between individuals with mental illness and the general population, mental health services remain under-resourced relative to other health sectors (WHO, 2022). Addressing these inequities requires the establishment of parity of esteem through concrete policy measures. These should include budgetary instruments, such as ring-fenced funding for mental health services, and ensuring financial resources are allocated specifically for improving physical health outcomes for patients with mental illness.

2. Aims and Objectives

This position paper aims to:

- Enhance awareness and understanding of the *factors contributing to increased morbidity and mortality* among individuals accessing mental health services.
- Examine approaches to standardised, trauma-informed *screening, assessment and monitoring* of physical health needs within mental health care pathways.
- Encourage the development of collaborative, person-centred, *multidisciplinary management plans* to reduce health inequities and improve long-term health outcomes.

This position paper is intended for:

- Mental health professionals, including psychiatrists, trainees, mental health nurses, and Health & Social Care Professionals (HSCPs - occupational therapists, social workers, psychologists, pharmacists, exercise specialists, physiotherapists, medical officers, and dietitians) working within mental health services.
- Healthcare professionals who provide healthcare services but are not mental health specialists.
- Individuals with mental illness.
- Families and carers of individuals with mental illness.
- Healthcare managers and leaders with responsibility for policy and strategy development.

3. Background and Literature Review

As outlined, people with mental illness experience substantially reduced life expectancy compared to age-matched peers (Firth et al., 2019; Osborn et al., 2008; Moore et al., 2015; WHO, 2018). Younger adults (aged 15–34) are particularly susceptible to multimorbidity, being five times more likely to have three or more chronic conditions before age 35 (NHS, 2018 THIN).

There is increasing evidence to support the hypothesis of overlapping pathways leading to physical and mental health conditions. (WHO, 2018). These include biological mechanisms such as genetic susceptibility, inflammation, immune system dysfunction and metabolic dysregulation. Adverse health behaviours, substance use disorders and psychological factors

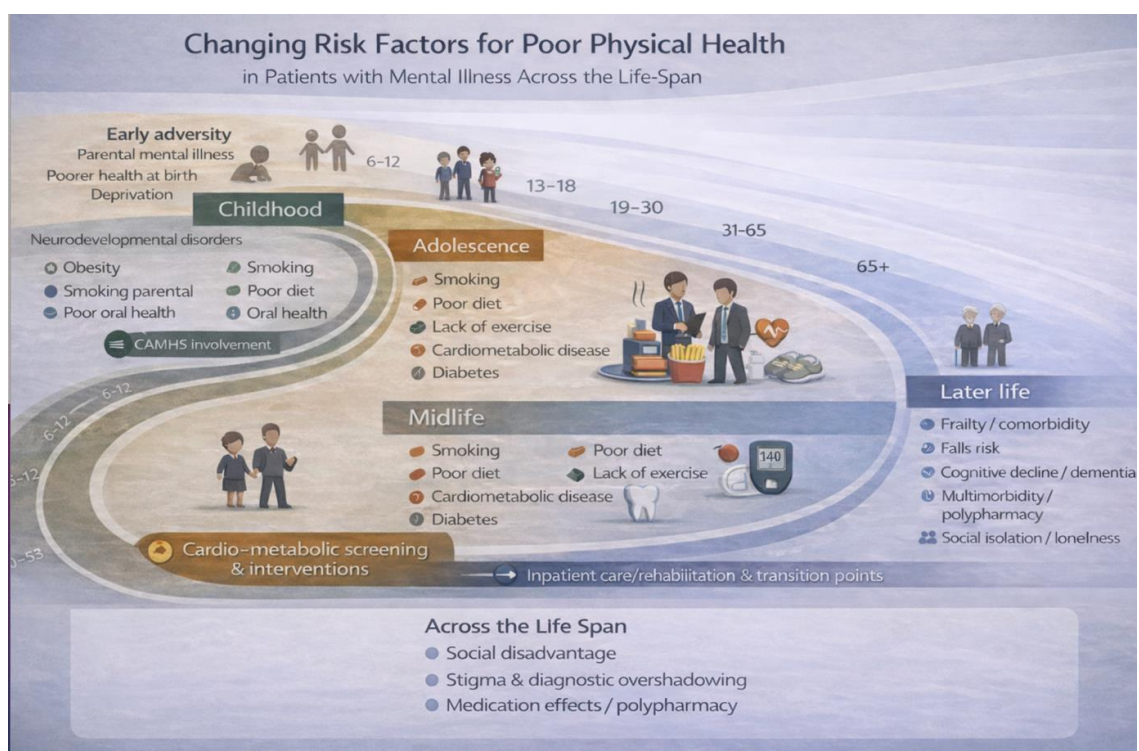
- including stress from life adversities - along with broader socioeconomic determinants also contribute to this interconnected relationship.

