Primary health care and the challenges of identifying bipolar disorder – a regional comparative study in Sweden

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Abstract

Bipolar disorder (BD) is a severe psychiatric diagnosis that is difficult to identify. Diagnostic delays are 5-10 years and cause irreversible harm for the patient and burden health care systems. Health deterioration and societal costs may be avoided if BD were diagnosed and treated at an early stage in the disease progression. BD is supposed to be treated by specialised psychiatric health care, yet primary health care (PHC) is an important part of the process as it is often the first contact of care for patients. It would therefore be of interest to investigate the preconditions of PHC in relation to the process of early detection of BD. PHC is organised by regional administration and due to regional inequality in health care it would also be of interest to apply a geographic perspective, investigating potential geographic variation in preconditions. In this study, PHC professionals from two regions were interviewed using semi-structured interviews and data was thematically analysed. Results present mostly similarities but also some differing preconditions in the regional analysis. The study concludes that PHC has an important in the role of early detection of BD, but also for patients who already received a diagnosed.

Key words

Bipolar disorder, primary health care, mental health, diagnostic delay, regional inequality
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Introduction

Bipolar disorder (BD) is rare and complex, making it difficult to identify and diagnose at an early stage. Early diagnosis and treatment are, however, vital in order to prevent negative health effects for patients. In 2011, WHO investigated the aggregate lifetime prevalence across eleven countries, where any diagnosis on the BD spectrum is estimated at 2.4%, affecting 40 million individuals globally and 110 000 in Sweden (IHME, 2019; Merikangas et al., 2011). Incidence rates are at 44 per 100 000 and 62 per 100 000 respectively and both prevalence and incidence rates in Sweden have increased during the last 20 years (Carlborg et al., 2015; IHME, 2019). Using data from 2017 Global burden of disease study, He et al. (2020) reports that absolute incidence cases and DALYs of BD are increasing globally, with an estimate of 47% and 54% during 1990-2017, adding to the burden on health care systems. Primary health care (PHC) has an important role in identifying any severe psychiatric illness, since it is often a patient’s first point of contact with health care. As the Swedish health care system strives towards efficiency and at the same time faces costly public health challenges, for example increasing mental ill health (MIH), it would be of interest to investigate the preconditions of identifying BD within PHC in order to improve possibilities for early detection and intervention. In Sweden, there is also a current debate on centre-periphery and regional inequalities and because PHC is organised and financed by regions it would motivates a geographic perspective and be of interest to investigate potential geographic variations between regions.

Bipolar disorder

BD is a severe, chronic psychiatric illness that affects mood and energy. It is characterised by recurring episodes of mania or hypomania (elevated mood) and depression, and patients may experience euthymia (symptom-free periods between episodes). The symptoms of BD were recognised by Hippocrates as far back as 400-300 BCE (Mason et al., 2016) and the concept and definition have changed over time, where a discussion of the bipolar spectrum is still ongoing. Disease aetiology is yet to be fully understood, but BD is suggested to be highly hereditary, with concordance rates from twin studies ranging between 43% to 75% (Freund & Juckel, 2019). The genetic factors that determine BD are not identified and environmental factors are considered to be an important factor for disease development as epigenetic modifications have been reported. In order to diagnose BD, clinicians use certain criteria based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the 11th revision of
the International Classification of Diseases (ICD-11) (APA, 2013; WHO, 2018). Criteria and classification for the diagnosis has changed over time and includes several subtypes, with type I and II being the most common (Häggström & Magnil, 2015). To diagnose BD type I, the patient must present one manic episode or one manic episode in combination with another episode, whether it would be manic, hypomanic, or depressive (SPF, 2014). The criteria for type II states that the patient must present one or several hypomanic episodes in combination with at least one depressive episode. In uncertain cases a patient may be diagnosed with BD NOS (not otherwise specified) or cyclothymia, which is when patients suffer from subthreshold symptoms, but never meet the full criteria for either types. The latter two can be useful in the diagnostic process as it marks suspicion of BD. Figure 1 shows a cycle of symptoms that make up the criteria for diagnosing BD type I and II. The debut of BD often involves the emergence of depressive episodes during young adulthood followed by manic or hypomanic episodes, with median age of disease onset ranging between 17.5 to 30 years of age (Carlborg et al., 2015; Taylor et al., 2011). It is common that initial depressive episodes, that are undistinguishable from unipolar depression, often lead to diagnostic error of major depressive disorder and can only be corrected as the first hypomanic or manic episode occurs (Duffy & Mahli, 2017; Taylor et al., 2011).

![Figure 1. Episodic characteristics for BD type I and type II (Source: Luty, 2020)](image)

The low prevalence, complexity and phenotypic heterogeneity of BD makes the disorder exceptionally difficult for clinicians to identify (Duffy & Mahli, 2017; Johnson et al., 2020; Stubbs et al., 2016). Symptoms may present in a multitude of ways and response to treatment can vary on an individual level. Due to the inherent difficulty of identifying BD, there is often a long diagnostic delay, with an average of 5-10 years (Carlborg et al., 2015; Taylor et al., 2011). The diagnostic, and hence treatment, delay affects the development of the disorder
negatively as treatments become less effective, episodes persist despite treatment, each new episode increasingly harms mood homeostatic mechanisms and episodes become more frequent and severe (Carlborg et al., 2015; Drancourt et al., 2013; Ågren & Backlund, 2007;). However, there is an ongoing debate amongst researchers of how to define the course of the disorder. Fountoulakis et al. (2017:100) highlight a common misconception, that the patient can “return to the premorbid level of functioning between the episodes”. By including facets like neurocognitive disorder, functional deficit, and disability in their clinical description of BD, Fountoulakis et al. (2017) challenge this conception in the same way as several other researchers have done. The view that episodes lead to lasting adverse health effects and that most patients do not return to same level of functioning as before, is to a large degree recognised. Some researchers go as far as to define BD as a progressive disorder, but studies have shown conflicting results (Berk et al., 2010; Stiles, 2019; Vieta, 2018). The theoretical perspective of the Kindling model has been used to explain how episodes trigger a development of increased episodic intensity, acceleration of episode frequency and progressive therapy resistance, but according to a literature review by Stroud (2018) studies have not been able to find sufficient evidence, as the results from several studies of varying scientific quality have been contradictory (Freund & Juckel, 2019). However, in a French study (n = 2351), BD patients were categorised depending on whether they experience long-term effects due to episodes or not, resulting in three different trajectories (Godin et al., 2020). A majority (72%) had a stable trajectory of mild functional impairment, 20% had a stable trajectory of severe functional impairment and 8% showed a moderate functional impairment that improved over time. Comparing the trajectories of mild and severe functional impairment, the severe group was characterised by higher level of unemployment (68%), but the majority group still reported 44% unemployment. This study does not confirm a progression in the sense that the effects of BD get worse over time, but it does recognise that a majority of patients suffer long term impact on function. This seem to be confirmed in an editorial by Miskowiak and Lewandowski (2020:95) where they claim that the scientific literature is conflicted regarding this issue, but that results from cross-sectional studies are consistent as “cognitive impairment follows a deteriorating course from initial onset to chronicity”, concluding that even though some groups of patients show no progression of cognitive impairment the baseline performance is still rated below that of controls. No matter if the disorder is progressive or not, patients with BD suffer a multitude of negative health effects and a late diagnosis seem to heighten the impact of the condition (Carta & Angst, 2016; Hauser et al., 2007; Ågren & Backlund, 2007). There is also consensus on developing methods to ensure early detection in order to provide optimal
treatment and minimise the negative health outcomes (Carlborg et al., 2015; Dietch, 2015; Drancourt et al., 2013; Howes & Falkenberg, 2011; SPF, 2014; Ågren & Backlund, 2007;).

