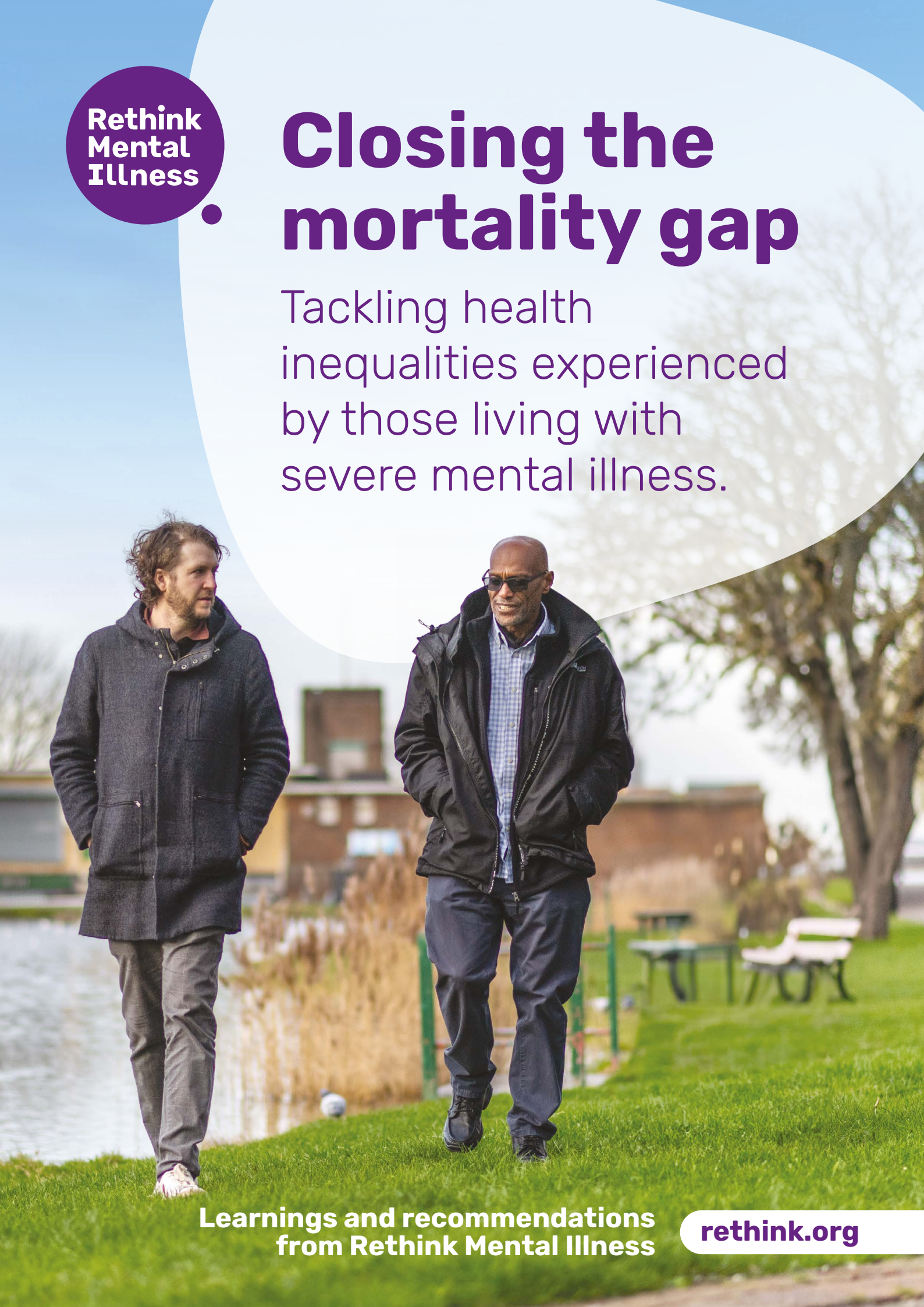
Rethink Mental Illness

Closing the mortality gap

Tackling health inequalities experienced by those living with severe mental illness.



