

**Title: Primary care and bipolar disorder**

## **Authors**

Dr Judy Shakespeare

Retired GP, Oxford

Orcid ID: 0000-0003-0770-809

Corresponding author: [judy.shakespeare@virginmedia.com](mailto:judy.shakespeare@virginmedia.com)

Dr Sharon Dixon

NIHR Doctoral Research Fellow, NDPCHS, University of Oxford

GP Partner, Donnington Medical Partnership, Oxford.

Orcid ID 0000-0002-7469-6093

Prof Steven Marwaha

Professor of Psychiatry, University of Birmingham,

Consultant Psychiatrist, Specialist Mood Disorders Clinic, Birmingham, and Solihull Mental

Health Trust.

Bipolar UK Commissioner

Orcid ID: <https://orcid.org/0000-0002-0303-9942>

Bipolar disorder (BD) is a severe mood disorder that affects more than one million people in the UK; this is a third more than dementia and twice the number for schizophrenia. This chronic disease is sub-classified into distinct categories: for example, BDI patients have more severe manic episodes, whereas in BD2 the episodes of elation are less severe and shorter, often not coming to medical attention. Whatever the type of disease, the outcomes can be poor (1). Without effective pharmacological and psychological interventions patients will suffer relapses. The aims of treatment are to prevent relapse and improve function. Most people with BD have a co-existing psychiatric illness, such as drug and alcohol misuse, eating disorders, anxiety disorders or ADHD (1).

‘The recent publication of the Bipolar Commission’s report, “Bipolar Minds Matter” by Bipolar UK (BDUK) makes it timely to revisit the place of UK primary care in BD (2). The Commission surveyed 2334 patients living with diagnosed BD and interviewed over 100 patients, relatives, clinicians, and academics.

It reports stark facts. Mortality is increased from natural (cardiovascular and respiratory disease) and unnatural causes (suicide, accidents, and homicide), with most attributable to physical health causes. People with BD die on average 10-15 years earlier than their peers without BD. They have a 20-30-fold greater risk of suicide than the general population; up to 20% of (mostly untreated) people with BD end their life by suicide. In the BDUK survey, it took an average of 9.5 years to receive a diagnosis, after first telling a clinician about symptoms suggestive of BD. The Commission estimates that only about half of people with BD are recognised as having the condition. The delay in diagnosis matters; those with unrecognised BD are unlikely to receive evidence-based treatment for their symptoms, with

potential long-term adverse impacts on education, employment, and social opportunities. They may be receiving antidepressants, known to be associated with triggering first manic episodes, in people later recognized to have BD. Those with a diagnosis frequently seek care; in the survey they made an average of 34 visits over three years to GPs, psychiatrists, and community mental health teams. The cost of BD to the UK economy is estimated at £20bn/year; this includes medical, education, employment, and housing costs (3).

The current National Institute of Healthcare and Clinical Excellence (NICE) emphasises episodic specialist care, with discharge to primary care for maintenance treatment (4). The primary care team's role, recognised in the Quality and Outcomes framework (QOF), is to optimise physical health, check mental state and review the patient's medication (as would happen in any chronic disease management). The Commission highlights how this can result in fragmented or limited care; 60% of patients who responded to their survey have no dedicated support, treatment, or plan for their BD. Relapses cause crises for patients, their families, healthcare services and society. There is evidence that specialist treatment may be effective in terms of reducing relapses, improving quality of life, and reducing health care costs (5). This includes psychoeducation for cases and their families which, as an adjunct strategy to pharmacotherapy in the treatment of BD leads to a reduction in the frequency of relapse, length of hospital stays, and better adherence to drug therapy (6). The Commission advocates for a specialist-led pathway of care, providing psychoeducation for patients with BD, continuity of care and easy access to provide early intervention and relapse prevention, and a review of NICE guidelines. A change such as this needs funding, but it would be cost-effective. As GPs and a specialist, we whole-heartedly support all these recommendations.

The diagnosis of BD is not easy, especially in BD2, and we do not think GPs can be expected to make it, or to exclude it alone. However, we can refer, advocate, and support our patients when they or their families have concerns, or when their difficulties are not resolved with primary care support or treatment. When a patient reports that they or their family think they may have BD, whether this is because of personal experience, a family history, or from online or social media, we could consider referral for specialist assessment. The slow rates of diagnosis ascertainment highlighted in the survey suggest that under, rather than over-diagnosis is the critical challenge.

BD usually present to primary care with a depressive episode (more common than manic or hypomanic episodes). An international systematic review showed that the pooled prevalence of unrecognized BD in patients with depression managed in primary care is 17% (95% CI = 12 to 22) (7). In an observational UK primary care study, the adjusted prevalence of unrecognised BD in patients with depression was 10.0% (8), and all the unrecognised patients had BD2. This means that there is a potential opportunity for GPs to consider the possibility of BD in patients with resistant depression (failure to recover after two antidepressant treatments). For example, we might ask if they have ever had an episode of elated, excited, or irritable mood lasting four days or more, a reduced need to sleep for days, or about buying things that they subsequently regret, gambling or using drugs or alcohol to calm themselves. Asking about a family history of BD could be helpful, or agitated or hypomanic adverse reactions to anti-depressants.

QOF rewards checks for risk factors for physical disease in all patients with SMI. While rates of offering appointments and undertaking the measurements are high, the Commission highlights these are rarely followed by appropriate interventions such as weight loss (44% are obese), smoking cessation, statin prescription or exercise on prescription. When specialist care is episodic, the annual review may need to include a mental health review, considering symptoms, relapse markers, and medication review. However, a recent realist review in UK, found that GPs did not feel they had the confidence and experience to appropriately review and adjust doses of antipsychotic medication without secondary care support (9). In addition, clinicians and patients had low expectations of recovery from illness.

In another primary care study, clinicians reported concerns about initiating treatment when there was uncertainty in diagnosis and lacked experience in prescribing medications for BD; they may use low or cautious dosing, or have experience and knowledge about using a limited range of mood-stabilizing medication only (10).

Lithium is known to reduce the risk of suicide in people with BD (11). There is a documented international reduction in lithium prescribing and even in secondary care prescribing is often not NICE compliant (12). One thing GPs could do is to encourage their patients not to stop their lithium without specialist guidance or support.

The Commission has shown that there is huge scope to improve care for people with BD. Patients want continuous access to a named bipolar specialist, typically a psychiatrist; this would facilitate care within primary and secondary care. At a time when primary care is under particular pressure in the UK, GPs should not be asked to make diagnoses or initiate

or stabilise treatment. They could be curious about considering the possibility in patients with resistant depression. However, general practice has a key role in offering support throughout patients' longitudinal care journeys, including before, during, in between and after episodes of specialist input; in supporting their physical health; and social advocacy.

**Word count 1203**

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