Bipolar disorder in general practice: challenges and opportunities

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Initiatives to improve the management of high-prevalence disorders in general practice have been extensive, but the same cannot be said for the mental health disorders which are of lower prevalence, such as schizophrenia and bipolar disorder. Nevertheless, many general practitioners are involved in providing continuing care for a large number of people affected by chronic mental illnesses.[1]

There is general acknowledgement that managing acute exacerbations of chronic mental illness — acute psychoses or severe exacerbation of a major depressive disorder in particular — may be beyond the realm of most GPs (with the exception of some working in rural and remote areas).[2] However, GPs are involved in the shared care of patients with chronic mental illness, particularly those who have common comorbid psychiatric conditions (such as anxiety and depression) and comorbid physical disease. Psychiatrists are particularly reliant on GPs to monitor and treat a range of medical conditions apart from the psychiatric condition that necessitates specialist care.

Bipolar disorder falls into this category. Other articles in this Supplement describe the nature and management of bipolar disorder. Here, we focus on the very specific challenges that face GPs who manage patients with bipolar disorder, and examine opportunities that exist within the current health care system in Australia to improve quality of care for these patients in general practice settings. We also provide information on what is new in the management of this condition as it pertains specifically to general practice.

ABSTRACT

- General practitioners are involved in the continuing care and shared care of patients with chronic mental illness, including bipolar disorder. Psychiatrists are particularly reliant on GPs to monitor and treat comorbidities as well as the psychiatric condition itself.
- Management of chronic mental illness is compromised by a number of factors, including problems with diagnosis, physical comorbidity, erratic attendance and poor compliance with treatment.
- Diagnosis of bipolar disorder is often delayed, and differential diagnoses to be considered include unipolar depression, anxiety disorder, drug and alcohol dependence, personality disorder, attention deficit hyperactivity disorder, and general medical and central nervous system diseases.
- New Medicare items have been introduced under the Better Access to Mental Health Care initiative. However, uptake for patients with chronic psychiatric illness, including bipolar disorder, is low.
- Patients with bipolar disorder may be prone to a range of comorbid psychological, social and physical problems, and GPs need to be vigilant to detect and manage comorbidity and social problems as part of the overall plan. This includes assistance with certification for sickness and unemployment benefits.
- GPs may become involved during crises affecting patients and this may pose significant problems for GPs who need to provide ongoing care following patient discharge from hospital.
- Despite these difficulties, opportunities exist for GPs to play a vital and ongoing role in the management of patients with bipolar disorder.

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Prevalence and management of bipolar disorder in general practice

While the community prevalence of bipolar spectrum disorders is 4%–5%,[3] and this group of disorders is the sixth leading cause of disability, the true prevalence of bipolar disorder in general practice is unknown. Based on the most current available Bettering the Evaluation and Care of Health (BEACH) data (2007–2008),[4] 36 of 3374 GP–patient encounters sampled included a history of bipolar disorder; this represents 1.1% (95% CI, 0.6%–1.5%) of the sample. The reasons for the lack of accuracy of GP data relate to a number of factors, which include: the failure to diagnose the disorder altogether, or incorrectly diagnosing the disorder as unipolar depression; poor and erratic attendance of patients with the condition; presence of comorbid psychosocial problems, particularly those related to drug and alcohol, that may override the diagnosis of bipolar disorder; and limitations associated with methods of collecting the BEACH data.

The management of bipolar disorder in general practice is compromised by a number of factors, including problems with differential diagnosis, dual diagnosis, physical comorbidity, erratic attendance and poor compliance with treatment. Differential diagnosis may include psychiatric disorders, namely unipolar depression, anxiety states, drug and alcohol dependence, attention deficit hyperactivity disorder, personality disorders and eating disorders. Physical disorders presenting as bipolar disorders include: hyperthyroidism and hypothyroidism, acquired brain injury, cerebrovascular accidents, dementia, and multiple sclerosis. Diagnosis may therefore be delayed, particularly when there is late onset or atypical onset of bipolar disorder.

Although it is common for GPs to provide repeat prescriptions, supervise use, encourage adherence and periodically check blood levels of medications,[1] it is unlikely that they would commence pharmacological treatment for bipolar disorder, particularly during an acute phase of mania or hypomania. Experience with the use of atypical antipsychotics in general practice may therefore be limited, and regimens involving combined use of mood stabilisers and antidepressants may be continued but seldom commenced by GPs.

Nevertheless, GPs have an important role in promoting and overseeing adherence with psychotropic medication in this group of patients, who commonly cease medications once they are stable, often in the misguided belief that levels of hypomania are more acceptable than "normality". It is therefore important for GPs to encourage patients to accept the chronic and relapsing nature of this disorder, to optimise adherence with treatment.