Learnings and recommendations from Rethink Mental Illness

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Through collaboration with people with lived experience, health professionals, and community partners, Rethink has developed and piloted practical tools, peer-led programmes, and place-based interventions aimed at addressing these barriers.

Executive summary

People living with severe mental illness (SMI) in England face a persistent and unacceptable health inequality, dying on average 15-20 years earlier than the general population, largely due to preventable physical illnesses. This report from Rethink Mental Illness examines the complex drivers of this mortality gap and sets out a comprehensive case for urgent national action.

Evidence shows that people living with SMI have higher rates of long-term conditions such as cardiovascular disease, diabetes, respiratory illnesses and higher body weight, and are disproportionately affected by smoking, poor diet and low physical activity. Systemic issues such as fragmented care, poverty, stigma and poor housing, all contribute to worsen health outcomes.

Through collaboration with people with lived experience, health professionals, and community partners, Rethink has developed and piloted practical tools, peer-led programmes, and place-based interventions aimed at addressing these barriers. Successful models include peer support for health checks, community-based smoking cessation, and accessible physical activity initiatives – particularly those that focus on enjoyment, social connection, and co-production.

This report provides recommendations for improving practice and reforming policy. Key factors that should inform both of these include:

- The integration of mental and physical healthcare to provide tailored person-centred support, with the VCFSE organisations involved as a key partner.
- A shift from reactive to preventative approaches - focusing on preventing weight gain and smoking uptake, and increasing physical activity.
- Improve training across health sectors – upskilling the mental health workforce in physical health care, and ensuring the physical health workforce are appropriately trained and understand how to work with people with mental illness.
- An increased proportion of health spending funding prevention - to enable the development of targeted, preventative interventions.
- Involve people with lived experience in co-production of services, and the delivery of services through peer support roles.
- Use data about interventions and outcomes to track progress and inform commissioning and service development.
- Ensure that physical health of people with SMI is a key element a cross-government Mental Health Strategy.

About Rethink Mental Illness

We are Rethink Mental Illness. We believe people severely affected by mental illness deserve to live longer, safer and more fulfilling lives, whoever they are and wherever they live. We are also there for the families, carers and loved ones who support them, whose own needs too often go unrecognised. We do this through local services in communities across England, advice and information, peer support, and campaigning for the changes people need to recover, thrive and participate fully in society.

We know mental illness should not mean shorter lives, fewer opportunities or facing life's challenges alone. That's why we work alongside people with lived experience, families and carers to challenge stigma, discrimination and misinformation, improve care and treatment, and build Communities that Care.

Introduction

People who are severely affected by mental illness can experience symptoms that are so distressing and debilitating that it has a significant impact on their daily life, relationships, and their ability to work[1]. As well as this, people living with severe mental illness (SMI) are more likely to experience serious physical illnesses, which means that their life expectancy is 15–20 years shorter than that of the general population.

This report explores the relationship between physical health and mental health in greater depth. We consider the various factors that can contribute towards poor physical health among those living with a mental illness and draw on robust evidence and our own extensive experience to suggest interventions to improve the physical health outcomes of those living with a mental illness and close the mortality gap.

Our expertise in this area

Our Communities That Care model[2] highlights good physical health as one of six foundational pillars essential to sustaining individual wellbeing. In alignment with this principle, Rethink Mental Illness has undertaken extensive initiatives to address the health inequalities faced by individuals living with mental illness.

Between 2021 and 2025, Rethink collaborated with Sport England on a programme funded to investigate and overcome barriers to physical activity among those severely affected by mental illness. The overarching aims were to enhance both physical and mental health outcomes for individuals with long-term mental health conditions and their carers, reduce health disparities, and demonstrate the efficacy of inclusive, community-led strategies.

Our Sport England funded project to understand barriers to physical activity for people severely affected by mental illness.

Rethink Mental Illness was funded by Sport England to work with people with lived experience to better understand the complex interaction between physical activity, physical health and mental health, and to identify what local barriers were preventing people with SMI from accessing physical activity, and how to overcome them.

