Figure 4.

Sidebars From the VA/DOD Clinical Practice Guideline for the Management of Bipolar Disorder

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
- Sleep log/history with onset, maintenance, wake time, change in sleep pattern from work week 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 to 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-SSRS or CAMS. When positive, continue to the following.
  - Assess modifiable and non-modifiable risk factors.
    - Self-directed violence
    - Current psychiatric conditions/current or past mental health treatment
    - Psychiatric symptoms
    - Recent bio-psychosocial stressors
    - Availability of lethal means
    - Physical health conditions
    - Demographic factors
  - Assess 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.
- Obtain a basic set of laboratory tests:
  - Thyroid stimulating hormone,
  - Complete blood count,
  - Comprehensive metabolic panel, and
  - Urine drug screening.

Reserve neuroimaging or advanced neurologic studies (e.g., EEG) for patients who have abnormal findings in the history or neurologic examination

Sidebar 4: Maintenance Treatment/Rehabilitation 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:

- Psychoeducation 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[b]
- 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
- Considering psychotherapy to build coping and self-management skills and to prevent recurrences
- Considering programs providing psychoeducation and 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., mental 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 among available programs to enhance wellness
- Specifying indications and timeframes for reevaluating the plan

Sidebar 5: Reassessment after Specialty Evaluation

- Repeat a full medication reconciliation (including prescribed and nonprescribed medications, supplements, and vitamins), giving attention to neuropsychiatric side effects.
- Investigate treatment non-adherence, using laboratory measurement when feasible.
- Consider repeat or expanded laboratory evaluation for nonmedical substance use.
- Consider the need for expanded neurologic 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 [e.g., regarding possible costs of untreated mania, importance of medication adherence] might still be important even for 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., LGCC).

Sidebar 7: Approach to Treating a Manic Episode

- Taper and discontinue antidepressants.
- Address medical factors.
- Address substance intoxication and withdrawal, and treat active SUDs[c]
- 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.

[a]See the VA/DOD CPG for the Assessment and Management of Patients at Risk for Suicide, https://www.healthquality.va.gov/.
[b]See Kilbourne AM, Post EP, Nossek A, et al. *Bipolar Disord*. 2008;10(6):672–683.
[c]See the VA/DOD CPG for the Management of Substance Use Disorders, https://www.healthquality.va.gov/.
Abbreviations: BD = bipolar disorder, BD 1 = bipolar 1 disorder, BD 2 = bipolar 2 disorder, CAMS = Collaborative Assessment and Management of Suicidality, CBT = cognitive behavioral therapy, CPG = Clinical Practice Guideline, C-SSRS = Columbia-Suicide Severity Rating Scale, DOD = Department of Defense, EEG = electroencephalogram, IPSRT = interpersonal and social rhythm therapy, LGCC = Life Goals Collaborative Care, MTF = military treatment facility, PHQ-9 = Patient Health Questionnaire-9, SUD = substance use disorder, VA = Department of Veterans Affairs.