What is our position on physical health and how does it support children and young people?

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The problem

- People living with severe mental illness die up **to 20 years younger** than the rest of the population
- This is usually from **preventable physical illness**
- Similar (and worse) risks to **people with ID and NDD**

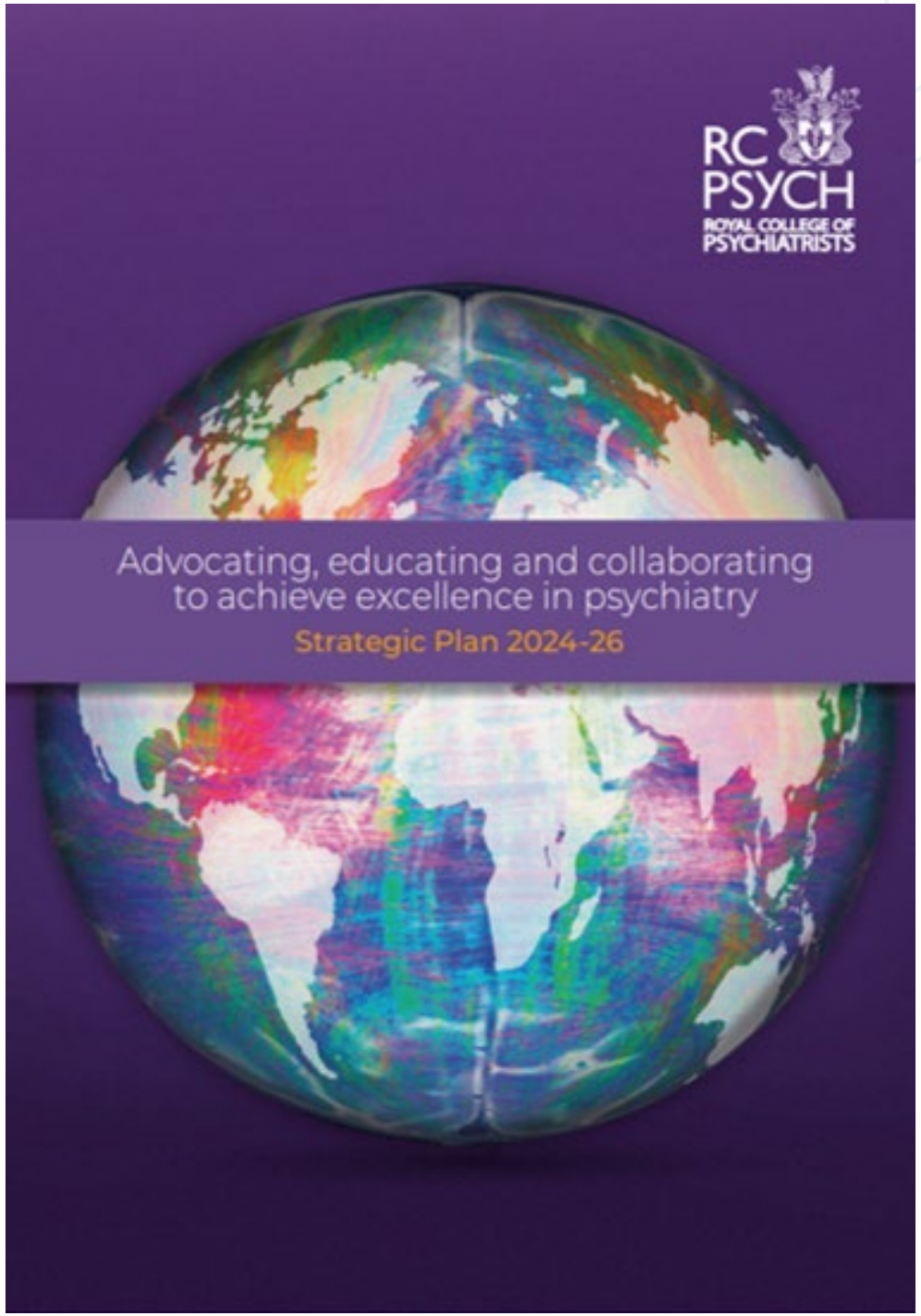
The mortality gap: 4 messages

The problem is getting worse

It starts early

It is due to multiple, intersecting causes

It is a form of inequity which comes from inequality



College strategic plan 2024-26

"Influencing systems across the UK to implement measures that will help to close the mortality gap and to reduce the risk of early death for individuals with mental illness, including encouraging research and innovation aimed at reducing the risk of early death for individuals with mental illness.