Socioeconomic deprivation compounds these risks, with higher rates of both mental illness and physical illness observed in areas of socioeconomic disadvantage. In Ireland, disparities in physical and mental health are particularly evident among women, members of the Traveller community, ethnic minorities, patients with intellectual disabilities and individuals experiencing socioeconomic deprivation. These groups face intersecting barriers including higher rates of multimorbidity, reduced access to preventive and primary care, and experiences of discrimination within health services (All-Ireland Traveller Health Study, 2010; Mental Health Commission, 2019; McMahon & Hatton, 2021).

Barriers to the recognition and diagnosis of physical health conditions in individuals with mental illness effectively deny them access to the same standards of care that other members of the community would expect (Kisely et al., 2009; Lawrence et al., 2013). Such barriers require attention at structural, systemic, healthcare provider, individual and psychosocial levels.

4. Key Considerations

Clinicians and patients should focus on modifiable risk factors across the lifespan to reduce morbidity and mortality among individuals with severe mental illness.



4.1 Factors Contributing to Increased Morbidity and Mortality

Smoking

Individuals with mental illness demonstrate higher rates of tobacco use. A robust association exists between smoking and mental health conditions which intensifies relative to the severity of the mental health condition, with the highest prevalence observed in psychiatric inpatient facilities (RCP & RCPsych, 2013).

Smoking cessation is particularly important for this population, as tobacco use constitutes the single largest contributor to their 10-20 year reduction in life expectancy (Royal College of Psychiatrists, 2014). Smoking also impacts on antipsychotic medication blood levels requiring higher doses to be used in this population.

Internationally, smoking rates in the general population range between 15 and 20 percent. This figure rises to 40.5 percent among individuals with severe mental illness (SMI) in the UK and 36 percent among individuals with any mental illness in the USA, making them approximately twice as likely to smoke compared to the general population.

In Ireland, smoking in enclosed workplaces was prohibited under the Public Health (Tobacco) Act 2002. However, exemptions were granted to prisons and psychiatric institutions reflecting the residential and custodial character of these settings rather than any evidence-based rationale for differential health protection. The continuation of smoking within psychiatric settings reinforced a longstanding inequity whereby people with severe and enduring mental illness were afforded a lower standard of physical health protection than the general population.

In 2012, the Health Service Executive extended its National Tobacco Free Campus Policy to encompass mental health services and psychiatric inpatient units. This marked an important policy shift reframing tobacco dependence as a healthcare issue rather than a behavioural or cultural norm within psychiatric care. The policy acknowledged the disproportionate burden of tobacco-related morbidity and premature mortality experienced by people with severe mental illness and sought to de-normalise smoking within healthcare environments (Harrington et al., 2024). Despite this policy commitment, implementation remains inconsistent with only 5% of surveyed units reported have fully enforced the HSE Tobacco-Free Campus Policy. This implementation gap highlights the persistence of structural and cultural barriers to achieving equitable physical healthcare within mental health services.

Historically, smoking has been perceived as having a therapeutic or calming effect for individuals with mental illness (Sheals et al., 2016). However, this assumption has been challenged by more recent evidence (Taylor et al., 2020; NHS England Tobacco Dependency Programme) and many institutions in the UK have successfully implemented comprehensive smoke-free policies, including South London and Maudsley NHS Foundation Trust.

The continued exemption of certain acute mental health settings is particularly concerning given the high prevalence of smoking among this population. Irish inpatient studies report smoking rates of approximately 35% (Burns, 2018; Finnerty, 2018), which is roughly double that of the general adult population (IPSOS B&A, 2025). Of further concern, one study found that 7% of individuals initiated smoking during inpatient admission (Srikumar et al., 2023). The same study also reported increased tobacco consumption and expenditure among smokers during admission, with fewer than 10% of patients having smoking addressed within their care plans.

