healthwatch Herefordshire

Severe Mental Illness

Breaking Barriers Together

Contents

Background

Severe Mental Illness (SMI) is a term used to describe a group of mental health conditions that are **long-term, complex, and significantly impact an individual's ability to function in daily life**. This includes but not limited to conditions such as **schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), eating disorders, and severe depression.**

Individuals living with SMI often experience **poorer physical health outcomes and reduced life expectancy and live 15-20 years less** compared to the general population. Research consistently shows that people with SMI are more likely to experience preventable chronic physical health conditions, such as cardiovascular disease and respiratory illness, and face significant challenges in accessing appropriate healthcare.

These health inequalities are not solely due to individual health conditions but are shaped by a range of **social, economic, and systemic factors.** These include poverty, housing instability, social isolation, stigma, and barriers within healthcare systems such as limited access, lack of continuity of care, and diagnostic overshadowing (where physical symptoms are attributed to mental health conditions).

In England, over 500,000 people are currently living with SMI, highlighting the scale of this issue at both national and local levels. Contributing factors include higher rates of smoking, poor diet, reduced physical activity, and the side effects of antipsychotic medication, alongside wider social determinants such as deprivation and isolation.

Within Herefordshire, although the overall population is smaller and more rural, these inequalities remain evident. There are around 1500(23/24) Individuals diagnosed with an SMI and registered at GP. Rurality, transport barriers, and limited access to specialist services can further impact engagement with both mental and physical healthcare.

Aim of Project

This project aims to investigate the health inequalities experienced by individuals with severe mental health conditions in Herefordshire, such as schizophrenia, bipolar disorder, PTSD, eating disorder and severe depression.

- Explore how SMI impacts physical health, daily life, and overall wellbeing
- Identify barriers to accessing healthcare and support services
- Examine the social, economic, and systemic factors contributing to health inequalities
- Understand lived experiences of individuals navigating both mental and physical healthcare systems

Definition of Severe Mental Illness (SMI)

Severe Mental Illness (SMI) refers to mental health conditions that are typically long-term and significantly impair a person's ability to function in daily life. In UK clinical practice, SMI most commonly includes diagnoses such as schizophrenia, bipolar disorder, and other psychotic disorders, although the term may be used more broadly in research to describe other conditions when they are severe and enduring. *(Public Health England, 2018; NHS England guidance)*

Methodology

Methods and Recruitment

The recruitment approach was designed to support a two-part project, engaging both organisations and individuals with lived experience of Severe Mental Illness (SMI) across Herefordshire. The strategy aimed to ensure meaningful, inclusive, and representative participation.

Key objectives

- Engage adults aged 18+ with direct lived experience of SMI, including individuals from groups experiencing health inequalities.
- Achieve representation from both rural and urban communities within Herefordshire.
- Prioritise depth of insight by focusing on 1-to-1 engagement with service users and organisational stakeholders.
- Use a supported participation model, ensuring individuals felt safe, informed, and able to contribute fully.
- Adopt a targeted recruitment approach, with social media used primarily as a signposting tool rather than a method for collecting responses.

A multi-method recruitment approach was used to engage both organisations (Phase One) and individuals with lived experience of SMI (Phase Two). The aim was to build strong partnerships, reach diverse communities, and ensure meaningful participation.

Engagement with Organisations

- Direct outreach: Email invitations were sent to 90 organisations across Herefordshire.

    - 30 organisations responded and agreed to participate.
    - 7 later withdrew or did not commit to an interview.
    - 23 organisations were interviewed.
    - Following interviews, 3 were excluded from analysis as they did not work directly with people living with SMI.
- **Presence at community network meetings:** Project information and promotional materials were shared at local forums to encourage organisational involvement and raise awareness.
- **Relationship-building:** Time was invested in understanding each organisation's services, developing trust, and creating pathways to reach service users.
- **Physical and digital materials:** Flyers and information sheets were distributed both in person and electronically for staff to share within their teams and networks.

Engagement with Individuals (Lived Experience)

- **Working through trusted organisations** to share project leaflets and invite service users to take part.
- **Offering flexible participation options**, including face-to-face conversations, phone interviews, email responses, or involvement with a trusted person present.
- **Spending time in familiar community settings** where individuals felt comfortable, reducing barriers to engagement.
- **Using personal networks and word-of-mouth connections** to build trust, increase visibility, and reach people who may not engage through formal channels.
- **Promoting the project through newsletters and social media**, raising awareness across a wider audience.
- **Encouraging organisations to champion the project internally**, ensuring staff and service users were aware of opportunities to participate.

Project and Scope Limitations

A central aim of the project was to work through organisations as trusted intermediaries, helping to build confidence and create safe pathways to individuals with lived experience of Severe Mental Illness (SMI). While organisations were consistently positive about the project in principle, significant challenges emerged in translating this support into active engagement with service users.