The project, based in North East Lincolnshire and Tower Hamlets, showed that people with SMI understand the mental and physical benefits of physical activity and are motivated to be active. However, over two thirds of people living with SMI did less than 30 minutes a week of at least moderate intensity activity.

The barriers identified included a lack of social support, the impact of health conditions and medications, and negative emotions such as anxiety, stress and self-consciousness leading to avoidance and reduced participation in physical activity.'

We found that personalised care and support from healthcare professionals, peer support and trusted companions reduced anxiety and boosted confidence; welcoming, tailored environments encouraged participation; and co-designed approaches with people with lived experience made interventions more effective.

Phase one concentrated on identifying and addressing individual barriers through engagement with peer support groups. Phase two focused on systemic challenges, operating in Tower Hamlets and North-East Lincolnshire – locations selected due to high levels of deprivation and contrasting demographic contexts[3].

From its UK launch through to its 5th anniversary in 2023, we co-delivered Equally Well UK to promote collaborative efforts improving physical health for those with mental illness. By co-ordinating the Expert by Experience Group, we empowered lived experience experts to contribute to research[4] and advocate for policy improvement[5].

We have also worked in partnership with people with lived experience of SMI to co-develop practical tools and resources tailored to adults with SMI, Integrated Care Systems, primary healthcare providers, and local authorities. This includes a physical activity tool[6] designed to support the integration of physical activity into peer support groups, and a co-produced Physical Health Check Tool[7] designed to support individuals, their carers and clinicians to navigate Physical Health Checks for those living with severe mental illness and other aspects of managing their physical health.

What do we know about physical health and severe mental illness?

Premature mortality among people with SMI

The premature mortality gap for people living with SMI in England is a significant and growing public health concern. Adults living with SMI are almost five times as likely to die before the age of 75 than adults who don't live with SMI[8].

People living with SMI often develop chronic physical health conditions such as higher body weight, asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke, heart failure and liver disease. People with SMI are likely to develop these conditions at a younger age than the general population and are also more likely to develop more than one of these chronic conditions[9].

Before the age of 75, people living with a mental illness are:

6.3 times as likely to die from liver disease

6.0 times as likely to die from a respiratory disease

3.8 times as likely to die from a cardiovascular disease

2.25 times as likely to die from cancer[10]

Why people with SMI are more likely to have physical illnesses

People with SMI can be prone to physical illnesses for different reasons. They may use food as a source of comfort[11], have low levels of physical activity, smoke cigarettes or misuse drugs and alcohol[12].

People with SMI who are experiencing physical health issues can struggle to receive the care they need. A lack of integrated physical and mental healthcare[13] results in fragmented treatment, lacking a holistic, person-centred approach. Diagnostic overshadowing – where physical health symptoms are mistaken for symptoms of an existing mental illness and not investigated further[14] – can compromise people's access to the timely and effective treatment for physical health issues[15].

People with SMI are much more likely to live in poverty which can limit their ability to afford healthy food, access healthcare, and increase stress, which worsens health[17].

> **"I'm trying to explain that my mental health impacts my ability to look after my physical health and my diabetes more specifically. Mental health [services] don't want to know about my physical health and they'll say 'Oh, you need to go and see the doctor.'"[16]**

> My sister smokes like a chimney. I think she uses it as a comfort[25].

The effect of smoking on the physical health of people with SMI

Smoking is likely the biggest factor in the difference in life expectancy between those with and without SMI.

People with SMI are much more likely to smoke than people without SMI, and are more likely to smoke heavily[18]. **40% of people with SMI are smokers, compared with 13% of the general adult population**[19], and the effects of this are significant – **around 50% of deaths in people living with SMI are attributable to smoking**[20]. Smoking increases the risk of health conditions including cardiovascular disease, cancer and diabetes[21] which also increases risk of mental ill health and reduced wellbeing[22].

People with mental health conditions may smoke to reduce stress and alleviate symptoms of their condition[23]. Social determinants of poor mental health can make it harder to stop smoking, such as stressful living conditions and low income[24].

