

Part 6. Recovery from Bipolar Disorder

Self-management in the treatment of bipolar disorders

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Abstract

There is a significant shift in the focus of care throughout the medical profession, where care in the community, alongside patient education and empowerment are being prioritised. We, as care providers, should be looking to reflect this in the management of bipolar disorder by empowering our patients to manage their own condition. Of course the difficulty with this is that with any psychiatric disorder, self-monitoring and patient-led care is dependent on the patient being competent to make appropriate decisions and having insight into the effect of their condition on their life. It is therefore a difficult balance to control, between clinician-led and patient-led care, but one that could be potentially liberating for many of our patients trying to run their lives alongside their condition.

Key words: bipolar disorder, community, empowerment, self-monitoring, insight.

We are practising in a time where there is rapid and significant change within the healthcare system. Policy setters are encouraging individualised care and care within the community; this is affecting how we are able to provide care for our patients. These features are being reflected in the clinical guidelines that are being published and should therefore also be reflected in the manner in which we practice.

National institute for health and clinical excellence (NICE) guideline for bipolar disorder

This guideline (1), published in 2006, gives us a clear outline of how care should be provided for patients with bipolar disorder. It includes pharmacological management using acute antimanic drugs and long-term prophylaxis. The guidance highlights triggers that suggest when referral from primary to secondary care may be clinically indicated, aiming to boost the confidence of those managing patients in primary care. The guideline provides clear information about the monitoring of biological parameters, particularly related to drug adverse effects. The advice for particular patient groups, such as pregnant women, children and adolescents is particularly useful.

This paper will focus on three points from the guidance that allude to the changes in care that are being recommended and how such changes could be reflected in our care provision.

- 'Healthcare professionals should aim to develop a therapeutic relationship with all patients with bipolar disorder, and advise them on careful and regular self-monitoring of symptoms (including triggers and early warning signs), lifestyle (including sleep hygiene and work patterns) and coping strategies.'
- 'If a patient is at risk of suicide, exploitation or severe self-neglect, is a significant risk to others (including neglect of dependents), or has a history of recurrent admissions, particularly compulsory admissions, a crisis plan should be developed in collaboration with the patient, covering:
 - a list of identified or potential personal, social or environmental triggers, and early warning symptoms of relapse
 - a protocol for increasing the dose of medication or taking additional medication (which may be given to the patient in advance) for patients who are at risk of rapid onset of mania and for whom clear early warning signs can be identified – protocols should be monitored regularly,

and are not a substitute for an urgent review'

- '...care programmes should include; written treatment plans that promote the principles of self-management, and are shared with the patient and, where appropriate, with families and carers.'

When reading through these sections of the guidance it is clear that there should be an element of 'self-management' of bipolar disorder. The difficulty with this is that self-management is very much a soft marker, something that will be experienced by both the clinician and the patient, but is very hard to measure. This leads to it being a part of care that is unquantifiable, difficult to research objectively, and therefore less readily implemented. I will look to suggest that despite these hurdles, it remains something that we as clinicians should be adopting as a part of the care we provide, in the hope that it will eventually translate into better patient care. More importantly, the outcome will be that it should lead to lives changed for the better, as patients are no longer controlled by a condition, but able to balance managing life alongside their condition.

Evidence for self-management

There has been a climate shift in the management of a number of other conditions over the past decade where patients are being encouraged to manage their conditions themselves. The aims of this are not only to make treatment and care more cost effective but also to increase patient satisfaction and, importantly, to improve patient outcome.

Hypertension is a condition that has gone from being perceived as a mystery by many, to something of which the general public is more aware. The provision of care has changed from a condition controlled by the general practitioner, where patients present to have their blood pressure checked, to a condition where patients have been monitoring their own blood pressure and present with a trend of their recent ambulatory readings. This reflects the change in clinical guidance (2) where a diagnostic requirement is to 'offer ambulatory blood pressure monitoring to confirm the diagnosis of hypertension' and management advice includes 'encouraging people to monitor their condition'. Building on this, a recent study by McManus et al (2010) (3) has proposed that encouraging patients to titrate their medication based on home blood pressure monitoring has led to significantly tighter control of the condition.

