The Burden of Bipolar Disorder

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Objectives

• To review the burden of illness in bipolar disorder

• To discuss the burden of treatment in bipolar disorder
Bipolar disorder: The burden of illness
What is bipolar disorder?

• Cyclical chronic mood disorder

• Periods of profound mood disruption
  – Mania (Bipolar 1)
  – Hypomania (Bipolar 2)
  – Depression
  – Mixed states

• Interspersed with periods of symptomatic remission
The components of the burden of bipolar disorder

• Burden of illness to the individual
  • Employment
  • Financial
  • Relationships
• Family & care providers
• NHS
• Wider society
What is the burden of bipolar disorder to the individual affected?

Consider:

– Time spent ill
– Impact of mania / hypomania / depression
– Difficulty in normal activities
  Family / work / employment
– Disability
– Premature death
Outcomes after first episode of mania

Status within 2 years

Syndromal recovery
(diagnostic criteria no longer met)

98%

Symptomatic recovery
(depression or mania ratings within normal range)

72%

Functional recovery
(regaining previous occupational and residential status)

43%

Discharged from hospital

New episode of mania

20%

New episode of depression

20%

Tohen M, Zarate CA, Hennen J et al.
Am J Psychiatry 2003;160:2099-2107
Long-term symptomatic status

Bipolar-1

Asymptomatic 53%
Symptomatic 47%

Depressed 67%
Manic/hypomanic 20%
Mixed 13%

Judd LL, Akiskal HS, Schettler PJ et al.
The long-term natural history of the weekly symptomatic status of Bipolar I Disorder
Arch Gen Psychiatry 2002;59:530-37
Long-term symptomatic status

Bipolar-2

Asymptomatic 46%
Symptomatic 54%

Depressed 94%
Hypomanic 2%
Mixed 4%

Judd LL, Akiskal HS, Schettler PJ et al.
A prospective investigation of the natural history of the long-term weekly symptomatic status of Bipolar II Disorder
Arch Gen Psychiatry 2003;60:261-269

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Premature death

- Standardised mortality ratio in bipolar disorder for death by natural causes
  - Males = 1.9
  - Females = 2.1

**SUICIDE**

- Bipolar 1
  - About 17% of sufferers will attempt suicide
- Bipolar 2
  - About 24% of sufferers will attempt suicide
- Standardised mortality ratio
  - 15 for men
  - 22.4 for women

The highest suicide risk of any mental illness\(^2\)

National Collaborating Centre for Mental Health
Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care.
National Clinical Practice Guideline Number 38, Full Guideline

2. Rihmer Z, Kiss K. Bipolar disorders and suicidal behaviour.
Bipolar Disord. 2002; 4 Suppl 1:21-5
The components of the burden of bipolar disorder

• Burden of illness to the individual
  • Employment
  • Financial
• Relationships
• Family & care providers
• NHS
• Wider society
High unemployment

• Out of an estimated 297,000 people in UK with BPD (year 1999/2000)
• **Excess** unemployment estimated at 76,500

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The components of the burden of bipolar disorder

- Burden of illness to the individual
- Employment
- Financial
- Relationships
- Family & care providers
- NHS
- Wider society
What impact does bipolar disorder have on relationships / families?

Consider:

– Day to day living with the illness
  • Mania / hypomania / depression
– Behaviour
– Disability
– Emotional strain
– Money
Impact on relationships

“Bipolar disorder can take a terrible toll on those who care for people with the condition and other family members. Most carers are partners, not parents, and the high rate of divorce among couples in which one spouse has bipolar disorder is a reflection of the emotional damage the illness can have on long-term relationships.”

“Excessive spending, infidelity, offensive, abusive or domineering behaviour and talking incoherently are just a few of the symptoms of mania that can cause distress to carers.”

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Impact on relationships

“Depression takes a toll in a different way. The patient can seem ‘cut off’ from their family and friends, isolated in their own misery. Their loss of interest and any enthusiasm in life makes it hard to get on with life as normal.”

“Family members and carers may also live with the fear that their relative or friend will attempt suicide. During depressive episodes carers said they felt less able to talk to their partner about how they were being affected by the illness. This difficulty in sharing their worries and concerns with their partners when they were depressed affected their ability to cope with the situation.”

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The components of the burden of bipolar disorder

- Burden of illness to the individual
- Employment
- Financial
- Relationships
- Family & care providers

- NHS
- Wider society
What is the burden of bipolar disorder on the NHS and society?