Apart from the recurring episodes of mania and depression, which of course causes suffering, this section will provide a summary of the negative health effects of BD. Patients suffer increased risk of mortality with a shortened life expectancy of 10-20 years, due to cardiovascular and cerebrovascular disease, and suicide (Angst et al., 2013; Nielsen et al., 2019). Results from two Swedish population studies show mortality rate amongst BD patients as more than double that of the general population and that patients with BD suffer a risk of suicide that is 32-fold that of the general population (Carlborg et al., 2015; Hällgren et al., 2019). BD patients also experience high level of comorbidity, like cardiovascular disease, substance abuse disorders, general pain, sleep disturbances and autoimmune disease (mainly thyroid disease) (Miskowiak & Lewandowski, 2020; Nielsen et al., 2019; SayuriYamagata et al., 2017; Stiles et al., 2019; Ågren et al., 2013). Berk et al. (2010) reports a marked loss of brain volume after recurrence of episodes using neuroimaging data. A Dutch population study by Maassen et al. (2018) concluded that living with BD involves many challenges and that patients struggle to surmount with functional, occupational, and psychosocial impairment, low energy, and cognitive problems that persist even when patients recover from episodes. Patients are continuously adapting their lifestyle in order to prevent stress and in turn decreasing the risk of new episodes. The early onset of BD can be economically and socially devastating as a patient will lose function at a time in life when studies and career should be established, leading to long-term psychological, economic, and social consequences (Carlborg et al., 2015; Dietch, 2015). These effects can be observed in socioeconomic characteristics of BD, for example in the study by Carlborg et al., where in 2009 around 60% (n=5644) were unemployed. Of the 40% that were employed, over 60% had experienced sick leave during the last year and 32% had long-term sick leave over 100 days.

The individual impact accumulates to a wider public health concern containing high direct and indirect cost in form of health expenditure and lost productivity due to unemployment (Carta & Angst, 2016; Conus et al., 2014; Maassen et al., 2018; Vieta, 2018). Ekman et al. (2013) performed calculations on the cost-of-illness for BD in Sweden and estimated the average annual cost in 2008 to be €28,011, but the cost almost doubled during episodes and hospitalisation. The study was limited to specialised health care and the total national cost was estimated to 1,5 MEUR, or 0.4% of GDP in 2008. According to results from GAMIAN-Europe
(n=1041), which conducted a study on BD patients from eleven European nations, patients with BD suffer effects of stigma (Morselli & Elgie, 2003). Close to 90% reported a significant negative impact on their lives and over 50% of the sample reported high degree of stigma at a social level, but also regarding ability to work, handle financial responsibilities and pursuing leisure activities, where 38% felt rejected by their environment and 39% felt frequently ridiculed. The impact of stigma decreased over time, suggesting improvement in management of the disorder, providing further rationale for the benefits of early detection. Stigma can also affect health care seeking behaviour and has been reported to be a barrier to detecting BD in a PHC setting (Cerimele et al., 2019; IVO, 2016). The barrier includes clinician’s unawareness of BD, leading to patients not feeling listened to or understood. Patients recognise stigma attached to BD and are reluctant to identify with the diagnosis leading to an avoidance of referrals to specialised psychiatric health care (SPHC). Reluctancy to identify with the diagnosis is also understood as a barrier to early detection in general, which affects the diagnostic delay negatively (Bonnington & Rose, 2014; Budenz et al., 2020; Stiles et al., 2020). Stiles et al. highlight the importance of receiving a diagnosis as a turning point for the patient, a possibility for reconciliation and a means of overcoming the stigma and learning to manage the condition.

Comparing Swedish BD cohorts from 2006 to 2009, Carlborg et al. (2014) found that the mean age at diagnosis have decreased by 5.2 years. This is a positive development as the diagnostic delay is decreasing, but the authors argue that there is room for improvement and that it should be a major priority to develop strategies for early detection. Another positive aspect is that out of all psychiatric disorders, BD is the one where the disease burden would decrease the most if patients were offered optimal treatment (Ågren et al., 2013). Evidence-based treatment is available and consist of a combination of medical, psychoeducational treatment and therapy where long-term medication has been correlated with lowered mortality rates (Angst et al., 2013; Häggström & Magnil, 2015; Smith et al., 2017). There are several pharmacotherapeutic options for treating acute episodes as well as prophylactic mood-stabilizing pharmaceuticals, which should be the first line of treatment (Smith et al., 2017). It is of high importance that treatment is provided at the most optimal time, which according to Berk et al. (2010) is early in the illness development, as treatment response decline with progression of episodes. Due to the diagnostic error of major depressive disorder, treatment with anti-depressants as monotherapy is common for undiagnosed patients with BD, but the efficacy of the treatment has been questioned and provides further rationale for decreasing the diagnostic delay. Because
of the risk of developing episodes, anti-depressants should only be prescribed in combination with mood-stabilizing pharmaceuticals (Taylor et al., 2011; Ågren et al., 2013).

Health care organisation and the role of PHC

Swedish health care is working in accordance with the Health and Medical Services Act (HSL, 2017:30), which states that the national goal is good health and equal care for the whole population, where health care should be provided in respect of equal value and dignity of each individual. The provision of health care should be prioritized based on health care need and should work towards preventing ill health. The productional and financial aspects are, in international comparison, highly dependent on public agency, with 90% of health care services under public administration and 75% of health care financed by tax funding, with health care costs making up 11% of BNP in 2018 (Blomqvist, 2019; SKR, 2019a). During the last 30 years, the organisation of the Swedish health care system has become increasingly driven by economic incentives, as it is defined to strive toward cost efficiency (HSL 2017:30; Lindgren, 2014). The health care system is considered highly decentralised as regions and municipalities are responsible to organise and provide health care, depending on the regional and local demand (Blomqvist, 2019). Even though national agenda steer the development of health care, the decentralisation has led to a variety of strategies and organisation differ between regions. In order to counteract any regional imbalance of supplying health care, regarding the variation in tax base and health care need, a system to insure equalisation of resources has been in place since 1995 (Blomquist, 2019).

