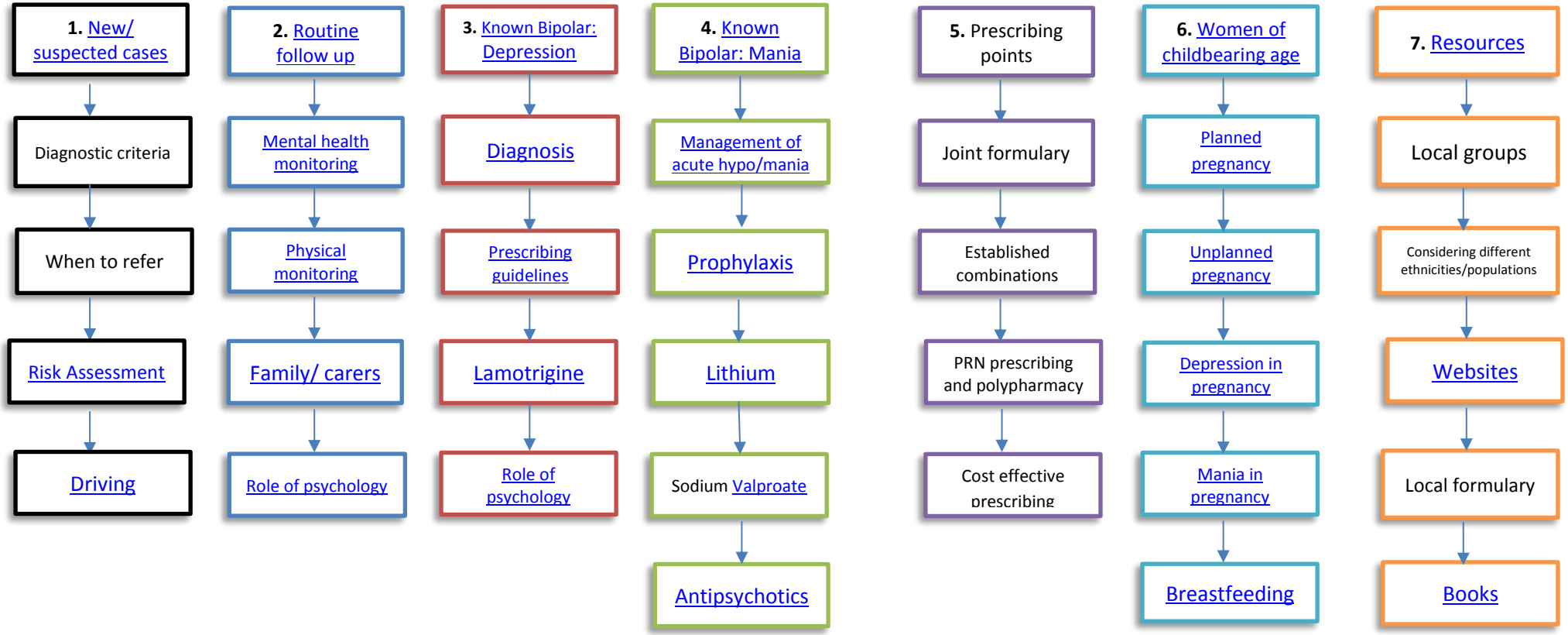
Bipolar Disorder Pathway

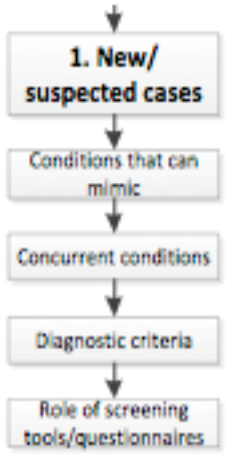
NHS
City and Hackney
Clinical Commissioning Group

Hold down 'control' and click to follow links



Suspected Cases of Bipolar

Back to top



Suspect bipolar disorder in people who present with mania, hypomania, depression and a history of previous episodes of possible mania or hypomania, or a mixture of both manic and depressive symptoms.