Challenges in Organisational Engagement

- High organisational interest but limited practical support: Although 20 organisations expressed support for the project, initial recruitment methods that relied on them sharing leaflets or encouraging participation resulted in *no* individuals coming forward. Many organisations were willing to speak to us themselves but were reluctant to facilitate direct contact with their service users, even when those users had SMI and could have contributed meaningfully.
- Referral pathways were ineffective: A revised approach—allowing professionals to refer individuals with consent—led to only one completed interview. Despite repeated efforts, this method did not generate further engagement.
- Internal promotion within the Health and Care Trust did not translate into participation: Several professionals shared project information and leaflets with colleagues, yet this again resulted in no direct links to individuals with SMI.
- Organisational caution around connecting researchers with people with SMI: Even when organisations worked directly with individuals with SMI, many did not feel able or willing to make introductions. This reflects a wider pattern of gatekeeping, risk-aversion, and concerns about burdening service users — but it also highlights deeper issues of trust and confidence within the system.

Challenges in Individual Engagement

- Higher-need individuals were often unable to participate: Professionals, including those in NMHT, highlighted that many individuals with more complex needs were not in a position to engage in interviews or research activities.

- **Low response rates despite broad outreach**: Outreach to 90 organisations produced limited engagement, and some individuals who initially agreed to participate later withdrew, became difficult to contact, or cancelled meetings.
- **Alternative participation methods had limited depth**: Two individuals preferred not to engage through any of the offered interview formats. They completed an online survey instead, but the responses lacked the depth and nuance achieved through face-to-face or supported conversations. This reinforces the importance of informal, relational interviewing approaches when working with people with SMI.

What These Challenges Reveal

These difficulties are not simply logistical. They reflect wider systemic issues in Herefordshire, including:

- **Low levels of trust** between individuals with SMI and services or external projects
- **Limited organisational capacity** to support engagement beyond core duties
- **A fragmented system** where pathways to individuals with SMI are unclear or inconsistently supported
- **A broader pattern of disengagement**, shaped by past experiences, stigma, and the complexity of living with SMI

These factors significantly shaped the scope of the project and the size of the participant sample.

Implications for Interpretation

Given the qualitative nature of the research and the small sample size, findings should be understood as indicative of themes within the participant group, rather than generalisable to the wider population of people living with SMI in Herefordshire. However, the recruitment challenges themselves offer valuable insight into the barriers faced by this community and the systemic issues that influence engagement.

How These Challenges Were Addressed

In response to the recruitment difficulties, the approach was adapted to prioritise more relational, flexible, and trust-building methods. Rather than relying on formal organisational pathways—which proved largely ineffective—the project shifted towards approaches that centred on personal connection and presence.

- **Greater use of personal networks and word-of-mouth** became essential, and ultimately more effective, in reaching individuals with lived experience of SMI.
- **Spending time within organisations and community spaces** allowed for informal, opportunistic engagement, helping to build familiarity and reduce the perceived formality of taking part.
- **Offering flexible, low-pressure participation options** enabled individuals to choose the method that felt safest and most manageable for them.
- **Focusing on environments where people already felt safe and supported** helped to create the conditions for more open and meaningful conversations.

This shift from a formal recruitment model to a **relationship-based engagement approach** improved opportunities for connection, even though overall participation remained limited. The experience demonstrates that trust cannot be accelerated, and that meaningful engagement with individuals living with SMI requires time, consistency, and presence.

A longer project timeframe would likely have improved engagement. For comparison, a similar project working with carers of people with SMI in Norfolk reported strong participation levels—but the work took place over **three years**, allowing trust to develop gradually.

The recruitment process therefore highlights the importance of **trust, flexibility, and relationship-building** when engaging individuals with SMI. It also reflects broader systemic barriers in Herefordshire, where issues of trust, capacity, and fragmented pathways can limit participation not only in research but also in wider service access. A more extended, relationship-centred approach is essential for improving engagement and ensuring that the voices of people with SMI are meaningfully included.

Who we spoke to?

18 people engaged with us to share their lived experience.

As part of stakeholder engagement, interviews were held with 20 local organisations and individuals across Herefordshire, including mental health services, counselling services, bereavement support, food banks, domestic abuse services, carers organisations, community hubs, and voluntary sector providers.
Statutory organisations included Health and care Trust Engagement Team, Perinatal Team and Neighbourhood Mental Health Team.