A debate on striving for cost efficiency in health care relative to the increased workload of current public health developments has been recognised (Blomqvist, 2019). In relation to future challenges of sustainable provision of health care the Swedish Agency for Health and Care Services Analysis mention chronic conditions, as well as increasing health care need for mental ill health (MIH) (SKR, 2019b; Vårdanalys, 2020). 44% of the Swedish population suffer from chronic conditions, which make up 85% of the health care costs and health insurance expenditures for psychiatric diagnosis have more than doubled from 2009 to 2018 (Försäkringskassan, 2018; Vårdanalys, 2014). A majority of these health care needs are provided by PHC, where an estimated 25-30% of patients seek help due to MIH (SKR, 2019b). Providing adequate care and meeting the growing demand for health care services in regard to chronic disorders and MIH with limited public spending, are concerns worth mentioning. The
Swedish government presented a national mental health strategy in 2015, that concluded a need for development in five focus areas: prevention and promotion efforts; accessible early interventions; focus on vulnerable groups; participation and rights and organisation and leadership. This led to a four-year project, Mission Mental Health and The Agreement 2016-2020 with plans to coordinate several government agencies preparing the health care system so that it can manage future challenges. The second focus area, accessible early intervention, has been stated to be of high importance for MIH and that evidence-based approaches should be offered at an early stage of developing ill health (SKR, 2020). Absent or delayed health care efforts for MIH is recognised to have effects like prolonged suffering, loss of function, reduced ability to work, increased risk of suicide as well as negative effects on family and relatives (SKR, 2019b).

According to the report from the Agreement, PHC is seen as an important agent in the process of identifying and diagnosing MIH (SKR, 2019b). It is therefore significant that PHC is well adapted and staffed in order to meet the demands of increasing MIH and it is predicted that if provided adequate methods, resources, and competent staff, PHC have great possibilities to meet the increasing need for care from patients with MIH. The responsibility of organising PHC falls under regional administration and its assignment is defined as ‘a part of outpatient care that shall, without delineating regarding disease, age or patient groups supply the need of basic medical treatment, care, prevention, and rehabilitation that does not require the medical and technical resources of hospitals or other specific competency’ (chapter 2, 6§ HSL 2017:30). PHC is financed by a combination of reimbursement models that can vary depending on regional organisation. The main model is capitation which is a fixed prospective compensation based on the population that a health care provider is responsible to provide care for (Lindgren, 2014). The population can be defined by the PHC unit’s geographic catchment area or by the registered (listed) patients at the unit. The sum of compensation by capitation is further decided by the health care needs of that population, calculated by measurements of ACG (adjusted clinical groups) and CNI (care need index). In addition, PHC is also reimbursed using a fee for service model, where certain activities (visits) are compensated retrospectively, and by a pay for performance model, where units are compensated as certain goals or targets are achieved. The role of PHC is considered a foundation for the health care system and has been investigated by Anell (2015), who has written about the organisation and function of PHC in Sweden. He describes four defining functions, that PHC is expected to:
• be the populations first contact with health care for most health care needs
• be responsible for prevention, treatment and diagnostics for most health care needs
• focusing on individuals’ collected preconditions and needs rather than on singular medical diagnosis and,
• if needed, refer to other relevant specialised health care as well as coordinate and integrate the care given by other health care providers.

This definition emphasizes broad responsibilities and the role of PHC as coordinators of health care. It also captures the conditions for PHC as a ‘gate-keeper’ to specialised health care as it holds the power to decide when and where to refer patients. But as the role of PHC has developed and received more responsibility, is it gaining the resources needed in order to fulfil its assignment?

Anell (2015) highlights three problematic aspects concerning the provision of optimal preconditions in PHC. Firstly, as a result of trying to make health care more cost efficient, the number of patient visits has increased whilst that resources have not. Secondly, shifting public health concerns of an aging population, chronic disorders and increasing MIH place an increased workload on PHC. Third, as PHC is supposed to be the first contact for most health care needs PHC professionals are more often faced with matters that are not of medical concern, but rather of ill health with origin in social conditions. The role of PHC is of importance, but in order to fulfil the mission certain problems, like the three mentioned above, must be recognised and solved. Furthermore, coordination and cooperation between different levels of health care, as well as other government agencies, need to improve in order to minimise the risk of losing track of patients (Anell, 2019; SKR, 2020). This is especially true for patients with MIH, that generally have a high level of mental and somatic comorbidity with reports of them not receiving equal health care opportunities regarding their somatic conditions (IVO, 2018; SKR, 2020; Vårdanalys, 2014). Continuity, defined as having a fixed contact in health care, is also of concern, where PHC is considered a base to continuity where the foundation of trust is established for patients (SKR, 2020; Vårdanalys, 2020). In a report from the Health and Social care Inspectorate (IVO, 2016) continuity and the mobility of personnel in PHC was reviewed, in which they concluded that PHC constitutes a key role for continuity and for coordinating the relation between patient and the health care system. Anell (2019) emphasize the problem of coordinating and integrating individual care needs, due to the of lack of
communication between levels of health care but also because of the shortage of staff. There are reported difficulties in recruiting health care staff, both for provincial and rural regions as for provincial and rural areas within regions (Socialstyrelsen, 2019). The shortage of general practitioners has led to the use of temporary employments (or medical locums) of which several concerns have been reported (IVO, 2016). Higher amount of medical locums is a threat to maintaining continuity in PHC, which leads to decreased quality of care for patients, increased workload for ordinary staff and increased costs for regions. Patient safety is also of concern when staff turnover is high as failure to provide quality care can go unnoticed and unreported, as well as the increased responsibility and workload on ordinary staff lead to a stressful work environment. It is therefore of importance to fund the resources required to provide PHC with optimal preconditions in their work towards treating and preventing disease in a manner to ensure patient safety. Accessibility and availability to both PHC and SPHC also needs to improve, in order to provide treatment at the right time within reasonable geographic proximity to the patient (SKR, 2020). Accessibility to SPHC also has a further impact on the role of PHC regarding BD, as PHC is considered easier to access but can only offer less intensive treatment in comparison to SPHC (Cerimele et al., 2019).

**Regional inequalities**

Sweden is a country with a high level of urbanisation, where 87% of the population lives in urban areas, creating the foundations for a dichotomy of the city and the countryside (SCB, 2018). There are 21 regions and 290 municipalities, of which the municipalities have been categorised by *The Swedish Association of Local Authorities and Regions* (SALAR, 2017). The three main categories (A, B and C) and following nine subcategories (1-9) are based on factors like population and commuting patterns (see Table 1).

**Table 1. SALAR categorisation of municipalities and counties 2017.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Large cities</td>
</tr>
<tr>
<td>A2</td>
<td>Commuting municipalities near large cities</td>
</tr>
<tr>
<td>B3</td>
<td>Medium-sized towns</td>
</tr>
<tr>
<td>B4</td>
<td>Commuting municipalities near medium-sized towns</td>
</tr>
<tr>
<td>B5</td>
<td>Commuting municipalities with a low commuting rate near medium-sized towns</td>
</tr>
<tr>
<td>C6</td>
<td>Small towns</td>
</tr>
<tr>
<td>C7</td>
<td>Commuting municipalities near small towns</td>
</tr>
<tr>
<td>C8</td>
<td>Rural municipalities</td>
</tr>
<tr>
<td>C9</td>
<td>Rural municipalities with a visitor industry</td>
</tr>
</tbody>
</table>
The regional development in Sweden focuses on a debate on centre and periphery and the growing gap between the city (the urban) and the countryside (the provincial and the rural), where demographic developments involve a redistribution of the population from the periphery towards the centre (Amcoff, 2019; Stenbacka & Cassel, 2020). The process of urbanisation has led to structural problems in provincial and rural environments as well as in urban areas, although the problems are of different character. The countryside has faced problems regarding depopulation, low availability of services and poor municipal economy. The city is, in relation to the provincial and rural areas, portrayed as a national necessity for economic development and is set as a norm, in turn creating the opposing side of the dichotomous pair, where the countryside is often perceived as problematic or burden-like. The debate has been characterised by a divide between inhabitants and their differing preconditions, where the provincial and rural areas have been described as neglected, where services have low availability and accessibility, and as a place that the public sector has withdrawn from. There are of course several challenges in regard to urban areas as well, for example that great population growth increases the demand for investments in physical planning especially regarding housing, communication, and infrastructure (SKL, 2015). Following the increased pressure from a rapidly growing population are matters of environmental impact, sustainability, and concerns of growing social inequality, which all ultimately influence health. According to The Commission for Social Sustainability in Stockholm (2015), the city of Stockholm faces a future of growing inequalities and increased segregation between areas of the city. Regarding health, these differences are noticeable in mortality rates, dental health in children and living conditions, amongst others. Just as there are inequalities between regions, there are also inequalities within regions and urbanisation affect both sides of the dichotomy.

