Management of Bipolar Disorder (2023)

About the Guideline

- The Veterans Administration (VA) and Department of Defense (DoD) established the Evidence Based Practice Work Group (EBPWG) in 2004.
- The EBPWG developed clinical practice guidelines for the VA and DoD populations with the goal of improving patient health and well-being.
- In 2021, the EBPWG developed the clinical practice guideline for bipolar disorder with an emphasis on patient-centered care and shared decision-making.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in an acute care or mental health setting.

Diagnosis and Triage in Primary Care

- Establish the presence of known or suspected bipolar disorder according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, text revision (DSM-5-TR) criteria. Screen the patient with a validated instrument.
- Conduct a psychiatric and medical health history.
- Conduct medication reconciliation including herbs, supplements, over-the-counter, and prescription products.
- Conduct a mental status and physical examination.
- Obtain basic labs, including:
    - Thyroid-stimulating hormone level (serum)
    - Complete blood count (CBC) with differential
    - Comprehensive metabolic panel (CMP)
    - Drug screen
- Complete a safety screening.
- Assess for alternative diagnoses to explain presenting symptom(s).
- Assess for stability; if the patient is unstable, refer them to a higher level of care.
- Refer the patient to specialty care (psychiatry) for diagnosis confirmation, initiation of treatment, and ongoing management.
- After specialty evaluation, reassess the patient, including medication reconciliation; pay attention to the neuropsychiatric side effects of the medication, investigate treatment nonadherence, repeat laboratory evaluation including medication adherence and evaluation for nonmedical substance use. Consider a more extensive neurological work-up.

Safety Assessment

- Assess the patient for risk of harm to self or to others, including the need for hospitalization.
- Complete a validated screening tool such as the Patient Health Questionnaire (PHQ-9), the Columbia Suicide Severity Rating Scale (C-SSRS), or the Confusion Assessment Method (CAM). When positive, assess for risk factors such as:
    - Self-injury
    - Current psychiatric conditions/current or past mental health treatment
    - Psychiatric symptoms

  - Recent biopsychosocial stressors
  - Physical health
  - Availability of lethal means
  - Demographic factors
- Assess protective factors.
- Create a safety plan with the patient.

Specialty Care

- Confirm the patient's bipolar diagnosis based on history and presentation.
- Complete a safety screening.
- Assess for stability; if the patient is unstable, refer them to a higher level of care.
- Assess for alternative diagnoses to explain current symptom(s).
- Initiate treatment and/or provide ongoing care of mania/hypomania and depression.

Management of Mania/Hypomania

- For patients with mania and mixed features, start QUEtiapine, another second-generation antipsychotic (SGA), or lithium. If there isn't a satisfactory response, switch to another SGA; consider valproate sodium or carBAMazepine.
- For patients without mania and mixed features, initiate lithium. If there isn't a satisfactory response, initiate another SGA or QUEtiapine.
- To avoid polypharmacy, stop ineffective medications in patients who do not achieve a satisfactory response to the medication. Do not give two SGAs at the same time.
- Consider other reasons for unsatisfactory medication response.
- Options to consider, if not already used, include risperidone, haloperidol, OLANZapine, carBAMazepine, valproate sodium, ARIPiprazole, ziprasidone hydrochloride, asenapine, cariprazine hydrochloride, or cloZAPine. Electroconvulsive therapy (ECT) should also be considered.

Management of Acute Bipolar Depression

- Suggested indications for ECT include:
  - Severe suicidal ideation
  - Catatonia
  - Not caring for self
  - Not achieving an adequate response to a mood stabilizer or to SGAs with antidepressants
- Consider ketamine if ECT is unsuccessful, unacceptable, or unavailable.
- If the patient is on lithium carbonate, optimize lithium level to 0.6 to 0.8 mEq/L and add lamoTRIgine, OLANzapine, or QUEtiapine; or add lumateperone or lurasidone.
- If the patient is on lamoTRIgine, valproate sodium, carBAMazepine, QUEtiapine, lumateperone, lurasidone, or cariprazine hydrochloride, optimize the dose.
- If the patient is on OLANzapine, a combination of OLANzapine and FLUoxetine, or one of the other antidepressants, consider trying the patient on QUEtiapine, lurasidone, cariprazine hydrochloride, lumateperone, or a combination of lithium and lamotrigine.
- For a patient in a mixed state, or if the patient has a history of rapid cycling or a history of a manic or hypomanic state after starting an antidepressant, initiate a trial of an adjunctive antidepressant. Avoid using an antidepressant alone in these patients.

Nonpharmacological Therapy

- Adjunctive treatments to pharmacological therapy (when not experiencing an acute manic episode) include:
    - Cognitive Behavioral Therapy (CBT)
    - Family or Conjoint Therapy
    - Interpersonal and Social Rhythm Therapy (IPSRT)
    - Psychoeducation lasting at least six sessions
    - Light therapy, which can be used at any point in treatment

Treating a Manic Episode

- Taper and discontinue antidepressants.
- Address medical factors, substance use, and intoxication or withdrawal.
- Avoid carBAMazepine, topiramate, and valproate sodium if the patient is of childbearing potential.
- Assess the effectiveness and tolerability of previous treatments used during current and past manic episodes.
- Consider mandatory referral to a behavioral health prescriber for DoD patients; if unavailable, use the nearest telepsychiatry military treatment facility for confirmation.

Maintenance Treatment/Rehabilitation and Recovery

- Provide psychoeducation about bipolar disorder, pharmacotherapy, and psychotherapy.
- Engage in shared decision-making with the patient, their social supports, and the care team.
- Plan to monitor moods, symptoms, and treatment adherence; engage the patient and social support in this process.
- Identify the early warning signs of a possible recurrence; emphasize the importance of reporting this to providers.
- Consider psychotherapy to build self-management and coping skills and to prevent recurrences.
- Provide access to peer support in the care system or community.
- Address behavioral health comorbidities as well as specific problems with other social issues like unemployment, housing, and educational problems.

Reference

Department of Veterans Affairs & Department of Defense. (2023). *VA/DoD clinical practice guideline for management of bipolar disorder, Version 2.0*. https://www.healthquality.va.gov/guidelines/MH/bd/VA-DoD-CPG-BD-Full-CPGFinal508.pdf