



Bipolar Disorder Treatment Guideline

All Team Members: Patient self-management education & support

Bipolar disorder is a mental health condition in which patients switch back and forth between periods of mania and depression. Mania is an “up” period of feeling VERY happy, energetic and excitable. Sometimes mania is a period of feeling overly-excited: restless and agitated with difficulty concentrating and sleeping. Manic people may make impulsive decisions based on unrealistic beliefs. Depression is a “down” period of feeling very sad, hopeless, or worthless. Sometimes depressed people have thoughts about ending their lives. These periods of mania and depression may last weeks to months, and there may be periods of normal mood in between.

Mood state	Mania (manic)	Depression (depressed)
Words or concepts related to this state.	<ul style="list-style-type: none"> • Frenzied activity • Thoughts or speech that jump from one topic to another very quickly • “Pressured” or very fast speech • Strange or unusual behaviors • Impulsively spending money • Impulsive sexual activity • Difficulty with sleep • Sometimes associated with psychosis (hallucinations or a very distorted sense of reality) 	<ul style="list-style-type: none"> • Low energy • Slowed activity or speech • Feeling guilty • Difficulty with focus and concentration • Loss of pleasure or interest in usual activities • Difficulty with sleep • Sometimes associated with “suicidal ideation” (thoughts and plans to kill oneself)



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Quit smoking and drugs. Limit alcohol.	Smoking, in addition to increasing the risk of cancer and heart disease, affects psychiatric drug metabolism. This means that the drug may not be able to reach a level to which benefits will occur. Psychostimulants (like meth) can affect mood and worsen psychotic symptoms. These types of stimulant drugs can cause symptoms of mania when the person is using, and symptoms of depression when the person is withdrawing. Alcohol, stimulants, and hallucinogens can decrease a person’s ability to control their impulses. Alcohol can also contribute to dehydration, which is a big concern in patients on lithium. Support your patients to quit.
Monitor dietary intake	Atypical antipsychotic and anti-epileptic medicines can increase risk of weight gain, high blood pressure, diabetes, and high cholesterol. Encourage patients to eat more vegetables, fruits, unrefined whole grains, and fish—while reducing fatty meats, trans fats, sugary drinks, and salt.
Encourage physical activity	Encourage daily exercise, such as walking, for at least 30min.
Take medications as directed	<p>Patient will usually be prescribed:</p> <ul style="list-style-type: none"> - a mood stabilizer or combination of more than one such agent—e.g., lithium, carbamazepine, divalproex, or oxcarbazepine - possibly an atypical antipsychotic <p>Assess medication noncompliance with questions such as, “How many missed doses have you had in the last 2 weeks?” Explore barriers to regular use of medication, including side effects, stigma, etc.</p>

Educate the patient about warning signs of worsening symptoms and when to seek help from the treatment team, including:

- trouble sleeping
- increased agitation, impulsiveness
- social withdrawal or, alternately, unusually high social engagement which is normally out-of-character for the patient
- increased violence/aggression
- increased alcohol/substance use
- hallucinations or psychotic thinking
- “pressured” or very fast speech

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NP

Every visit	As appropriate/needed:
A. Evaluate mood and (if present) psychotic symptoms.	
B. Address comorbid psychiatric concerns.	
C. Evaluate drug levels (if carbamazepine, divalproex, lithium) & side effects.	G. Labs, metabolic syndrome monitoring. (see G. below) H. Abnormal Involuntary Movement Scale (AIMS).
D. Medication reconciliation and management.	
E. Review use of substances.	
F. Review diet/exercise plan.	

A. Evaluate mood symptoms. (For psychotic symptoms, refer to Schizophrenia protocol.)

1. Definitions

a. Episodes types

1. Major depressive episode (MDE). Most common presentation in bipolar disorder (ratios of 3:1 for MDE:mania in bipolar I or as high as 40:1 for MDE:hypomania in bipolar II).

a. Minimum duration: 2 weeks

b. At least 5 symptoms required

i. At least one must be:

1. decreased mood

2. anhedonia

ii. insomnia or hypersomnia

iii. guilt/worthlessness

iv. low energy

v. impaired concentration/focus/thinking

vi. significant weight loss or weight gain (unintentional) from appetite change

vii. psychomotor slowing or acceleration

viii. recurrent thoughts of death / suicidal ideation

2. Manic episode.

a. Minimum duration: 1 week

b. functionally impairing symptoms which include:

i. Elevated mood (plus 3 additional symptoms)

ii. Irritable mood (plus 4 additional symptoms)

iii. Additional symptoms:

1. distractability



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2. decreased need for sleep
 3. grandiosity
 4. flight of ideas
 5. increased goal-directed activity [e.g., a flurry of plans to start new businesses, ventures, or exotic travel—often with poor follow-through, increased pleasure-seeking (e.g., sexual or financial disinhibition or indiscretions)]
 6. pressured speech
3. Hypomanic episode
 - a. Near-identical definition to A.1.a.2 EXCEPT:
 - i. Minimum duration: 4 days
 - ii. By definition, NOT functionally impairing.
 4. Mixed episode.
 - a. Requires at least 1 week of fulfilling criteria for both mania (as defined in A.1.a.2) and depression (as defined in A.1.a.1.b)
 - b. Subjectively, best described as ‘irritable depression’ or ‘dysphoric mania.’
 - c. Of note, this category of episode is being eliminated in DSM-V and will instead be captured by a ‘mixed features’ specifier
- b. Mood disorders
1. Bipolar I disorder
 - a. Requires at least 1 manic or mixed episode.
 2. Bipolar II disorder
 - a. Requires at least 1 major depressive episode.
 - b. Requires at least 1 hypomanic episode.
 3. Cyclothymic disorder
 - a. 2 years of subsyndromal mood cycling shy of a formal major depressive episode or manic or mixed episode (i.e., dysthymia and hypomania, instead).
 - b. No more than 2 months symptom-free.
 - c. Depressive, manic, mixed episodes are allowed after a 2-year window of cyclothymia to allow concurrent diagnoses of Cyclothymic disorder and either Bipolar I or Bipolar II.
 4. Major depressive disorder
 - a. Major depressive episode(s) only.
 5. Dysthymic disorder
 - a. 2 years of subsyndromal depression without hypomania
 - b. Requires 2 of the following:
 - i. Sleep disturbance
 - ii. Appetite disturbance
 - iii. Decreased energy
 - iv. Decreased self-esteem
 - v. Decreased concentration
 - vi. Hopelessness
2. Consider possible mood disorder “phenocopies”



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- a. General medical etiology (not an exhaustive list)
 1. Hypothyroidism (depression), hyperthyroidism (mania)
 2. multiple sclerosis (depression or mania)
 3. right-sided neurological problems affecting cortical or subcortical structures
- b. Substance etiology (not an exhaustive list)
 1. antidepressants (e.g., SSRIs) (mania)
 2. corticosteroids (mania)
 3. interferon (depression)
3. Consider the use of an objective instrument/scale to track clinical outcomes.
 - a. Patient Health Questionnaire, 9-item (PHQ-9)
 1. English version: http://www.depression-primarycare.org/images/pdf/phq_9_eng.pdf
 2. Spanish version: http://www.depression-primarycare.org/images/pdf/phq_9_spanish.pdf
 3. range of 0-27
 4. a score of 10 or above raises clinical concern for depression
 - a. item #1 or #2 should be at least 2 points to qualify for a major depressive episode
 - b. regardless of score on #9, always verbally inquire about suicidal ideation
 5. assesses the last 2 weeks
 - b. Young Mania Rating Scale (YMRS)
<http://dcf.psychiatry.ufl.edu/files/2011/05/Young-Mania-Rating-Scale-Measure-with-background.pdf>
 1. range of 0-60
 2. cut-offs:
 - a. 20 mild mania
 - b. 26 moderate mania
 - c. 38 severe mania
 3. assesses the last 48 hours
 4. NOT intended to be a diagnostic instrument
 - c. Generalized Anxiety Disorder, 7-item (GAD-7)
http://www.phqscreeners.com/pdfs/03_GAD-7/English.pdf
 1. range of 0-21
 2. cut-offs:
 - a. 10 moderate anxiety (overcalls anxiety, 23% of primary care patients meet this cut-off)
 - b. 15 severe anxiety (only 48% sensitive for clinical anxiety, however)
 - d. Brief Psychiatric Rating Scale (BPRS) http://www.public-health.uiowa.edu/icmha/outreach/documents/BPRS_expanded.PDF
 1. (see Schizophrenia protocol)
 - e. SCREENING instruments (to evaluate for the possibility of bipolar disorder)
 1. NOT intended to track clinical outcomes/course
 2. NOT reliable for confirming a diagnosis of bipolar (i.e., poor positive predictive value)



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3. better for ruling-out bipolar disorder (i.e., good negative predictive value in primary care and psychiatric clinic populations)
4. Examples:
 - a. Mood Disorders Questionnaire (MDQ)
 - i. Positive screen requires:
 1. 7 symptom endorsements under question #1
 2. 'yes' to question #2
 3. 'moderate' or 'serious' to question #3
 - b. Bipolar Spectrum Diagnostic Scale (BSDS)
 - i. Access on <http://www.psycheducation.org/depression/BSDS.htm>
 - ii. Cut-offs:
 1. <10 low probability of bipolar
 2. 11-18 moderate probability of bipolar
 3. 19+ high probability of bipolar
 - c. Altman Self-Rating Mania Scale
 - i. Scoring:
 1. <5: Less likely to be mania or hypomania
 2. >6: Indicates need for assessment
 3. Caveat: Score unusable if 2 or more items are not answered
4. Regular safety screening (i.e., SI, HI, ability to continue attending to self-care, psychosis).
 - a. Be aware that bipolar disorder has a 15% lifetime risk for completed suicide.
 1. Most suicide attempts occur within depressive or mixed episodes.
 - b. Document risk assessment (low/med/high risk), considered factors.
 - c. If there is a high acute risk:
 1. consider stepping-up level of care (e.g., transfer to emergency room or inpatient psychiatry)
 2. determine if there are sufficient criteria for an involuntary commitment
 3. depending on statutory and case law pertinent to your jurisdiction, consider if there is a duty to warn others and/or law enforcement (in cases of safety threat to other individuals, identified or general)
 4. consider available interventions to reduce access to means for self-harm or harm against others (e.g., involving family to remove firearms or stockpiled Rx's)
 5. if the patient is not in the clinic and there is a perceived high acute risk, consider:
 - a. dispatching police for a welfare check
 - b. dispatching a mobile crisis mental health team for a field evaluation
 - d. Prioritize A.5, below, in high-risk situations.
 1. In some jurisdictions, under emergency circumstances, it may be legally permissible to gather collateral even without patient consent, to formulate a response plan.
5. Gather input from other providers (particularly case managers), family/social circle (if patient consents).