Regarding regional inequalities in health, according to a public health report from 2019, the Swedish public health is considered to be good and improving over time, but there are regional inequalities in health as well as between categories of municipalities (Folkhälsomyndigheten, 2019). Regional differences in mortality range between 2-3 years, however, it is stated that mortality for individuals with MIH has not improved over time, like the general population, as they are more likely to suffer worse health, increased mortality, and worse living conditions. Inhabitants in urban municipalities have a higher rating of self-assessed health in comparison with provincial municipalities, but also a higher rating of impaired mental well-being. Provincial and rural municipalities have a higher percentage of obesity. A report by the Swedish Commission for Equity in Health suggest that Swedish
geographical health inequalities are more likely due to socioeconomic differences than geographic location (SOU, 2017:47). Yet, geographic difference in health care availability and accessibility are recognised to be of importance to health care consumption and is ultimately considered a public health matter (Styrning och vårdkonsumtion ur ett jämlikhetsperspektiv, SOU 2018:55, 2018). In a PHC context, there are several matters of concern regarding the differing preconditions of health care in urban and provincial environments, where distance to health care can affect care seeking behaviour and factors like close geographic proximity is the most common motivation for why patients register at a PHC unit. It is also suggested that individuals with a greater need for care would prefer a PHC unit close to where they live, in turn highlighting the importance of geographic location and context for health as well as health care seeking behaviour. The development of new PHC units have increased mostly in areas that are densely populated and the same goes for private actors, affecting the level of diversity offered in terms of health care services. There are also reported regional differences in health care consumption in regard to specialised health care (Socialstyrelsen, 2018).

Aim and research questions
The general aim is to explore the role of PHC for patients with MIH and more specifically, for the identification of BD. Little attention has been paid to the role of PHC in the process of identifying BD patients, but because these patients are likely to first seek contact in PHC it should be investigated more. The aim is to explore and provide examples of the preconditions in a PHC setting to highlight potential possibilities and challenges involved in the process of identifying BD. Motivated by the regional difference in organisation and regional inequalities, the study also conducts a regional comparison in order to detect any variations between provincial and urban environments.

Research questions:
1. How do PHC professionals experience the increasing responsibilities regarding patients with mental ill health?
2. How is the role of primary health care perceived in the process of identifying bipolar disorder?
3. Are there any specific factors that could be considered as obstacles or advantages in the process of identifying bipolar disorder?
4. Are there any regional variations in the preconditions to general practitioners’ ability to identify bipolar disorder at an early stage?
Methods

The study is of comparative design with a qualitative approach. There is a national patient register database for BD in Sweden, but it does not include any information of the patient prior to diagnosis. PHC does not have a patient register according to diagnosis which further complicates a quantitative approach. With an interest of investigating the diagnostic delay in BD from a PHC perspective, there is unfortunately no quantitative data available at regional level, hence a motivating a qualitative approach. According to Bryman (2012), a comparative design requires contrasting cases where identical methods are applied. He argues that one strength of comparative design is the ability to build on existing theory or suggest emerging theories, which would be of pragmatic advantage in this case as no quantitative data is available for regional comparison. By using a comparative design, the researcher is enabled to intensely examine factors connected to a specific context, which in this thesis is geographic and connected to the process of urbanisation and the variation of health care organisation amongst the different regions in Sweden.

The first step of the process is to select cases, which preferably should be done on the basis of the cases representing two extremes. As this study is interested in regional variations in Sweden, two opposing regions were selected based on their levels of urbanisation, according to SALARs categorisation of municipalities (see table 1). Region Stockholm would be the only region suitable to represent major urban areas, since Region Skåne (Malmö) and Region Västra Götaland (Göteborg) also include municipalities that represent the B and C categories. Region Kalmar consist of 100% C-category which would represent provincial environments. This should be indicative of the varying preconditions inherent to urban and provincial areas, respectively. The choice of geographic delineation is motivated by the organisational aspect of PHC, as it is administered at a regional level. Since every region has their own organisation of health care, the comparison between rural or provincial municipalities from different regions would not be suitable, because they would have varying preconditions based on their regional organisation. This choice is also motivated by the probability of access. Not limiting participation to a specific municipality, but instead to an entire region, it was expected to include a higher number of willing participants. The delineation by region is also impacted by ethical considerations and the ability to uphold anonymity for the interviewees.
Data and sampling

Data was collected via semi-structured interviews with PHC professionals such as general practitioners (GP:s), nurses, psychologists, and counsellors, as these individuals would be able to supply detailed information about the process of identifying potential BD patients as well as give insight to the preconditions determined by their geographical location. Participants were recruited using non-probability purposive sampling, where PHC unit managers were contacted with an information letter explaining the rationale behind the study and were asked to share the document with the employees of the health care unit. Willing participants were asked if they could recommend any potential participants. Semi-structured interviews were conducted during February and March 2020 using an interview guide including three chapters of questions based on previous research and literature (see Appendix I). The first chapter includes questions on personal information and professional experience, second chapter involves thoughts on increasing MIH and cooperation with specialised health care, and third focus on matters regarding the identification of BD. All participants were informed about the study and were asked to give their written consent prior to the interview. All interviews were planned to be face-to-face, but due to the Covid-19 crisis, the last two interviews were done online or by phone. All interviews were recorded and transcribed. No collected data will be stored after the completion of this thesis, as audio recordings and transcripts will be deleted.

The thematic analysis was performed in line with the process described by Braun & Clarke (2006), which includes six phases:

1. The familiarisation of the data set in form of transcription, reviewing, and noting of initial ideas and patterns. Each interview was transcribed, which resulted in approximately 40 pages of text (26 400 words).
2. Phase 2 involves generating initial codes and this was done while reading and re-reading the transcripts, marking, and coding certain aspects that could be of interest for the posed research questions. This resulted in a list of 133 codes (94 for Region Kalmar and 39 for Region Stockholm).
3. Phase 3 involves searching for themes in the collated list of codes and should re-focus to a broader analysis. The codes were sorted according to content and within similar groups of codes the initial themes emerged. These initial themes were colour-coordinated and presented in a preliminary mind map containing five main themes and eleven subthemes, that in certain cases overarched main themes.
4. Themes were further reviewed and refined in the fourth phase, where themes and subthemes were reviewed through the initial codes from phase two in order to ensure that the codes formed a coherent pattern and that themes were exclusively distinct. During this phase, an extra analysis of regional comparison was conducted in order to identify if some themes were exclusive or over-represented to one case or the other. Furthermore, this analysis was done to ensure that the themes were accurate in representing the meaning of the original data.