What people told us

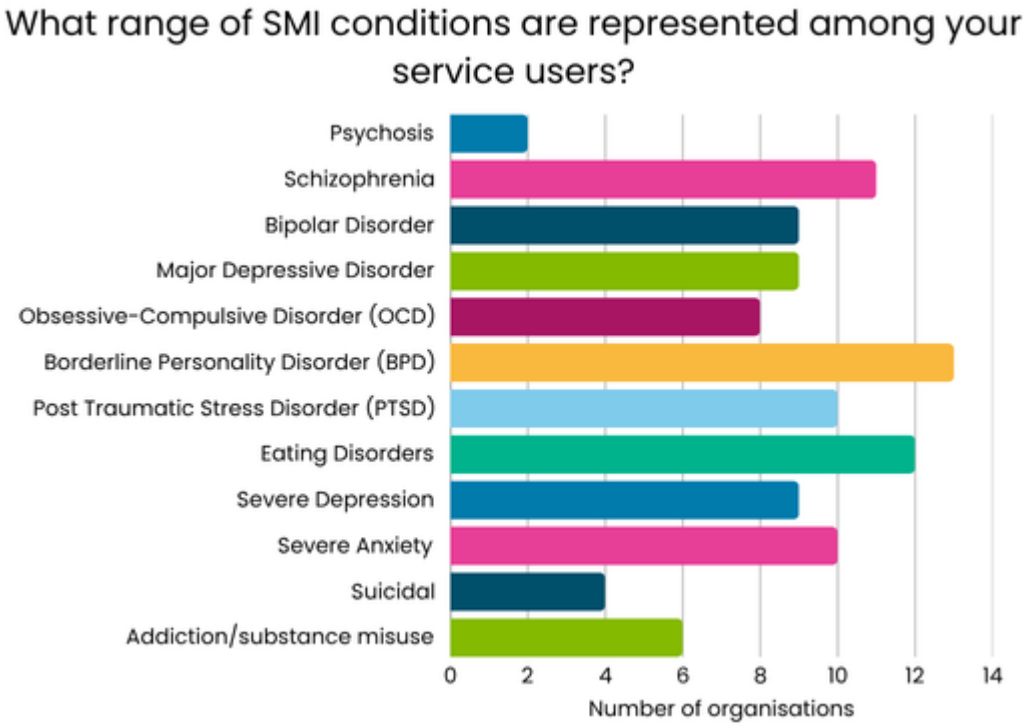
Key Findings.

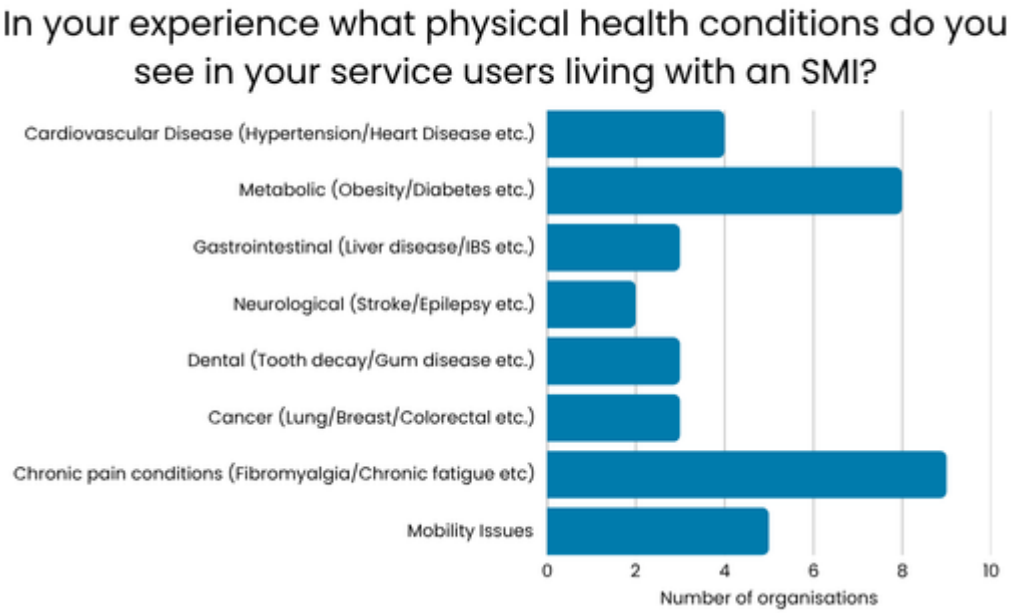
- Most participants had experienced low self-esteem, loneliness, stigma, and relationship difficulties, showing that social isolation and feeling judged were among the most common challenges faced by people with SMI
- Most people said that their health condition limits their daily life a lot.
- 70% of people have a disability or Long Term Condition and 50% have a physical or mobility impairment.
- Arthritis is a common ailment alongside hearing issues and Chronic pain conditions like fibromyalgia.
- Most people we spoke to were also living with a learning disability diagnoses mostly ADHD and Dyslexia which impacts their barriers and makes their needs more complex.
- We found that most participants described a strong connection between their mental and physical health. When mental health declined, people often found it harder to attend appointments, maintain routines, eat well, exercise or manage long-term conditions. Poor physical health also negatively impacted mental wellbeing, creating an ongoing cycle affecting overall health.
- Most participants reported experiencing low self-esteem (88%), loneliness (82%), and feeling judged or stigmatised (76%). Many people described feeling misunderstood or not listened to, which affected confidence and willingness to seek support

What Organisations said..

We used a structured survey interview to speak to organisations to find out about the types of Severe Mental Illness (SMI) they see in service users, the barriers People face when accessing healthcare, how these could be overcome and what physical health conditions are commonly experienced alongside SMI.

Organisation are seeing a wide range of SMI's. Information about physical health conditions was not always available as some organisations did not routinely collect or record this information due to the nature of their relationships with service user





Barriers to accessing Health care

System barriers

Professionals consistently described significant barriers within the local system that affected service users' ability to access timely and appropriate support. Many individuals experienced **long waiting times, delays in referrals,** and support that was **too short-term** or ended before they felt ready.