This will include encouraging expansion of the scope and equitable reach of physical health check programmes.

This will also consider those within the traditional severe mental illness (SMI) cohort (such as patients with psychosis) and those with other conditions leading to similar access needs and risks (such as patients with complex nonpsychotic disorders and those with co-existing substance use disorders)."

Specific considerations for CYP

- The seeds of long term physical and mental illness are sown at the start of life
- The earlier we address potential harmful behaviours the better (e.g. vaping)
- We are seeing people at the start of potentially long illnesses – now is the time to intervene
- Multimorbidity is disproportionately high in younger people with mental illness
- Other policy areas (e.g. education) can be engaged

Current workstreams

- RCPsych position statement
- Clozapine protocol
- Prevention of weight gain
- Smoking cessation
- Materials for curriculum/training
- CPD podcasts
- And others…

GRATEFUL

RCPsych position statement

- The RCPsych position statement on **improving the physical health of people with mental illness, intellectual disability and neurodiversity** is in draft

1. **The mortality gap is getting worse and not better, and is an equity & intersectionality problem**
2. **We need to pivot towards prevention and act much earlier and expedite access to physical health services for our patient group**
3. **We propose a model for change based on a life cycle approach**

A “life cycle” approach

Prevention

Early intervention

Proactive, preventive care

Support to access treatment

Learning from outcomes

FEWER PREVENTABLE DEATHS

Closing the Mortality Gap:
A whole system, life cycle approach

PRINCIPLES

- Involvement of people with lived experience
- Active engagement with carers
- Continuous learning and quality improvement
- Reducing inequity and reaching marginalised people
- Parity of esteem

PRIMARY PREVENTION

Focus on prevention

Intervene Early

SECONDARY PREVENTION

Intervene proactively when people are diagnosed with mental illness

TERTIARY PREVENTION

Support access to treatment for physical illness

Learn from outcomes

FEWER PREVENTABLE PREMATURE DEATHS

ENABLERS

- Policy
- Resource Allocation
- Research and Development
- Implementation of Innovation
- Data and Digital

Key principles

- Involvement of people with lived experience
- Active engagement with carers
- Continuous learning and quality improvement
- Reducing inequity and reaching marginalised people
- Parity of esteem

Key enablers

- Policy
- Resource allocation
- Research and development
- Implementation of innovations
- Data and digital

Recommendations

- For policy makers, commissioners, for psychiatrists and MH providers, for RCPsych and for Academia
- Includes commitments/offer to work with other Royal Colleges and professional bodies
- Working on prioritising and structure – likely 5 “tasks”
- Need to be achievable and likely to happen (and resource neutral)
- Some are very specific but others are about general principles such as improving access to general population programmes

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Draft Recommendations CYP - 1

- **Support programmes of public health work which are focused specifically on children and young people with a view to preventing long term physical and mental illness**
- Fund and deliver research programmes into preventive interventions such as psychiatric input/out-reach in schools, youth services or within the home environment.
- Support programmes to tackle deprivation in families where there is particular risk of mental illness.
- RCPsych PMHIC to consider specific workstreams around prevention of poor health in children and young people.

Draft Recommendations CYP - 2

- **Embed physical health monitoring and preventive interventions into mental health care for children and young people.**

- Reduce lower age of health check programmes to 14 if currently higher.

- In upcoming service specific for Tier 4 CYPIMHS in England include target of 100% of patients prescribed antipsychotics being offered appropriate PH monitoring.

- Disseminate and implement the adolescent Lester tool as standard for CYP with psychosis. (all EIP in England Q4 2025, all CYPIMHS services Q4 2026).

- Encourage adoption of the tool in other parts of the UK, and use it for any CYP with SMI or prescribed an antipsychotic medication, irrespective of diagnosis.