Mania is suggested by:

- Abnormally elevated mood, extreme irritability, and sometimes aggression.
- Increased energy or activity, restlessness, and a decreased need for sleep (e.g. the person feels rested after only 3 hours of sleep).
- Pressure of speech or incomprehensible speech.
- Flight of ideas or racing thoughts.
- Distractibility, poor concentration.
- Increased sexual drive, disinhibition, and sexual indiscretions.
- Extravagant or impractical schemes (e.g. business investments, spending sprees).
- Psychotic symptoms: delusions (usually grandiose) or hallucinations (usually voices speaking directly to the person).

Hypomania is suggested by symptoms of mania that are not severe enough to cause marked impairment in social or occupational functioning, with the absence of psychotic features. Such people may present with:

- Mild elevation of mood or irritability.
- Increased energy and activity.
- Feelings of wellbeing, or physical and mental efficiency.
- Increased sociability, talkativeness, and over-familiarity.

Management

Refer all people with new or suspected bipolar disorder for a specialist mental health assessment. elt-tr.chamhras@nhs.net 020 8510 8011

Determine the urgency of any referral by assessing the risks to the individual and others. Refer for *urgent* assessment if:

- The person presents with mania, severe depression, or with a mixed episode, *or*
- They are a danger to themselves or other people.
- Consider whether the urgency of the situation requires the person to be admitted to hospital.
- If admission is thought to be necessary but the person refuses consider compulsory admission

While awaiting specialist assessment, alter or start treatment only on specialist advice.

Back to top

Risk assessment

Determines the urgency of referral to specialist mental health services. Assess the risk of suicide. Consider risk factors for suicide, such as:

- Previous suicide attempt.
- Hopelessness.

Assess for suicidal ideation:

- Ask a single question such as 'Are you feeling suicidal?'
- If the answer is yes, assess for suicidal intent.

Assess for suicidal intent by asking:

- Have you made any plans for ending your life?
- Do you have the means for doing this available to you?
- What has kept you from acting on these thoughts?

Consider other risks of harm to the individual as a consequence of hypomanic or manic symptoms:

- Financial ruin arising from overspending.
- Traumatic injuries and accidents.
- Sexually transmitted infections and unplanned pregnancy arising from disinhibition and increased libido.
- Damage to reputation, income and occupation, and relationships.
- Self-neglect, exhaustion, and dehydration during a manic episode.
- Exploitation by others.
- Alcohol and substance misuse.

Consider the risks of harm to others, including:

- Family, in particular children and other dependents and the public.

Back to top

Driving

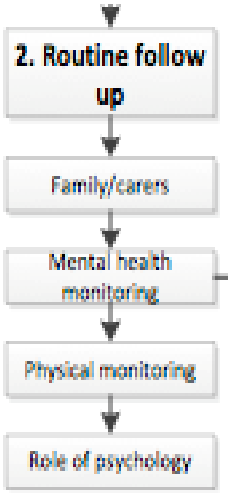
Driving must cease during the acute illness.

For further information on the DVLA's medical rules regarding hypomania/mania, severe depression, or acute psychotic disorders see the DVLA '*At a glance guide*' at www.dvla.gov.uk/medical/ataglance.

Advise the person that it is their responsibility to inform the Driver and Vehicle Licensing Agency (DVLA) of any condition that may affect their ability to drive.

The General Medical Council guidelines advise breaking patient confidentiality and informing the DVLA if the person cannot understand that driving during psychosis is unsafe (usually because of lack of insight into their illness) or if the person refuses to stop driving.
Back to top

Routine follow up



What routine follow up is needed in primary care?
To ensure follow up, include all people with bipolar disorder on a register of serious mental illness.

Arrange to review all people with bipolar disorder at least annually.

Review more frequently:
- People managed solely in primary care.
- If there is sleep disturbance.
- After significant life events, such as loss of a job or bereavement.

Attempt to make contact (within 14 days) with people who do not attend. Consider informing their key worker (who may be their psychiatrist, community psychiatric nurse, or social worker).

At the review appointment(s):
- Do a physical health review.
- Do a mental health review.
- Address the needs of family and carers.
- Do a medication review:
  - Check that the person is taking their medicines as prescribed.
  - Ask about adverse effects and assess the risk of interactions: see Prescribing information.
  - Ensure that there are arrangements for monitoring of lithium, valproate, carbamazepine, and antipsychotics.
  - In women, discuss the need for contraception and any plans for pregnancy.