People with a mental health condition who smoke experience more severe symptoms of psychosis, depression and anxiety and require higher doses of some psychotropic medicines[26].

Efforts have been made to address the risk that smoking poses to people with SMI. Mental health inpatient services became smoke-free in 2018[27], meaning that smoking is banned across the whole inpatient estate, and smoking cessation services are provided for patients on site[28]. The NHS Long Term Plan (2019) contained specific actions to address smoking in people with long-term mental health conditions[29] including tailored smoking cessation services and clinical pathways.

In 2024, the Royal College of Psychiatrists' National Collaborating Centre for Mental Health conducted an evaluation[30] of NHS early implementer sites of tobacco dependency in community-based services for people with severe mental illness. Their main findings showed that effective smoking cessation services for people with SMI require long-term funding and flexible services that accommodate challenges such as reduced motivation, missed appointments, or the need for tailored treatment. They identified that people with SMI are more likely to access clinics in locations they already use, that they benefit from peer support and staff trained in working with those who live with severe mental illness, and that financial or voucher-based incentives improve engagement.

Historically, smoking in inpatient settings has been deeply entrenched within their culture[31]. Despite the implementation of smoke-free policies across mental health trusts (such as the Healthy Lives, Healthy People Tobacco Control Plan in 2011), patients in inpatient settings continue to smoke.

Action on Smoking and Health (ASH) found that in inpatient settings, 37% of trusts said patients were found smoking in their bedrooms at least every week; 35% said patients were found smoking in secure courtyards/gardens every day; and in nearly half of trusts (48%), patients were found smoking in hospital grounds every day[32].

ASH highlighted major barriers to delivering effective smoke-free interventions in mental health settings, including negative and inconsistent staff attitudes and culture at all levels. Some staff viewed smoking as a 'patient's right' or a low clinical priority. The ASH report also stressed that without sustained investment, ambitions to reduce smoking-related health inequalities will fall short.

Positively, the organisation's survey[33] of Mental Health Trusts found that 70% of Mental Health Trusts now provide dedicated quit-smoking support to patients who smoke - representing a significant improvement compared to the position five years earlier. However, only 42% of trusts reported being able to offer support to all smokers, highlighting ongoing gaps in coverage.

The challenges of weight management for people with SMI

People with SMI aged 15-74 are almost twice as likely to have a high body weight than their peers in the general population. At the younger end of this cohort (ages 15-34), they are three times as likely[34]. They are also more likely to have a higher body mass index (BMI) than the general population, increasing their risk of health problems like cardiovascular disease, type 2 diabetes, osteoarthritis, and certain cancers[35].

Antipsychotic medicines can cause rapid and significant weight gain[36]. As such, NHS England guidance recommends that anybody starting on the medication should have their physical health monitored from the onset[37]. Other factors that can cause weight gain in people living with SMI are related to sedentary behaviours, poor diet and social factors such as poverty[38].

Different interventions have been tried to address the issue of weight gain in people with SMI. Some local NHS Trusts and councils commission tailored weight management services for people with SMI[40]; and Early Intervention Psychosis services include weight monitoring to address the link with anti-psychotic medication[41].

With my medication, it has led to weight gain and more physical symptoms. This impact on my physical health doesn't make me feel better[39].

A 2020 Equally Well review found that there are significant gaps in evidence related to weight management interventions for people living with SMI. Whilst the review found that sustained (6+ months) lifestyle interventions combining exercise and dietary advice, delivered by qualified professionals like dietitians, reduced BMI by more than 5% (which is clinically significant and effective in reducing diabetes and heart disease), it was unclear which interventions had the most impact[42].

The previous NHS Enhanced Weight Management service was replaced in 2026 by two Quality Outcomes Framework indicators focusing on obesity management. Operational guidance for the Quality Outcomes Framework and eligibility criteria related to these indicators fails to make the link between obesity and mental illness and identify those living with a mental illness as an at-risk population[43]. This could be a missed opportunity to provide weight management support for people with SMI.