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6. For first presentations, collect recent hospital discharge summaries from inpatient psychiatry.
 7. Present patient to Project ECHO clinic if:
 - a. Patient is not responding to mood stabilizer medication within an adequate trial of at least 1 month.
 - b. Patient's psychiatric presentation or medical issues are presenting acute concerns.
 - c. There is diagnostic uncertainty.
 - d. Patient is not sufficiently engaging in treatment plan or with treatment providers.
 - e. You have any questions about patient management.
- B. Address comorbid psychiatric concerns.
1. Accompanying psychotic symptoms:
 - a. should be evaluated for:
 1. relative timing with mood dysregulation
 2. congruence of delusions/hallucinations with mood presentation
 3. command-type hallucination presence
 - b. other diagnostic possibilities to consider include:
 1. Schizoaffective disorder
 - a. A diagnostic entity in which psychosis tracks closely with mood problems, but in which there is at least a single 2-week period of active psychotic symptoms in the absence of an acute mood decompensation;
 - b. DSM-IV does not define an exact percentage for overlap, and only comments that 'most' of the psychotic symptom burden is accompanied by concurrent mood symptoms;
 2. Schizophrenia (i.e., an independent process from mood decompensation)
 2. Note that anxiety diagnoses have significant symptom checklist overlaps with major depressive and hypomanic episodes.
 3. Explore primary cognitive diagnostic possibilities, as well, including:
 - a. Delirium (from a general medical condition or substances)
 1. typically waxing-waning
 2. can impair attention, orientation, consciousness
 - b. Dementia
- C. Evaluate drug levels & side effects.
1. Switch to mania [i.e., conversion from acute depression to acute mania, often as a result of unopposed (i.e., without a concurrent mood stabilizer) antidepressant use]
 - a. Selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAO-Is), and other antidepressant agents used for unipolar depression (e.g., mirtazapine, bupropion) as monotherapy are not generally considered standard-of-care in the management of bipolar disorder.
 - b. Unopposed SSRI use may risk precipitating an acute manic or mixed episode in bipolar patients.
 - c. Evidence does support the use of an antidepressant in conjunction with an anti-manic agent (e.g. valproate, lithium, carbamazepine, antipsychotic).
 2. by agent

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- a. lithium, therapeutic level is 0.6-1.2 mEq/L (measure 5d after introducing Li+ or increasing dose)
 1. bradycardia
 - a. from direct effect on SA node
 - b. may require alternative mood stabilizer
 2. edema
 3. end-organ effects (sometimes permanent interstitial changes)
 - a. kidney
 - i. check Cr Q6mos
 - ii. if consistently elevated/worsening, replace mood stabilizer
 - iii. Avoid administration with NSAIDs, ACE-Is (caution with diuretics)
 - b. thyroid
 - i. check TSH Q6mos
 - ii. if consistently elevated/worsening, replace mood stabilizer
 - c. Skin
 - i. Can cause or worsen psoriasis
 - ii. Can cause or worsen cystic acne
 4. nausea
 - a. sometimes improved by going to ER formulation (Lithobid)
 5. polyuria
 - a. sometimes rescued with amiloride or thiazides, but more often is an indication to find an alternative mood stabilizer
 6. teratogenicity:
 - a. absolute risk of 1-2:1000 for Ebstein's anomaly with 1st trimester exposure
 7. tremor
 - a. check level
 - b. may require dose reduction
 8. Rx-Rx interactions to avoid:
 - a. NSAIDs (except aspirin, sulindac)
 9. Toxicity: Uneliminated lithium (often due to renal impairment) can lead to lethal drug levels.
 - a. Symptoms of lithium toxicity
 - i. Altered mentation
 - ii. Hyperreflexia
 - iii. Nystagmus
 - iv. Nausea/Emesis
 - v. Ataxia
 - vi. Worsening tremor
 - b. When toxicity is suspected
 - i. Immediate lithium serum level
 - ii. Hold dose until level is confirmed
 - c. If toxic:
 - i. If level is below 4: Hold dose, hydrate, check levels daily
 - ii. If level is above 4 mEq/L: Dialysis is needed

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- d. Risks for toxicity:
 - i. Dehydration
 1. Heavy alcohol use
 2. Poor fluid intake
 3. Vigorous exercise
 4. Emesis or diarrhea
 5. Diuretic use
 - ii. Overtaking medication
 - iii. Renal impairment (causes poor elimination)
- b. carbamazepine (CBZ), reference range 4-12 mg/L (measure 5d after initiation or increasing dose)
 1. agranulocytosis
 2. risk of Stevens-Johnson syndrome
 - a. especially heightened in East Asians, who should be screened for HLA-B*1502 prior to starting CBZ
 3. teratogenicity:
 - a. absolute risk of 2.7% for neural tube defects with 1st trimester exposure
 4. Rx-Rx interactions:
 - a. b/c CBZ induces CYP3A4, there is the phenomenon of 'auto-induction' where CBZ dose likely needs to be increased ~1mo after initiation (to maintain a therapeutic level)
 - b. concurrent antipsychotic use frequently requires increased antipsychotic dosing b/c of 3A4 induction
- c. divalproex (VPA), therapeutic level 85-125 µg/ml (higher than that for seizure prophylaxis) (measure 5d after initiation or increasing dose)
 1. hyperammonemia
 2. polycystic ovarian syndrome
 - a. best to avoid in young women
 3. teratogenicity:
 - a. 10% absolute risk of neural tube defects with 1st trimester exposure
 4. thrombocytopenia
 5. transaminitis
 6. weight gain
 7. Rx-Rx interactions: (see lamotrigine)
- d. lamotrigine
 1. Stevens-Johnson syndrome
 - a. Titration must be gradual:
 - i. 25 mg x 2wks → 50 mg x 2wks → 100 mg x 2wks → 200 mg thereafter.
 - b. STOP lamotrigine for any rash
 2. teratogenicity:
 - a. absolute risk of 2.7% for neural tube defect with 1st trimester exposure
 - b. absolute risk of 0.9% for oral palate defect with 1st trimester exposure (6 to 12 weeks)