Consider:

– Prevalence
– Disability
– Premature death
– Cost of management / treatment
– Societal costs
  
  Disability / loss of productivity / unemployment
Bipolar Disorder: Severe Disability

Using estimates of

– Years of life lost
– Years lived with disability

BPD ranked by WHO as 6th leading cause of disability worldwide
Costs of BPD

• Annual cost to UK economy £5.2 billion (2006 prices)
• Greatest costs associated with unemployment & loss of productivity
• NHS costs approx £1.6 billion
Bipolar Disorder: Cost of Care

% of total

Psychiatrist
Inpatient
CMHN
Day care
Residential care
Therapist
GP
Other doctor
Social worker
Medicines
Informal care

Paying the price: the cost of mental health care in England to 2026
London, King’s Fund, 2006

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Bipolar disorder:
The burden of treatment
Treatment options

• Consider:
  – Antipsychotics
  – Mood stabilisers / anticonvulsants
  – Antidepressants
  – Benzodiazepines
Evidence-based guidelines for treating bipolar disorder: revised second edition—recommendations from the British Association for Psychopharmacology

GM Goodwin  University Department of Psychiatry, Warneford Hospital, Oxford OX1 2XX, UK. Consensus Group of the British Association for Psychopharmacology

Abstract

The British Association for Psychopharmacology guidelines specify the scope and target of treatment for bipolar disorder. The second version, like the first, is based explicitly on the available evidence and presented, like previous Clinical Practice guidelines, as recommendations to aid clinical decision making for practitioners: they may also serve as a source of information for patients and carers. The recommendations are presented together with a more detailed but selective qualitative review of the available evidence. A consensus meeting, involving experts in bipolar disorder and its treatment, reviewed key areas and considered the strength of evidence and clinical implications. The guidelines were drawn up after extensive feedback from participants and interested parties. The strength of supporting evidence was rated. The guidelines cover the diagnosis of bipolar disorder, clinical management, and strategies for the use of medicines in treatment of episodes, relapse prevention and stopping treatment.

Key words: antidepressants; antipsychotics; bipolar disorder; CBT; depression; evidence-based guidelines; lithium; mood stabilizers; treatment
Drug treatment for acute mania for people not taking antimanic medication

1.4.2.3 If a patient develops acute mania when not taking antimanic medication, treatment options include starting an antipsychotic, valproate or lithium. When making the choice, prescribers should take into account preferences for future prophylactic use, the side-effect profile, and consider:

- prescribing an antipsychotic if there are severe manic symptoms or marked behavioural disturbance as part of the syndrome of mania
- prescribing valproate or lithium if symptoms have responded to these drugs before, and the person has shown good compliance
- avoiding valproate in women of child-bearing potential
- using lithium only if symptoms are not severe because it has a slower onset of action than antipsychotics and valproate.
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Abstract

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Key words: antidepressants, evidence-based

Diagram:

- **Diagnosis**
  - Bipolar Disorder Manic
    - Safety, patient and family preferences and consider need for admission
      - Explain treatment plan incl. need for medicines

- **Assessment**
  - Communication
    - Severe
      - i.m. Rx if required
      - Antipsychotic or Benzodiazepine
        - Oral Rx
        - Antipsychotic or Valproate
          - Taper and discontinue

    - Mild
      - Oral Rx
      - Antipsychotic or Valproate or lithium (or carbamazepine)

- **Severity**
  - On antidepressant?
    - Consider benzodiazepine short term
      - Optimize and continue

  - Sleep deprived?
    - Optimise and continue

  - Already on long term treatment?
    - Review Response
      - Good Response
        - Consider Maintenance Rx
      - Poor Response
        - Combination Rx or ECT
R revolving door = vicious cycle

- Delay in treating first episode
- Treatment response but subsequent poor adherence to treatment
- Progression to chronic illness and/or treatment resistance
- Relapse & need to re-establish treatment

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Burden of poor treatment adherence

Rates of poor adherence range from 20%-60

Burden of BPD in NW England is high: unplanned admissions 2010

Number of admissions

Trust A Trust B Trust C Trust D Trust E

Average length of non-elective stay (days)

A B C D E

Source: Harvey Walsh Ltd, Axon Data Analysis & Informatics
Burden of BPD in NW England is high: unplanned admissions 2010

Average cost per admission (£)

Total cost £ (millions)

Cost calculations based on:
Byford S, Sharac J, Lloyd-Evans B, et al
Alternatives to standard acute in-patient care in England: readmissions, service use and cost after discharge
Br J Psychiatry 2010; 197: s20–s25

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Adherence is influenced by multiple factors