Similar clinical outcomes have been noted in the management of asthma. When patients are encouraged to manage their own condition, through symptom monitoring, peak flow monitoring, and the availability of oral steroids for the management of an exacerbation, clinical outcomes significantly improve. This has been expressed in a host of trials, including Osman et al (2002) (4) who looked at the impact of empowering patients following a hospital admission for acute asthma, on their clinical outcome. This is reflected in the content of the most recent British Thoracic Society guidelines (5) for asthma, which states:

'The purpose of education is to empower patients and/or carers to undertake self-management more appropriately and effectively. Information given should be tailored to individual patient's social, emotional and disease status, and age. Different approaches are needed for different ages.'

It also provides an outline of points that should be considered in a patient education session:

- 'Nature of the disease
- Nature of the treatment
- Identify areas where patient most wants treatment to have effect
- How to use the treatment
- Development of self-monitoring/self-assessment skills
- Negotiation of the personalised action plan in light of identified patient goals
- Recognition and management of acute exacerbations
- Appropriate allergen or trigger avoidance.'

The degree of patient involvement in care has also grown in chronic obstructive pulmonary disease (COPD). Open discussions between GPs and their patients leads to some patients having an 'exacerbation kit' as advised by NICE guidance (6):

'Patients at risk of having an exacerbation of COPD should be given a course of antibiotic and corticosteroid tablets to keep at home for use as part of a self-management strategy' This gives the patient confidence that they are able to manage their condition further, and also is shown to decrease hospital attendance, improve outcome and therefore improve the patient's quality of life in an exacerbation (7).

The provision of oral anticoagulation therapy shows particular similarities to the pharmacological management of bipolar disorder in the monitoring and dosing changes that are required. Patients on warfarin are often protective over the management of their dosing, and are well informed about the risks of treatment being subtherapeutic or supra-therapeutic. The advent of a 'warfarin card' has encouraged the atmosphere in which the patient is the expert and the clinician is the service provider. Titration of dosing to achieve appropriate plasma concentration of lithium is closely aligned to the monitoring of the international normalised ratio (INR) in anticoagulation. Two developments within the management of anticoagulation that could be applied to the management of bipolar disorder are finger prick monitoring, which could be also applied to lithium blood-level measurement and using agents that do not require blood monitoring. An initial focus for improvement of clinical care for patients being treated with warfarin was the development of finger prick INR readings. This reduced the invasiveness of testing, and also permitted informed and appropriate patients to monitor and dose their warfarin themselves by following an algorithm (8). Being able to develop a similar test for capillary lithium levels that relates to serum lithium levels would permit quicker and easier testing for therapeutic dosing, and would also prove useful in monitoring for levels of toxicity.

More recently research has been looking into other oral anticoagulants such as Rivaroxaban, a direct factor Xa inhibitor. Implementing the routine use of drugs such as this aims to save on the costs of monitoring and to reduce adverse events, although there is an increase in cost of the drug itself. This is comparable to the broadening of therapeutic strategy for treating bipolar disorder, from the widespread use of lithium, to the use of mood stabilisers and atypical antipsychotics. There is still a need for further research into which pharmacological intervention is most effective, as currently decisions are made on an individual basis.

Diabetes management lies at the forefront of self-management, because it entails symptomatic monitoring, physiological testing, and pharmacological interventions. Interestingly paediatric diabetes patients demonstrate variable insight into the beneficial effect of treatment on their condition, in a similar way to the variable insight that patients with bipolar disorder show into their condition. Research into the role of self-management in paediatric patients with diabetes, I would suggest, is highly relevant when considering applying the same management principles to those patients with bipolar disorder.

NICE (9) has incorporated the idea of empowerment and self-management into their guidelines, even for young children as below:

'Children and young people with type 1 diabetes and their families should be offered timely and ongoing opportunities to access information about the development, management and effects of type 1 diabetes. The information provided should be accurate and consistent and it should support informed decision-making.'