Several people reported not receiving the right type of support at the right time. Examples included:

- New or emerging health concerns being overlooked or not followed up
- Not being invited to annual physical health checks
- Lack of regular medication reviews
- Appointments being cancelled or rearranged at short notice, further extending already lengthy waits

These issues collectively illustrate a system that is difficult to navigate, inconsistent in its follow-through, and often unable to meet the needs of people with SMI in a timely or sustained way. They also contribute to a wider pattern of disengagement, where individuals lose trust in services and become less likely to seek help or participate in research and improvement initiatives.

Overcoming system barriers

- Develop a single point of access for referrals and entry into services, so that support can be coordinated behind the scenes and the person can be connected to the right help more quickly.
- Ensure professionals receive training that promotes the right help at the right time, with stronger communication and a more compassionate, holistic approach.
- Invest in infrastructure to improve service coordination and delivery.
- Consider dedicated pathways or specialist provision for people with SMI within A&E and wider NHS services.
- Replace the current "three strikes and out" approach with a process where missed appointments trigger an escalation to the mental health team, recognising this may indicate a deterioration in the person's mental health and provide an opportunity for early intervention

Access to services

People reported difficulty getting appointments, challenges using online booking systems, literacy barriers, and limited awareness of what services were available or how to access them. Difficulties were also identified in accessing specialist services such as like psychiatry, crisis teams and dentistry. Transport, location of services, mobility needs and physical health conditions were also reported as barriers.

Overcoming Barriers to access

- Services reaching out to patients whether that be calling them, community outreach in hubs, drop in centres.
- Peer support available within the community.
- Accessible appointments formats, including remote, telephone and paper based options.
- Training in intervention and prevention for lower level services such as housing support.

Emotional Barriers

Past negative experiences of healthcare, either personal or a loved one, alongside feelings of fear, shame, embarrassment and hopelessness, often prevented people from seeking help or continuing with support. Some professionals reported service users felt unheard to, pushed from pillar to post and uncertain whether the service would meet their needs.

Overcoming emotional barriers

- Clear directories outlining what support is available.
- Improved knowledge of referral pathways and processes.
- Education and support around medication side effects and living well with SMI.

Barriers linked to SMI symptoms

Symptoms of severe mental illness could make it difficult for people to take the first step in seeking help, remain engaged with services, think clearly during crisis, or overcome stigma and labels associated with their diagnosis.

Wider determinants of health

Physical health needs, housing insecurity, financial hardship, rural and social isolation, and medication side effects were all identified as contributing to the health inequality experienced by people living with SMI.

Findings from organisations demonstrate that people living with SMI experience a combination of systemic, practical, emotional and social barriers, all of which contribute to poorer access to healthcare and wider health inequalities.

