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The Department of Health and the Equality Act 2010

In their otherwise excellent review of the Equality Act 2010 and mental health,[1] the authors did not highlight how the Department of Health currently discriminates against people with mental health problems.

The National Health Service (NHS) constitution has incorporated the Equality Act in terms of access to NHS care, including on the grounds of disability. However, a fundamental right of the constitution is that of choice. Section 2a states 'You have the right to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs'.[2]

Since April 2009, patients have had a right to choose the service that provides their treatment when they are referred for their first out-patient appointment with a consultant-led team. Patients can review outcome data, specialist expertise and user feedback for a service, discuss it with their general practitioner, and be referred for an elective medical or surgical problem to any NHS consultant-led service across the country. However, the Department of Health excludes patients detained under the Mental Health Act 1983, military personnel and prisoners. It also excludes services where speed of access to diagnosis and treatment is important, for example emergency admissions and maternity services. However, under this clause it also excludes elective mental health services. This appears to be discriminatory under the Equality Act for people with mental health problems who are disabled by their disorder. So anyone with a mental disorder who is disabled and has had treatment locally cannot by right obtain a referral to a specialist mental health service. Most National Institute for Health and Clinical Excellence guidelines on mental disorders envisage stepped care. Where treatment has failed, the next step is onward referral to more intensively delivered cognitive–behavioural therapy (e.g. more frequent, longer sessions with more experienced therapists) or to specialised pharmacological advice that may not be available from a local community mental health team or psychology service.

Patients with mental disorders who are disabled therefore have the right to choose where they have treatment for their cancer, for example, but not for their mental disorder. Access depends entirely on the vagaries of local funding panels. The legal right to choice of elective care should be extended to mental health services, or withdrawn from surgery and medicine. The present discrimination is unconscionable.

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Monitoring cardiometabolic risk in schizophrenia

I commend De Hert *et al*[1] for their attempt to clarify appropriate monitoring for cardiometabolic risk in schizophrenia. I agree that cardiometabolic risk is one important consideration for these patients.

I note that their findings included generally low scores for the rigour of existing guidelines and a lack of evidence of long-term patient outcomes. It is perhaps a little surprising then that they nevertheless make recommendations on what appears to be less than robust evidence.

I have previously expressed concerns that cardiometabolic screening programmes of this type are unevaluated and that the benefits are unknown, as are the risks, which seem to have received little attention.[2]

The authors quite rightly highlight that guidelines can be biased because of lack of scientific evidence, but the evidence they present to support their protocol appears to fall well short of the levels of evidence recommended for interventions.[3] I can find no evidence that patients will benefit from such a protocol, and none that they will not be harmed.

I also note that their suggested protocol differs from National Institute for Health and Clinical Excellence (NICE) quality and outcomes framework standards for mental illness (www.nice.org.uk/aboutnice/qof/indicators.jsp) and NICE guidelines for lipid modification, both of which recommend primary preventive screening for patients aged over 40.[4]

I wish to support the notion that interventions should be evaluated before implementation.[3]

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Physical care of people with severe mental illness is an important clinical issue, as the potential health benefits of cardiovascular disease prevention for the general population are astonishing. Each year, cardiovascular disease kills about 20 million people, including 10 million prematurely (before the age of 65 years) and inflicts high morbidity, disability and socioeconomic costs.[1] This problem is more pronounced in schizophrenia, with standardised mortality rates (SMRs) of 2.7 for diabetes and 2.3 for cardiovascular disease.[2]

Cardiovascular mortality increased in schizophrenia from 1976 to 1995, with the greatest increase in SMR in men from 1991 to 1996.[3]

In the current climate of austerity in the National Health Service and internationally, it is interesting to know that in high-income countries, preventing or postponing 100 cases has been reported as saving about US$1 million (£0.6 million, €0.7 million).[4]

A few important issues have been highlighted by De Hert *et al*.[5] First, involvement of patients and carers in screening and monitoring of patients' physical health is a vital part of patients' and carers' education and empowerment, which will be reflected positively in management and outcome. Second, their study raised the legitimate question of who should screen and monitor physical health: the psychiatrist or the general practitioner (GP). The care programme approach of 2008 indicates that mental health professionals should consider service users' needs holistically and aim to improve their quality of life and their health. Assessments and care plans should identify and tackle the impact that mental illness symptoms and possible treatment programmes can have on physical health and the impact that physical symptoms can have on an individual's mental well-being.[6] I think the way forward is a proper collaboration through the local shared care protocol as the process should be initiated by psychiatrists and results should be communicated to GPs who would plan management through proper referral to different specialties.