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3. Rx-Rx interactions
 - a. Should be halved when combined with divalproex d/t doubling of blood levels; this is primarily an issue at introductory doses of VPA
 - b. Should NOT be combined with estrogen-based contraceptives if the dose of estrogen varies through the menstrual cycle (changes could precipitate SJS)
 - c. Carbamazepine can decrease dosage by one half
- e. oxcarbazepine
 1. hyponatremia is a unique side effect (2.7% of patients), and chemistries should be checked if a patient complains of fatigue
- f. antipsychotics
 1. extrapyramidal
 - a. check for extrapyramidal symptoms (EPS) with AIMS test
 - i. Q-6 months (on typicals)
 - ii. Q-12 months (on atypicals)
 - iii. Double frequency for at-risk populations (e.g., elderly)
 - b. can include:
 - i. dystonia → rescue with benztropine or diphenhydramine
 - ii. parkinsonism → alleviate with benztropine or diphenhydramine
 - iii. akathisia → alleviate with low-dose propranolol or clonazepam (caution for benzodiazepines in patients at risk for chemical dependence or on opioid analgesics)
 - iv. tardive dyskinesia (TD) [a long-term complication which can occur with chronic antipsychotic use involving involuntary movements of the mouth, lips, tongue, but, also, sometimes extremities or the trunk]
 1. (see AIMS below, Item H)
 - v. neuroleptic malignant syndrome [fever, autonomic dysregulation, rigidity, granulocytosis, orientation changes—the most extreme form of EPS, and potentially life-threatening]
 1. requires immediate cessation of all antipsychotic agents and inpatient care (medical ICU)
 2. cardiovascular
 - a. examples include:
 - i. isolated tachycardia (risperidone)
 - ii. orthostasis (multiple antipsychotic agents)
 - b. if appropriate, consider an EKG.
 - i. with cardiovascular complaints
 - ii. with concurrent medications that may synergize with antipsychotic to prolong QTc
 - iii. safety concerns increase at QTc ≥500 msec
 3. metabolic
 - a. can include:
 - i. weight gain

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- ii. high blood pressure
 - iii. glycemic dysregulation
 - iv. dyslipidemia
 - b. consider:
 - i. use of a less metabolically burdensome atypical antipsychotic
 - ii. use of a typical antipsychotic
 - iii. adjunctive metformin use
- g. Electroconvulsive therapy (ECT)
 1. Not formally a 'medication,' but included for completeness.
 2. Indication: Depression with psychotic features, mania with psychotic features
 3. Logistics:
 - a. most often initiated in the inpatient setting, and can be continued outpatient.
 - b. typically 3x in a week, with one session per treatment day.
 - c. 9 sessions is an average number for a total ECT course.
 4. Requires general anesthesia.
 5. Electrode placement is typically right unilateral (to minimize side effects), but may progress to bilateral if treatment response is lacking.
 6. Side effects
 - a. Generally restricted to transient headache, musculoskeletal pain, and temporary confusion
 - b. Cognitive side effects have rarely been noted to persist for more than 1 month after the last ECT session
 - i. Some investigators believe that <1% of the time, there may be permanent retrograde amnesia
 - c. Mortality risk is primarily related to general anesthesia.
 7. Procedure-Rx interactions to avoid include:
 - a. anti-epileptic mood stabilizers (which may undermine ECT efficacy)
 - i. carbamazepine
 - ii. divalproex
 - iii. lamotrigine (except at low doses—e.g., ≤50 mg/d)
 - b. benzodiazepines (sometimes used adjunctively to control acute mania) (--again, may undermine ECT efficacy)
 - c. lithium (controversial, but may increase post-ECT delirium)

MEDICATION	INDICATION	CAVEAT
Lithium	Mania & Depression	Narrow therapeutic window
Valproate	Mania	Weight gain, PCOS
Carbamazepine	Mania	Drug-drug interactions



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Antipsychotics	Mania Psychosis	Weight gain
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I wonder if we should add lab monitoring parameters in this section for each?

- D. Medication reconciliation and management (should include an antipsychotic whenever psychotic symptoms are an issue)
1. for acute mania (note that combination treatment frequently used in the inpatient setting: i.e., antipsychotic + non-antipsychotic)
 - a. essentially all antipsychotics
 - b. carbamazepine (formal FDA approval is for XR formulation)
 - c. divalproex
 - d. lithium
 - e. ECT
 2. for acute mixed episode
 - a. carbamazepine (again, formally, XR)
 - b. divalproex (does not have formal FDA approval)
 - c. specific antipsychotics: aripiprazole, asenapine, olanzapine, risperidone, ziprasidone
 - d. ECT
 3. for acute [bipolar] depression
 - a. olanzapine-fluoxetine (if not using SYMBYAX, recommend dosing of between 5-20 and 15-40, respectively)
 - b. quetiapine (recommend at least 300 mg PO QHS)
 - c. ECT
 4. for maintenance
 - a. aripiprazole
 - b. lamotrigine
 - c. lithium is the only bipolar agent vetted to reduce suicide risk
 1. though this is a double-edged sword with respect to toxicity potential in an overdose
 - d. olanzapine
 5. special situations
 - a. rapid cycling (i.e. more than 4 switches per year)
 1. divalproex may be preferable to lithium
 - b. pregnancy
 1. consider electroconvulsive therapy (ECT)
 2. Li+ may be a reasonable choice, despite risk for Ebstein's anomaly, but careful psychoeducation and discussion of risks/benefits should precede this decision
 3. Atypical antipsychotics are another option. No firm link to teratogenicity has been established, but this has not been exhaustively studied. (see www.womensmentalhealth.org)
 6. In case of persistent medication non-adherence, consider use of depot medication:
 - a. First give patient a PO trial of corresponding antipsychotic to ensure the agent is well-tolerated.
 1. Examples:



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- a. IM Risperdal Consta or IM Invega Sustenna
 - b. IM haloperidol decanoate
 - c. IM fluphenazine decanoate
- E. Review use of substances.
1. Curb alcohol use.
 2. Refer to smoking cessation classes/hotline as appropriate/available.
 - a. Bupropion, varenicline are not recommended in patients with psychotic symptoms.
 3. Curb/eliminate cannabis (can worsen paranoia, and some evidence suggests that it increases the frequency of manic episodes) and stimulant use (will likely precipitate mania).
 4. Likewise for hallucinogens.
- F. Sleep hygiene:
1. Disruption of the sleep-wake cycle (e.g. "pulling an all nighter") can precipitate a manic episode.
 2. Consistent sleep-wake schedule is important.
 3. Use of sleep aides may be warranted, even on an as-needed basis, if the patient finds that their sleep-wake cycle is becoming dysregulated
- G. Review diet/exercise plan.
1. The American Heart Association (AHA) has eliminated "Step I" and "Step II" designations to prior dietary recommendations, and has moved away from specifying calorie counts or component %'s to instead emphasize specific food suggestions.
 2. Recommend as much adherence as possible to AHA guidelines, outlined at: http://www.heart.org/HEARTORG/GettingHealthy/Diet-and-Lifestyle-Recommendations_UCM_305855_Article.jsp
 3. Daily exercise per universal table above and as discussed on above http link.
- H. Labs and metabolic syndrome monitoring.
1. Initial labs.
 - a. CBC (with differential if using or considering clozapine)
 - b. Chemistry panel, including creatinine and fasting glucose
 - c. Liver function tests
 - d. Thyroid function tests
 - e. Syphilis serology
 - f. Pregnancy test (if reproductive-age female)
 - g. Urine or serum toxicology screen
 1. be aware of potential false positives, negatives
 2. consider use of gas chromatography / mass spectroscopy for confirmatory testing
 - h. HIV test
 - i. Hepatitis panel
 2. Imaging.
 - a. Consider head CT or MR in cases of new-onset psychosis in patients over 30 or atypical clinical presentation.

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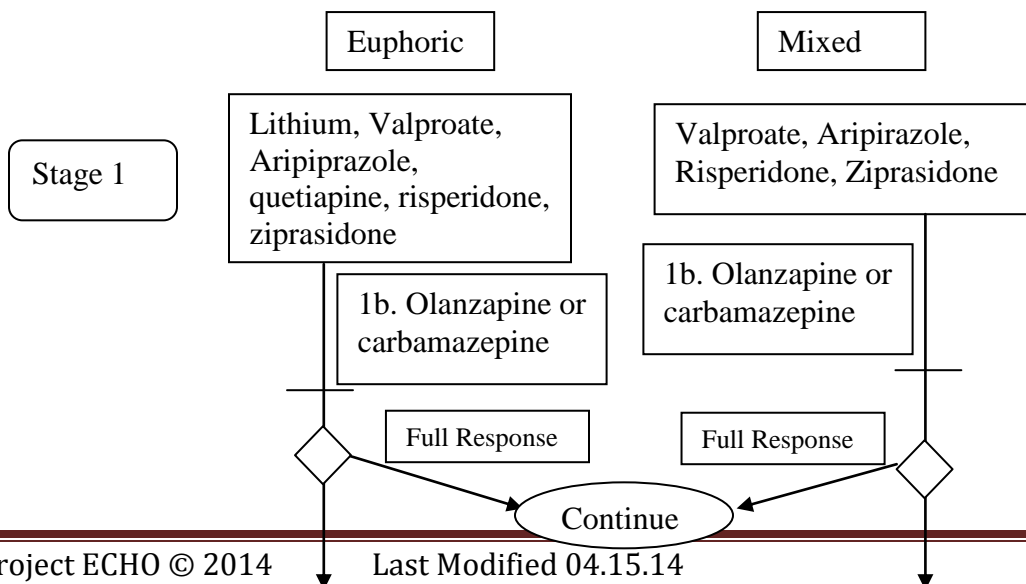
3. Metabolic syndrome monitoring.