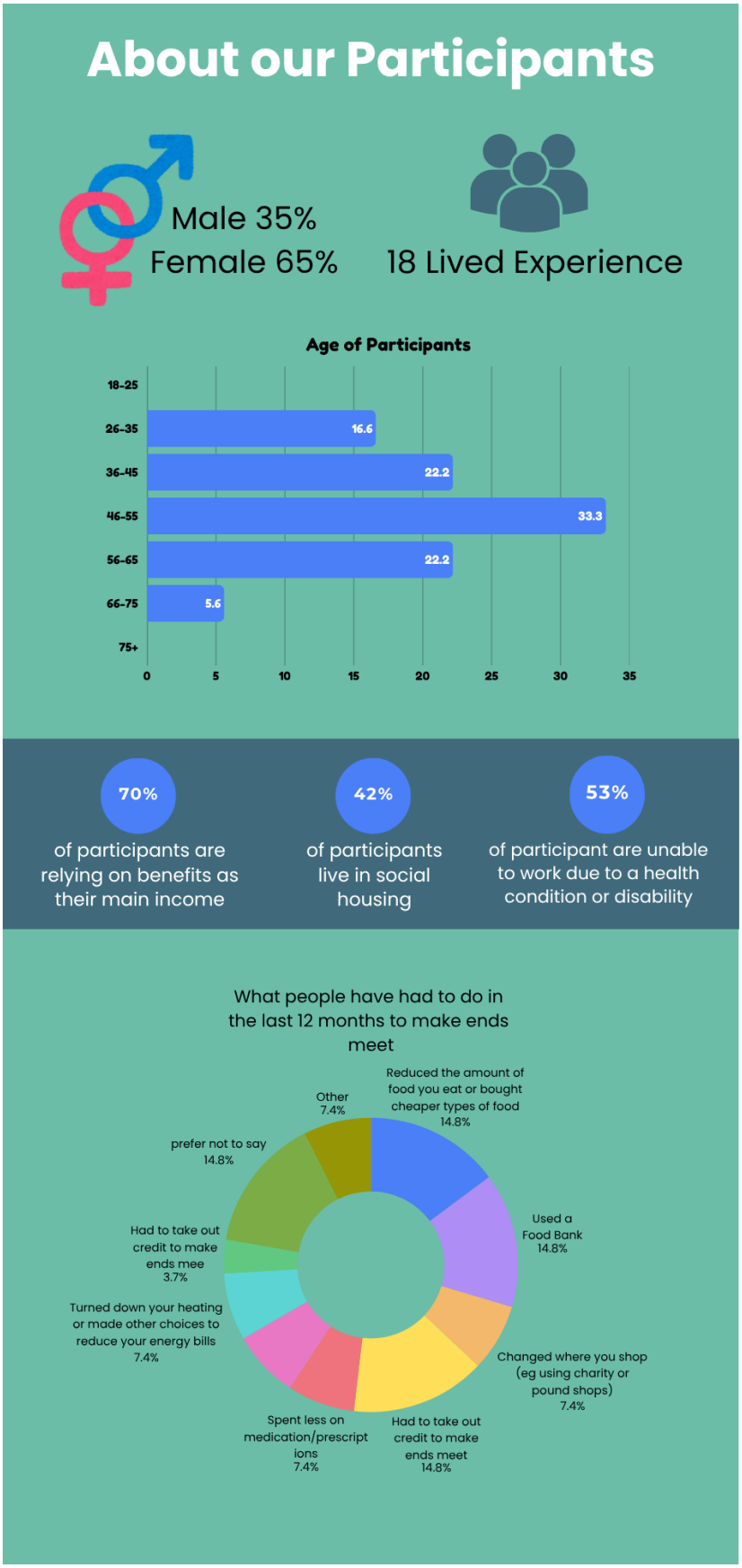
Lack of knowledge

A significant theme from participants was that they lacked the knowledge of how to navigate services to know where to go to get help or to which service they are entitled to.

Findings from organisations demonstrate that people living with SMI experience a combination of systemic, practical, emotional and social barriers, all of which contribute to poorer access to healthcare and wider health inequalities.

A snapshot of what we found from interviews

A breakdown of the 18 responses and key findings from the project are below. For a full list of responses see (Appendix A).



Impact of SMI on daily life

When talking to people about how their SMI affects their lives, individuals described a wide range of experiences using different words and expressions. While some experiences were more complex than others, they all related to the overarching themes identified throughout this report.

The word cloud below shows the language people used to describe the impact of living with an SMI. The larger the word, the more frequently it was mentioned. Some words are closely related in meaning and, when grouped under the same theme, would appear even more prominent

The relationship between SMI and Physical Health

Participants often described a cycle in their mental health, using phrases such as *"spiralling", "having an episode", or "feeling low"*. During these periods, individuals reported burnout, withdrawing from relationships, finding it difficult to leave the house, and struggling to maintain routines that support their physical health, such as attending appointments, eating well, exercising or managing long-term conditions.

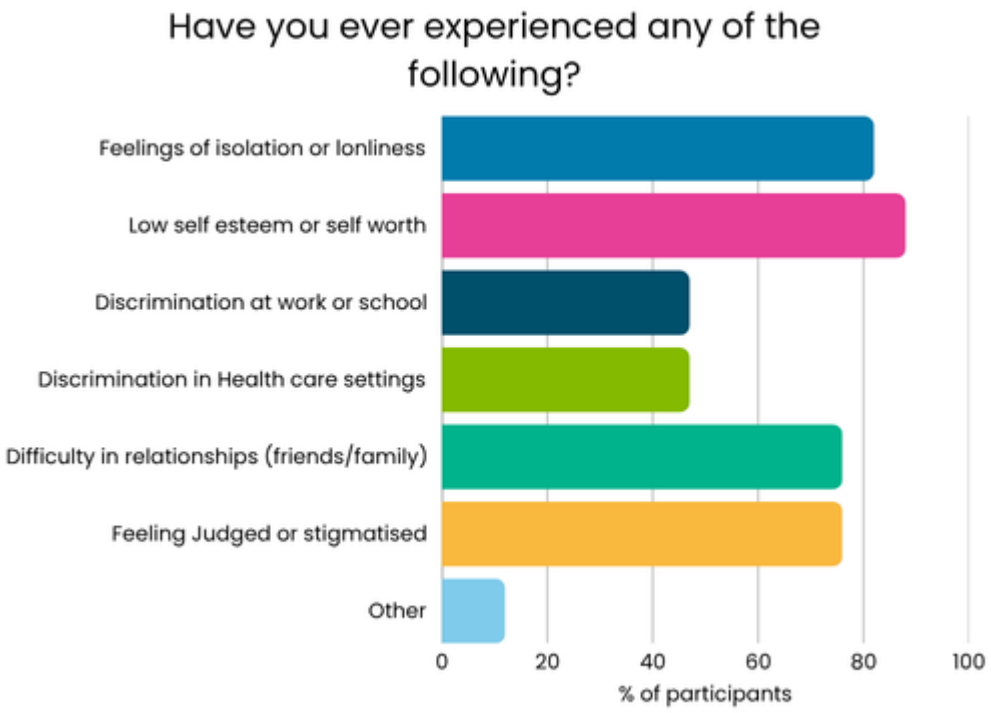
Many people explained that when their mental health declined, their physical health was often affected as a result. Some described low motivation, increased isolation, changes in appetite, disrupted sleep, reduced activity levels, and difficulty managing existing health conditions or seeking medical help. Participants also shared that medication side effects and lifestyle changes linked to poor mental health could contribute to weight changes, fatigue, or worsening physical symptoms.