For the Equally Well report 'More Than a Number: Experiences of weight management among people with SMI' (2020)[44], we spoke to over 50 people with lived experience, as well as practitioners and commissioners. They explained the difficulties of remaining motivated during fluctuations in their mental health; how eating habits related to their emotions; and the lack of long-term support. Practitioners and commissioners spoke about challenges of providing weight management support to people with SMI, with priority given to psychiatric care over issues such as weight; and a lack of clarity about who is responsible for coordinating physical health care of people with severe mental illness.

People with lived experience told us they wanted:

- early, proactive interventions, especially before or when starting antipsychotic medication
- support that prioritises weight gain prevention and lifestyle maintenance over purely weight loss targets
- person-centred, flexible, and motivational approaches, grounded in trusting relationships, peer support, and enjoyable activities. Goal setting should emphasise habits, not numbers

Research shows very high rates of patients being overweight and with a BMI over 30 in inpatient psychiatric settings, especially secure units. In secure mental health units, this rate can reach up to 80%, compared to around 60% in the general adult population[45]. Studies show that weight often increases further after admission: one found a mean gain of 4 kg in the first 12 weeks, with 52% overweight or obese at admission rising to 68% after six months[46].

As well as priority being given to psychological health over physical health, patients have easy access to unhealthy food[47], and limited opportunity for, and support to access, physical activity[48].

When I went into hospital, I'm not really sure if it was due to the pandemic but there wasn't really much to do. I went to the gym a couple of times and had a walk and cooked a meal, though generally it was just sitting around. I was in hospital for two months and only had two occupational therapy appointments. Hospitals could be better[49].

The link between SMI and physical activity

It is widely known that physical activity is good for our physical, mental, social, and emotional wellbeing, and even relatively small increases in physical activity can contribute to improved health and quality of life[50].

The World Health Organisation defines physical activity as 'any bodily movement produced by skeletal muscles that requires energy expenditure'[51]. The Richmond Group report, 'Millions more moving', advocates for a focus on the term 'movement' rather than 'physical activity' (2024), as 'movement' feels more accessible and recognises that activities such as gardening and housework also have positive impacts.

As stated earlier in the report, people who are severely affected by mental illness are also likely to have serious physical illnesses. Physical activity is known to have significant positive impacts on reducing the risk of illnesses, reducing psychiatric symptoms, improving cognition and improving cardio-respiratory fitness[52].

People who are severely affected by mental illness are, however, less likely than those without to do any moderate or vigorous physical activity[53] because of the barriers they face in taking part.

In England, a range of interventions such as lifestyle and exercise programmes are available to people with SMI to increase their levels of physical activity. Researchers have found that current interventions have not necessarily been successful in engaging people with SMI in physical activity, with the interventions not routinely offered to people with SMI in NHS settings. This study recommended that bespoke interventions should be developed to better engage people with SMI in physical activity[55].

Through our place-based work that was funded by Sport England, we engaged with people with lived experience of mental illness and their carers, to understand what the barriers to engagement in physical activity were, and how they might be overcome. The work took place in Tower Hamlets (in London), and North East Lincolnshire. These areas have significant differences, but also some similarities. One is urban and diverse, the other coastal and predominantly White British – but both face high levels of deprivation and significant health inequalities. While the specific challenges vary, both places are working to improve access to integrated, community-based mental and physical health support for people with severe mental illness[56/57].

> **"When my son's mental health is good, he is very interested in keeping physically well – gym most days, healthy eating. When he is mentally unwell he has no interest in being physically healthy[54]."**

We found that the greatest barriers to physical activity for people with SMI were:

Social influence - not having someone to undertake activity with, and people (healthcare professionals as well as friends and family) not talking about physical activity.

Emotions - feeling anxious about starting an activity they would like to do, or life being too stressful to think about exercising.

Belief about capabilities - mainly related to effects of medication and medical condition.

Environmental context and resources - time and cost were more of a barrier for carers than for the person living with SMI. Lack of access to culturally appropriate activities was found to be a barrier in Tower Hamlets but not NE Lincs. Lack of understanding of SMI amongst instructors and coaches was a barrier in both areas.