- Develop and implement adapted or novel cardiometabolic risk prediction tools which are accurate for young people with mental disorders

Lester UK Adaptation 2023 update. *Adolescent supplement added 2025.**

Positive Cardiometabolic Health Resource

Lester UK Adaptation: Positive Cardiometabolic Health Resource

This Cardiometabolic Health Resource supports the recommendations relating to monitoring physical health in the NICE guidelines on psychosis and schizophrenia in adults (www.nice.org.uk/guidance/cg178) and young people (www.nice.org.uk/guidance/cg155). In addition it also supports the statement about assessing physical health in the NICE quality standard for psychosis and schizophrenia for adults (www.nice.org.uk/guidance/qs80).

National Institute for Health and Care Excellence, November 2015

This resource aligns with the Core20PLUS5 initiative aimed at addressing the 15-year mortality gap experienced by individuals with severe mental illness.

The primary factors driving this decreased life expectancy are comorbid cardiometabolic and cardiovascular diseases. There is a pressing need to concentrate on potentially preventable health issues, medication side effects, and limited access to healthcare services.

Although this resource primarily addresses antipsychotic treatment, its principles are equally applicable to other psychotropic medications used in managing long-term mental health conditions, such as mood stabilisers.

For all people in the "red zone" (see next page): Care should always be person-centred, tailoring discussion to enable shared decision-making.

The primary healthcare team and specialist mental health team will collaborate to support the individual, ensuring appropriate monitoring and interventions are provided and communicated.

Don't just SCREEN – INTERVENE for all people in the "red zone"

** In 2025, the authors added an adolescent supplement targeted to those aged 14-17 years experiencing psychosis.*

ADULT Positive Cardiometabolic Health Resource

An **intervention framework** for people aged 18yrs and over experiencing **psychosis** and **schizophrenia.**

Smoking	Health Behaviours and Life-skills	Body Mass Index (BMI) Weight	Blood Pressure	Glucose Regulation Assess by fasting blood glucose (FPG) and HbA1c	Blood Lipids
RED ZONE					
Current smoker	**Unhealthy diet** **AND/OR** **Physical inactivity/sedentariness** **AND/OR** **Harmful alcohol intake** (>14 units/wk)	**BMI ≥25 kg/m²** (≥23 kg/m² if from Black, Asian, minority ethnic background) **AND/OR** Rapid weight gain: particularly after new antipsychotic initiation	>140 mm Hg systolic **AND/OR** >90 mm Hg diastolic	**HbA1C or Glucose threshold:** HbA1C ≥42 mmol/mol (≥6%) **AND/OR** FPG ≥5.5 mmol/l **OR** RPG ≥ 11.1 mmol/l	**High risk of CVD by validated tool,** e.g. QRisk3 http://qrisk.org *NB: Current CVD risk scores likely to underestimate risk in people aged <30*
INTERVENTIONS					
CARE SHOULD ALWAYS BE PERSON-CENTRED, TAILORING DISCUSSION TO THE NEEDS OF THE PERSON TO ENABLE SHARED DECISION-MAKING					
Follow NICE guidelines on tobacco use www.nice.org.uk/ng209 **Brief intervention/ behavioural support** **Offer combined NRT and/or varenicline** **Referral to Smoking Cessation service**	**Promote positive health behaviours:** • Healthy eating guidance www.nhs.uk/live-well/eat-well **Follow UK Chief Medical Officers' Guidance on:** • Physical Activity • Low-risk alcohol intake	**Follow NICE obesity guidelines:** www.nice.org.uk/cg189 **Clinical review if** >5% (av.3-4kg) wt gain within 4 weeks of taking a new antipsychotic	Refer for investigation, diagnosis and treatment by appropriate clinician if necessary. *Note: family history of diabetes and/or premature heart disease heightens cardiometabolic risk.* **Offer antihypertensive therapy** if safe and appropriate Follow NICE hypertension guidelines www.nice.org.uk/ng136 Limit salt intake in diet	**At High Risk of Diabetes** HbA1c 42-47 mmol/mol (6.0%–6.4%) FPG 5.5–6.9 mmol/l i Offer referral to evidence-based, lifestyle-change programme ii. If ineffective, offer metformin modified release if safe and appropriate	**Diabetes** HbA1c ≥48 mmol/mol (≥6.5%) FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l Diabetes review Follow NICE diabetes guidelines www.nice.org.uk/ng28	**Offer lipid lowering therapy if safe and appropriate** Follow NICE guidelines www.nice.org.uk/ng238 **AND** Refer to specialist if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l)
TARGET					
Stop smoking **Anticipate impact on antipsychotic drug metabolism; alter dose appropriately**	**Improve quality of diet** **Daily physical activity** ≥30 mins/day **Alcohol intake** <14 units/wk	**BMI 18.5-24.9 kg/m²** (18.5-22.9 kg/m² if from Black, Asian, minority ethnic background)	**<140/90 mm Hg**	**Prevent or delay onset of diabetes** HbA1c<42 mmol/mol (<6%) FPG <5.5 mmol/l	**Individualise HbA1c target** but typically 47-58 mmol/mol (6.5–7.5%)	**Primary Prevention:** Offer atorvastatin 20mg od if ≥10% risk (validated risk tool) **OR** **Secondary Prevention:** Offer atorvastatin 80mg od Aim: reduce non-HDL chol by 40%; review 3 months

