

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 bipolar disorder (BD).¹ Bipolar disorder is a severe mood disorder that affects more than 1 million people in the UK; this is nearly one-third more than dementia and twice the number for schizophrenia.

This chronic disease is subclassified into distinct categories; for example, patients with BD1 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.² 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 attention deficit hyperactivity disorder.²

THE BIPOLAR COMMISSION'S REPORT

The Bipolar Commission surveyed 2334 patients living with diagnosed BD and interviewed over 100 patients, relatives, clinicians, and academics. It reports stark facts.^{1,3}

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 times greater risk of suicide than the general population; up to 20% of (mostly untreated) people with BD end their life by suicide.¹

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 Bipolar 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

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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 recognised as having BD. Those with a diagnosis frequently seek care; in the survey they made an average of 34 visits over 3 years to GPs, psychiatrists, and community mental health teams. The cost of BD to the UK economy is estimated at £20 billion per year; this includes medical, education, employment, and housing costs.⁴

The National Institute for Health and Care Excellence (NICE) emphasises episodic specialist care, with discharge to primary care for maintenance treatment.⁵ 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 Bipolar Commission highlights how this can result in fragmented or limited care; 60% of patients who responded to their survey had no dedicated support, treatment, or plan for their BD.¹ 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 healthcare costs.⁶ 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.⁷ The Bipolar 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 ROLE OF GENERAL PRACTICE IN BIPOLAR DISORDER CARE

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 overdiagnosis, is the critical challenge.¹

BD usually presents to primary care with a depressive episode (more common than manic or hypomanic episodes).² An international systematic review showed that the pooled prevalence of unrecognised BD in patients with depression managed in primary care was 17% (95% confidence interval = 12 to 22).⁸

In an observational UK primary care study, the adjusted prevalence of unrecognised BD in patients with depression was 10.0%, and all the unrecognised patients had BD2.⁹ 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

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they have ever had an episode of elated, excited, or irritable mood lasting 4 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 antidepressants.

QOF rewards check for risk factors for physical disease in all patients with severe mental illness. While rates of offering appointments and undertaking the measurements are high, the Bipolar Commission highlights these are rarely followed by appropriate interventions such as weight loss (44% are obese), smoking cessation, statin prescription, or exercise on prescription.¹

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 the 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.¹⁰ 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-stabilising medication only.¹¹

Lithium is known to reduce the risk of suicide in people with BD.¹² There is a documented international reduction in lithium prescribing and even in secondary care prescribing, it is often not NICE compliant.¹³ One thing GPs could do is encourage their patients not to stop their lithium without specialist guidance or support.

CONCLUSION

The Bipolar 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.

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Provenance

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Competing interests

The authors have declared no competing interests.

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