

# Discrepancies Between Knowledge, Attitudes and Beliefs and the Actual Practice (KABP) of Physicians who Care for Patients with Depression and/or Bipolar Disorder

Jewell M<sup>1</sup>, Keck P<sup>2</sup>, Golden WE<sup>3</sup>, Brewster C<sup>1</sup>, Farley AP<sup>1</sup>, Harshaw, Q<sup>1</sup>

<sup>1</sup>EPI-Q, Inc., Oak Brook, IL, USA, <sup>2</sup>University of Cincinnati, Cincinnati, OH, USA, <sup>3</sup>University of Arkansas for Medical Sciences, Little Rock, AR, USA

## Abstract

**Background:** Bipolar Disorder (BPD) and depression are associated with a broad burden of illness which may affect as much as 6% of the U.S. population. In the STAndards for BiPoLar Excellence (STABLE) project we developed specific performance measures for BPD and, as part of this project we determined the knowledge, attitudes and beliefs about depression and BPD among primary care (PCP) and psychiatric specialty care (Psych) providers. Additionally, we field-tested performance measures in a geographically diverse sampling of PCP and Psych practices to assess actual practice.

**Methods:** A questionnaire was administered to a random selection of PCPs and Psychs to determine their knowledge, attitudes and beliefs about bipolar disorder. Selected clinical performance measures were subsequently evaluated through medical record review of 80 outpatient practice sites (the providers at these sites did not necessarily participate in the KABP survey). Partial results are shown here.

**Results:** 95.3% of the KABP survey respondents believed recognizing bipolar disorder was their responsibility (98.6% of Psychs, 91.1% of PCPs). Additionally, 87.6% of the KABP respondents believed that they routinely assessed depression and BPD patients for substance abuse (98.2% of Psychs and 73.7% of PCPs). In the field testing phase of the project, (through medical record review) we found that only 47.6% documented BPD screening prior to treatment of depression (62.8% of Psychs and 38.4% of PCPs). 41% (78.1% Psychs vs. 18.1% of PCPs) documented screening for substance abuse among depressed patients and 78.3% (87% Psychs vs. 37.8% PCPs) document substance abuse screening in their BPD patients.

**Conclusions:** While providers demonstrated awareness of assessment and treatment guidelines for depression and BPD, appraisal of actual physician practices did not conform to KABP survey results. These observations provide an opportunity to improve care through professional organizations and health plans, and require different approaches than just guideline dissemination.

## Background

### Bipolar disorder (BPD) epidemiology:

- Severe, lifelong disorder; recurrent illness >90% of patients
- Among the most heritable of all brain diseases
- Prevalence estimates as high as 4%
- Long delays in diagnosis (> decade)

### Presentation:

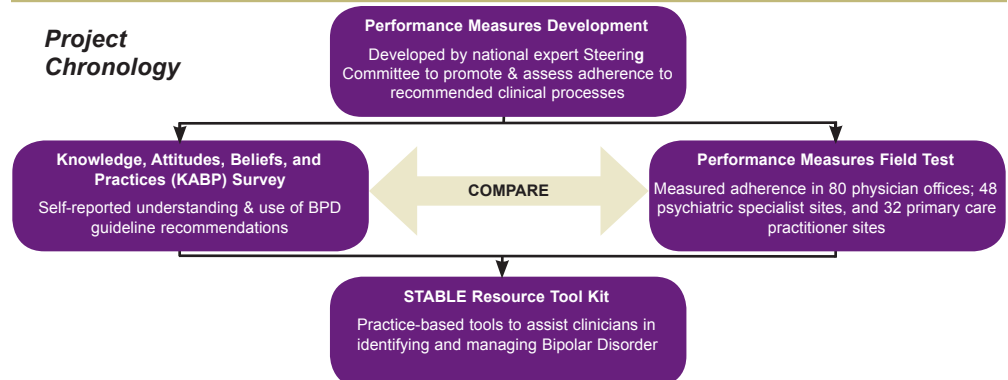
- Patients often presents in a depressive state; frequently to primary care
- 40% misdiagnosis, mistaken for depression
- Differentiated from depressive disorders by presence of mania/hypomania
- Challenging co-morbidities: substance use; anxiety disorders

### Consequences of misdiagnosis and mistreatment:

- Failure to provide appropriate pharmacological and psychotherapeutic treatment
- Risk of use of antidepressant monotherapy, which can precipitate:
  - switch into manic or hypomanic episode or mixed episodes
  - rapid cycling
- Untreated risk of suicide; 15-19%

## Objectives

### STABLE: STAndards for BiPoLar Excellence



## Results

KABP Response		Performance Measure Field Test Data			
KABP Survey Respondents		Performance Measure Field test Demographics			
	Physicians n=670 (%)		Practice sites n=80 (%)	Bipolar Disorder records n=419 (%)	Depression records n=383 (%)
Psychiatry (Psych)	381 (57)	Psychiatry (Psych)	48 (60)	345 (72)	145 (38)
Primary Care (PCP)	289 (43)	Primary Care (PCP)	32 (40)	74 (18)	238 (62)

### Disease Recognition and Treatment

KABP Response	% agreeing	PCP	Psych
Psychiatrists and PCPs agree that recognizing depression and BPD is their responsibility.			
— depression		99.0	97.3
— bipolar disorder		91.1	98.6
PCPs less frequently reported responsibility for BPD treatment.			
Responsible for treating:			
— depression		97.6	98.6
— bipolar disorder		77.5	98.4

### Recognition of Bipolar Disorder: Younger Population Presentations

KABP Response	% responses	PCP	Psych
Only 77% of all respondents correctly agreed that: "Patients presenting for treatment of depression for the first time in adolescence or in their early 20's are more likely to have BPD than patients presenting for treatment of depression later in life".			
Agreed		72.9	80.1
Disagreed		11.7	7.5
Uncertain		15.4	12.4

- Over 10% of PCPs incorrectly expressed disagreement with this statement.
- Both PCPs and Psych tended to express uncertainty with the statement.