The issue of insight is pertinent. It was noted by Rewers et al (2009) (10) that often children under 6 have poor hypoglycaemic awareness, and consequently they are less suitable for self-monitoring. This would be comparable to bipolar patients that have poor insight into whether or not they are in a manic, or a depressive phase. In the same way that those younger children are not suitable for self-monitoring glucose levels, this would suggest that patients with bipolar disorder that have poor insight would be unsuitable for self-management.

How can this apply to the management of bipolar disorder?

The recommendations for monitoring of therapy in patients with bipolar disorder are demanding. As a consequence of this, it is difficult for clinicians to provide appropriate monitoring, especially when

liaising between primary and secondary care in the monitoring process. I would suggest that involving patients with this monitoring process is an obvious area where we can look to empower patients to take a management role in their condition.

To aid this transition, further research into the relationship between serum lithium and capillary lithium, salivary lithium, or urinary lithium in patients on lithium therapy is needed. This would help to clarify if there is scope in the future to use salivary, urinary, or capillary samples to monitor therapeutic dosing of lithium. This would reduce the need for blood testing for levels within primary or secondary care, which may or may not be a current hurdle for patients, although there would of course still be the need for renal and thyroid function monitoring. This also does not help the patients with bipolar disorder who are not using lithium for therapy.

It is particularly worth noting that there is no benefit in self-monitoring if the patients are not compliant with their medication. Self-management is something that would put the ball into the patient's court in terms of shaping their recovery. Carter et al (2005) (11) highlighted the fact that clinicians are providing a service that the patient may or may not engage with, and that this will vary from patient to patient and from condition to condition. They found that compliance with medication was correlated to the perceived need for treatment. In specialties such as oncology, adherence was highest, whereas this fell with conditions such as asthma. Although medication use in psychiatric conditions was not included in the study, I would suggest there would be a wide variety of opinions among psychiatric condition patients, ranging from patients that have respect and gratitude for their medications, to patients that detest the need to take medications to be 'normal'. I would expect this variety to be reflected in their compliance. This further highlights the need to select out patients that would not be suitable for self-management. NICE guidance has picked up on this finding, and has produced generic guidance for 'medicines adherence' (12) which suggests:

'Patient involvement in the decision-making process requires that healthcare professionals acknowledge patients' views about their condition and its treatment, and that both healthcare professional and patient have a role in making decisions about treatment. Simple interventions to increase patient involvement do not necessarily increase the overall length of consultation and may be justified by benefits, particularly over the course of a long-term condition.'

This guidance clearly encourages patient empowerment, and reflects evidence that patient involvement increases medication compliance, something that is a constant battle for patients with bipolar disorder.

Current situation

The current situation with self-management in patients with bipolar disorder is that there is great variability from patient to patient and from clinician to clinician. Interventions such as the 'lithium card' start to encourage patients to take ownership over their condition and to feel like they have an element of control over their management. However there remains great scope for increasing the degree of patient involvement, and for the extent to which the patient leads changes in therapeutic strategy to grow.

How things could be different?

As mentioned above, development of devices to enable fingerprick monitoring for lithium levels, or accessible monitoring for sodium valproate or carbamazepine could allow more power to be shared with, or given to the patients. That said, the main development I feel needs to come from inclusiveness and shared decision-making rather than technological advances.

The intervention that I feel would be most beneficial in increasing the involvement of the patient in their care is provision of a clear plan for increasing a patient's mood stabilisation medication, appropriately using antidepressants, and recognising triggers that may be an indication for anti-psychotic medication or inpatient care. This would increase the confidence and ownership of the

patient, as well as equipping the approved mental health professional and GP to manage the condition when required. This could be undertaken using a refined version of the empowerment strategy from the BTS/SIGN guidelines included above.

What would be the benefits?