Although individuals with mental illness tend to have higher levels of nicotine dependence and lower abstinence rates, evidence suggests they are at least as likely, if not more likely, to engage with tobacco treatment services (Kacmarek, BMC, 2025). Irish Stop Smoking Services data (Quitmanager, 2026) further indicate that individuals with mental health difficulties are equally likely to participate in cessation programmes and achieve successful quit outcomes when provided with appropriate supports.

Advances in the pharmacological treatment of tobacco dependence, including Cytisine, Varenicline and Bupropion, have demonstrated efficacy and tolerability in individuals with mental illness (Anthenelli et al., 2016). These developments reinforce the importance of integrating evidence-based tobacco dependence treatment into mental health services as a core component of care.

Poor dietary practices

Poor dietary practices are now understood as modifiable risk factors for mental health (Mudd, 2024). Individuals with psychiatric illness are more likely to have dietary patterns, disordered eating behaviours and nutritional deficiency, which further increase their cardiovascular risk (Firth et al, 2019). In particular, patients with schizophrenia and mood disorders are more likely to have higher caloric intake and a dietary pattern mainly constituted by carbohydrates,

saturated fat and an excessive use of convenience and highly processed foods, with concurrent low intakes of fruit and vegetables (Firth et al., 2020).

Eating disorders are associated with the highest mortality rate of all mental health conditions and carry a significant risk of both acute medical complications and long-term physical health consequences. The development of the Medical Emergencies in Eating Disorders (MEED) framework (RCPsych, 2022) has strengthened approaches to risk assessment and acute management, providing clear, practical guidance for all professionals involved in patient care across medical, psychiatric, psychological and emergency settings.

In parallel, the National Clinical Programme for Eating Disorders (NCPED) has prioritised early identification and timely referral to specialist services (Driscoll et al., 2024). This programme has expanded access to dedicated multidisciplinary teams and specialist expertise, supporting the delivery of evidence-based treatment and improving outcomes for this high-risk population.

The World Health Organization identifies nutrition as a key component in reducing the life-expectancy gap between individuals with psychiatric disorders and the general population (Teasdale et al., 2020). However, despite growing evidence supporting the integration of lifestyle interventions, including nutrition management, in the treatment of individuals with psychiatric illness (Firth et al, 2019) such interventions remain rarely integrated into standard psychiatric practice.

Physical Inactivity

Physical inactivity has serious implications for population health. Prolonged sedentary behaviour increases the risk of cardiovascular disease, type 2 diabetes, cancer and premature mortality. (WHO, 2020). Approximately two million deaths per year are attributed to physical inactivity according to WHO estimates.

To mitigate these risks, current guidelines recommend that individuals engage in at least 150 minutes of moderate-intensity physical activity or at least 75 minutes of vigorous-intensity physical activity per week (WHO, 2020). Acknowledging the multilevel barriers to physical activity that people with mental health difficulty experience, supported professional led programmes appear optimal to facilitate autonomously motivated activity (Teasdale, et al. 2025). Examples of such include community-based Ex-Well programmes (Kehoe, 2020) and integrated exercise practitioners in Wexford mental health services (Denieffe et al.,

2021/2022). These initiatives can help inform service design and audit processes. Prolonged sedentary time during the day is associated with almost 70,000 deaths annually in the UK (Firth et al, 2019).

Cardiovascular Disease and Diabetes

Cardiovascular disease remains a leading cause of mortality both for the general population and for individuals with mental illness. A large international study demonstrated that smoking, diabetes mellitus, hypertension, dyslipidemia, abdominal obesity, diet and physical inactivity (the INTERHEART study, Yusuf et al., 2004) contribute to 90% of this risk. Smoking increases the odds of myocardial infarction by almost threefold, as does elevated levels of atherogenic cholesterol. The odds of cardiovascular disease are also approximately 25% higher for every 10 mmHg increase in systolic blood pressure above the normal level of 120 mmHg. Therefore, because hypertension is so common, it is the risk factor that causes most CVD events worldwide.

In addition, individual factors such as sex, gender, age, frailty, socioeconomic status, comorbidities and psychotropic medication, influence the relationship between cardiovascular disease and mental health and may necessitate individualized approaches (Bueno et al., 2025).

Reducing stigma and ensuring access to high-quality, guideline-directed cardiovascular care is essential, with particular emphasis on supporting treatment adherence and monitoring for clinically significant drug-drug interactions.