De Hert *et al* rightly state that all previous evidence indicates that guidelines have an impact on real-life screening and that monitoring rates are minimal to poor.

The national Prescribing Observatory for Mental Health (POMH)[7] has included screening for metabolic syndrome in community patients receiving antipsychotics as a topic for its quality improvement programme. The POMH group conducted a retrospective case-note audit of patient's prescribed antipsychotic medication with a standard of yearly monitoring of blood pressure, measure of obesity, glucose and lipids. Results showed that between 0 and 41% (0 and 48% at re-audit a year later) of trusts were monitoring for all four aspects on an annual basis. Our study is consistent with these figures, with 40% conducting physical examinations and liver function tests (further details available from the author on request).

Scrutinising guidelines is a very important issue but what is more important, as De Hert *et al*'s article indicated, are clear, comprehensive, inclusive and up-to-date local policies and procedures to implement physical health check-ups, with an initial assessment of risk factors and identification of people with metabolic problems with a view to referring them to a metabolic clinic for management, and to continue to monitor patients who are on atypical antipsychotics regularly, at least annually. It has been reported that establishing a metabolic clinic and managing patients at risk has improved physical check-ups and referral to GPs for abnormal results by 25% in the re-audit.[8] All efforts should be directed towards patient and carer involvement, education and promotion of healthy living.

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Authors' reply: Dr Najim highlights the valuable resource of the UK Prescribing Observatory for Mental Health (POMH) which appears to show that National Health Service trusts record suboptimal levels of metabolic monitoring and, indeed, of physical examination of high-risk patients prescribed antipsychotic medication. We would be most interested to know whether the POMH database can help highlight monitoring rates in those taking antipsychotics for indications other than schizophrenia, particularly bipolar disorder and dementia. Further, are there data on metabolic monitoring in individuals taking depot antipsychotic medication? This has been a question very much overlooked in the literature to date.

Dr Reed rightly queries whether the recommendation to screen for cardiometabolic problems is evidence based. He is no doubt aware of the controversy regarding screening for depression and for dementia when screening is not necessarily translated into measurable patient benefit. We would argue that the case for screening for cardiometabolic risk has strong face validity and at least a moderate evidence base that does justify our recommendations. We concede, however, that the detail of how much and how often is not fully resolved and is disputed in the current guidelines. The case for cardiometabolic monitoring is supported by the undeniably large prevalence of the problem. Some studies suggest that as many as 90% of patients with chronic schizophrenia maintained on antipsychotics have at least one clinically important cardiometabolic risk factor.[1] Further, in this population, the risk is at least in part iatrogenic, thereby promoting the responsibility of the medical profession to detect and deal with it. Direct evidence comes from guideline implementation studies. Screening guidelines do seem to increase monitoring rates, although the increase is less than is often hoped. We recently examined this using a meta-analysis of screening rates before and after guideline implementation.[2] Seven studies have directly monitored rates in the same sample before and after guideline introduction and these reported on glucose surveillance. These studies showed a significant 15.4% (95% CI 4.8–25.9) increase ($\chi^2 = 8.1$; $P = 0.005$) in glucose testing following the introduction of guidelines. This increase is significant but nevertheless rather disappointing, although when combined with gradually increasing awareness of metabolic complications could increase further with time.

Another type of evidence is the additional yield of significant complications found after the introduction of a systematic screening or surveillance programme. Several such studies exist but, as far as we are aware, none have randomised a group to metabolic screening and no metabolic screening, for ethical reasons. In non-randomised studies the yield from systematic monitoring for cardiometabolic problems is appreciable. For example, Kusumi *et al*[3] began testing 537 patients who had schizophrenia but no pre-existing diabetes in June 2008 across 25 Japanese hospitals. At baseline, only 51% had a normal body mass index and 12% had glucose abnormalities of which 9.5% was for the pre-diabetic type. Equally concerning, during the next year of follow-up, 42% of those with pre-diabetes progressed to probable diabetes, such that by the end of the study 25% of patients with schizophrenia had recognised glucose abnormalities.[4] Collectively this seems to constitute a strong case

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