- Improved patient outcome – in many other chronic conditions, as shown above, incorporating self-management and patient empowerment into the therapeutic strategy leads to improved patient outcomes. The interventions in bipolar disorder are less clear, and the patient group more difficult to manage, but potential benefits could make the change worthwhile.
- Improved quality of life – this is the marker that we as clinicians should be always aiming to improve. Freedom from hospital monitoring, the independence to make informed health decisions, and tighter therapeutic control would start to contribute to an improved quality of life.
- Reduced clinician input – secondary care clinicians would continue to be involved in the management of difficult cases, and would provide more of a planning and equipping service. This would liberate primary care physicians, and the patients themselves, to manage their condition in the community.
- Empowered patients would recognise and respond to warning signs at an earlier point in time, facilitating prompt intervention. This would lead to less oscillation between manic and depressive phases, and more of a steady state. This concept was highlighted by Agius et al (13) in a paper which particularly focussed on identification of early warning signs and developing a relapse prevention plan.

What would be the difficulties?

The significant difference between patients with bipolar disorder and most of the patient groups above, for which there is clear evidence for self-management, is that of insight into their condition. Giving a patient the power and authority to control and change their therapy requires an understanding of the illness, the effect of treatment on the condition and essentially an appreciation that there is a condition that needs treating. With disorders that bridge the boundary between a psychotic and neurotic condition, it will not always be possible to affirm that patients appreciate the illness, the treatment, or the link between the two.

Clinical improvement as a consequence of patient-led care needs intelligence for appropriate decision making, a desire to see improvement in health, and insight into the condition and how it affects them. The clinician will assess indicators of each of these attributes from their interactions with the patient. It then requires a judgement to be made by the doctor as to whether the patient is suitable to take a leading role in his or her own therapeutic management. This judgement will be heavily influenced by an open discussion between the patient and clinician.

There is, of course, a risk that the judgements might be incorrect and that patients that should not be given such freedom take an inappropriate lead in their care. It could be proposed that this would raise a risk that poor patient selection would lead to manic patients being a risk to the public, or patients in the depressive phase are at increased risk to themselves. I would highlight the fact that short of treating patients under the Mental Health Act, we are never able to enforce treatment. We do not therefore ensure that patients take their medications or engage with treatment. There will therefore be little change in the treatment provided but a major shift in the attitude with which that treatment is received.

It seems unlikely that encouraging self-management will increase the risk of non-compliance in this patient group. On the contrary, I feel that empowering the patients will give them an ownership that leads to greater engagement with healthcare professionals and the treatment they are able to advise.

Conclusions and recommendations

I am not able to provide clear guidelines as to what will be successful in the management of bipolar disorder. My role is to highlight the success that has been proven in other conditions, to note the suggestion in current guidance for bipolar disorder to 'promote principles of self-management', and to propose avenues by which this can be implemented.

The interventions that can be patient led are less clear-cut than in many of the other conditions that I have explored above. That said, I would hope that in developing a therapeutic relationship, and empowering the patient, it will lead to patients feeling more equipped to tackle life alongside managing their condition. I feel that self-management is a vision that allows the clinician the role of becoming an overseer and enabler rather than a dictator in the management of a patient's condition. This is something that should, over time, significantly improve patient care.

GP Comment

What have I learned from this paper?

This is an interesting article highlighting the evolution of clinical medicine to a shared treatment platform between patient and doctor. A doctor may prescribe but to be effective, the clinician needs the patient to be concordant with the treatment plan. Unlike the other medical conditions listed hypertension, asthma, COPD there is no objective numeric measurement tool, that could be utilised. There are downloadable smartphone applications called 'Mood Trackers' which allow a patient to tap on a visual representation of their mood i.e. smiling face=happy etc. This is a good starting point but perhaps initiating a 'buddy-up' with an objective member of the patient's family to help assess their mood and symptoms as described in the article would be better. This could increase understanding, awareness and participation of the patient and their family & friends. It might also help to break the social stigma of mental health disorders in the community and make it comparable to checking BP daily.

Simple monitoring of lithium levels would be excellent. However, R&D is too often focussed on the next big 'pharmaceutical' compound that can be licensed and become an income generator for the company. Monitoring may not be on the priority list of many multi-national pharmaceutical companies.

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