We found that improving access to physical activity for people with SMI and their carers requires strong, community-based action. At present, the barriers to engagement for people with SMI are so significant, that unless they are addressed, people with SMI will face further inequalities. These barriers are rooted in social factors such as race, income, and gender – and tackling them calls for long-term, coordinated efforts.

General physical healthcare

People who are on the SMI register, because they have a diagnosis of schizophrenia, bipolar, or psychosis, have access to annual physical health checks. In Q1 (2026/27), 58.6% of people with SMI had received a full physical health check in the previous 12 months[58]. What we don't know, however, is what interventions took place as a result, and crucially, what difference they made.

The Five Year Forward View for Mental Health (2016) aimed to reduce the mortality gap by requiring all mental health providers to deliver physical health interventions in inpatient settings[59], and the Care Quality Commission (CQC) strengthened their inspection criteria around physical health in inpatient settings[60].

However, the quality and comprehensiveness of physical health provision remains variable, and the barriers to improvements have not changed[61].

There remain gaps in training for mental health professionals such as nurses and psychiatrists around core physical health competences, with physical and mental health care needs regarded very separately. Mental health inpatient units often have a lack of access to basic equipment to assess and monitor physical health.

How to improve the physical health of people with SMI

Despite clear evidence that people who are severely affected by mental illness face a shocking and persistent mortality gap, action to address this crisis has not gone far enough or fast enough. The government must act with urgency to tackle the systemic inequalities that continue to drive poor physical health outcomes for this group. Immediate and coordinated action is needed across health, social care, and in the community to ensure people with SMI can access the same standard of care as everyone else. Without urgent investment, workforce support, and a national cross-government plan that treats mental and physical equally, this unacceptable gap will continue to cost thousands of lives each year.

Recommendations for commissioners and providers

Our recommendations for improving the lives of people with SMI through local practice are detailed below, with separate national policy recommendations at the end of the report.

Get checked out

Physical health checks for people with SMI are critical to identifying potential physical health issues. Incentivising physical health checks for people with SMI through the Quality and Outcomes Framework has been shown to significantly improve uptake[62]. Work by Rethink Mental Illness in Somerset has shown how the use of peer support workers can significantly increase the number of physical health checks taking place and improve the patient experience.

The physical health check alone cannot make a difference to the mortality rate. It is the follow-up interventions that will make a difference. Unfortunately, there is no tracking or monitoring that shows us what follow-up interventions are taking place, and what impact they are having.

In Somerset, discussions with services and the people using them identified a need for dedicated follow-on support for people living with SMI. Two physical health navigators were recruited to link people living with SMI to services in their community, and to create a directory of services for partners, so that they could have all comprehensive information in one place.

Case study

Using peer mentors to increase engagement with SMI physical health checks

In 2019, Somerset was selected as an early implementer site for community mental health services transformation. It brought together the NHS, local authority, the voluntary, community, faith and social enterprise (VCFSE) sector and those with lived experience to develop a model for the county – Open Mental Health, which provides 24/7 support to adults experiencing mental health issues. Improving the physical health of those living with a severe mental illness (SMI) is a key component of this model.

Somerset NHS Foundation Trust created four dedicated roles to deliver SMI physical health checks for people who historically had not engaged in the process. Peer mentors were introduced as SMI physical health check (SMI PHC) practitioners, each of whom linked in with a primary care network (PCN). A key aspect of their role has been to increase engagement with SMI physical health checks by those living with SMI, including by supporting them during a check, helping them to understand the process and results and to take sustainable actions in response.

The approach resulted in Somerset ICB communicating more with GPs to request data about the number of people on their SMI register, while SMI PHC practitioners built relationships with GP practices to raise awareness of the register and physical health checks among GPs and people with SMI. By taking this approach, the SMI register in Somerset increased by 27% between over a six month period.

RECOMMENDATIONS

Expand peer support roles for physical health engagement to help people with SMI complete their physical health checks and engage with follow-up care, boosting check completion rates and enabling earlier prevention of physical health problems.

