

Foothills Behavioral Health Clinical Guideline
In collaboration with MHCBBC and JCMH
Bipolar Disorder*

DSM-IV-TR Diagnostic Code: 296.0x; 296.40; 296.4x; 296.6x; 296.5x; 296.7; 296.89; 301.13; 296.80

Screening/Diagnosing Guidelines:

1. **Differential diagnosis** should include ADHD, substance-induced mood disorder, and mood disorder/personality change due to a general medical condition. General medical conditions that may cause mood lability and/or behavioral disinhibition and dyscontrol may include endocrinologic disorders, seizure disorders, structural brain disorders, e.g. neoplasm, stroke, infectious brain disorders, toxic/metabolic disorders, and traumatic brain injuries.
2. **Substance abuse/dependence** should be evaluated as a possible primary or secondary diagnosis with this disorder. At a minimum substance use/dependence should be evaluated every 6-months.
3. **History** from other, objective informants is important, as many persons with bipolar disorder may deny or may not recognize symptoms of their illness. Information from a number of informants, such as family or teachers, is particularly important in assessing children and adolescents
4. Although the core symptoms are the same for **children and adolescents**, their expression may be developmentally influenced. For example, manic episodes in adolescents are more likely to include psychotic features, which may be associated with school truancy, antisocial behavior, school failure, and/or substance use. In many youth, the behavior problems precede the development of frank manic episodes. Mixed episodes may be more common in younger individuals
5. The development of manic-like episodes following **somatic treatments for depression** may place individuals at increased risk for the development of Bipolar Disorder. This may be an especially important consideration in **children and adolescents**
6. Over-diagnosis, in **children and adolescents** must be guarded against. This disorder should not be diagnosed unless DSM criteria (including careful evaluation of exclusionary criteria) have been met.
7. Do not assume that a **positive response to medication** is confirmation of a bipolar diagnosis, as similar medications are used to treat non-specific target symptoms such as over-activity, impulsivity, aggression, and lability.

8. **Late life onset** (after 60 years) is inconsistent with the natural history of bipolar illness. Alternate etiologies for symptoms, e.g. medication side-effects or an organic brain disorder, should be carefully considered.

Treatment Guidelines:

1. The following should be **assessed regularly**: suicidal/homicidal risk, manic symptoms, especially high-risk behaviors, and psychotic symptoms.
2. **Pharmacologic treatment** is critical and the treatment foundation for this disorder. The prescriber should have regular contact with the consumer to improve medication compliance, provide medication education, and carefully monitor effects of the medication.
3. The attached **medication algorithm** is recommended in prescribing medications for consumers with bipolar disorder. Clinical rationale for deviations from this algorithm should be documented in the clinical record
4. Special caution must be exercised in **medication management in children and adolescents**. Most psychoactive medications used in children will be used for off-label indications. Dosing must be appropriate to the child's age and weight, and consideration of long-term effects must be given. Avoid polypharmacy except when medically necessary based on the child's symptomatology.
5. **Evidence-based therapy** methods, in combination with pharmacologic treatment, including psycho-educational, cognitive behavior therapy, interpersonal and social rhythm therapy, are recommended. It is highly recommended that, in treating youth, the family be regularly involved.
6. **Education** about bipolar illness and its treatment, teaching skills in coping with psychosocial stressors and attendant problems, facilitating compliance with treatment, and monitoring occurrence and severity of symptoms, should be a focus of therapeutic interventions. Involve the family in education programs whenever possible.
7. **Collaborate** with the consumer and family as partners in their recovery, focusing on their goals. Identify, with the consumer, effective ways they have used in the past to cope with their bipolar illness and support continued use of these methods.
8. Assist the consumer in maintaining a **regular pattern of daily activities**, including regular sleep-wake cycles, meal times, physical activity, and emotional stimulation. Disruption in these social rhythms, with disrupted sleep-wake cycles may trigger manic episodes.

*Adapted from American Psychiatric Association (2002). Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Second Edition). Washington D.C.: Author