5. In the fifth phase of this process, the themes were more concisely defined and renamed in order to capture the essence of the theme and connect them to larger structure.

6. In the last phase, the themes are presented in text, with detailed accounts adding examples using quotes and ultimately referring back to previous literature to see if any results can be corroborated.

**Participants**

Seven individuals participated in the study which had a range of 4-33 years of work experience (see Table 2). Five identified as female and two as male. Two GP:s were interviewed in Region Stockholm and two in Region Kalmar, adding three interviews with one nurse, one psychologist and one counsellor in Region Kalmar. The six PHC units in which the participants worked are located in A1-A2 municipalities in Stockholm and C6-C7 for Kalmar and they cover between 14 000-28 000 patients in Stockholm and between 7000-9500 in Kalmar. GP4 and Nurse worked in the same PHC unit. It is worth noting that the C6-C7 municipalities are not categorised as rural, but as ‘Small town’ and ‘Commuting municipalities near small towns’.

The time of the interviews ranged between 25-49 minutes with a mean of 38 minutes per interview.

*Table 2. Participants*

<table>
<thead>
<tr>
<th></th>
<th>Female/Male</th>
<th>Profession</th>
<th>Type of municipality</th>
<th>Years of professional experience</th>
<th>Number of patients (per unit)</th>
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Results

Description of cases
To be able to compare the two cases, one must first describe the chosen regions, depicting any similarities or differences between them as some of these factors could be considered explanatory. What motivates the choice of regions is their stark contrasts in population, population density and age structure, presented in Figure 2. Region Stockholm has a larger population than Region Kalmar, which includes over a fifth of the total population of Sweden (SCB, 2018a). Population density reflect the urban characteristics of Region Stockholm with almost 360 inhabitants per km², compared to 22 in Region Kalmar (SCB, 2019). Age structure of the population in Region Stockholm is larger in the younger age groups between 25-54, whilst Kalmar has a larger percentage of older age groups 65+ (SCB, 2018a). The population in Region Stockholm has a higher percentage of higher educational attainment compared to both national average and to Region Kalmar (SCB, 2018b).

Regarding financial aspects and how different reimbursement models are used in PHC, capitation stands for 70% of all compensation in Region Kalmar, whereas it is 60% in Region Stockholm (Lindgren, 2014). Both regions use fee-for-service, but Region Kalmar has this exclusive to certain types of visits. Goal-oriented compensation is broader in Region Stockholm but make up less than 5% of all compensation for both regions. In Sweden there are 1140 PHC units, of which 210 are in the Region Stockholm and 35 are in Region Kalmar (SKR, 2019c). Region Stockholm has a higher percentage of privatised PHC units, 68% in comparison to the national average at 44% and Region Kalmar at 31%. The number of visits in PHC per 1000 inhabitants in 2019 were higher in Region Stockholm than both the national average and Region Kalmar. The net health care cost per inhabitant was smaller for both regions compared to the national average, although the cost for PHC was somewhat larger for both regions compared to national average. The number of BD diagnosis in SPHC, including both in- and outpatient care, is higher in Region Stockholm whilst Region Kalmar is more similar to national

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average (Socialstyrelsen, 2019b). Both regions have a clear division of responsibility where BD should be diagnosed and treated by SPHC.

Figure 2. Map, population pyramid, demographic and health care data of Region Stockholm and Region Kalmar (SCB, 2020).
**Thematic analysis**

The list below presents a summary of the five themes and additional subthemes resulting from the thematic analysis.

1. PHC preconditions
   1.1. MIH requires more time
   1.2. Psychologists in PHC
   1.3. Cooperation with psychiatric clinics
   1.4. MIH caused by social or financial problems

2. GP:s awareness of BD
   2.1. BD patients belong in specialist health care
   2.2. To ask about symptoms of elevated mood in patients with depression

3. Continuity
   3.1. Medical locums
   3.2. Affects how BD is identified

4. Patient attitude
   4.1. Stigma
   4.2. Avoiding psychiatric clinics
   4.3. PHC as easily accessible

5. Other requests
   5.1. Medical records
   5.2. Psychiatric nurses in PHC
   5.3. Local training

1. PHC preconditions
   1.1. MIH requires more time

Most professionals expressed that they have experienced increasing pressure in workload with MIH patients but are at the same time confident in their ability and knowledge to handle the inflow of patients. Some interviewees express concerns for future developments in regard to increasing workload when the financial resources provided remain the same, as a nurse from Kalmar points out:
"Yes and of course, the resources in health care have not increased, but the number of patients with mental ill health has increased quite considerably. Becomes a tough equation to solve!"

GP:s express that MIH requires more time than other somatic conditions and two concerns were mentioned. First, that patient visits are short in PHC and it can be difficult for the patient to properly explain their problem, perform screenings and for the GP to arrive at a solution in that short time span. The only option is then to divide the work to several patient visits, which involves a risk of losing track of the patient. Secondly, MIH requires longer time for treatment and more follow-up visits which, when compared to somatic patients, has impacted the workload. GP4 states that:

"It is more common with mental health disorders today than a few years ago…like with exhaustion, and I have really noticed that change in workload. Then it is not very easy to do anything, I cannot give them a pill and then they will be fine the next week, the need is comprehensive and often requires a lot of time. Then comes the whole complex of problems with the National Health Insurance and the contacts there, sick leave, and all. Mental ill health takes up quite a lot of time."

In following quote, by GP1, it is suggested that time limits involve a risk of losing track of a patient:

"A visit with a new patient is 30 minutes, including all admin. It takes time to think about these things and then you would need to book several visits and then run the risk of losing track of the patient. There is always a lack of time, but with these matters, I think that you sometime miss vital stuff."

1.2. Psychologist in PHC

The second subtheme entails a positive attitude toward the growing numbers of psychologist, therapists and counsellors that have joined the PHC workforce. All interviewees express the development as beneficial, as they can easily refer patients with MIH to the local psychologist or, in some cases, patients can book appointments straight away. All interviewees would welcome a further increase of this group of professionals. Although, the demand for therapeutic treatment is high and there might be risk for longer waiting times for patients in PHC, however still not as long as in specialist health care.
1.3. Cooperation with psychiatric clinics

Cooperation with SPHC clinics work well overall, at least regarding the process of referrals. However, most interviewees do express a desire for further cooperation especially in terms of general advice and advice on prescribed medication but also for a chance to discuss specific cases. They express an understanding for an equally pressured situation in SPHC clinics, but that it would be beneficial if there were easier ways of communicating between the different levels of health care. GP2 describes attempts of communication as:

"If you have a number to call, you will reach a nurse who is very questioning. Of course, they are also busy with meeting patients, but it is like a barrier. You are disputed before you even got to the matter you contacted them for, it would be nice if there was an easier way. Psychiatry cares for very ill patients, but sometimes we get these patients back when psychiatry feel ‘we can’t get any further with this’ or ‘this patient is reluctant to visit us’ and then this patient will come to us, with the problem and challenges that don’t have the special training for. Then we could sure use some sort of contact for discussion and advice."