Increase regular reviews of smoking status and support rather than relying on annual physical health checks.

Smoke-free future

Reducing smoking among people with SMI is the most important step to closing the mortality gap, and it is a national NHS priority. Addressing this requires a whole-system approach that delivers effective stop smoking interventions, tackles negative cultures and stigma, improves cancer screening, and prevents people from starting to smoke[63].

RECOMMENDATIONS

Embed smoking cessation support into a range of mental health services and ensure availability to all applicable patients - increasing accessibility, normalising support and enabling peer-led encouragement.

Mandate specialist training to ensure all mental health and tobacco dependency professionals complete training on the physical and psychological impacts of smoking in people with SMI.

Offer financial incentives, such as vouchers, to motivate and sustain quit attempts for people with SMI, particularly those facing socio-economic disadvantage.

Enforce smoke-free environments by monitoring the implementation of smoke-free policies across all inpatient and community mental health settings, ensuring consistent enforcement and cultural change.

Getting moving

Between 2018 and 2021, we delivered a project (funded by Sport England) which found that embedding activities in peer support groups and local services, thus developing social support networks, increased physical activity levels in people with SMI[64]. We also developed a toolkit for anyone supporting people with SMI who want to be more active, including peer support group coordinators and mental health services. It was designed to provide all necessary information and guidance on how to start facilitating physical activity opportunities to benefit people's health and wellbeing[65].

Our more recent work with Sport England further shows the importance and benefits of social interaction that can be gained through physical activity interventions. Peer-led activity groups, for example, such as walking clubs, gentle yoga, dance, and low impact circuit training prioritised enjoyment, connection, and psychological safety over performance or competition. Support was also available for family carers, which helped to sustain participation, and opportunities to take part in activities alongside their loved ones[66]. Physical activity, plus the social connections, can help to reduce stress and mental health symptoms[67].

> **Sometimes the only place in which people receive any information regarding physical health and physical activities is when they have the annual health checkup or when they visit hospital. Sometimes it's because there is not enough time but it felt like they were being reprimanded for not doing enough activity. Or just receiving a leaflet and [being told], 'you should do this' and that's it. There is not more encouragement or discussion of what options are available.**

RECOMMENDATIONS

Strengthen access to activity through primary care pathways by embedding physical activity advice and signposting within primary care, including social prescribing and peer support, to help people with SMI identify, access, and attend local opportunities.

Embed evidence-based training tools such as Mind and Sport England's 'Safe and Effective Practice Guide'[68] in physical activity projects, ensuring frontline staff and commissioners are equipped to support people with SMI effectively.

Scale up peer support across physical and mental health pathways – including embedding peer support workers within multidisciplinary teams to improve access to physical activity for people with SMI.

Weight matters

In 2020, we co-produced the following report with partners in the sector: 'More than a number – experiences of weight management amongst people with SMI'[69]. People with lived experience consistently call for early, proactive support – especially at the start of antipsychotic treatment – alongside services that are person-centred, flexible and focused on motivation, trust, peer support, and enjoyable, sustainable lifestyle changes.

RECOMMENDATIONS

Strengthen antipsychotic prescribing protocols and follow-up to require regular (and more frequent than annual) physical health monitoring when initiating or continuing antipsychotic medications. Ensure equitable access to nutrition and weight-management support for all people on antipsychotics, beyond those in early intervention services.

Investing in inpatient health

People admitted to psychiatric hospitals in England often see their physical health decline during admission.

In our report, 'Managing a Healthy Weight in Secure Services'[70], we drew on feedback from over 1,000 people in low-and medium-secure psychiatric services to highlight key barriers and enablers of healthy weight management. Issues that contribute to rapid weight gain in inpatients included lack of nutritious food, and limited movement and exercise opportunities. People with lived experience wanted accessible, straightforward guidance and motivational support, as well as more staff awareness about the emotional links between mood, motivation and eating. People stressed the value of trained, supportive staff and peer champions to inspire healthy change.