While antipsychotic medications are essential for the management of mental illness, they are associated with an elevated risk of diabetes. Antipsychotic agents may cause weight gain and insulin resistance, leading to increased risk of developing type 2 diabetes, compounded by lifestyle factors such as poor diet and physical inactivity (DeHert et al., 2011).

Individuals with mental illness demonstrate higher rates of diabetes, the delayed diagnosis of which may result in visual impairment, renal failure, cardiovascular complications, sexual dysfunction, neurological symptoms and recurrent infections (Firth et al., 2019).

Patients with diabetes show a disproportionately higher incidence of eating disorders, reflecting the complex interplay between metabolic control, psychological burden and behaviours such as dietary restriction or insulin manipulation.

Accordingly, mental health professionals should maintain a high index of suspicion for diabetes, ensure regular metabolic monitoring, and collaborate with primary care to mitigate risk. In Ireland, patients who develop diabetes should be referred to their GP for appropriate follow-up and enrolment in the Chronic Disease Management (CDM) programme.

Obesity

Obesity is now recognised as a chronic disease that requires proactive treatment to reduce associated disease burden (NICE, 2025). Obesity rates are higher among patients with mental illness than in the general population (Scott et al., 2008; Mazereel et al., 2020). Fortunately, several newer incretin-based medicines (e.g., semaglutide, tirzepatide) have demonstrated substantial reductions in body weight/BMI in adults with obesity; and semaglutide has been shown to reduce major adverse cardiovascular events in people with overweight/obesity and established cardiovascular disease without diabetes (Lincoff et al. 2023). However, these medicines have significant cost and access implications in Ireland, and licensing/eligibility criteria restrict use to diabetic patients and to defined BMI thresholds (e.g. for people who are overweight only, with weight-related comorbidity). Other strategies for preventing anti-psychotic induced weight gain in patients with mental illness include recent Irish guidelines on the use of metformin in this cohort (Carolan et al., 2025). Expanded commissioning and access to effective obesity pharmacotherapy is therefore an important policy priority for patients with mental illness.

Alcohol and Illicit drugs

Substance use disorders, including alcohol and illicit drugs, are common among individuals with mental illness and contribute significantly to excess physical morbidity and premature mortality. The relationship between mental illness and substance use is complex and mutually reinforcing, and is associated with increased risk of cardiovascular disease, liver disease, respiratory illness, infectious diseases and reduced treatment adherence (Firth et al., 2019; WHO, 2018; De Hert et al., 2011).

Mental health services should incorporate routine screening for substance use within physical health assessment, alongside brief interventions, harm reduction strategies and referral to specialist addiction services, where appropriate. For individuals with severe mental disorders and comorbid substance use disorders, interventions should be considered in accordance with WHO mhGAP guidelines (WHO,2023). Close collaboration between mental health, primary care and addiction services is essential to support integrated, person-centred care and improve outcomes.

Oral Health

The aetiology of oral diseases in individuals with mental illness is multifactorial and includes smoking, sleep disorders, poor self-care, high dietary intake of sugar, alcohol consumption and side effects from psychotropic medications (e.g. bruxism, xerostomia/periodontal effects). Individuals with mental health difficulties are less likely to access dental services for routine dental examinations and treatment, potentially driven by similar barriers to accessing medical healthcare (Kisely, 2016).

Complications arising from untreated dental decay constitute common reasons for potentially preventable acute non-psychiatric hospital admissions (Kisely et al., 2021)

Furthermore, the interaction of these conditions promotes inflammatory processes associated with elevated cardiometabolic and cardiovascular disease risk (De Hert et al., 2011).

Dental diseases can be prevented through maintenance of appropriate oral hygiene and dietary practices, early diagnosis and proactive rather than reactive care.

4.2 Other Physical Health Considerations

Cancer Risk

Multiple lifestyle factors are associated with elevated cancer risk. Risk is further increased by low rates of self-examination among individuals with mental illness, reduced screening uptake leading to delayed diagnosis, low rates of participation in follow-up care and medication effects including hyperprolactinemia. Diagnostic overshadowing may result in clinicians misattributing symptoms to mental illness; and inadequate assessment of medical family history may further prevent identification of warning signs (Lawrence et al., 2010).

Respiratory Conditions

Elevated rates of active and passive smoking are associated with increased incidence of bronchitis, asthma and other respiratory conditions. A recent publication in the Lancet (Laguna-Muñoz et al., 2025) demonstrated that overall respiratory disease-related mortality risk was two times higher in individuals with severe mental illness compared with the general population. Disease-related mortality risk was similarly increased for all specific respiratory diseases (risk ratios ranging between 2.28 and 4.48) apart from lung cancer.