1.4. MIH caused by social or financial problems

The fourth subtheme was identified in Region Stockholm. The two GP:s working in Stockholm both highlighted a group of MIH patients with acute problems, but where the health problems were more likely to have social or financial origin. GP2 described how patients seek their help and advice, but because their health problems stem from non-medical causes she felt hopeless in her efforts to help them. She explains:

"The problem is that I, as a doctor, am not the right medium. If it is a life crisis, then a counsellor or a psychologist with the right qualifications might provide better help, cause pharmaceuticals may not be a solution... In this area (of Stockholm) there are a lot of people that feel mentally unwell because of their social situation and I will never be able to help them with those parts... I can sit and listen, but I won’t be able to solve the problem. I can write as many medical certificates as they wish, but that won’t solve the underlying problem... I wish for a broader cooperation between social services, job centres and primary health care. We don’t have any counsellors who can do that, so we [doctors] sometimes do work that we are not trained or qualified to do and it is a great waste of resources."

GP2 explained that when these patients seek help at a PHC unit and all have to meet a doctor, it creates a bottleneck effect where time is not used efficiently. In this context, GP2 expressed
a need for a more effective sorting process between patients, which is exactly what GP1 from the second PHC unit in Stockholm could present a solution to. GP1 works in a different area of Stockholm, where the PHC unit has developed a strategy to sort the patients from their initial contact with the unit. Unlike other interviewees, GP1 had not experienced an increase of MIH patients, rather the opposite. She explains that patients who contact them with inquiries regarding MIH are referred to a psychosocial team, which puts a stop to the bottleneck effect mentioned above. When asked if she had noticed the increasing levels of patients with MIH she answered:

“Both yes and no. The PHC unit where I work has, during the years that I have worked there, since 2011, from the start there were one or two counsellors and a part-time psychologist and now we have nine full-time psychologists, but no counsellors. That is a total change, we have a complete psychosocial team to care for all ages and that has restructured the work process. Patients contact nurses via phone and can book a psychologist straight away. So, for problems with sleep or depression or any psychiatric problem, the first meeting is nowadays mostly with a psychologist. It has been a successive change during these years. When I started, a lot of new visits were acute psychiatric assessments. So, mental ill health might have increased in society but for me, as a GP, it has decreased among the patients I see, drastically! … We now receive a more selected material, patients with precise problems and hence more clearly delineated assignments… Which is very nice, I rarely deal with acute psychiatric assessments now, what used to be a big part of workload in PHC.”

This example also relates back to the beneficial factors in the second subtheme, ‘psychologists in PHC’, although the focus cannot be withdrawn from the quote from GP2. Social inequality is effecting health and as Region Stockholm is experiencing increasing inequality and segregation, it is of importance to highlight this problem.

2. GP:s awareness of BD

2.1. BD patients belong in specialised psychiatric health care

BD is acknowledged to be a rare disorder amongst the interviewed professionals. As reflected in regional guidelines, interviewees express a clear delineation between levels of health care. BD should not be treated in PHC, it requires specialist knowledge and should be diagnosed and treated in SPHC. Although rare, most interviewees shared experiences of BD patients in their care, either during medical internships, in their practice when caring for stable patients, when
referring patients with suspicion of BD or when treating comorbidity. Patients with BD are involved in other levels of health care and not exclusively in SPHC. Even though there are clear delineations of who should treat patients with BD, professionals of PHC are still faced with uncertainty in their tasks when managing BD patients, as described by a GP1 in Stockholm:

"It becomes very difficult, because we don’t have the experience of treating BD. For example, the medication, just yesterday I got a prescription for Lamotrigin and I have no clue how to follow this up, and with a patient I have never met before. As a doctor in PHC, we don’t have that experience, like with lithium, I have no idea what concentration levels, how often to check and all that."

The same GP explains how the long waiting times in SPHC can effect PHC as patients contact them with pressing issues like notes for sick leave or renewing prescriptions:

“It was about three weeks ago I had this patient with a BD diagnosis, at the beginning of a depressive episode. She had called specialised psychiatric health care unit, but they didn’t have any available visits, ‘call your PHC unit if you need to sign off sick’. So, she comes to visit me for a 10-minute appointment, I have never met her before and she has a severe psychiatric disorder and her psychiatric doctor knows her well and then I’m supposed to sign her off on sick leave? And at the same time evaluate the depressive episode, it’s not, or it wouldn’t be the best quality of care for the patient.”

Even though BD patients should be assigned to SPHC, interviewees share experience of them still taking part of PHC. As mentioned above, this might lead to confusion about treatments and ultimately affect the quality of health care.

2.2. To ask about symptoms of elevated mood in depressed patients

In a PHC setting, the challenge of identifying BD patients seem to be embedded in ‘being aware of’ or ‘having the time’ to ask about manic or hypomanic symptoms, when GP:s are being presented with cases of depression and problems regarding sleep or anxiety. All interviewees show great awareness about this challenge, to think about BD when meeting depressed patients, remembering to ask questions about heredity and elevated mood. The psychologist from Region Kalmar explains:
"What I think is difficult with these [BD] patients is that they seek health care when in a depressive episode, not when they are manic or hypomanic. So that's the only side that we get to see in health care. I think you should always have that awareness, if I meet someone with recurring depressions and where it has been like that for years, to also focus on how the patient feels between the episodes of depression. I think that is what is important, and the challenge lies with us not having the best continuity in health care. We also have difficulties accessing medical records for patients who have moved or that patients don't get to see the same doctor, even when they have been listed at the same PHC unit for a long time. All this makes it difficult to discover the pattern."

Several GP:s also added that even when these questions are asked, it can be difficult to explain symptoms of elevated mood so that the patient can fully understand. When reflecting on how to improve this situation, all interviewees were positive to implementing combined screening tools. Screening tools are already used to diagnose depression and including questions about heredity and elevated mood would help GP:s to flag patients with any suspicion of BD. GP1 added that this type of screening should be mandatory when prescribing anti-depressants in order to avoid causing episodes in potential undiagnosed BD patients.

3. Continuity
3.1. Medical locums
The theme was mostly identified amongst interviewees from Region Kalmar which, among other provincial and rural regions in Sweden, has a high dependency of medical locums. Dependency on medical locums affect continuity, which in turn influence PHC professional’s ability to deal with the responsibilities of increasing levels of MIH patients. GP3 describes the situation at his PHC unit as dependent on medical locums, making up half of the staff, which stay for periods ranging from a week to several months, mentioning three aspects of concern. First, how medical locums affect continuity and follow-ups. He explains:

“\textit{When we have long-term employment, then we get to meet the same person several times and when you meet a person several times or get to know that person better, then you might get a hint if something is different than what it first appeared to be.}”

Second, there is a variety of competence and experience amongst medical locums and third, that it becomes difficult to spread information and establish routines in the workplace.
3.2. Affects how BD is identified

The nurse in Region Kalmar explains that her PHC unit successfully managed to diminish the dependency on medical locums, which has resulted in a more stable work environment. She spoke about the patient experience and how it might be confusing and unsettling for patients with MIH to meet different GP:s for each visit and how it would be better for them if they can meet the same GP, in order to establish trust. She explains:

"No exactly, one would feel so exposed and have to tell the whole story again. Maybe some doctor thinks completely opposite to what another doctor said, and who is right? This doctor, or that doctor, or myself? If you are already mentally unstable, then it will only get worse, it’s bad enough for the people who have asthma. I think we strive towards having a stable unit, as much as we can."

