Management of Bipolar Disorder

Module A: Diagnostics and Triage

1. Adults who present with either suspected or known BD (see Sidebar 1)
2. Perform safety screening (see Sidebar 2)
3. Does the patient need immediate evaluation, hospitalization, or both because of safety concerns (e.g., self-harm)?
4. Exit algorithm; refer to appropriate setting
5. Does the patient have established BD?
6. Is the patient reaching crisis? If yes, go to Module B: Specialty Care
7. Evaluate presenting symptom or symptoms in primary care (see Sidebar 3)
8. Rule patient to specialty mental health for evaluation
9. Access for alternate diagnostic or to explain the presenting symptom or symptoms; exit algorithm, as needed

Module B: Specialty Care

13. Adults who present with either suspected BD or symptomatic known BD
14. Assess for safety (see Sidebar 2)
15. Does the patient need immediate evaluation, hospitalization, or both because of safety concerns (e.g., self-harm)?
16. Exit algorithm; refer to appropriate setting
17. Does the patient have established BD?
18. Confirm diagnosis of BD 1 by DSM-5-TR criteria
19. Does the patient have acute mania or hypomania with marked impairment?
20. Go to Module D: Management of Acute Bipolar Depression
21. Go to Module C: Management of Manic/Hypomania
22. Does the patient have acute depression?
23. Go to Module D: Management of Acute Bipolar Depression
24. Go to Module C: Management of Manic/Hypomania
25. Reasons: (see Sidebar 3 and 5)
26. Consider maintenance treatment (see Sidebar 4)
27. Reasons: diagnosis: recur latter BD 1
28. Go to Module C: Management of Manic/Hypomania
29. Go to Module D: Management of Acute Bipolar Depression
30. Is the patient stable with no symptoms?
31. Go to Module D: Specialty Care
32. Consider maintenance treatment (see Sidebar 4), or continue non-pharmacological treatment (see Sidebar 6) to prevent illness recurrence

Sidebar 1: History and Symptoms Relevant to Identifying Possible Bipolar Disorder

When gathering data on history and symptoms (e.g., by establishing medical history as well as personal and family history of mental health issues), the following might be especially relevant to identifying possible BD, particularly in combination:

- First degree family member with BD.
- Evidence of mania, hypomania, or both or of irritability, agitation, or both after antidepressant initiation.
- Extended periods of functioning with high energy on little or no sleep.
- Atypical depression, such as leaden paralysis, psychomotor retardation.
- Other symptoms of mania or hypomania.
- Severe initial onset of depression or onset of depression at a young age (<25) or multiple prior episodes of depression (>5).
- High levels of comorbid anxiety, substance use, depression with psychotic features.
- Treatment-resistant depression.
- Step log/history with onset, maintenance, wake time, change in sleep pattern from work to weekend, and change in energy levels.

Sidebar 2: Safety Assessment

The VA/DOD CPG for the Assessment and Management of Patients at Risk for Suicide should be reviewed and used for this sidebar. A safety assessment should include the following:

- Assess the patient for risk of harm to self or others, including the need for hospitalization.
- Complete a validated suicide screening tool (VA/DOD CPG for the Assessment and Management of Patients at Risk for Suicide recommends PHQ-9 Item 9 as a universal screening tool to identify suicide risk). Also consider C-CSSR or CAMS.
- When possible, continue to the following:
  - Assess modifiable and non-modifiable risk factors.
    - Self-directed violence.
    - Current psychiatric conditions/current or past mental health treatment.
    - Psychotropic symptoms.
    - Recent bio-psycho-social stressors.
    - Availability of lethal means.
    - Physical health conditions.
    - Demographic factors.
    - Access protective factors.
  - Create a crisis response plan with the patient.

Sidebar 3: Primary Care Evaluation

When there is suspicion for BD, conduct a primary care evaluation.

- Screen the patient with a validated instrument.
- Conduct a psychiatric and general medical history.
- Conduct a full medication reconciliation (including prescribed and nonprescribed medications, supplements, and vitamins), giving attention to neuropsychiatric side effects.
- Conduct a mental status and physical examination.