Patients with bipolar illness are prone to seek alternative remedies to try to stabilise mood or alleviate symptoms of depression, or to generally enhance wellbeing. This may lead to difficulties in interpersonal relationships between GPs and patients, particularly if the GP is not sufficiently patient-centred or is judgemental about "health provider shopping". Also, patients with bipolar illness often search the internet for alternative explanations for their symptoms or to seek alternative remedies. Negative attitudes to these patients and a failure to undertake motivational interviewing during the course of a consultation, as well as failure to apply the principles of gradual behaviour change, may result in patients becoming alienated from general practice, therefore compromising continuity of care.

Systems of care

Under the Better Access to Mental Health Care initiative, introduced in 2007, the Australian Government provided new Medicare items for GPs providing mental health care.[5] These are:

- Preparation of a GP Mental Health Care Plan (Item 2710)
- Review of a GP Mental Health Care Plan (Item 2712)
- GP Mental Health Care Consultation (Item 2713).[5,6]

When a patient also has other chronic comorbid physical illnesses, these care plans may be combined with a GP management plan. The funding arrangements and patient pathways in relation to this are outlined in the Australian General Practice Network charts, which can be accessed online (http://www.agpn.com.au).

People who need mental health services can access these services via their GP. The Better Access to Mental Health Care initiative encourages a team-based, multidisciplinary approach to mental health care in the community, with GPs working with psychologists, psychiatrists and other allied mental health professionals. GPs can provide assessment, early intervention and management for patients at the practice level as part of a GP Mental Health Care Plan.[7]

Although the uptake of items related to the Better Access to Mental Health Care initiative for high-prevalence disorders such as depression and anxiety has been excellent,[5] this has not been the case for patients with chronic psychiatric illness such as bipolar disorder.

Shared care

After diagnosis and commencement of treatment (particularly when treatment is instigated during a hospital admission), the patient may be referred back to his or her GP for ongoing surveillance and treatment monitoring. In addition to sharing care with a psychiatrist or the community mental health service, shared care may also occur with a psychologist who can provide specialist psychological therapies (see Lauder et al, *page S31*).[8] To receive a Medicare rebate, the patient must be referred to a psychologist by an appropriate medical practitioner (GP, psychiatrist or paediatrician), who must first make an assessment that the patient needs the services of a psychologist.[9]

Sharing of information and up-to-date patient records, including medication and medication changes, among members of the team caring for patients with chronic mental illness is essential. At present, medical software systems are not sufficiently well developed to enable team members, including the pharmacist, to share this information in an electronic format.[10] It is therefore possible that different medication lists exist among each of the providers sharing the care of these patients. In addition to poor patient adherence, this may compromise continuity of care and lead to drug-related complications in this vulnerable group of patients.

Comorbidity

Patients with bipolar disorder may be prone to a range of other psychological, social and physical problems (see Parker, *page S18*).[11] GPs providing continuity of care for these patients need to be vigilant to detect and manage comorbidity as part of the overall management plan.[6,12,13]

Psychological comorbidity

Psychological comorbidity may take the form of anxiety, which may be superimposed on bipolar depression or even associated with hypomania. It is essential to detect a difference between anxiety and hypomania as the former may be treated with short-term benzodiazepine therapy, notwithstanding potential problems related to addiction from the use of this class of drugs in this group of patients.[4,14]

Major depression itself is not considered to be a comorbid association, but is a component of bipolar disorder. However, adjustment disorders may often occur and require psychological support, including the use of specialist psychological therapies.[4,12,15]

Drug and alcohol dependence

Drug and alcohol dependence are common in patients with bipolar disorder.[4] Patients suffering from bipolar depression may seek to elevate their mood with stimulants such as amphetamines; others may use various "designer drugs" and, on occasions, become addicted to cocaine or heroin. Indeed, drug dependence may be a manifestation of an underlying bipolar disorder; it is therefore essential for GPs with patients who have a history of drug dependence to question these patients appropriately about past episodes of hypomania or a clinical pattern that is suggestive of cycling between poles or bipolar depression.

Along with illicit drug dependence, alcohol dependence is a common accompaniment of bipolar disorder; it may take the form of binge drinking, particularly among adolescents and young adults. Again, GPs who treat this patient population need to enquire about symptoms that are suggestive of bipolar disorder.[4,16]

Other psychological comorbidities include personality disorders, eating disorders and general disruption of social and intimate relationships.

Physical comorbidities

Patients with bipolar disorder have an increased cardiovascular risk; this is associated with the condition itself,[17] as well as obesity related to poor diet and some antipsychotic and mood-stabilising medications (see Malhi et al, *page S24*).[18] Thus, patients with bipolar illness require regular checks for diabetes and hyperlipidaemia, along with the usual checks of blood pressure and body mass index. Patients taking lithium require regular renal function and thyroid function tests. In cases where illicit drug use is a problem, checks for hepatitis B, hepatitis C and HIV should also be carried out.

