BlueCare Tennessee Practice Guidance
For the Treatment of Bipolar Disorder
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The following document is prepared in an effort to provide BlueCare guidance for the treatment of Bipolar Disorder absence of updated Clinical Practice Guidelines by the American Psychiatric Association.
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BlueCare Practice Guidance – Bipolar Disorder

The following BlueCare bipolar disorder guideline is based on the Clinical Practice Guidelines published by the American Psychiatric Association in 2002 and updated through a Guideline Watch in 2005 (http://psychiatryonline.org/guidelines.aspx). In the interim the American Psychiatric Association has published the Diagnostic Statistical Manual, 5th edition. The first guideline watch since the publication of DSM-5 was published for Alzheimer’s disease in September 2014, and it is anticipated that other guidelines or watches will be forthcoming. This document is an effort to provide BlueCare endorsed guidance for the treatment of bipolar disorder absent updated Clinical Practice Guidelines by the American Psychiatric Association.

These guidelines are intended to guide the identification and treatment of Bipolar Disorder and to promote member recovery through application of available benefits and levels of care to promote limited interruptions to their life and contributions to community, job and family.

Goals of Psychiatric Management

- Establish and maintain a therapeutic alliance
- Ongoing monitoring of the member’s psychiatric status
- Ongoing education regarding bipolar disorder
  - To assist the member/family and identified supports to anticipate stressors and manage them proactively
  - To assist in the identification of new episodes early and to implement pre-planned strategies
  - To minimize functional impairments
- Promotion of treatment adherence
  - Through linkage with community and natural supports to promote resiliency and recovery
- Integration of strategies to support behavioral health needs with physical health needs

Assessment of risk

(Risk determination is necessary to provide for the safety of the member and to identify the proper level of care to safely treat the member while promoting recovery and providing the least disruption to the member’s role in their community, job and family.)

- Assess for factors of risk
  - Agitation
  - Pervasive insomnia
  - Impulsiveness
  - Psychosis
  - Personality disorder
  - High risk behaviors
- Suicide
  - Thoughts
  - Plans
  - Means
  - Prior history of plans/attemptst
  - Family history of plans/attemptst/completed suicides
• **Risk to self by other means**

**Complete a diagnostic evaluation**

• Assess for the presence of co-occurring alcohol and/or substance use issues that contribute and/or complicate the expected bipolar disease process

• Assess for the presence of neurological conditions commonly associated with secondary mania such as multiple sclerosis, and lesions involving the right-sided subcortical structures or cortical areas closely linked to the limbic system.

• Assess for the presence and use of medications (i.e., L-Dopa and corticosteroids) associated with secondary mania

• Assess for the presence of co-occurring physical health conditions for which members with bipolar disease may be at higher risk (thyroid disease, migraine headaches, heart disease, diabetes, obesity). These conditions may also cause symptoms of mania or depression. They also may result from treatment for bipolar disorder.

• History should include a comprehensive review of periods in a member’s life marked by mood dysregulation or lability accompanied by associated manic symptoms. This will be accomplished by member, family and caregiver sources of collateral information.

**Medications**

Medications should be prescribed after a comprehensive evaluation, inclusive of medication, family and physical health history. All prescribers must remain familiar with the risks and benefits for the use of each medication as it is matched to the individualized presentation of each member. Specific risks must be managed by prescribers as members present with specific physical health comorbidities and risks associated with side-effect monitoring/management that some medications will require. Prescription of medications requires ongoing monitoring of treatment adherence and symptom resolution. Ongoing member/family education is required as changes in symptoms and the risk of medication side-effects require. Prescribers are encouraged to remain up to date with FDA approvals and warnings related to all medications used.

Prescribers are responsible to remain aware of the available individual coverage benefits for each member and the formulary rules that would guide prescribing for individual members. This is useful to promote compliance especially following an inpatient stay and avoids issues that a member may have difficulty navigating alone and may opt to discontinue medications rather than seek assistance.

Some medications are available in long-acting, injectable form which may be useful to promote medication adherence when there is an assessed risk and/or history of medication compliance issues.

• Mood stabilizers

• Atypical antipsychotics

• Antidepressants – Antidepressants used to treat depression in bipolar disorder are recognized to pose a risk of switching to mania or hypomania. Antidepressants are frequently paired with a mood stabilizer to mitigate this risk.
Psychotherapy
• Cognitive Behavioral Therapy (CBT) – Assists the member in identifying and changing harmful or negative thought patterns.
• Family focused therapy – engages the Member’s family in the recovery process through helping to promote family coping strategies skills to identify new episodes early through improved communication and problem solving strategies.
• Psycho-education – Teaches the member and family the importance of managing daily routines, sleep schedules and course of the illness. It also teaches the members what they need to safely and consistently manage medication compliance while monitoring side-effects and promotion of prescriber communication.

Other Treatments
• Electroconvulsive Therapy (ECT) – used in situations where medications and/or psychotherapy have not provided the expected benefits.
• Sleep medications – Used when all efforts to assist the member in improving sleep have not been successful.

References