Sidebar 4: Maintenance Treatment/Relabilization and Recovery

When individuals with BD stabilize after an acute episode of mania/hypomania or depression, or when they present for treatment between episodes, there are opportunities and needs to plan for maintenance treatment to prevent recurrences and for the supports that might be needed to enhance living with and recovering from BD. The planning process should incorporate:

- Psychosocial issues about BD, including information about the effectiveness of maintenance pharmacotherapy, psychotherapy and psychosocial rehabilitation, strategies for clinical management, and opportunities for recovery.
- Shared decision making with the patient, the patient’s social supports (where appropriate), and the treatment team.
- Issues to think about include the following:
  - Defining the relationship with the provider, treatment team, or both.
  - Scheduling appointments, other contacts, and procedures for addressing urgent needs and emergencies.
  - Specifying when and how caregivers, family members, and significant others should be involved with treatment.
  - Considering whether care management (e.g., employing a non-physician health professional to coordinate interactions of the patient and providers, monitor symptoms and side effects, and promote self-management) is needed (BD).
  - Planning monitoring of moods, symptoms, and treatment adherence.
  - Discussing methods and availability of tools to support day-to-day self-monitoring.
  - Engaging caregivers, family members, and significant others in monitoring, when appropriate.
  - Identifying early warning signs of possible recurrences and reporting them to providers.

Agreeing on a medication regimen with effectiveness for preventing mania and depression, including discussing side effects and their management, is needed. Considering psychosocial therapy to build coping and self-management skills and to prevent recurrences.

- Consider programs providing psychosocial support for caregivers, family members, and significant others.
- Providing access to peer support in the care system or the community.
- Addressing behavioral health comorbidities (e.g., medical health conditions, alcohol and drug use conditions, tobacco use, insomnia).
- Addressing specific problems (e.g., unemployment, problems at work or school, housing instability, relationships with family members and others).
- Addressing health and wellness.
  - Engaging with primary care.
  - Choosing available programs to enhance wellness.
- Specifying indications and timeframes for reevaluating the plan.

Abbreviations: BD: bipolar disorder; PHQ-9: Patient Health Questionnaire-9; DSM-5-TR: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
Module C: Management of Mania/Hypomania

Key Points

- Manage severe emergent agitation. (57)
- Consider ECT for patients resistant to pharmacotherapy, with history of positive response to ECT, or with adverse effects or intolerable side effects to medications.
- See Sidebar 7 before proceeding with treatment (especially considerations for individuals of childbearing potential).

Module D: Management of Acute Bipolar Depression

Sidebar 5: Reassessment after Specialty Evaluation

- Repeat a full medication reconciliation (including prescribed and nonprescribed medications, supplements, and vitamins), giving attention to neuro-psychiatric side effects.
- Investigate treatment non-adherence, using laboratory measurement when feasible.
- Consider repeat or expanded laboratory evaluation for nonmedicinal substance use.
- Consider the need for expanded neuropsych workup.

Sidebar 6: Non-pharmacological Therapy

Outside acute manic episodes, the following psychotherapies might be considered as adjunctive treatments to psychopharmacology for individuals with BD 1 or BD 2 (not ranked).
- CBT
- Family or Conjoint Therapy
- IPSRT
- Psychoeducation lasting at least six sessions. (Note that some types of psychoeducation may be more effective for some patients with acute mania.)
- Consider light therapy as an augmentation for medication being used at any step of the algorithm.

The Work Group notes, as well, that other psychotherapeutic approaches might include components of these treatments (e.g., IPSRT).

Abbreviations: BD 1: bipolar 1 disorder; BD 2: bipolar 2 disorder; CBT: cognitive behavioral therapy; IPSRT: interpersonal and social rhythm therapy; LGC: Life Goals Collaborative Care

Sidebar 7: Approach to Treating a Manic Episode

- Taper and discontinue antipsychotics.
- Address medical factors.
- Address substance intoxication and withdrawal, and treat acute SUDs.
- Avoid carbamazepine, topiramate, and valproate if the patient is of child-bearing potential.
- Assess the effectiveness and tolerability of previous treatments for the current and past manic episodes.
- Consider mandatory referral to a behavioral health prescriber for DOD patients; if unavailable, use the nearest telepsychiatry MTF for confirmation.

*Mixed episodes as defined before DSM-5 in 2013 are no longer part of the diagnostic system. Mixed features as a course specifier was added in DSM-5, but this approach has not been studied systematically in mania or depression, so the ability to make evidence-based recommendations for patients with mixed features is limited.

Abbreviations: ECT: electroconvulsive therapy; mg: milligram; SGA: second-generation antipsychotic