	Baseline	Week 4	Week 8	Week 12	Quarterly	Annually	Every 5 years
Weight/BMI	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X					X	
A1c or fasting glucose	X					X	
Fasting lipids	X						X

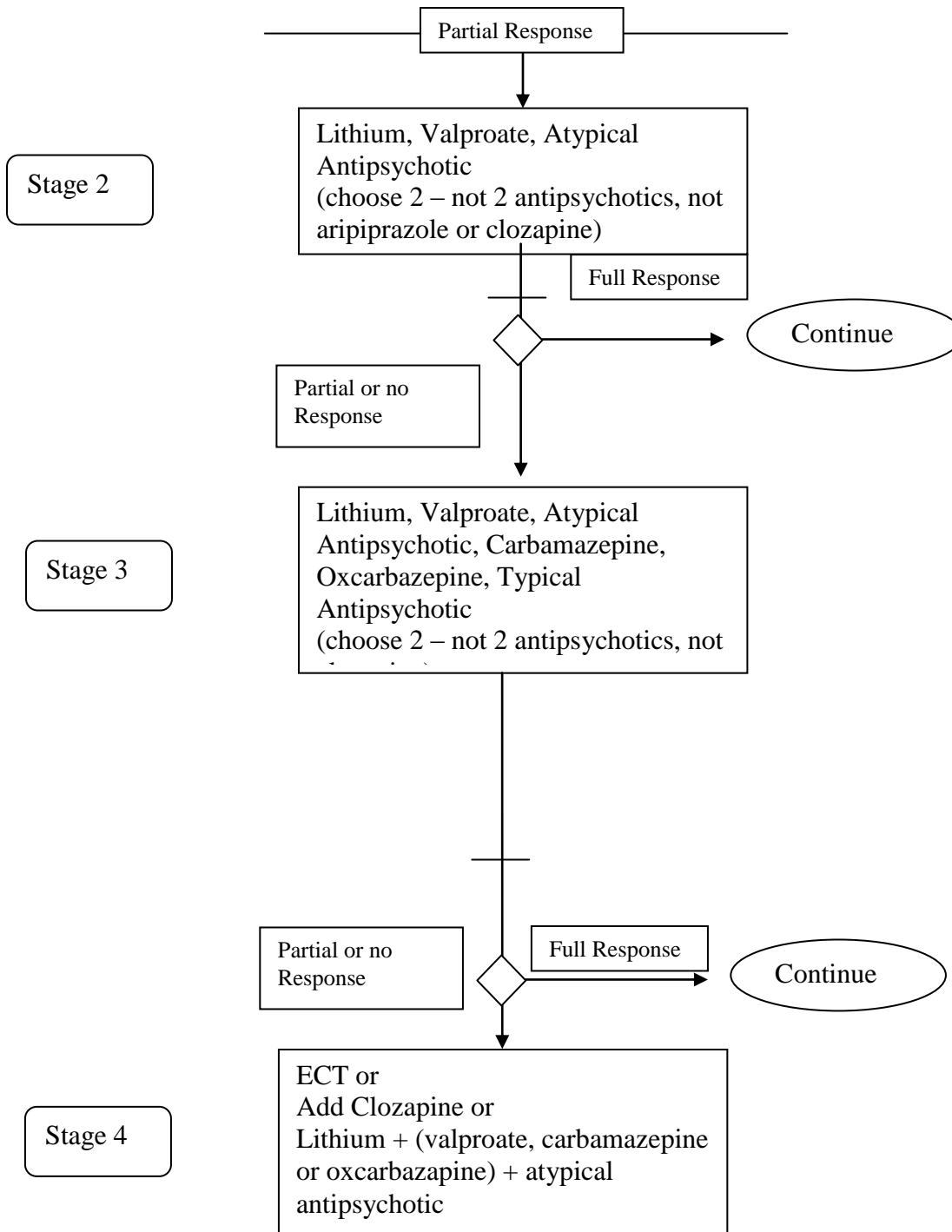
- I. Abnormal Involuntary Movement Scale. <http://www.atlantapsychiatry.com/forms/AIMS.pdf>
 1. indicated for evaluation of tardive dyskinesia (TD).
 2. NOTE that the total score is not reported
 - a. A positive AIMS test consists of at least:
 1. 2 separate movements with a score of ≥ 2
 2. 1 movement with a score of ≥ 3
 3. consider use of video capture (de-identified) to present to Project ECHO clinic if there are questions
 4. approaches to consider to reduce TD:
 - a. dose reduction of antipsychotic
 1. would likely worsen TD acutely, but still preferable to dose increases
 - b. adjunctive therapies
 1. poor evidence base
 - c. alternative agent
 1. consider clozapine

TREATMENT ALGORITHM FOR BIPOLAR DISORDER (adapted from the Texas Medical Algorithm Project)