Back to top

What should I do at a mental health review?

Ensure that the person has a documented care plan:
If the person is being treated under the care programme approach (CPA), they should already have a documented care plan.

If solely managed in primary care develop a care plan by discussing and recording the following information, including the views of relatives and carers as appropriate:

- The person's current health status and social care needs (including how needs are to be met, by whom, and the person's expectations).
- Social supports, including family, friends, and voluntary sector involvement.
- Coordination arrangements with secondary care and/or mental health services, and a summary of what services are actually being received.
- Occupational status.
- Early warning signs of relapse.
- The person's preferred course of action (discussed when well) in the event of a clinical relapse, including who to contact and the person's own wishes around medication (this may be included in an advance directive).

For relapse prevention, advise:

- Treatment adherence.
- Sleep hygiene and a regular lifestyle.
- Avoidance, if possible, of shift work, night flying and flying across time zones, or routinely working excessively long hours.
- Self-monitoring of symptoms (including triggers and early warning signs) and coping strategies.
- **Provide information about self-help and advocacy groups** (if this information has not already been given in secondary care):

MDF, the Bipolar Organisation, has local self-help groups and its website provides practical advice (see www.mdf.org.uk or phone 08456 340 540).

Back to top

What should I do at a physical health review?

As people with bipolar disorder have high levels of physical morbidity, assess and manage:

- Lipid levels (including cholesterol) in people 40 years of age and older (even if there are no other risk factors for cardiovascular disease).
- Plasma glucose levels.
- If on Lithium: Lithium levels every 4 months and TFTs/U&Es every 6 months
- Weight and body mass index.
- Smoking status.
- Alcohol intake.
- Blood pressure.

Note that smoking induces the metabolism of olanzapine and clozapine. If the person stops smoking, monitor for increased adverse effects and seek advice about dose adjustment if necessary.

Back to top

How should I address the needs of family and carers?

Consider:

- The impact of the disorder on relationships.
- The welfare of dependent children, siblings, and vulnerable adults.
- Carers' physical, social, and mental health needs.
- Referral of family or carers to a counsellor (or for other psychological therapy) if necessary.

Advise family and carers:

- To encourage treatment adherence and regulation of lifestyle.
- To monitor for signs of relapse

About self-help and support groups and encourage them to get involved.

Back to top

Role of Psychology

Individual structured psychological interventions should be considered for those who are relatively stable but may be experiencing mild – moderate affective symptoms.

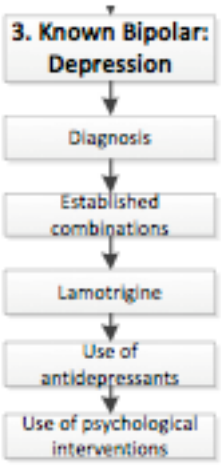
Therapy should be **in addition to** prophylactic medication

- Recommended 16 sessions over 6 -9 months
- Psycho-education about the illness, importance of daily structured routine, sleep hygiene, medication concordance
- Mood monitoring – early warning signs and relapse prevention
- To enhance general coping strategies
- Additional support after significant life event e.g. bereavement
- Consider focused family intervention for those in regular contact with their family. This should cover psycho-education about the illness, ways to improve communication and problem solving

Also role of CBT for those with mild – moderate depressive symptoms and chronic or recurrent depression

Back to top

Known Bipolar: Depression



Diagnosis: When should I suspect a depressive episode?

Depression is suggested by feelings of persistent sadness or low mood, loss of interest or pleasure, and low energy.

Associated symptoms of depression that may also be present include:

- Disturbed sleep.
- Poor concentration or indecisiveness.
- Low self-confidence.
- Poor or increased appetite.
- Agitation or slowing of movements.
- Guilt or self-blame.
- Suicidal thoughts or acts.

Diagnosis of a depressive episode is identical to that for unipolar depression.

The presence of coexistent hypomanic or manic symptoms may suggest the person is having a mixed episode.

What advice should I give to someone with known bipolar disorder in a depressive episode?