Renal disease

Population and cohort studies consistently show higher rates of chronic kidney disease (CKD), and in some settings faster progression and poorer renal outcomes, compared with people without mental illness. This association is understood to be multifactorial: cardiometabolic comorbidity (hypertension, diabetes, obesity), high rates of smoking and substance use, deprivation and reduced access to preventive healthcare, and medication-related factors (e.g., lithium-associated nephrotoxicity in bipolar disorder; dehydration risk and metabolic adverse effects with some antipsychotics) all contribute. Importantly, renal impairment also increases clinical complexity in mental health care - affecting prescribing, toxicity risk and physical health inequality - highlighting the need for integrated monitoring, early detection (eGFR/albuminuria), and proactive management of cardiovascular and metabolic risk in mental health services (Cogley et al., 2022; Li, H., et al., 2025).

Osteoporosis and Bone Health

People with serious mental illness are at increased risk of osteoporosis and fractures due to interacting biological and behavioural mechanisms, including antipsychotic-associated hyperprolactinaemia and hypogonadism, low levels of weight-bearing physical activity, smoking, alcohol and other substance use, poor diet and micronutrient deficiency, and limited sunlight exposure contributing to vitamin D deficiency (RANZCP, 2016). Medication effects (e.g., sedation and postural hypotension) may further increase risk of falling, compounding fracture risk (Firth et al., 2019).

Obstructive Sleep Apnoea (OSA)

OSA is increasingly recognised as a significant modifiable risk factor for patients with many co-morbid diseases including hypertension. OSA rates are higher in individuals treated with antipsychotic medication (Shirani & Paradiso, 2011). Identifying and treating OSA could reduce both physical and psychological risk as poor sleep quality is noted to occur across every major mental disorder as a precipitant, aggravating and perpetuating factor.

Venous thrombo-embolism (VTE)

Recently published evidence-based guidance on venous thromboembolism (VTE) prophylaxis for adults hospitalised for psychiatric illness highlights that VTE risk assessment, monitoring, and prophylactic treatment are not consistently implemented in mental health inpatient settings, despite many patients having physical risk profiles comparable to those admitted to medical units (Purcell et al., 2026). While overall VTE risk is influenced by multiple factors, immobility is a key differentiator in medical inpatient populations and is strongly associated

with markedly increased risk of deep vein thrombosis (DVT) and VTE. However, immobility is not routinely considered in psychiatric inpatient facilities, even though some patients may experience significant reductions in mobility due to psychomotor retardation, catatonia, sedation, physical restraint or other clinical and environmental factors (Purcell et al., 2026). Promoting and embedding this guideline across the service would support consistent VTE risk assessment and prophylaxis where indicated, helping to ensure that people with mental illness receive equitable standards of physical healthcare comparable to those without mental illness.

5. Assessment and Screening Approaches

Mental health services should ensure that a comprehensive assessment of comorbid physical health is undertaken at initial presentation and reviewed at regular intervals throughout an individual's engagement with the service. Patients should be routinely screened for eating disorders at initial assessment.

Given the robust evidence demonstrating elevated rates of cardio-kidney-metabolic (CKM) disease among people living with mental illness, cardio-kidney-metabolic risk assessment should be prioritised as a core component of routine clinical assessment.

Initial assessment should also incorporate relevant sociodemographic and clinical information, including age, gender, ethnicity, accommodation status, educational attainment, indicators of socioeconomic adversity, rurality, marital status, employment and income, and levels of social support. A thorough family history should be obtained, particularly relating to diabetes and cardiovascular disease, as well as household exposure to tobacco smoke. Personal history should include smoking status, alcohol use and substance use. Clinicians should document previous or current treatment for obesity, diabetes (including gestational diabetes), cardiovascular disease, sleep disorders, constipation and sexually transmitted infections. Assessment should also identify involved services and include attention to oral health, including dental hygiene and xerostomia.

6. Intervention and Management Approaches

Mental Health Services

Many services have increased the screening of people with mental illness for physical health conditions. However, rates of intervention and treatment remain comparatively low (Carney et al., 2018).

