Dear Editor,

The Chair, Section Leaders and Senior Authors of the *Lancet Psychiatry Commission1* on protecting physical health in people with mental illness are pleased by the constructive dialogue on the report. We agree with Steptoe & Fancourt that a broad range of psychological and biological processes contribute to poor physical health in people with mental illness – not all of which were explicitly focused upon by the Commission. While psychological therapies are a core component of evidence-based treatment for managing stress associated with mental illness, it has yet to be established if these interventions effectively improve cardiometabolic outcomes or reduce physical comorbidities in people with mental illness. Thus, the Commission’s recommendations must focus on the implementation of lifestyle and pharmacological interventions with existing strong evidence from meta-analyses of randomised controlled trials (RCTs)3 for improving physical health outcomes in even those with severe mental illness. Furthermore, it is important to note that evidence-based lifestyle interventions address stress-related processes, as components these (including exercise, diet, smoking cessation and sleep) both improve perceived stress and reduce the oxidative stress and inflammatory processes implicated in both physical and mental illnesses2.

Our Commission also aims to address the impact of social isolation, loneliness and impoverished social support with regards to physical health outcomes for people with mental illness, through (i) recommending better use of supportive community-based referral schemes (see Part 4), and (ii) specifically calling for public health policy to urgently confront the social and environmental factors driving physical-mental comorbidities (see Part 5, Figure 1 and Appendices). In addition to the recommendations of the Commission, we agree that ‘social prescribing’ initiatives present another promising platform for tackling health disparities for people with mental illness, partly through potentially providing greater access to ‘community-based’ lifestyle interventions (e.g. walking groups and exercise classes).

We also thank Hengartner, Read & Moncrieff for their letter on antipsychotics and mortality risk. As discussed extensively in the Commission, many second-generation antipsychotics (SGAs) increase cardiometabolic risk, over and above other risk factors associated with schizophrenia. However, we disagree with Hengartner, Read & Moncrieff’s interpretation of the literature on long-term mortality. A 2017 meta-analysis of RCTs and observational studies found a pooled risk ratio reduction in mortality of 0.57 from antipsychotics usage4. A meta-analysis of short-term mortality associated with SGAs found no difference in mortality for any, natural and non-natural causes in schizophrenia5. Although Hengartner, Read & Moncrieff draw on mortality data from risks of antipsychotic treatment in dementia, this is a separate issue from the mortality risks discussed within the Commission. Our recommendations around antipsychotic treatment are specifically made only with regards to their use in treating psychotic disorders. Nonetheless, we agree that further research and intervention is urgently needed for preventing the physical health risks associated with these medications. Alongside this, our Commission’s report presents the evidence, implementation strategies, and research priorities for using multidisciplinary interventions to protect the physical health of people with mental illness*1*.

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