**Patient**
- Concerns about side effects
- Few perceived benefits
- Stigma
- Daily routine
- Concerns about dependence
- Lack of involvement

**Clinician / Service**
- Poor therapeutic relationship
- Poor explanation / communication
- Inadequate follow-up

**Illness**
- Severity of illness
- Depression / psychosis
- Cognitive impairment

**General**
- Complexity of treatment
- Duration of treatment
- Lack of support

Mitchell AJ, Selmes T
Why don’t patients take their medicines? Reasons and solutions in psychiatry.
Advances in Psychiatric Treatment 2007;13:336-346
Necessity / Concerns model for understanding adherence

Necessity = understanding and accepting necessity of treatment
Concerns = concerns about accepting treatment

= poor adherence

= good adherence

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Potential solutions

Medicines management

Patient & carer information

Therapeutic relationship

Patient and carer education
Putting patients and public first

4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control:

   a. Shared decision-making will become the norm: *no decision about me without me.*

   b. Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.

   c. Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.
“Choice varies according to who is choosing, what choices are on offer, and the extent to which the policy framework supports people in making choices.”
Barriers to Choice

• Lack of capacity of services to offer Choice including
  – an apparent lack of a range of treatment options and
  – restrictions on local service provision that make choices meaningless

• Lack of support from health professionals including
  – a reluctance to support service users to make choices that might differ from their own
  – a reluctance to involve carers in decisions about treatment or care

Information “. . . is fundamental to choice and making informed decisions. Without information there is no choice. Information helps knowledge and understanding. It gives patients the power and confidence to engage as partners with their health service.”
Reaching agreement on the necessity for treatment

- Benefits of treatment vs no treatment
- How likely is it to work?
- How does it compare with other options?
- Risks associated with poor adherence to treatment
All about your medicines

From this page you can find comprehensive information about medicines, including known possible side effects, interactions and dosages.

Use the A-Z listings above to look up medicines by name or by the conditions they treat. The information covers drugs you might be prescribed and over-the-counter (OTC) medicines you can buy without a prescription.
NO INFORMATION ABOUT
• Benefits of treatment vs no treatment
• How likely it is to work
• How it compares with other treatment options
• Risks associated with poor adherence to treatment

Zyproxa (Zyproxa 15mg tablets)

Overview

Information specific to: Zyproxa 15mg tablets

Zyproxa (Zy-prex-ar) is a medicine which is used in the treatment of manic episodes of mania. Zyproxa contains the active ingredient ziprasidone, which has calming and anti-psychotic effects in the body.

The information in this summary relates to the treatment of manic episodes in patients with mania. Its use is not recommended for children and young people under 15 years of age.

Your medicine

Zyproxa is used to treat manic episodes in patients with mania. It works by calming and anti-psychotic effects in the body. It can help to reduce the symptoms of mania and improve the quality of life of the patient.

Other information about the medicine

• your prescriber
Do not share your medicine with others.

The pharmacy label on your medicine tells you how much medicine you should take, how often you should take your medicine. This information should be followed carefully. If you have any questions about taking your medicine, please contact your prescriber.

If you feel that the medicine is making you unwell or you feel that you need to see your prescriber.

Whether this medicine is suitable for you

Zyproxa is not suitable for everyone and some people should only use it with special care. It is important that the prescriber has full medical history.

About

Information specific to: Zyproxa 15mg tablets when used in Mania and Bipolar Disorder.

This medicine is also available as:

• Oral 25mg tablets
• Oral 50mg tablets
• Oral 100mg tablets
• Oral 200mg tablets
• Oral 400mg tablets
• Oral 500mg tablets
• Oral 1000mg tablets
• Oral 2000mg tablets
• Oral 5000mg tablets
• Oral 10000mg tablets
• Oral 20000mg tablets

Mood Disorders
Schizophrenia and Psychosis

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Side effects

Very common: More than 1 in 10 people who have Zyprexa

- abnormal gait
- abnormal laboratory test results
- appetite gain
- falls
- metabolic problems
- sedation including certain sleeping problems, lethargy, or sleepiness
- sleepiness
- worsening of parkinson's symptoms and hallucinations when given to people with Parkinson's disease

- Mood Disorders
- Schizophrenia and Psychosis
Conclusions

• Bipolar disorder is associated with a high burden of illness

• Burden of treatment is increased by
  – Poor adherence
  – Lack of choice
  – Lack of information
Improving the use of medicines in severe mental illness

Medicines in Mental Health Ltd offers a range of services designed to obtain maximum benefit from medicines in the treatment of severe mental illness.