Importantly, people also described the impact working in the opposite direction. When their physical health worsened, this often had a negative impact on their mental health, contributing to lower mood, increased anxiety, reduced confidence, and feelings of hopelessness. Physical illness, chronic pain, fatigue, or difficulty accessing treatment were described as making it harder to maintain emotional wellbeing, daily routines and independence.

> I have times when I am active and go to the gym, cycle, swim but when my mental health declines I don't do any of those things and I lose weight and I get ill. And it is a cycle like that

As individuals began to feel stronger mentally or physically, they described gradually rebuilding routines, relationships and self-care. However, many explained that they could experience setbacks, returning to the beginning of the cycle. This cyclical interaction between mental and physical health was commonly described as part of living with an SMI, and highlights how fluctuations in wellbeing can create ongoing barriers to accessing care, maintaining health, and sustaining recovery.

The Impact of Stigma, Isolation and Self-Worth



The experiences shown in the chart closely reflect what people described about living with an SMI. Rather than being separate challenges, participants' experiences show how low self-worth, isolation, stigma and discrimination interact, often creating a cycle that impacts both mental and physical.

A large majority of participants reported low self-esteem or self-worth (88%), feelings of isolation or loneliness (82%). Many described feeling misunderstood or not listened to, which contributed to withdrawing from others and struggling to maintain confidence.

Isolation and relationship difficulties were commonly linked to worsening mental health. Participants described periods of decline where they disengaged from activities, relationships and looking after themselves.

I feel depleted *and not listened to*

I have attempted suicide a number of times. I am held on by my wife and my son. they are the reason that I live

Sometimes I feel suicidal I don't want to do anything or get out of bed. Don't want to do housework or shower every day,. I don't have many friends and only have my mum as my family. I feel better being in my bed it helps my depression go faster

Feeling like I am misunderstood due to the diagnosis I have *and* not listened *to*

Some participants describe close relationships in a positive and help to get them through tough times when they feel like services are not reliable. With some saying they would not be here if it wasn't for that relationship.

Stigma and discrimination were also widely reported, with 76% of participants feeling judged or stigmatised and 47% experiencing discrimination in healthcare settings.

For some caring responsibilities and life pressures added to the SMI cycle contributes to burnout and emotional distress.

My daughters both have Mental health, health and learning difficulties and this has had a significant impact on their time as children in mainstream school but it also affected my mental health as I couldn't cope with the constant communication with school about them and the meetings, I would worry that they would get taken off me

Been made to feel stupid, thick and insignificant. I feel discriminated against when I go to the GP

Had a meltdown on Sunday because it was too much... when I had those 2 days off I was still answering calls and did not really rest at all

These findings demonstrate that living with an SMI often involves navigating interconnected challenges affecting emotional wellbeing, relationships, physical health, and access to care. The experiences shared highlight the importance of holistic, person centred support that recognises how stigma isolation and low self-worth can influence both mental and physical health outcomes.

Care and support accessed

It was identified that more than half (53%) of the people we spoke to were not currently accessing any help except for that of a GP as and when needed or for a medication review. With only 47% of participants currently receiving support for their SMI, this highlights a clear health inequality, as many individuals are not accessing the ongoing mental and physical healthcare needed to manage long-term conditions, increasing the risk of poorer health outcomes and reduced

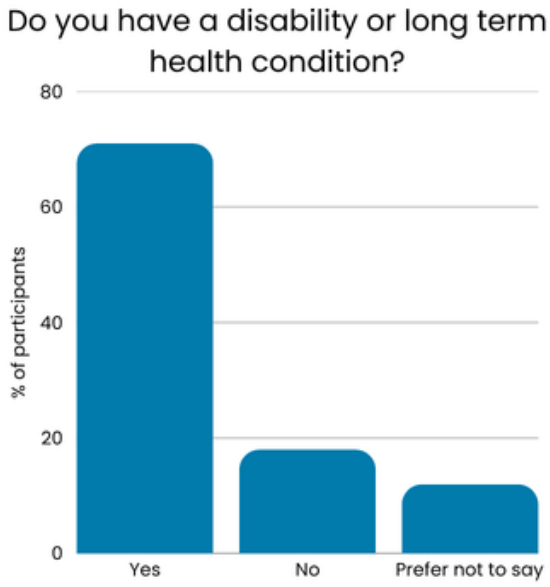
life expectancy. Others (47%) were accessing VCSE partners like @the hub in Ross, Ledbury Food bank and 1 person was attending groups at Mind. 1 person was actively talking to Talking Therapies at the time of interview.