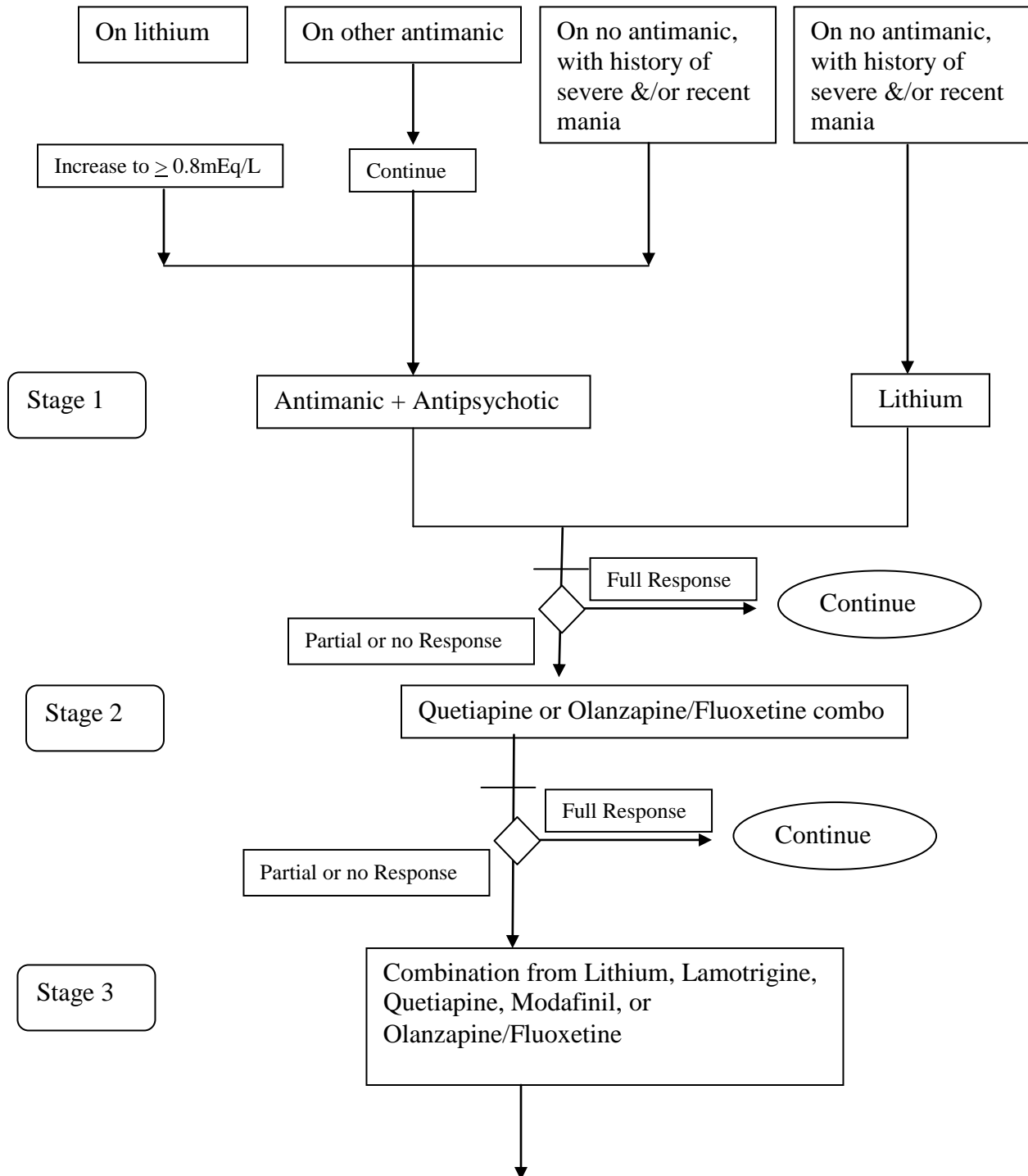
Algorithm for HYPOMANIA/MANIA

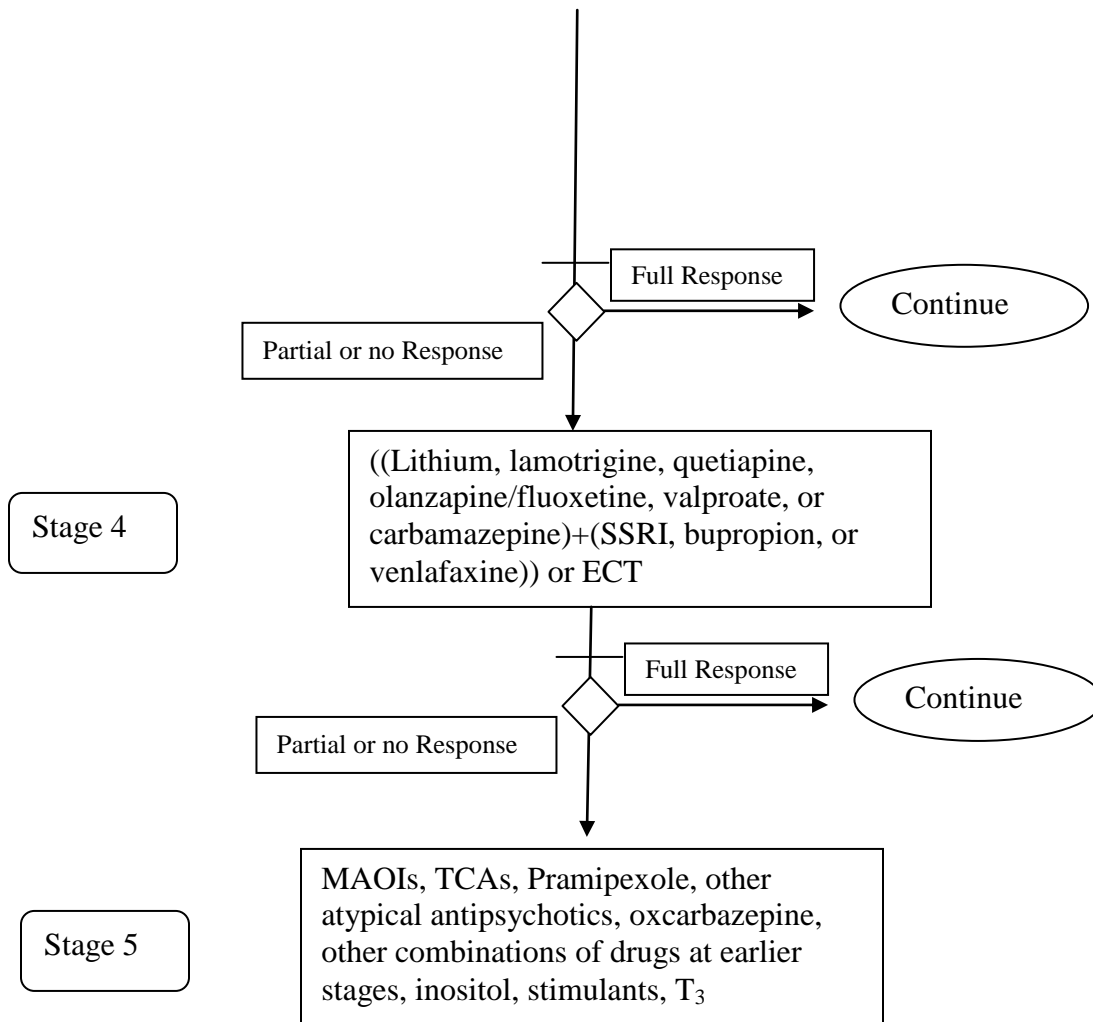


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Algorithm for Bipolar Depression