Continuity might affect the ability to identify BD at an early stage, as meeting the same patient over time might illuminate changes in behaviour or symptoms, but GP1 from the Region Stockholm opposes this line of thought. She proposes that it might be just as helpful for a patient to meet several health care professionals, to increase probability of detecting suspicion of BD, instead of repeat visits to a doctor that does not, as GP:s might have different levels of awareness regarding BD.

4. Patient attitude and behaviour

4.1. Stigma

From the staff perspective, the role of PHC can be perceived differently depending on patient attitude, especially regarding patients with BD. Although some interviewees reflect on how stigma has decreased surrounding patients with MIH in general, others emphasize that it is still a strong stigma connected to BD. GP1 shares that:

"It is really difficult and there is still stigma around it, or not so much with depression. One is rather exhausted than depressed, but it is not really difficult, but for bipolar it is still very stigmatised I would say."

Due to stigma, patients might be unwilling to accept the diagnosis or find it difficult to identify themselves as having a severe psychiatric diagnosis. GP4 points out that stigma is in this way connected to diagnostic, and treatment, delay:
“...but the disorder is difficult to identify at an early stage, maybe that is because the patient doesn’t want to have that diagnosis, and for good reasons as it is quite stigmatizing, or has been quite stigmatising in public awareness.”

Although interviewees show an increased awareness of BD within the medical profession, some also highlight the importance of greater public awareness in order for potential patients and their relative’s ability to recognise early symptoms and seek medical help.

4.2. Avoiding psychiatric clinics
Stigma might also contribute to other patient behaviour, for example the avoidance of psychiatric clinics. Several interviewees express that BD patients are unwilling to visit SPHC and instead grows dependent on PHC, which might not be able to provide the right treatment or care. Other than stigma, possible explanations for this unwillingness might stem from patients’ previous experience with psychiatric care or, as GP2 puts it, a BD patient who is stable might feel relatively healthy and does not necessarily feel like they require SPHC:

"They feel that they don’t belong in psychiatric care, I think it is still pretty common that patients don’t want to go there. Sometimes it might be due to bad reception and I have to be respectful towards that, one might not feel, with this ‘what is illness and what is healthy’? To consider what is healthy is also important.”

This quote reflects that PHC would also be important for diagnosed BD patients that are in stable phase of euthymia.

4.3. PHC as easily accessible
Furthermore, interviewees express that patients prefer to visit their local PHC unit to SPHC clinics, for reasons like longer distance to and longer waiting times at these clinics. The nurse in Region Kalmar says:

"If your soul is hurting, it might be easier for that person to come here and feel comfortable in their surroundings instead of getting on a bus, go to Kalmar, change bus, and go to the hospital, to the huge complex. Maybe that person will not cope with all that if they already feel bad.”
The patient might consider PHC as safer and more accessible option in comparison to SPHC clinics. GP4 points out, a positive effect is that PHC units can in this way relieve the workload for SPHC clinics but on the other hand also diminish the level of quality in the health care delivered to BD patients, as PHC units are not supposed to treat them.

5. Requests

5.1. Improved visualisation of medical records

Apart from improving access to medical records, GP1 wished for improved visualisation of medical records, where today there is no clear overview of a patient’s medical history. This would not only enable GP:s to detect any suspicion of BD at an early stage but would also be a helpful tool for their practice in general.

5.2. Psychiatric nurses in PHC

A previous subtheme mentioned a positive attitude toward including psychologists in the PHC workforce and a similar suggestion was mentioned by several interviewees, that psychiatric nurses would be able to fill the need to manage patients with MIH in PHC. GP2 explains:

"Nurses could perhaps take on more responsibility, with special experience from psychiatry. We already have nurses who deal with diabetes, heart failure and COPD but it is not as common to find nurses [in PHC] with a psychiatric background and that is pretty strange since it involves a rather large proportion of patients."

5.3. Local education and training

Interviewees in Region Kalmar requested local options for further education and training, as most courses are only available in larger cities like Stockholm.

Discussion

The two regions had many themes in common and these will be discussed first, followed by a discussion of the themes that made the regions stand apart. The interviewed PHC professionals are of the opinion that the ability and knowledge within their respective PHC unit is currently enough to deal with increasing demands, although, concerns of limited financial resources were raised. This result is in line with the debate on increasing level of workload contrasted by a
focus on limiting resources for cost efficiency, highlighted by Blomqvist (2019) and Anell (2015). The theme of preconditions in PHC illuminate how interviewees experience the change in workload regarding patients with MIH as it often requires more time, for visits as well as treatment and rehabilitation. As PHC is considered an integral part of managing increasing levels of MIH and that requiring more time, it is of highest importance that PHC receive the necessary resources to fulfil this assignment. The inclusion of psychologists, therapists, and counsellors in the PHC workforce is seen as positive by all interviewees. A suggestion to improve efficiency when managing patients with MIH, was to include more nurses with specialist training from psychiatry into the PHC workforce. In corroboration with the Agreement (SKR, 2020), the results identify another area of concern involving the cooperation with SPHC, which will be discussed below as an obstacle to identifying BD.

In the following two themes, GP:s awareness of BD and Patient attitude, the role of PHC does at first appear to be clearly delineated and defined - BD belongs to SPHC. Referring back to recommendations by Dietch (2015), that is most certainly the case but at closer inspection the role of PHC for patients with BD appears rather blurred. PHC would be the first contact with health care for patients and all interviewees confirm this in their experiences of meeting patients with suspicion of BD. However, even patients with an established BD diagnosis, that for whatever reasons does not wish to have contact with SPHC, experience PHC as more secure and comfortable in regard to accessibility. The Agreement (2020) voiced concerns regarding accessibility in SPHC, which could explain a development of BD patients turning to PHC instead. What is of importance to discuss in this matter is in reference to Cerimele et al. (2019) who also concluded that there is a reluctance of some BD patients to be referred to a specialist as they consider easy access to PHC valuable, but as PHC does not have the competency to treat BD it also involves less intensive treatment. It would in this case be of interest to further discuss the role of PHC for already diagnosed BD patients and how PHC could adapt in order to care for them. PHC also seem to be involved in treating already diagnosed BD patients in regard to comorbidity as well as managing stable patients in euthymia. The role of PHC is important to identify suspicions of BD and for initiating referrals to SPHC as well as coordinating the patient within the different levels of health care. All interviewees were positive towards including questions of heredity and elevated mood in screening questionnaires that are routinely administered when evaluating a patient with depression. This would be helpful in order to establish a routine to detect suspicion of BD, in line with suggestions by Dietch (2015). These results also seem to corroborate with what Anell (2015) called ‘gate-
keepers’ and concerns raised by the Agreement (SKR, 2020), regarding coordination of patients with MIH. Furthermore, the role of PHC seems to be equally important for patients who already received a BD diagnosis, even though they should theoretically be assigned to SPHC. However, because of the lack of framework on the role of PHC regarding BD patients there is a motivation to discuss a potential development of guidelines.