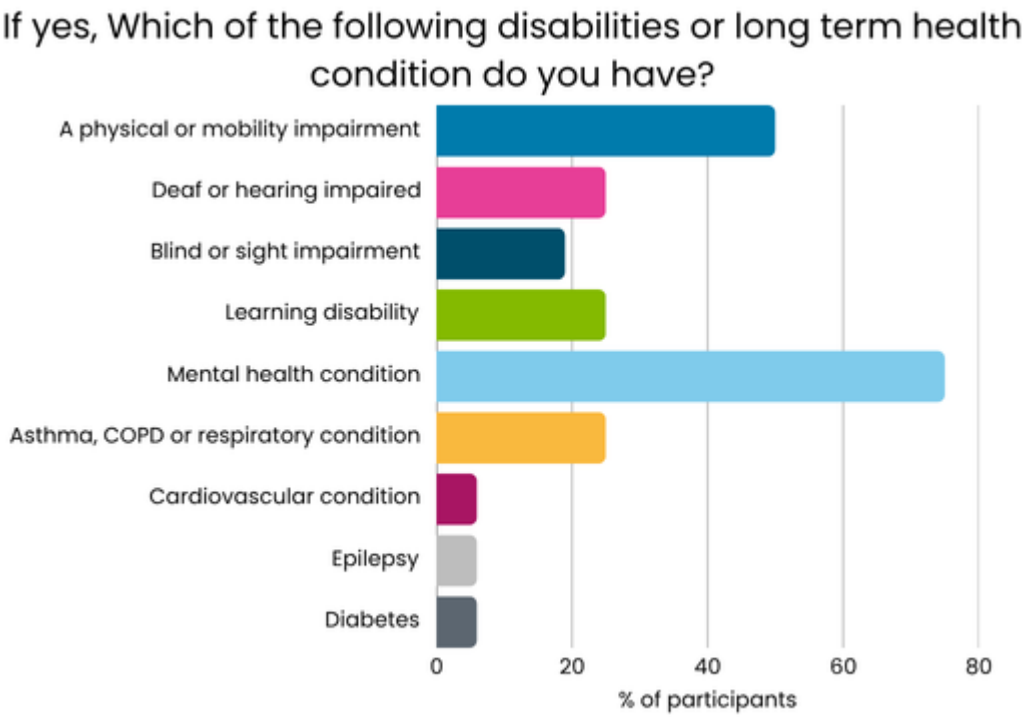
Physical Health

Most participants rated their current health as fair, showing that many people feel their health is neither particularly good nor particularly poor. A notable proportion described their health as reasonably good, suggesting some positive wellbeing. However, a significant number of people reported their health as quite poor or very poor, highlighting that a considerable group are experiencing

poorer health outcomes. Overall, the results suggest that many individuals living with SMI experience moderate to poor health, reinforcing the link between severe mental illness and poorer physical health.

Long-term conditions and co-existing health needs





71% of participants reported living with a disability or long-term condition (LTC). Of these, 50% described physical or mobility impairments, including arthritis, fibromyalgia, and chronic fatigue syndrome. A large proportion (75%) also reported additional mental health conditions such as anxiety and depression alongside their SMI.

Notably, relatively few participants reported living with cardiovascular conditions, while a higher number reported respiratory illnesses within this sample group.

The high proportion of participants reporting ADHD/ADD, Autism, and Dyslexia indicates that cognitive and communication differences are common within this group, which may further increase barriers to accessing healthcare and contribute to inequalities in physical health outcomes for people living with SMI. This is reflected in the barriers to support.

Now my ADHD is like it is too much effort to go back through so I give up trying

I am dyslexic so I struggle with letters and communication

Barriers to Support

This report shows that people living with Severe Mental Illness (SMI) face multiple interconnected barriers when trying to access physical and mental health support. Many participants described feeling judged, misunderstood or not listened to, which contributes to disengagement from services and worsening health outcomes. Experiences of stigma, difficulty navigating complex systems, and challenges maintaining ongoing relationships with professionals were frequently highlighted.

Stigma and Negative Experiences from Professionals

Many participants described feeling judged, dismissed or treated differently because of their diagnosis.

Experiences of discrimination in healthcare settings (47.06%) and feeling judged or stigmatised (76.47%) highlight the ongoing impact stigma has on engagement with services.

I think some of the help and advice from multiple agencies need a re vamp on how they talk to u try to understand what ur trying to say

I have been in to hospital to a and e and Stabenow. I find the staff in there rude and not understanding of people with suicidal thoughts. I have heard them say comments like 'we haven't got time for you and they talk down to you

Not listened to.

Feeling like I am misunderstood due to the diagnosis I have

Suggested ideas to overcome this barrier

- Provide training for professionals to improve understanding of SMI and reduce stigma.
- Encourage compassionate, person-centred communication that validates lived experience.

- Promote advocacy support to help individuals feel heard and understood Improve awareness in schools and communities to reduce stigma earlier in life.

Lack of continuity of care

Participants spoke about inconsistent support, frequent changes in GP and services ending before they felt ready.

This lack of continuity makes it difficult to build trust and means individuals often have to repeat their story multiple times, which can be distressing and discouraging.

> Other GPs didn't have time to look over all of my history so only judged me on what they saw in that appointment

> I had online therapy CBT for 2 hours once a week for 6 months - I felt like this was too short I need ongoing support

> Having to talk about my past and explaining what has happened in my past was a bit of a trigger for me so I stopped my support due to not wanting to keep going over it as I feel this would have an impact on my mental health even more

Suggested ideas to overcome this barrier

- Named GP – allocated professional who understands the person's history
- Longer appointments – double appointments where needed.
- Trusted relationships – personable professionals who listen.
- Consistency in care – seeing the same professional over time

Diagnostic Overshadowing

Many participants described attending GP appointments for physical health concerns, but feeling that their symptoms were dismissed or attributed to their mental health diagnosis rather than being fully explored as potential physical health conditions.