FPG = Fasting Plasma Glucose | **RPG** = Random Plasma Glucose | **BMI** = Body Mass Index | **Total Chol** = Total Cholesterol | **HDL** = High Density Lipoprotein | **TRIG** = Triglycerides |

ADOLESCENT Positive Cardiometabolic Health Resource

An **intervention framework** for adolescents aged 14-17 yrs experiencing **psychosis.**

Smoking	Health Behaviours and Lifestyle changes		Body Mass Index (BMI) Weight	Blood Pressure		Glucose Regulation	Blood Lipids
				Age 14-15 yrs use centile charts (ESH guidance tables 1-3)	Age ≥16 yrs use Lester BP guidance for adults	For diagnosis, fasting blood glucose tests are preferred if achievable	Blood tests can be fasting or non-fasting
RED ZONE							
Current smoker (tobacco, vaping) – ask regularly	**Dietary concerns AND/OR Physical inactivity/ sedentariness**	**Harmful alcohol intake or other substance use**	**Rapid weight gain:** >5% within 4wks of new antipsychotic initiation **OR** BMI ≥91st centile (assess using RCPCH BMI charts)	**BP** persists ≥90th centile systolic and/or diastolic (ESH guidance table 1 > 95th= hypertension 90-95th= high-normal < 90th normal)		**Glucose or HbA1C threshold:** FPG ≥5.5 mmol/lORRPG ≥11.1 mmol/l HbA1C ≥42 mmol/mol (≥6%)	**Abnormal lipids:** use local laboratory reference range for adolescent assessment QRisk3 should not be used to assess CVD risk in adolescents (see appendix)
CARE SHOULD ALWAYS BE PERSON-CENTRED, PRIORITISE SHARED DECISION-MAKING, ASSESS CAPACITY/COMPETENCE, AND INVOLVE PARENTS/CARERS/IMPORTANT OTHERS							
INTERVENTIONS				Close primary/secondary care liaison: assessment and onward referral to appropriate specialist. *Note: Family history of diabetes and/or premature heart disease heightens cardiometabolic risk.*			
Follow NICE guidance on tobacco use and consult latest vaping evidence i. Offer brief intervention/ behavioural support ii. Offer combined NRT iii. Refer to Smoking Cessation service	**Offer personalised assessment to support structured daily routines in:** • Healthy eating • Physical activity • Screen use	**Promote positive health behaviours –** refer to guidance: Coexisting psychosis and substance misuse (including alcohol)	If rapid weight gain with new antipsychotic discuss risks and benefits of antipsychotic switching If BMI ≥91st centile **AND** • presence of cardiometabolic risk or weight-related co-morbidity (see appendix): refer to local weight management programme • absence of cardiometabolic risk or weight-related co-morbidity: counsel on healthy weight reduction strategies If BMI ≥ 98th centile: refer to local weight management programme	**Co-manage with GP:** i. If BP remains in 90-95th centile range: active follow-up ii. If BP remains >95thcentile: assess and refer onwards to appropriate specialist		**At High Risk of Diabetes** FPG 5.5 - 6.9 mmol/l HbA1c 42-47 mmol/mol (6.0% - 6.4%) **Co-manage with GP:** i. Offer referral to a local evidence based lifestyle change programme ii. If ineffective: reassess and refer onwards to appropriate specialist	**Diabetes** Follow NICE guidance FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l HbA1c≥48 mmol/mol (≥6.5%) At diagnosis refer those with suspected type 2 diabetes to a multidisciplinary paediatric diabetes team	**Co-manage with GP:** i. Offer referral to a local evidence based, lifestyle change programme ii. If lipid levels remain abnormal: assessment and onward referral to appropriate specialist iii. Refer as priority if possibility of familial hypercholesterolaemia
TARGET							
Smoking cessation AND Anticipate impact on antipsychotic drug metabolism; alter dose appropriately Promote smoking/vaping prevention in non-smokers	**Healthy diet** **Physical activity** ≥60 mins/day **Safer screen use** (e.g. frequent active breaks)	**Prevention and harm reduction for alcohol intake and drug misuse**	**Mitigate rapid weight gain** after new antipsychotic initiation Manage weight as part of a CVD risk-reducing approach	**BP** <90th centile systolic and/or diastolic **Manage BP** as part of CVD risk-reducing approach		**Prevent or delay onset of diabetes** * FPG <5.5 mmol/l HbA1c<42 mmol/mol(<6%)	**Target HbA1c** ≤48 mmol/mol (≤6.5%) to minimise risk of long-term complications	**Manage dyslipidaemia** as part of a CVD risk-reducing approach