Although clinical decision-support tools such as the Lester Tool can assist clinicians in identifying cardiometabolic risk and guiding management (Lester et al., 2014), the decision to initiate treatment is influenced by wider service and system factors. These include clinician competence and confidence, access to primary care support, availability of secondary medical services and access to Health & Social Care Professional (HSCP) led lifestyle interventions such as dietetics and exercise physiology (Firth et al., 2019; Teasdale, 2025; Solmi et al., 2019).

Existing HSE policy on Tobacco Free Health Care should be championed especially by psychiatrists and others involved in care of patients with mental illness. Policy should be implemented in all inpatient units and in CMHT facilities. Nicotine addiction should be treated like any other medical condition.

Achieving equitable physical healthcare for people with mental illness requires integrated working across health and social care sectors. Community Mental Health Teams (CMHTs) should develop structured liaison pathways with General Practitioners (GPs), secondary medical services and relevant tertiary supports, including dentistry. In parallel, CMHTs should establish referral pathways to social supports where required including housing services and interpreting services. Patients and carer representatives should be meaningfully involved in the design and evaluation of these pathways.

Physical health should be considered at every clinical contact within the CMHT (Health Service Executive, 2021). Eligibility for relevant screening programmes should be reviewed routinely; and individuals and carers should receive tailored information regarding appropriate screening and chronic disease management programmes. Where indicated, service users should be supported and encouraged to engage with their GP for follow-up assessment and treatment.

Finally, CMHTs should ensure that every individual is linked with primary care, including having a named GP, to support continuity of care and timely access to prevention and treatment services.

Primary Care

General Practitioners (GPs) are funded to deliver preventive and chronic disease care in the community. Establishing a Chronic Disease Management (CDM) programme specifically for individuals attending mental health services would reduce barriers to accessing physical healthcare, support earlier intervention, and facilitate referral into existing CDM programmes and secondary care when clinically indicated. Over time, existing CDM programmes, particularly those targeting obesity and diabetes, should be adapted to better meet the needs of people with mental illness in line with international best practice recommendations for integrating physical and mental healthcare (Firth et al., 2019).

Significant gaps persist in access to core primary care services for patients with mental illness. Disciplines such as dental services, physiotherapy, occupational therapy, speech and language therapy and dietetics remain variably accessible, despite their importance in supporting overall health and functional capacity. Of particular concern, there are instances where a diagnosis of mental illness may explicitly or implicitly limit eligibility for certain services, reinforcing existing health inequities.

Although these services may not provide direct physical healthcare, they are integral to addressing the complex interplay between physical and mental health. For example, physiotherapy and occupational therapy are critical in managing comorbid physical conditions, improving mobility and supporting engagement with health-promoting activities. Similarly, dietetic input can play a key role in addressing metabolic risk factors that are disproportionately prevalent among individuals with severe mental illness.

The role of social care is of particular importance. People with mental illness experience significantly higher levels of social deprivation, including homelessness and reliance on state-supported accommodation, which are well-established determinants of poor physical health outcomes. Without adequate social supports, efforts to improve physical health are unlikely to be effective or sustained.

The ongoing implementation of Sláintecare (HSE), alongside the reconfiguration of services into integrated community healthcare networks, provides a critical opportunity to address these disparities. A whole-system approach to ensure that individuals with mental illness have equitable access to the full spectrum of primary and social care services must include

the explicit inclusion of this population in service eligibility criteria, care pathways and resource planning.

A model for mental health services

Mental health services are well positioned to assist individuals in problem-solving regarding engagement with physical health interventions. Mental health services should be developed to enhance this capacity.

Proposed CMHT physical health workforce model

1) Physical Health Champion in each CMHT

A physical health “champion” (community mental health nurse) embedded within each CMHT (1 WTE per CMHT) would provide practical support to improve access and follow-through for physical healthcare, including:

- Assisting service users to access lifestyle interventions
- Supporting individuals to establish and maintain contact with GPs and secondary care providers
- Encouraging attendance at physical health appointments and following up recommendations
- Attending outpatient departments where needed to support engagement and continuity
- Ensuring metabolic screening is completed, documented and tracked in line with clinical guidelines

2) Advanced Nurse Practitioner (ANP) for Physical Health (service-wide lead)

An ANP (1 WTE per 25,000 population) for physical health would provide regional/service-wide oversight and supervision by:

- Supervising and supporting CMHT physical health champions
- Ensuring compliance with national and local physical health policies
- Driving consistent implementation of screening and intervention pathways across services
- Facilitating a multidisciplinary team (MDT) approach to physical health integration, including liaison and pathway development with:

- dental services
- primary care dietitians
- physical health practitioners
- smoking cessation services
- Coordinating interim access to these supports until they are embedded within CMHTs

3) ANP integration under the Regional Health Area (RHA) model

Within the new Regional Health Area (RHA) structure, the ANP would strengthen integration between mental health and broader community health services by:

- Liaising with medical and surgical ANPs through the community hub
- Enhancing existing linkages across disciplines
- Supporting stigma reduction by positioning mental illness on an equal footing with other community clinical specialties

In addition, the ANP role would support continuous structured dialogue between mental health services and primary/secondary care during pathway design and implementation.

Based on the prevalence of mental illness in Ireland with an average caseload of 500 patients per CMHT, a minimum of 1.5 - 2 ANPs per population of 100,000 would be necessary to meet the needs of this cohort as outlined.

Population needs differ in Child and Adolescent Mental Health Services (CAMHS). A significant proportion of young people aged 15–17 years present with underweight or normal weight profiles (e.g. eating disorders or those prescribed stimulant medication for ADHD, where established monitoring protocols are typically in place). A smaller subgroup with severe mental illness requiring antipsychotic treatment may have needs more closely aligned with the adult population described above. Accordingly, staffing models in CAMHS should be proportionate to population need; for example, an initial model of one Clinical Nurse Specialist (CNS) or equivalent per CAMHS service may be appropriate, rather than per individual team. While staffing requirements may differ, the underlying principles of systematic, proactive and integrated physical health monitoring remain consistent across CAMHS and adult services.

Collaboration Model within Community Mental Health Teams: Enhancing Physical Health Care

Physical Health Champion in Each CMHT

Core Functions

- Supporting service users to access lifestyle interventions
- Helping individuals establish and maintain GP & secondary care links
- Encouraging attendance at **physical health** appointments
- Following up clinical recommendations
- Attending outpatient departments where required to support engagement
- Ensuring metabolic screening is completed – tracked in line with clinical guidelines

Advanced Nurse Practitioner (ANP) for Physical Health Service-Wide / Regional Lead

Leadership & Oversight

- **Supervising** and supporting CMHT Physical Health Champions
- Ensuring compliance with national and local physical health policies
- Driving **consistent** implementation of screening and intervention pathways



ANP Integration within Regional Health Area (RHA)

System Integration

- Liaising with medical and surgical ANPs through community hubs
- **Strengthening existing links** across disciplines
- Supporting shared clinical pathways across community services

Stigma Reduction

- Positioning mental illness on an **equal footing** with other community clinical specialties
- Promoting parity between mental and physical health care



System-Level Outcomes

Governance & Quality

- Improved **clinical oversight** of physical health in mental health services
- Consistent standards across CMHTs

Care Experience

- Better engagement, continuity, and follow-through
- Reduced fragmentation between services

Equity & Access

- Improved access to physical healthcare
- Reduced health inequalities for people with mental illness



Integrated Pathways & Support



- Coordinated physical health screening and interventions
- Clear referral pathways across mental health, primary, and secondary care
- **Strengthened community partnerships**
- Sustainable integration within the RHA model

Psychoeducation and Health Literacy

Mental health services should provide quality psychoeducation regarding physical health, lifestyle, and management, including information on:

- Medication effects and risk factors
- Symptoms requiring clinical attention
- Importance of regular health assessments
- Smoking cessation
- Lifestyle modifications including diet and exercise
- Regular attendance at health assessments and the importance of physical healthcare
- Adherence to treatment for physical health conditions
- Provision of diet and nutrition advice including meal planning, shopping, and preparation
- Impact of physical wellbeing on brain health
- Social connections and their importance
- Organization of access to subsidized or publicly funded physical health programmes.

7. Roles and Responsibilities

Mental Health Commission

The statutory role of the Mental Health Commission Ireland is central to protecting and improving physical health care for this particularly vulnerable population. Currently, its focus is on inpatient settings where risk, dependency and restricted liberty can amplify health inequalities. Its Judgment Support Framework for inpatient facilities is especially important in this context, as it promotes structured, transparent and person-centred clinical decision-making, supporting staff to make consistent, defensible decisions and to evidence how risks are balanced against autonomy, dignity and recovery.