- Take regular exercise, preferably as part of a structured exercise programme.
- Try to schedule regular activities and have a daily routine.
- Engage in both pleasurable and goal-directed activities.
- Ensure adequate diet and sleep.
- Seek appropriate social support.

How should I manage a depressive episode in someone with known bipolar disorder?

Determine the urgency of any referral by assessing the risks to the individual and others.

For people with mild depression:

- Provided the person's previous episodes of mild depression have not developed into chronic or more severe depression (and a more severe depression is not likely), an initial period of watchful waiting may be appropriate.
- Arrange for repeat further assessment in primary care or by their mental health professional within 2 weeks (1 week in children and adolescents).
- If the person's previous episodes of mild depression have developed into chronic or more severe depression, or a more severe depression is otherwise likely:
- Seek specialist mental health advice and consider an early specialist mental health review.
- All pregnant women presenting with depression should be referred. For more information
- Children and adolescents should only be treated by specialists.

Admit urgently those people who are considered to be a danger to themselves or others.

Refer urgently for specialist mental health assessment:

- People for whom the degree of risk is increasing such that they are likely to become a danger to themselves or others.
- People with severe depression.
- People in a mixed episode.
- People with rapid cycling.
- For people on anti-manic medication, check that they are taking their medication at the prescribed dose and encourage adherence.

For people with moderate depression and no increase in the degree of risk to self or others:

- Arrange a prompt specialist mental health review.
- Contact a mental health specialist for advice on initial management whilst the person is waiting to be seen.

Back to top

Prescribing guidelines for depression in bipolar disorder

Episodes of bipolar depression differ from unipolar in that they are more rapid in onset, more frequent and more severe.

- In bipolar disorder antidepressant treatment carries the risk of “switching” to a manic episode
- When prescribing an antidepressant an anti manic agent should also be prescribed
- Risk of switching must be explained to patient
- Antidepressant treatment should begin at a low dose

If already on an anti-manic agent – check that dosing is adequate and confirm adherence

Assess severity of symptoms

Mild depressive symptoms – watchful waiting – re assess within 2 weeks

Moderate or severe depressive symptoms-

Refer for specialist advice

Treatment Options include

- Prescribe an SSRI at low dose

Or

- Add Quetiapine if not already on an antipsychotic

Quetiapine- can be used as first line monotherapy in bipolar depression. There is an extensive evidence base for efficacy in bipolar depression. It prevents relapse into depression and mania and appears not to be associated with switching to mania. Probably **drug of choice** in bipolar depression.

Avoid antidepressants in those with

- Rapid cycling bipolar disorder
- A recent hypomanic episode
- Recent functionally impairing rapid mood fluctuations

Instead increase dose of anti-manic agent or add a second anti-manic agent (including Lamotrigine)

Back to top

Lamotrigine – Important Information Points

Should not be routinely initiated in primary care for treatment of bipolar disorder.

- Effective both as a treatment for bipolar depression and as prophylaxis against further episodes
- Does not induce switching or rapid cycling

Prescribing points

- Dose should be titrated slowly to minimise risk of **skin rashes**, including Stevens – Johnson syndrome
- Patient must be advised to stop drug and seek urgent medical attention if rash develops
- May reduce effectiveness of oral contraceptives

Back to top

When should I suspect a hypomanic or manic episode?

A manic episode is suggested by:

- Abnormally elevated mood, extreme irritability, and sometimes aggression.

- Increased energy, activity, and restlessness, and a decreased need for sleep (e.g. the person feels rested after only 3 hours of sleep).
- Pressure of speech or incomprehensible speech.
- Flight of ideas or racing thoughts.
- Distractibility, poor concentration.
- Increased sexual drive, disinhibition, and sexual indiscretions.
- Extravagant or impractical schemes (e.g. business investments, spending sprees).
- Psychotic symptoms: delusions (usually grandiose) or hallucinations (usually voices speaking directly to the person).

A hypomanic episode is suggested by symptoms of mania that are not severe enough to cause marked impairment in social or occupational functioning, with the absence of psychotic features.

