Background:
Physical health of people suffering from severe mental illness is a neglected area. They suffer more than general population and they die earlier. Looking after such disadvantaged groups of people is mandatory to improve their outcome and quality of life. Monitoring current clinical practice is essential to try to improve it.

Methods:
37 patients who were on long acting injectable antipsychotics, attending the Tyre's Centre were approached to establish their physical care management and check against the POMH-UK guidelines of antipsychotics, whether they suffer from metabolic syndrome or not, physical illness was recorded.

Results:
Patients were interviewed face to face, physical and mental health issues were reviewed. The mental health review covered checking for psychotic features, side effects and psychological functioning. Physical history covered past medical history, medication for physical illnesses, allergies, family history, weight, body mass index, waist measurement, blood pressure, smoking habits, alcohol intake, illicit substance abuse. Blood investigations included fasting Blood Sugar (FBG). Urea and Electrolytes (U&E), Liver Function Tests (LFT), Gamma Glutamyl Transpeptidase (GGT), Hba1c (haemoglobin A1c) for glycaemic control and Fasting and Post Fasting Lipids. An electrocardiogram (ECG) was also requested if the patient had not had one within the past twelve months of the review. If the blood pressure measurement was high during the appointment a taken a second measurement. If it remained elevated the patient was advised to attend their GP surgery and the readings were given to the patient by the GP. The GP is also informed in writing about every appointment.

The patients’ medical notes were assessed by HU using the POMH-UK Audit 2a Screening Tool for monitoring metabolic side effects of patients on antipsychotics. The results were verified by the Prescribing Audit Department with POMH-UK Ethical approval was secured from relevant department in SEPT. Patients’ diagnosis was recorded according to the International Classification of Diseases, Tenth Revision (9). Criteria for metabolic syndrome, according to the International Association of Diabetes (7), were recorded although they were not formally audited by the Audit Department. Higher than the following figures were considered as abnormal according to National Institute of Clinical Excellence (NICE) 2009(3), waist circumference 102 cm for men and 90 cm for women, Hba1c ≥48 mmol/l, persistent raised blood pressure > 140/90, hyperlipidaemia total cholesterol/high density lipoproteins >6.

Results
Men were more than women by 1.85:1. Most patients were above forty years old. Table I demonstrates age and age distribution. 96% was Caucasian. 87% suffered from schizophrenia as shown in Table I. A total of 46% were on antipsychotics alone either as depot or in combination with oral antipsychotics. 7.5% of patients were known by the National British Charity (BNF). 48.6% were on other psychotropic medications including mood stabilisers, antidepressants and hypnopeptics.

Patients who were known to suffer from Non Insulin Dependant Diabetes, were 22% (22/100); 9 of them were identified by DWBC review. 22% tended to hypertension which was identified by DWBC. All patients smoked tobacco and 35% of them were offered help to stop. They all declined the offer.

Discussion
The present study highlights the importance of physical care of severely mentally ill patients and indicates that this group of patients are the least to look after their physical health. This was demonstrated by the low level of involvement in the DWBC (57%), in spite of the free medical advice, care and encouragement offered, the response was still poor. The bulk of the sample were male, nearly twice, which consistent of other studies in the depot populations in the United Kingdom and Europe(10). Majority were above the age of 40 years, which again consistent with local and European studies(7,8). This is concerning in the present study, as it is understandable that risk of metabolic and cardiovascular illnesses increases with age. Again, 96% men and 67% of women were overweight which increases the risk as indicated by the International Diabetes Federation (7). It is interesting to note that there was a high comorbidity of metabolic abnormalities, i.e. high lipids 73%, 84% of them were identified by DWBC, diabetes 22%, 75% identified by DWBC and all patients with hypertension were identified by DWBC. It is known that these illnesses are silent at the beginning but the more they continued undiagnosed the more the damage they cause. This is the benefit of the BWBC were regular follow ups and checks would be identified as soon as possible, which will improve the outcome. POMH-UK conducted a retrospective case note analysis of patients who were identified through this clinical pathway. They found that a majority of patients were not identified through DWBC. The present study highlights that after the routine physical examination, metabolic and cardiovascular status be monitored regularly (act at an annual basis(11)), results in our trust is consistent with these findings (11).

It is obvious that this area of care is neglected nationally and internationally. Regular reviewing and monitoring of physical health is not satisfactory and even if it is done, it is not documented or managed properly.

At the beginning the nonattendance rate was high. A reminder service was therefore developed to improve patient attendance. This entailed writing to the patient, to encourage them to attend and liaising with the community mental health teams, to remind patients when they attended for their injection. Some patients got their injection at home, their community psychiatric nurse(CPN) reminds them about their appointment at the DWBC. Some patients require a home visit by HU either because they are persistent non attenders at the DWBC, or physically unwell or having a relapse. However, as patients are now more familiar with the clinic, this is often not required anymore.

The patients were non CPD and one would speculate that those who are on CPD may be on higher doses of antipsychotics and on polypharmacy, therefore more at risk of the metabolic complications. However at present these patients continue to be seen in the genic outpatient clinic. A discussion should be initiated to extend this model to all patients on a depot.

Conclusions
Regular monitoring of the physical health of patients with severe mental illness is an essential part of care. It is important to identify these high morbidity and their serious consequences. Evidence indicates that care is suboptimal with whom to identify up to 46% of patients require consistent monitoring, which will lead to early identification and treatment of such problems, which will improve outcome and quality of life of these patients.

Limitations
Small sample due to lack of interest and motivation of patients. It included non-CPD patients who are relatively stable and their illness under control.

Recommendations
To extend this model to all patients who are on antipsychotic medication.

To advocate DWBC activity to promote the recovery model through psychosocial rehabilitation of patients and their carers.

References:
8. British National Formulary. Antipsychotic Drugs (4.2.1-2) Sept 2010 P25-26 and 4.2.2-7 4.2.5-10