ADOLESCENT Positive Cardiometabolic Health Resource

An **intervention framework** for adolescents aged 14-17 yrs experiencing **psychosis.**

Considerations for young people aged 14-17 years

Proactive cardiometabolic screening is recommended by NICE for this young population with psychosis (NICE CG155). This should be offered 6 monthly as a minimum when their condition is stable. When abnormalities or increased risk are identified, onward referral for further assessment and intervention is appropriate. Whilst many aspects of risk identification and management apply irrespective of age, some specific considerations for young people are necessary:

Developmentally appropriate: physical development varies greatly in adolescence related to growth and stage of puberty. Thus, differing developmental trajectories preclude the use of rigid age boundaries to assess cardiometabolic risk and rely more on clinical judgement and experience. For example, 16–18 year olds sit between adolescent and adult guidance in terms of risk identification and management (adult ranges vs centile charts).

Capacity: the Mental Capacity Act (MCA) applies to young people aged 16-17 years, who clinicians should assume have capacity to make decisions unless proven otherwise. For under-16s, the MCA does not apply and Gillick competence should instead be considered to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Shared decision making should underpin physical health screening and management in partnership with the young person, their family/carers, and include consultation with other key stakeholders (e.g. GP, Children and Young People's Mental Health services practitioner, Paediatrician).

Involve parents/carers/important others: encouraging and incorporating their unique perspectives, insight and observations empowers their active role in a young person's treatment plan and recovery.

Consider the particular needs of disabled young people, autistic young people, those with a learning disability or SEND: they are more likely to experience inequitable care and practitioners must make reasonable adjustments (Equality Act 2010) to ensure they can access effective care.

Looked After Children: monitoring should be an integral part of statutory annual health assessments.

Safeguarding: practitioners should bear in mind principles of safeguarding in all consultations with children and young people.

Ethnicity: BMI and BP centile charts provided were developed for CYP for White ethnicities. Currently a higher index of clinical suspicion will be required for all other ethnic groups.

Collaborative working: proactive management of cardiometabolic risk in this age group depends on mental health services (usually Early Intervention in Psychosis services or Children and Young People's Mental Health services) and primary care aligning aspects of monitoring and risk identification (e.g. use of centile charts rather than adult ranges for BP and BMI).

- Whilst antipsychotic initiation and proactive identification of potential cardiometabolic risk remain key functions of mental health services, the context for collaboration with primary care may be different. For instance, General Practitioners (GPs) are less familiar with psychosis in younger people (typically seeing a new case under age 16 every five years).
- Whilst GPs usually feel able to manage physical comorbidities in older people, they may not feel confident in assessing or initiating treatment of a physical health problem in an under-18 with psychosis.

Inequalities in core determinants of health (e.g. affordability of healthy foods, access to physical activities); consider how social prescribing and signposting to local services could help overcome these.