There is also a higher incidence of cigarette smoking among patients with chronic mental illness and this exacerbates the cardiovascular risk.[6] Mortality and morbidity associated with

Web-based resources for patients with bipolar disorder and their families

- **SANE Australia:** http://www.sane.org
- **beyondblue:** http://www.beyondblue.org
- **Young Adult Health**: http://www.cyh.com/SubDefault.aspx?p=160
- **Depression and Bipolar Support Alliance:** http://www.dbsalliance.org
- **Even Keel:** http://www.evenkeel.org.au
- **Black Dog Institute:** http://www.blackdoginstitute.org.au
- **InfraPsych:** http://www.infrapsych.com
- **Reach Out:** http://au.reachout.com
- **MindMatters:** http://www.mindmatters.edu.au
- **HealthInsite (Australian Government):** http://www.healthinsite.gov.au/topics/Support_for_People_with_a_Mental_Illness
- **Mental Health Coordinating Council:** http://www.mhcc.org.au ◆

physical conditions are therefore higher in this group of patients, who find lifestyle change difficult. To manage lifestyle change and promote wellbeing, GPs need to take advantage of their long-term relationships with these patients, particularly while these patients are in remission from their bipolar illness.

Family and social welfare issues

Rates of unemployment and underemployment are high in patients with bipolar illness,[19] which leads to financial hardship and inequalities of access to housing and transport. Further, mental illness can impair a person's development and education, and diminish quality of life.[4,20] Patients with bipolar illness are often alienated from family and friends; they may live in a subculture which is conducive to drug and alcohol use and, at times, other behaviour such as gambling and crime.

GPs are often required to provide certification regarding the chronic nature of a patient's bipolar illness for the patient to receive sickness benefits or pensions and to link the patient with appropriate agencies. It is therefore essential for GPs to be aware of support structures and organisations within the community that provide ongoing assistance to patients with bipolar illness and their families. Ready access to information such as contact details for beyondblue, SANE Australia and helpline numbers may be helpful in this regard. Self-help books and web-based information can also be of assistance (Box).

Acute emergencies

GPs may become involved during crises that affect patients with bipolar illness.[6] These include episodes of mania, which may contain a number of psychotic features, as well as episodes of major depression, with or without suicide attempts (see Bassett, *page S21*).[21]

Under these circumstances, GPs may need to call on the assistance of emergency psychiatric services, police services or ambulance officers to assure patient safety and the safety of those in the vicinity of the patient. As patients with mania or profound depression may be reluctant to voluntarily seek hospital admission, it may be necessary for GPs to implement certification procedures, taking into account the normal ethical considerations and the legal implications which emerge from such procedures. Such scenarios may pose significant problems for GPs who need to provide ongoing care following discharge of their patient from hospital — the patient's memory of the certification process may impair the ongoing GP–patient relationship. Careful and sensitive post-hoc analysis of such episodes can be useful in rebuilding the therapeutic alliance and enabling the formulation of risk management plans for such eventualities.

Conclusions

Despite many of the difficulties mentioned here, opportunities exist for GPs to play a vital and ongoing role in the management of patients with bipolar disorder. Taking advantage of their unique position in the provision of long-term continuing community-based care, GPs who can establish a working relationship with patients with bipolar illness may be well placed to monitor patient compliance with medication, facilitate patient self-monitoring (using patient-held diaries), detect exacerbation of symptoms (hypomania or depression) at an early stage, and carefully monitor related physical illness.

As in any chronic condition, team-based care is essential, as is patient education and self-management.[22,23] Under current funding arrangements related to chronic disease management and mental health care plans, GPs are better rewarded financially for managing patients with bipolar illness than they have been in the past, and need to be familiar with the benefits of using a "chronic disease model" approach for patients with bipolar illness.

GPs can also play an integral role in supporting and engaging family members of patients with bipolar disorder — this includes those with direct involvement in patient care and extended family members — as well as community members and agency staff, all of whom can assist in providing patient care.

Competing interests

Leon Piterman has received funding and payment from AstraZeneca for membership on an advisory board for GP education, developing a bipolar education program for GPs, developing an AstraZeneca online education program and travelling to Sydney and Stockholm for meetings. Kay Jones has received funding and payment from AstraZeneca for developing a bipolar education program for GPs and developing an AstraZeneca online education program. David Castle has provided consultancy services to AstraZeneca, Pfizer, Eli Lilly, Lundbeck and Boehringer, and has received research grants, honoraria, speaker fees and funding to attend scientific conferences from AstraZeneca, Pfizer, Eli Lilly, Lundbeck and Boehringer.

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