Bipolar spectrum: consequences for the development of services.

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Abstract

There is a strong case for providing specialist services and structured clinics to manage bipolar disorder and mixed affective states, particularly to reduce suicide risk. Because mood can be very changeable in this disorder, especially in mixed affective states and rapid cycling bipolar disorder, the service must be responsive, implying that fixed occasional outpatient appointments might not constitute adequate management. A flexible approach is needed with a service that is tailored to the individual.

Key words: bipolar disorders, suicide risk, design of services.

The bipolar spectrum challenges the concept that it is reasonable to see patients in secondary care on the basis of a three-monthly outpatient assessment.

There are four factors that make such an arrangement inappropriate in managing patients with bipolar disorder.

1. Mood changes from time to time.
2. The patient with bipolar disorder needs to be assessed fully, often when he or she is euthymic or depressed, in order to establish the diagnosis.
3. Depressed patients need to be given antidepressants only for the time that they are depressed (1-3).
4. Because mixed states and rapid cycling cause an increase in suicide risk, patients with mixed states (or who are rapid cycling) need to be monitored closely and very frequently while medication is administered to treat the mixed affective state, so that the patient comes out of this state (4).

The assessment of a new patient will include an at least an hour-long consultation, in which the whole longitudinal history of the patient is elicited. Essential parts of the history will be establishing whether the patient has had hypomanic/manic episodes and recording when they occurred.

The Mood disorder Questionnaire is used to validate that the patient is subject to hypomanic episodes, and the PHQ9 and GAD7 are used to assess depression.

This assessment is carried out in our service as part of a new assessment service which has been specifically set up for the purpose. In our NHS Trust, this assessment service is carried out once weekly, on a specific morning, when only new patients are seen.

Management issues that imply that it is not adequate for patients to be seen 'routinely' at three-monthly intervals include the following.

When depressed, patients need to be given antidepressants only for the time that they are depressed.

Patients with mixed states (or who are rapid cycling) need to be monitored closely and very frequently, while medication is administered to treat the mixed affective state so that the medication can be adjusted promptly when the patient comes out of this state.

If patients are acutely suicidal, then they should be referred to the crisis or home treatment team; admission to hospital should be considered in the most serious cases. However, many patients with

bipolar disorder are not acutely suicidal, even if they may be seriously depressed, and therefore the crisis team may not consider that they should be involved. However, leaving patients on antidepressants when they are no longer depressed can increase the risk of switching to mania. Hence we have developed a special clinic, which we call "the emergency clinic" in which patients with bipolar depression who have been given antidepressants are seen every two weeks by the doctor, and the depression is monitored using the PHQ9 rating scale.

Also attending the emergency clinic are patients in mixed affective states who have had their antidepressants stopped, a mood stabiliser dose increased, and an atypical antipsychotic started, and who are not considered sufficiently high risk by the crisis team for the patient to be taken on by that team (5). These patients are seen every week, because of the risk of suicide developing.

The need for attendance at the emergency clinic is on the decision of the treating doctor alone. When the issue has passed, the patients return to attending the normal outpatient clinic.

By having an assessment clinic and an 'emergency clinic' as described above, the special medical needs of bipolar patients, including bipolar II patients, can be catered for, and the risk of suicide can be reduced. However there are also other needs that an outpatient service for bipolar disorder should fulfil.

It is important that patients should be offered care co-ordinators who will be able to offer psychoeducation, family support and cognitive interventions in order to help reduce stress.

Psychoeducation can also be offered to patients in groups.

In addition to controlling the general symptoms of bipolar disorder, the objectives of the service should include reducing suicide risk and controlling mixed affective states. There is a strong argument for arranging specially-structured clinics in order to respond adequately to these difficult-to-manage conditions. In our experience, the measures we have described go a long way towards fulfilling the needs of patients with bipolar disorder in secondary care (6).

GP Comment

What have I learned from this paper?

Treating bipolar affective disorder is a very complex task and patients would benefit from specialist services allowing frequent and easy access to a psychiatrist. It is hoped that changes in the structure of psychiatry clinics, as detailed above, could lead to a reduction in suicide risk. This should be an important consideration of commissioners when designing services to best meet the needs of patients.

Dr J Hopwood, GP Trainee.

References

1. NICE Bipolar Illness Guidelines, 2006.
2. Rihmer Z Akiskal H: Do antidepressants t[h]reat[en] depressives? Towards a clinically judicious formulation of the antidepressant-suicidality FDA advisory in light of declining national suicide statistics from many countries. J Affect Disord 2006; 94:3-13.
3. Masand P, Mago R Review: in people with bipolar disorder, short term antidepressants improve clinical response, although tricyclics risk inducing mania. Evid Based Ment Health. 2005 ;8:35.
4. Akiskal HS, Benazzi F, Perugi G, Rihmer Z: Agitated 'unipolar' depression re-conceptualised as a depressive mixed state; implications for the antidepressant-suicide controversy. J.Affect.Disord 2005, 85;245-258.
5. Ho J, Singh S, Agius M, Zaman R. Mixed affective states: a study within a community mental health team with treatment recommendations. Psychiatr Danub. 2011;23 Suppl 1:S25-8
6. Agius M, Bugler R, Tavormina G, Zaman R.The bipolar spectrum: do we need a single algorithm for affective disorders? Psychiatr Danub. 2010 ;22:450-1.