'A Time to Quit: Experiences of Smoking Cessation Support Among People with Severe Mental Illness'[71], highlights that people with SMI face unique barriers, including misconceptions that quitting smoking could have a negative impact on mental health and the belief that smoking helps in managing symptoms. Effective cessation strategies should be holistic and person-centred, include behavioural therapies, pharmacological support, and peer and social support, and be delivered by trained healthcare professionals.

RECOMMENDATIONS

Improve ward environments by introducing healthy food standards and ensuring access to safe, inclusive physical activity – adapted for secure settings where needed.

Start early support for weight management and smoking cessation from admission, especially for those starting antipsychotic medication.

Systems that care

Rethink Mental Illness deliver place-based mental health work in many different areas of England. Support is tailored to the specific needs of a local community by bringing together health services, local authorities, and voluntary organisations to deliver joined-up, accessible care. It recognises that mental health is shaped by social, economic, and environmental factors, and aims to address these through local collaboration.

Key components of our work include the importance of peer support workers and navigators to connect individuals with appropriate services, as well as the co-production of services with people who have lived experience to ensure they meet local needs effectively. Co-production is crucial, because people with lived experience of mental illness can help to identify how services can best meet their needs. This could include flexible appointments, personalised treatment options, and more.

Case study

'Unbreakable Men'

'Unbreakable Men' is run by the Somerset Activity and Sports Partnership and funded by Somerset Open Mental Health, a partnership delivered by the NHS, local authority and VCFSE organisations in Somerset to provide joined-up clinical and non-clinical support. Launched in early 2023, this programme blends physical activity, peer support and digital tools to foster mental and physical wellbeing.

The project aims to raise awareness of men's mental health, promote self-care, build supportive communities through conversation and movement, and lower barriers to accessing help.

The programme runs weekly informal sessions in a number of locations across the county, offering sports and conversations about wellbeing. Online resources are also a key part of the support offer, including virtual peer support sessions, a Facebook community offering activity suggestions, mindset tips and live-training opportunities, and a mobile app providing further resources and information on events.

Evidence collected by the service shows that participants report improved mood, better sleep, enhanced confidence, and even returning to work after long absences.

Policy recommendations for government

It is vital that national policy recognises the links between physical and mental health. People should be treated with holistic, person-centred care, and systems and policies should be created with the flexibility to provide that.

Cross-government plan
Improving the physical health of people with severe mental illness (SMI) and reducing the stark mortality gap they face requires meaningful policy reform, sustained investment, and a coordinated, cross-government plan.

A cross-government plan for mental health should be comprehensive, both improving mental health support and addressing key drivers of poor physical and mental health outcomes.

Investment in prevention
It is vital that more of our health spending focuses on prevention. This would allow services to ensure that sustainable, habit-forming lifestyle support for issues such as smoking and weight management are co-designed and delivered by mental health professionals and peer supporters and embedded across mental health pathways. Research is needed to determine what prevention approaches are most effective for people with SMI.

Interventions for groups most at risk of poor physical health outcomes - such as young people, people on antipsychotics, and inpatients - should be prioritised.

Co-production
It must be a requirement that all relevant services commissioned for people with SMI are co-produced with people with lived experience, include staff trained in mental health and physical health co-morbidities, and utilise local cross-sector collaboration to address accessibility and inequality in community provision.

Workforce
A long-term mental health workforce strategy is required for sustainable recruitment, training and retention of mental health professionals, ensuring that they are appropriately trained to recognise and manage physical alongside mental health needs. Particular focus should be given to expanding training routes, improving working conditions and pay, and embedding peer support roles across services to deliver holistic, person-centred care.

Data analysis
To ensure accountability and effectiveness, improved data collection is vital to track outcomes by socioeconomic status, diagnosis, and intervention type. This evidence should shape future guidance and commissioning.

Empower VCFSE organisations
To deliver meaningful and lasting change, government must support and empower local and grassroots responses. This includes improving access to grant funding for Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations, promoting the commissioning of VCFSE organisations and alliances, and embedding peer support and lived experience in service design through genuine co-production.

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Rethink Mental Illness

We are the charity for people severely affected by mental illness, no matter what they're going through.

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