NP:

- A. See NP section A. Evaluate mood symptoms
- B. See NP section B. Address comorbid psychiatric concerns
- C. See NP section C. Evaluate drug levels and side effects
- D. See NP section E. Review use of substances
- E. See NP section F. Review diet and exercise plan
- F. See NP section G. Labs and metabolic syndrome monitoring
 - a. Alert NP about abnormal lab / exam values.



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- Triglycerides > 150 mg/dl
 - HDL<40 in men, <50 in women
 - BP consistently > 140/90
 - fasting plasma glucose >100 mg/dl
 - waist circumference >40 inches (men), or >35 inches (women)
- G. See NP section H. Abnormal Involuntary Movement Scale
- H. Check vitals, including weight at each visit.
- a. Consider checking orthostatics for low blood pressure numbers.
 - b. Alert NP about abnormal values.
 - BMI>30
 - BP consistently > 140/90
- I. Assess Rx compliance.
- J. In cases of IM depot medication, administer Q-2week (e.g., fluphenazine decanoate, Risperdal Consta) or Q-month injection (e.g., haloperidol decanoate, Invega Sustenna), as appropriate.
- K. Disease and medication education

CHW

- A. Review Rx list, and assess adherence / obstacles to adherence.
- B. Explore extent of substance use, and alert NP if use is escalating.
- C. Review diet, using guidelines in universal table at the top of this document. Consider use of food logs.
- D. Review weight log, and alert NP if weight has changed by ≥ 5 pounds between visits.
- E. Review vitals log, and alert NP if systolic blood pressure (the top number) is less than 90 or greater than 140, or heart rate is less than 50 or greater than 95.
- F. Review patient understanding of disease, goals, motivation to continue with current treatment plan.
- G. Provide psychotherapy, which can take the form of:
- a. Supportive psychotherapy
 - i. Creating an atmosphere of safety for the patient
 - 1. By avoiding interrogation, confrontation, direct interpretation
 - ii. Bolstering existing defense mechanisms to prevent acute decompensation
 - iii. Fostering verbal expression of thoughts, feelings
 - iv. Provide practical strategies for coping, problem-solving
 - b. Cognitive Behavioral Therapy (CBT) for depression
 - i. Behavioral activation
 - ii. Explore and help correct cognitive distortions
 - c. Cognitive Behavioral Therapy (CBT) for psychosis
 - i. Engage in "collaborative empiricism":
 - 1. Explore advantages/disadvantages of delusions if true (v. false)
 - 2. Develop joint exercises/experiments to safely test and confirm/disconfirm beliefs



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- ii. Assign brief CBT homework assignments & review each visit.
 - 1. If assignments are not completed, evaluate in-session obstacles or cognitive distortions the patient experienced and collaboratively problem-solve, anticipate issues that might continue to pose challenges.
- d. Interpersonal and Social Rhythm Therapy (IPSRT)
 - i. Similar to Interpersonal Therapy (IPT) for depression, but also incorporates emphases on how stress, disruptions to wake/sleep can contribute to symptom relapse
 - ii. Reference clinician's guide by Ellen Frank (U. Pittsburgh)
- e. Motivational interviewing to improve:
 - i. Rx compliance
 - ii. Attendance of clinical appointments
 - iii. Sobriety from substances
- B. Consider family interventions. Can include:
 - o Family psychoeducation
 - o Couples or family psychotherapy
 - o Referral to National Alliance for the Mentally Ill (NAMI)
 - o Referral to Al-anon (family support for patients with Alcohol Dependence)
- G.
- H.
- I. Explore if any social pathways need to be added, revisited or updated.
 - o Consider referrals to county/state agencies for Medicaid, other funding assistance (likewise for federal agencies—e.g., for SSI, SSDI, Medicare, etc.)
 - o Consider referrals to subsidized housing.
 - o Consider referrals to supported employment.

References

- Hasnain M et al. Clinical monitoring and management of the metabolic syndrome in patients receiving atypical antipsychotic medications. *Prim Care Diabetes* 2009. 3:5-15.
- Hirschfeld RMA et al. Practice guideline for the treatment of patients with bipolar disorder. *APA Practice Guidelines*. ©2002, American Psychiatric Association.
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**ECHO Access Bipolar Disorder Treatment Guideline
NP Bipolar Checklist / Visit Documentation**

1. Interval psychosocial developments:

2. Status of mood symptoms:

euthymic dysthymic depressed hypomanic mixed manic

3. Status of psychotic symptoms:

subchronic chronic subchronic with acute exacerbation chronic with acute exacerbation in remission

4. Comorbid psychiatric concerns:

5. Medication reconciliation:

Prescribed:

Taking:

6. Medication side effects:



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7. Interval substance use:

8. Diet / Exercise:

9. Review goals from last visit:

10. Formulate goals for next visit:

11. Labs (as appropriate):