> I went to GP about back ache it was put down to my anxiety when actually it turned out I had arthritis in my spine

> Medications and diagnosis for health issues are hard when you have an SMI as the Dr's say It's part of my SMI that I have pain and because of the medication I take it is harder for Dr's to treat me. I have multiple health issues

> As soon as services know that you have got mental health issues your voice isn't heard and you are completely ignored

Participants reported that this can lead to missed or delayed diagnoses, untreated physical health problems, and feelings of not being listened to or taken seriously.

Suggested ideas to overcome this barrier

- better GP awareness of difference between physical and mental health
- full physical health checks
- professionals recognising SMI but not attributing all symptoms to it

Difficulty accessing services

Long waiting times, challenges booking appointments, and complex referral systems were frequently identified as barriers.

> Language barrier as I do not speak much English and I struggle to fill in forms i need help to do

> One time I had to wait 3 months

> when you are in desperate need or in crisis it is too much to fill in a form and wait for an appointment

Some participants also described difficulties using digital systems or understanding how to access the right support.

> I couldn't access the support and put it in place until I was in the situation

> I only have a basic phone that you call on not social media. I don't believe in all that stuff & apps

Suggested ideas to overcome this barrier

- accessible communication support
- education system awareness
- practical wellbeing activities
- easier navigation of services

Low trust and disengagement from services

Previous negative experiences, fear of being judged, and feelings of isolation contributed to some participants avoiding support or only seeking help when in crisis.

> Past experiences make it difficult to trust

> It is hard to access any help when you are spiralling, especially when you have bad experiences with trying to access help

> I told them that I felt suicidal and they got me a call with the duty team but the duty team only calls you between 1pm and 4pm. what if I am suicidal out of that time?"

Suggested ideas to overcome this barrier

- Advocacy for people who struggle with mental health issues to ensure they are supported through physical health care and their mental health care journeys

Findings suggest that health inequalities experienced by people living with SMI are strongly influenced by stigma, fragmented care, and barriers within healthcare systems. Participants' experiences highlight the importance of improving trust, communication, and accessibility within services to ensure both mental and physical health needs are addressed holistically.

Lived experience findings, closely mirrored organisation's insights, highlighting shared concerns around long waiting times, fragmented services, stigma, and the need for more coordinated, compassionate, and person-centred care for people living with SMI.

Conclusions, Learning and Recommendations

Learning

Outcome 1: SMI creates a cyclical relationship between mental and physical health

Learning: Services must recognise that deterioration in one area predicts decline in the other. Early intervention prevents crisis.

Outcome 2: Stigma and discrimination remain major barriers

Learning: Training must shift from awareness to accountability—ensuring staff behaviour changes, not just knowledge.

Outcome 3: People with SMI are under-supported in managing long-term conditions

Learning: Physical health pathways must be redesigned to proactively include people with SMI, not rely on self-navigation.

Outcome 4: System complexity disproportionately harms people with SMI

Learning: Simplifying access, reducing bureaucracy, and offering human-centred contact improves engagement.

Outcome 5: Neurodiversity is common and overlooked

Learning: Communication must be accessible by default—plain language, multiple formats, and flexible appointment options.

Recommendations

Recommendation 1: Create a Single Point of Access for SMI

A unified referral and triage system across mental and physical health services to reduce delays and improve coordination.

Recommendation 2: Replace "Three Strikes" with a Safety-First Approach

Missed appointments should trigger proactive outreach, recognising they may signal deterioration.

Recommendation 3: Mandatory SMI-Inclusive Training for All Health Staff

Training should include:

- Trauma-informed practice
- Anti-stigma behaviour standards
- Understanding neurodiversity
- Recognising diagnostic overshadowing

Recommendation 4: Proactive Physical Health Monitoring

- Annual health checks must be actively offered and followed up.
- Outreach clinics in community hubs.
- Mobile health checks for rural areas.

Recommendation 5: Expand Community-Based Support

- Peer support networks.
- Drop-in mental health hubs.
- Partnerships with VCSE organisations.

Recommendation 6: Improve Communication & Accessibility

- Paper, phone, and face-to-face options for all services.
- Clear directories of support.
- Simplified referral pathways.

Recommendation 7: Address Wider Determinants

- Strengthen links between mental health, housing, benefits advice, and social care.
- Embed financial wellbeing support into mental health pathways.

Conclusion

People living with SMI in Herefordshire face significant, interconnected barriers that affect both mental and physical health. Many are unsupported, isolated, and navigating complex systems without adequate help. Strengthening pathways, improving accessibility, and embedding compassionate, person-centred care are essential to reducing inequalities.

These recommendations align with the NHS Long Term Plan's commitment to improving physical health outcomes for people living with Severe Mental Illness, promoting integrated care, early intervention, and more personalised, accessible services that address both mental and physical health needs.

Healthwatch Herefordshire
6 St Peters Square
Hereford
Herefordshire
HR1 2PG

www.healthwatchherefordshire.co.uk
t: 01432277044
e: info@healthwatch.co.uk
@Healthwatchherefordshire
Facebook.com/Healthwatchherefordshire

healthwatch Herefordshire