As for specific advantages or obstacles in the process of identifying BD, no clear advantage was observed but several obstacles were. Short visits are standard in PHC and complicates the evaluation of patients with suspicion of BD. There is currently no easy way of accessing an overview of the information gathered in medical records and sometimes access to certain medical records are restricted. Improvements for visualising data in medical records were requested which would aid PHC professionals in their evaluation of patients’ medical history, in turn increasing time efficiency to better suit the short visit time as well as decreasing the risk of losing track of patients. These are suggestions aiming to solve the stated problem of coordinating health care and reducing the risk of losing track of patients between different levels of health care (Anell, 2019; SKR, 2020). Another obstacle was identified in the cooperation with SPHC, when brought up in the Agreement (SKR, 2020) it was mostly referred to as a need to improve cooperation between different levels of health care with focus on coordinating the health care for patients. In addition to improved cooperation, interviewees call for easier methods of communicating with SPHC in order to gain advice from specialist competency. If communication were improved, PHC would potentially be able to relieve some of the workload in SPHC. As mentioned above, this could be a possible solution to current lack of access to SPHC (SKR, 2020). A final aspect that complicates the identification of BD was patient attitude and stigma. Even when suspicion of BD has been identified, the reluctancy of patients to reconcile with the fact that they might suffer from severe psychiatric illness is something that lies outside of health care professionals’ control. This aspect corroborates results from Stiles et al. (2019), highlighting the importance of working to prevent stigma in a wider societal context.

Although the two regions presented many common results, there were a few findings that differentiated them. The regional analysis showed that PHC preconditions in Region Stockholm seem to be affected by MIH caused by social or economic situations and wish for better cooperation between health care and other authorities in order to give patients the help they require, a request that is recognised by the Agreement (SKR, 2020). Referring back to
Anell (2015), this might be explained by the broad responsibility of PHC and due to the role of being a first contact for any health care need, some problems that patients seek help for might have social origin. This would be of importance for PHC in Region Stockholm, considering the report of growing inequalities and increasing segregation. Region Kalmar discussed problems regarding continuity and medical locums and how that affected PHC preconditions to manage MIH and identify BD. As mentioned by IVO (2016), a high dependency of medical locums does affect the quality of health care provided as well as continuity. It is relevant to point out that even though it was not mentioned in the results of this study, problems regarding continuity may affect Region Stockholm as well, but might be caused by other aspects than high dependency of medical locums. Also, the matters of accessibility connect to regional inequality in terms of further education and training which in turn affects PHC preconditions in Region Kalmar.

Strengths and limitations of the study

This thesis set to investigate a novel perspective in the process of identifying BD, that of PHC, which previously has received limited attention. One strength is the explorative approach to gain new theoretical insights in order unveil potential solutions to the problem of the diagnostic delay of BD. Another strength is the variety of participants from several professions, gaining insight from an inside-perspective in order to provide a holistic perspective of the preconditions within PHC. Furthermore, a geographic perspective and regional comparison is useful to illustrate and understand the variation of preconditions in Swedish health care as both population characteristics and organisation differ from region to region. There are limitations regarding the number of participants and trustworthiness that are relevant to discuss. With only two participants from Region Stockholm, this affected the balance of codes drawn from the transcripts where Region Kalmar accounted for 94 codes and Region Stockholm for 39. In terms of credibility, interviews were recorded, and transcripts thoroughly investigated but there was no respondent validation. Dependability was ensured by following the procedures in thematic analysis mentioned by Braun & Clarke (2006) where transcripts, coding and mind maps document the process, yet this process has not been audited or reviewed. The criterion of confirmability links to a discussion of choice regarding geographic delineation and theoretical standpoints, and how these choices affect the conclusions that can be drawn from the results. The geographical delineations are supposed to represent two contrasting cases, Region Stockholm with urban characteristics and Region Kalmar with provincial characteristics. Based
on the municipal categorisation they certainly do, but does that mean that the results are transferable to other regions? There needs to be an awareness of scale, that there is a variation between regions, between regions of similar characteristics, but also within regions. Are results transferable to other regions, or similar regions? As mentioned by Nowell et al. (2017:3), “...the researcher is responsible for providing thick descriptions, so that those who seek to transfer the findings to their own site can judge transferability.” Some of the results might be transferrable but will have to be estimated on a case by case basis. The aim of this study was mainly explorative and although results and conclusions might bring insights, they should be cautiously transferred to other contexts.

Conclusions

In order for PHC professionals to manage increasing levels of patients with MIH and to identify potential patients with BD they need adequate preconditions. Participants of the study are optimistic regarding their ability to handle the responsibility but concerns of a focus on cost efficiency in relation to the increasing pressure were raised. The role of PHC seem to be of importance for the identification of BD as well as those already diagnosed with BD. The results from this study confirm that providing optimal preconditions for PHC professionals are vital in order to fulfil the responsibility it has been assigned, making sure they have enough staff, resources to manage unequal demands and well-functioning cooperation between different levels of health care as well as with other authorities. While it is important to erect and uphold guidelines in order to achieve certain national public health agenda, it is also of importance to understand regions underlying ability to implement that agenda and matters of equal preconditions should be dominating these efforts. If the aim is for all regions in Sweden to perform at the same standard, producing high quality care that is equally accessible, there needs to be an understanding of the differing preconditions under which regions operate and understanding the challenges of different regions is vital to developing strategies to overcome them in the most efficient way.
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SCB. (2018b). Educational attainment of the population 2018. UF 37 SM 1902


Appendix 1. Interview guide

Part 1

1. Personal information
   a. Professional title
   b. Gender

2. Professional experience
   a. How long have you worked as your current title?
   b. How long have you been employed in your current position?
   c. Have you had any previous experience with patients with bipolar disorder?

Part 2

1. Increasing mental ill health, how has the role and responsibility of primary health care changed
2. How do you experience the situation at your workplace, have you noticed a change?
   a. In your experience, do you have sufficient knowledge to handle the situation?
   b. Have you taken part of education regarding mental ill health?
   c. Are the resources at your workplace sufficient in order to manage the assignment?
      i. Any specific resources that could be seen as a strength or limitation?
3. Agreement 2016-2020 and the cooperation between primary and specialised health care.
4. How do you experience the cooperation with specialised health care?
5. Are you aware of any local or regional projects to ease the cooperation?
6. Is there access to a psychologist/counsellor at your health care unit?

Part 3

1. Are you aware of any challenges, difficulties, or obstacles in the process of identifying suspicion of bipolar disorder in your current workplace?
2. In your experience, how can we change the preconditions for the better in order to identify bipolar disorder at an early stage?
3. Screening tools that include manic/hypomanic symptoms – are there available screening tools that you can use in your practice?
4. What is your attitude towards using combined screening tools in order to identify bipolar disorder at an early stage?

Other comments/reflections/questions?