Such people may present with:
- Mild elevation of mood or irritability.
- Increased energy and activity.
- Feelings of well-being, physical and mental efficiency.
- Increased sociability, talkativeness, and over-familiarity.

If depressive symptoms are rapidly alternating with hypomanic or manic symptoms, suspect a mixed episode.

How do I assess risks in a person with a manic or hypomanic episode?

Risk assessment determines the urgency of referral to specialist mental health services. Consider these risks of harm to the individual as a consequence of hypomanic or manic symptoms:

- Financial ruin arising from overspending.
- Traumatic injuries and accidents.
- Sexually transmitted infections and unplanned pregnancy arising from disinhibition and increased libido.
- Damage to reputation, income and occupation, and relationships.
- Self-neglect, exhaustion, and dehydration.
- Exploitation by others.
- Alcohol and substance misuse.

Consider the risks of harm to others, including:
To family, in particular children and other dependents, from:
- Neglect.
- Paranoid delusions.
- Grandiosity, overspending, poor judgement, and erratic or chaotic behaviour during a manic episode.
- Rarely, violence and aggression (particularly if there is a personal history of violent behaviour).

To the public, from:

- Rarely, violence and aggression.
- Injuries arising from poor judgement or impulsive behaviour (e.g. whilst driving).

How do I manage a hypomanic or manic episode in someone with known bipolar disorder?
Refer all people in a hypomanic or manic episode for specialist mental health assessment.

Contact a mental health specialist for advice on initial management while the person is waiting to be seen in secondary care.

What advice should I give to someone with known bipolar disorder in a hypomanic or manic episode?

- Avoid excessive stimulation.
- Engage in calming activities.
- Delay important decisions.
- Establish a structured routine (including a regular sleep pattern) in which the level of activity is reduced.

What advice should I give about driving?

- Driving must cease during the acute illness.
- For further information on the DVLA's medical rules regarding hypomania/mania, severe depression, or acute psychotic disorders see the DVLA '*At a glance guide*' at www.dvla.gov.uk/medical/ataglance.

Advise the person that it is their responsibility to inform the Driver and Vehicle Licensing Agency (DVLA) of any condition that may affect their ability to drive. The General Medical Council guidelines advise breaking patient confidentiality and informing the DVLA if the person cannot understand that driving during psychosis is unsafe (usually because of lack of insight into their illness) or if the person refuses to stop driving.

Mood Stabilisers
Antipsychotics

Back to top

Management of acute mania or hypomania

Drug treatment is the mainstay of treatment for mania and hypomania.
Both **antipsychotics** and **mood stabilisers** are effective
Refer for specialist advice

- If patient is taking an antidepressant at onset of a manic episode – **STOP**

Is patient on antimanic medication?
If **NOT** – consider use of **an antipsychotic** – if symptoms severe or behaviour disturbed

OR

Lithium (consider likelihood of future adherence)

OR

Valproate (Avoid in women of child bearing age)

- If inadequate response – **combine** antipsychotic and Lithium or valproate
- In all patients consider adding **short term benzodiazepine**

If patient is already on anti manic medication

- If on antipsychotic – check **adherence and dose**. Increase dose if necessary. Consider adding Lithium or valproate
- If taking Lithium or valproate- check plasma level. Consider adding an antipsychotic
- In all patients consider adding short term benzodiazepines.

Back to top

Prophylaxis of Bipolar disorder- including mood stabilisers and antipsychotics

When should prophylaxis be prescribed?

- After a single manic episode that was associated with significant risk and adverse consequences or
- In the case of bipolar 1 illness , after two or more acute episodes or
- In the case of bipolar 2 illness, if there is significant functional impairment, frequent episodes or significant risk of suicide.

What should I consider when prescribing for prophylaxis of bipolar disorder?

Prescribing for prophylaxis will usually take place in secondary care

Choice will depend on:

- previous response to treatment
- Relative risk of manic versus depressive relapse
- Physical risk factors –especially renal disease, obesity, diabetes
- Patient preference
- Age and gender- Na Valproate should NOT be initiated on women of childbearing potential

What agents are recommended for prophylaxis?