Healthcare Managers

Healthcare managers should ensure that appropriate systems for physical health screening, detection, management and follow-up are implemented consistently across their regions. Existing programmes should be routinely evaluated to determine effectiveness and equity of delivery.

The development and implementation of Key Performance Indicators (KPIs) for physical health monitoring would enhance transparency, facilitate benchmarking and support monitoring of outcomes over time.

Managers should ensure adequate resourcing of staff who can lead and coordinate lifestyle interventions and physical health monitoring. This includes supporting workforce development through interdisciplinary education and training to strengthen staff competence in collaborative management of physical comorbidity. All staff should receive training in motivational interviewing and be familiar with the HSE MECC (Make Every Contact Count) behaviour change framework to support behaviour change and healthy lifestyle adoption.

Psychiatrists

Psychiatrists should ensure that physical health screening, detection, clinical formulation and follow-up planning are initiated from an individual's first contact with the service. They should ensure that appropriate medical investigations are requested, interpreted and acted upon, and that physical health risks are incorporated into care planning.

Psychiatrists should also ensure that each service user has a comprehensive and integrated physical and mental healthcare plan, clearly specifying clinical responsibilities (e.g., who is responsible for monitoring, referral, follow-up and ongoing management). This plan should be

communicated to relevant partners, including community health services, primary care providers and, where appropriate, families and carers.

Mental Health Nurses and Nurse Practitioners

Mental health nurses (in collaboration with medical practitioners and HSCPs) involved in assessment should be trained to complete a structured physical health interview as part of the initial assessment process.

In outpatient and community settings, Community Mental Health Nurses (CMHNs) should monitor key physical parameters including anthropometric measures, blood pressure and random blood glucose (where clinically indicated) at routine contacts, in accordance with local policy and best practice guidance.

CMHNs should also provide education on lifestyle modification and screening, and support individuals and families by signposting to relevant lifestyle, community, and preventive health resources.

Pharmacists

Evidence indicates that pharmacists can support individuals living with severe mental illness through interventions such as cardiometabolic risk screening and monitoring, medication optimisation and other physical-health focused care (Ng et al., 2022; Sud et al., 2021).

Additional Health Professionals

Evidence supports the contribution of a wider multidisciplinary workforce to improving physical health outcomes for people with mental illness. In the UK, and in international contexts including Uganda, smoking cessation officers have been successfully embedded within community mental health services, with positive outcomes reported (NCCMH/RCPsych, 2024; WHO Africa, 2023).

Occupational therapists may also provide holistic intervention that can support autonomous behavioural and physical health management (O'Connell & McKay, 2010).

Exercise physiologists and exercise practitioners have also been shown to improve physical and mental health outcomes for people with mental illness (Stubbs et al., 2018). Recent work in Wexford integrating an exercise practitioner into mental health services ("The Exercise Effect") has reported improved engagement in physical activity and associated wellbeing benefits (Denieffe et al., 2021/2022).

Family and Carer Engagement

Services should provide structured opportunities for training and information-sharing with families and carers. Families and carers should be supported to participate, where appropriate, in care planning and delivery, including understanding the rationale for physical health monitoring and supporting individuals to access screening and follow-up services.

Other stakeholders

Key community stakeholders include faith and spiritual leaders, as well as school teachers, sports leaders and counsellors, who act as trusted points of contact within communities. These partners have established long-standing relationships that position them as critical contributors to health promotion, early identification of physical illness and support for care engagement. Their meaningful involvement is essential to improving access, continuity of care and improved health outcomes.

Conclusion

This position paper underscores that improving physical health monitoring for individuals with mental illness is an essential component of delivering equitable, high-quality mental healthcare. The evidence is clear that excess morbidity and premature mortality in this population is driven predominantly by preventable and treatable physical illnesses, compounded by social disadvantage, fragmented care pathways and persistent stigma. Addressing these disparities requires a systematic and integrated approach in which physical health assessment and intervention are embedded within routine mental health care, supported by robust partnerships with primary care, specialist services and social supports. Investment in infrastructure, workforce capability and multidisciplinary service models is necessary to translate screening into meaningful intervention and improved outcomes. Ultimately, parity of esteem must be operationalised through coordinated clinical governance, shared responsibility across sectors, and active involvement of service users, families, and carers in service design, ensuring that people with mental illness receive the same standards of preventive care, early detection and chronic disease management as the wider population.

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