### Recognition of Bipolar Disorder: Screening for Family History

KABP Response	Performance Measure Field Test Data
98.4% of all KABP respondents correctly agreed that: "Family history of BPD in a first degree relative of a depressed patient increases the likelihood of the patient having BPD."	However, few patients had evidence of screening for a family history of BPD, although psychiatrists documented more evidence of screening for a mental health disorder, depression, or bipolar disorder
99.0% of psychiatrists correctly agreed with this statement	
97.6% of PCPs correctly agreed with this statement	

## Results (continued)

### Recognition of Bipolar Disorder: Symptoms of Bipolar Mania

KABP Response	% correctly agreeing	PCP	Psych
There was generally good recognition of common bipolar mania symptoms amongst PCPs and psychiatrists.			
"Racing thoughts and rapid speech are common symptoms of mania"		96.9	98.7
"A decreased need for sleep is a common symptom of mania"		95.2	99.2
"Excess energy and periods of physical agitation are common in mania"		96.9	99.7
"Rage episodes, spending sprees and hypersexual activity are common behaviors in mania"		95.8	99.0

### Recognition of Bipolar Disorder: Additional Symptom Findings

KABP Response	% incorrectly agreeing	PCP	Psych
Most physicians correctly recognized the relationship of irritability and episodes of mania.			
However, PCPs expressed less understanding regarding concomitant manic/depressive symptoms.			
PCPs were also less likely to recognize that psychotic symptoms are common in bipolar disorder.			
"Most patients do not experience irritability during a manic episode"		6.6	3.4
"Manic and depressive episodes in bipolar disorder do not occur at the same time"		30.8	4.5
"Psychotic symptoms are uncommon in patients with bipolar disorder"		23.9	6.3

### Recognition of Bipolar Disorder: Co-occurring Conditions

KABP Response	% correctly disagreeing	PCP	Psych
Only half of all respondents recognized, by correctly disagreeing with the statements, that BPD frequently occurs concomitant with obsessive compulsive disorder, social anxiety, and eating disorders.			
"Bipolar disorder is not commonly associated with obsessive compulsive disorder"		50.3	46.2
"Bipolar disorder is not commonly associated with social anxiety disorder"		58.5	50.7
"Bipolar disorder is not commonly associated with eating disorders"		57.5	52.5

### Recognition of Bipolar Disorder: Drug and Alcohol Disorder Co-morbidity

KABP Response	% incorrectly disagreeing OR expressing uncertainty	PCP	Psych
Respondents indicated good understanding that BPD symptoms can be masked by drug or alcohol abuse (96.7% agreement)			
However, about one-quarter of all respondents incorrectly disagreed or expressed uncertainty (23.4%) that BPD symptoms become overt shortly after sobriety begins in individuals with drug or alcohol disorders.			
"Bipolar disorder is not commonly associated with obsessive compulsive disorder"		50.3	46.2
"Bipolar symptoms become overt shortly after sobriety begins"		25.6	21.8

## Results (continued)

### Recognition & Management of Bipolar Disorder: Drug and Alcohol Screening

KABP Response	Performance Measure Field Test Data
87.6% of all respondents reported they screen for substance abuse "often" or "almost always".	However, documented screening rates were lower for specialists and much lower at PCP practice sites.
Psychiatrists self-reported much higher screening rates than did PCPs	

### Recognition & Management of Bipolar Disorder: Suicide Attempts & Suicide Screening

KABP Response	Performance Measure Field Test Data
90.9% of all physicians reported understanding that the risk of suicide attempts in BPD patients is comparable to that of patients with depression.	However, the suicide screening documentation rates were less than 90% for both specialties, and were particularly suboptimal at primary care practice sites.
However, PCPs reported a higher percent of incorrect responses or uncertainly regarding the statement than did psychiatrists.	

## Conclusions

- The STABLE KABP Survey provided a mechanism for establishing a baseline profile of clinicians' knowledge and use of evidence-based clinical guideline recommendations for the recognition of bipolar disorder. Findings suggest:
  - high degree of understanding about symptoms of bipolar mania
  - uncertainty about depression presentations of younger age populations and the relationship to BPD
  - gap between knowledge that substance abuse masks bipolar disorder symptoms and awareness that BPD symptoms become overt shortly after sobriety begins in same population
- The survey demonstrated that there were important differences in some areas in the knowledge base of specialty care psychiatrists versus primary care physicians, including gaps between specialists and primary care regarding:
  - knowledge of key symptom presentations
  - understanding of the rate of suicide attempts in individuals with BPD compared to individuals with major depression
- These differences are important as many patients with BPD present to primary care.
- Comparison of survey self-report results to the practice-site documentation collected as part of the STABLE Performance Measures field testing component identified gaps between knowledge and practice in some key areas, including:
  - understanding of significance of a 1st degree relative with BPD vs. actual practice of screening for a family history
  - self-reported practice that clinicians screen for substance abuse vs. actual documented findings of such screening
  - knowledge of rate of suicide attempts in persons with BPD vs. actual documented practice of screening for suicide
- Clinicians in both primary care and psychiatry could significantly benefit from practice-based tools provided in the publicly available STABLE Resource Tool Kit. ([http://www.cqalmh.org/pdf/STABLE\\_toolkit.pdf](http://www.cqalmh.org/pdf/STABLE_toolkit.pdf))