First line: Lithium, Olanzapine, Quetiapine, Aripiprazole
Second Line: Valproate, Carbamazepine, Lamotrigine, Risperidone

Prescribing points

- Treatment should continue for at least 2 years (longer in high risk patients)
- Antidepressants may be used in combination with a mood stabiliser to treat acute episodes of depression but should not be used for prophylaxis
- Combined Lithium and valproate recommended for the prophylaxis of rapid cycling illness
- Always maintain successful acute treatment regimens as prophylaxis (e.g. mood stabiliser +antipsychotic)
- Avoid long term antidepressants

Back to top

Lithium – Important information points

Indications for Lithium

- Prophylaxis of bipolar affective disorder – reduces both number and severity of relapses
- Lithium is more effective at preventing manic than depressive relapse
- Offers protection against antidepressant induced hypomania
- Effective in the treatment of moderate to severe mania – but usually takes at least 1 week for response
- Good evidence that Lithium reduces the risk of both attempted and completed suicide in patients with bipolar.

What other tests should I do when prescribing Lithium?

Pre-treatment: Renal function including eGFR, TFTs and Calcium. ECG and baseline Weight
Monitoring: Plasma Lithium 3 monthly, Renal Function and TFTS and weight 6 monthly

How to prescribe:

- Start at 400mg at night
- Check level after 3-4 days and then 3-4 days after every dose change until levels in therapeutic range.
- Prescribe by brand as not all preparations are bio equivalent.

What do I need to know about plasma levels?

- Optimal range 0.6-0.75mmol/L
- Samples should be taken 10-14 hours (ideally 12) post dose (taken as a single daily dose at bedtime)
- Check level –
  - 3-4 days after initiation
  - 3-4 days after every dose change until level stable
  - Every 3 months

What side effects should I be aware of?

Many are **dose related** – including GI upset, fine tremor, polyuria and polydipsia

- Li can cause weight gain, peripheral oedema and a metallic taste in mouth
- May get worsening of psoriasis and acne
- Can also cause nephrogenic diabetes insipidus
- Reduced GFR and renal impairment
- Hypothyroidism especially in middle aged women
- Hyperparathyroidism

What are the signs of Lithium toxicity?

Lithium toxicity can be fatal.

Symptoms may be **GI** – anorexia, nausea, vomiting and **CNS** – weakness, ataxia, coarse tremor, muscle twitching, drowsiness, and seizures.

Plasma levels may be used as a guide but individuals vary in susceptibility and may have symptoms of toxicity at higher end of therapeutic range– dehydration, low salt diets and drug interactions.

Important drug interactions include ACE inhibitors, Angiotensin 2 receptor blockers, diuretics and non-steroidal anti-inflammatory drugs.

Back to top

Na valproate – Important Information Points

Should not be routinely initiated in Primary Care for treatment of Bipolar disorder
Not to be prescribed for women of childbearing potential
Indications: mania, hypomania, bipolar depression (with antidepressant)
Prophylaxis of bipolar affective disorder
What should be checked prior to prescribing?
FBC, LFTs, height and weight

Do I need to monitor?

- FBC , LFTS and weight 6 monthly
- Routine measurement of levels not recommended unless evidence of poor adherence, ineffectiveness or toxicity

What side effects should I be aware of?

- Blood dyscrasias including leucopenia , thrombocytopenia and red cell hypoloasia
- Deranged LFTS and rarely fulminant liver failure
- Pancreatitis
- Alopecia
- Tremor
- Weight gain
- Hyperandrogenism in women

Back to top

Role of antipsychotic drugs

Not only antipsychotic actions- may also possess anxiolytic, sedative, anti-manic, mood stabilising and antidepressant properties. Olanzapine, Quetiapine, Aripiprazole, Risperidone and Asenapine are licensed in UK for the treatment of mania. Olanzapine –formally licensed as prophylaxis Quetiapine also shows robust efficacy in all aspects of bipolar

- Choice should take into account individual risk factors for side effects- such as risk of diabetes)
- Initiate treatment at lower end of therapeutic range

Physical Health Monitoring on antipsychotics

- Height and weight prior to commencement – then 3 monthly
- Blood glucose – at baseline, 1 month and 6 monthly
- Lipids- at baseline and 3 monthly
- ECG at baseline
- Prolactin at baseline and repeat if symptoms of raised prolactin

Back to top

Women of childbearing age
Bipolar women planning a pregnancy



Refer the woman to a psychiatrist for an assessment and discussion of drug treatment.