Local commissioners: should consider how young people with psychosis, as a vulnerable group for severe health inequalities, can access local evidence based lifestyle change programmes, that address key modifiable CVD risks (e.g. smoking cessation, weight management, nutrition and physical activity).

Complications of Excess Weight (CEW) Clinics: commissioned by NHSE at a national level as a tertiary referral service for children and young people organised by postcode in England https://www.england.nhs.uk/get-involved/cyp/specialist-clinics-for-children-and-young-people-living-with-obesity/

Polypharmacy: Where psychotropic polypharmacy is present, additional monitoring and supervision may be required to minimise the risk of physical health complications.

While this adolescent supplement focuses on protecting the cardiometabolic health of young people with psychosis, the principles can be applied to young people taking antipsychotic medication for other non-psychotic psychiatric disorders.

ADOLESCENT Positive Cardiometabolic Health Resource

An **intervention framework** for adolescents aged 14-17 yrs experiencing **psychosis.**

Appendix

BODY MASS INDEX (BMI) – see RCPCH BMI charts. A BMI ≥91st centile suggests overweight. A child ≥98th centile suggests clinically obese. Values for adolescents based on the RCPCH BMI centile charts are shown in Fig 1.

Fig. 1

	Girls (BMI kg/m2)		Boys (BMI kg/m2)	
Age (years)	91st centile	98th centile	91st centile	98th centile
14	23.5	26.5	22.5	25.2
15	24	27	23	26
16	24.7	27.7	24	26.7
17	25	28.2	24.5	27.5

- **If BMI ≥91st centile: offer referral** to local weight management services if:
  - i) assessed to have **hypertension, glucose or lipid disturbance** or
  - ii) evaluated to have **co-morbidities related to excess weight**. These include:
    - **Obstructive sleep apnoea** (OSA): typically restless sleep with snoring, stop/start breathing accompanied by morning headaches. OSA is more frequent in those with psychosis and increases the risk of CVD and diabetes and poorer mental and physical outcomes.
    - **Polycystic ovary syndrome** (PCOS): amenorrhoea, irregular periods, acne and hirsutism. PCOS can also arise from antipsychotic-induced hyperprolactinaemia (prolactin level needed).
    - **Non-alcohol related fatty liver disease** (NAFLD): asymptomatic, detect by liver function tests.
    - **Idiopathic intracranial hypertension:** typically, excess weight accompanied by regular night-time and morning headache.
- **If BMI ≥98th centile: offer referral** to local weight management services

BLOOD PRESSURE – see 2016 European Society of Hypertension guidelines for the management of high blood pressure in children and adolescents. Hypertension in children is defined as systolic blood pressure (SBP) and/or diastolic blood pressure (DBP) persistently **at least 95th percentile** for sex, age and height measured on at least three separate occasions.

- **For adolescents aged 15 years and under:** refer to the following ESH centile charts:
  - **ESH TABLE 2.** Blood pressure for boys by age and height percentiles
  - **ESH TABLE 3.** Blood pressure for girls by age and height percentiles
- **For adolescents aged 16 years and over:** follow the Lester BP guidance for adults with its threshold for the diagnosis of hypertension of **>140/90 mmHg.**

Monitoring: How often and what to do

	Baseline	Weekly for first 6 weeks	12 weeks	Every 6 months when stable
Personal/Family History	●			●
Lifestyle review[1]	●		●	●
Weight	●	●	●	●
Waist circumference	●			●
BP	●		●	●
FPG/HbA_{1c}	●		●	●
Lipid profile[2,3]	●		●	●

1. Smoking, diet, physical activity, alcohol and substance use.
2. A non-fasting sample is satisfactory.
3. While evidence supports the use of statins in adolescents with Familial Hyperlipidaemia, the evidence for lipid-lowering therapy in other groups is limited or lacking.

Monitoring table derived from NICE CG 155 supplementary information on baseline monitoring

Offer ECG: if physical examination has identified specific cardiovascular risk (e.g. hypertension); if there is a personal history of cardiovascular disease; if there is a family history of cardiovascular disease such as sudden cardiac death or prolonged QT interval; if specified in the SPC of the prescribed antipsychotic; or the child or young person is being admitted as an inpatient.

QRISK should not be used to assess CVD risk in adolescence.

Questions?

- Get in touch!
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