Psychiatrist may advise her to:

- Stop drug treatment prior to trying to conceive, and remain off it throughout the pregnancy.
- Stop drug treatment prior to conception, and to restart it either after the first trimester or immediately after birth.
- Remain on her current drug treatment throughout conception, pregnancy, and birth.
- Switch to another drug treatment prior to attempting to conceive.
- Explain strategy chosen will depend on her wishes and advice of medical team who need to balance the risks of under-treatment (e.g. relapse) with the risk of harming the unborn child by remaining on drug treatment.
- Give general pre-conception advice (e.g. smoking and alcohol consumption), and prescribe folic acid.

Back to top

Unplanned pregnancy?

For all women taking medication, immediately contact a psychiatrist to establish if drug treatment should be stopped.

- Refer urgently to a psychiatrist and specialist fetomaternal medicine service, for a risk assessment and further management, *those women who are taking medication with a known teratogenic risk at the time of conception or in the first trimester (i.e. lithium, valproate, carbamazepine, lamotrigine, or paroxetine).*

- Refer all other women to a psychiatrist for an assessment and a discussion of drug treatment.

Back to top

Depressive episodes in a pregnant woman?

All pregnant women who have bipolar disorder and experience a depressive episode require referral or possibly admission.

- **Admit urgently** if a danger to themselves or others.
- **Refer urgently** for specialist mental health assessment those women:

For whom the degree of risk is increasing such that they are likely to become a danger to themselves or others.

With severe depression.
In a mixed episode.
With rapid cycling.

For all other women, arrange an appointment with a psychiatrist as soon as possible to discuss treatment options.

Whilst awaiting specialist assessment, do not start or change treatment without specialist advice.

Back to top

Acute mania in a pregnant woman?

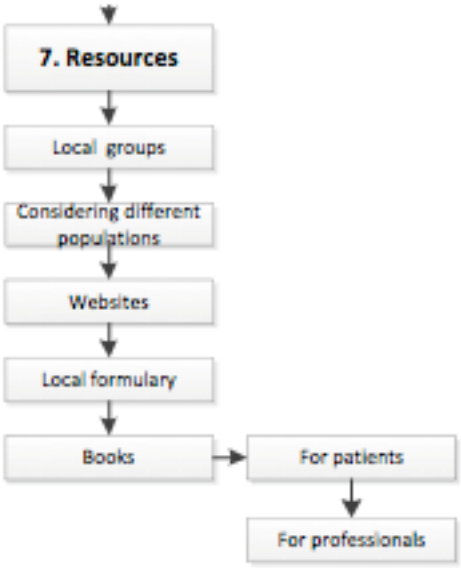
All pregnant women with mania need referral or possibly admission. For more detailed management information, see Scenario: Known bipolar, hypomania or manic episode.

If a woman is breastfeeding?

Advise the woman not to breastfeed if she is taking lithium, a benzodiazepine, or lamotrigine. A selective serotonin reuptake inhibitor (SSRI) may be prescribed if an antidepressant is being considered, but not fluoxetine or citalopram.

Back to top

Resources



Bipolar disorder support websites and foundations

Manic-depressive fellowship (MDF)

- Has a presence in Britain.
- Closest face-to-face support available at Islington centre
- Need to e-mail, register and password to make contact if possible

Bipolar supporter

- More for family members/loved ones trying to support patient
- Note many self-help and books for supporters on the market

http://www.psychosis-bipolar.com/understanding-psychoses-00.html
- Neat and Professional website

Mood charting applications for iPhone/android phones
- Chronorecord
- Mood Tracker
- Icharting (psycheducation)
- iPhone apps

Coping with depression podcasts – by Stephen Fry

Books
- Cyclothymia workbook
- Bipolar survival guide
- Bipolar disorder: Your questions answered by Neil Hunt - Excellent

Back to top

Author: Dr Nikhil Katiyar, July 2013
Reviewed: February 2015