BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

BIPOLAR DISORDER

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Executive Summary

Introduction and Statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Autism, Mental Retardation and Pervasive Developmental Disorder (PDD). It may also assist clinicians treating patients who have some of the signs and symptoms of Autism, PDD and Mental Retardation but who do not meet the full criteria for these diagnoses. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for these disorders within our clinic. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is, effective, efficient, culturally relevant, acceptable to clinicians, program managers, and patients

Definition of disorder

Bipolar disorder is divided into two subdivisions: Bipolar I and Bipolar II. The cardinal symptoms of both groups are similar with the cycling of Mania and Depression. Intensity, duration, and frequency of these two symptom clusters are the points of differentiation. In childhood and adolescence, the symptoms of mania (grandiosity, lack of need for sleep, pressured speech, flight of ideas, etc) and depression (apathy, subjective depression, amotivation, etc) may be different. Irritability, hyperkinesis, rapid cycling of moods, defiance, agitation, and hypersomnia may be primary presentation in the childhood manifestation of the disorder. (See Table 1 for DSM-IV-TR criteria)

Table 1: DSM-IV-TR Criteria for Bipolar I and Bipolar II

Diagnostic criteria for 296.0x Bipolar I Disorder, Single Manic Episode (cautionary statement)
A. Presence of only one Manic Episode and no past Major Depressive Episodes.
Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.
B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
Specify if: Mixed: if symptoms meet criteria for a Mixed Episode
Specify (for current or most recent episode):
Severity/Psychotic/Remission Specifiers
With Catatonic Features
With Postpartum Onset

Diagnostic criteria for 296.40 Bipolar I Disorder, Most Recent Episode Hypomanic (cautionary statement)
A. Currently (or most recently) in a Hypomanic Episode.
B. There has previously been at least one Manic Episode or Mixed Episode.
C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

Diagnostic criteria for 296.4x Bipolar I Disorder, Most Recent Episode Manic (cautionary

statement)
A. Currently (or most recently) in a Manic Episode.
B. There has previously been at least one Major Depressive Episode, Manic Episode, or Mixed Episode.
C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
Specify (for current or most recent episode):
Severity/Psychotic/Remission Specifiers
With Catatonic Features
With Postpartum Onset
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

Diagnostic criteria for 296.6x Bipolar I Disorder, Most Recent Episode Mixed (cautionary statement)
A. Currently (or most recently) in a Mixed Episode.
B. There has previously been at least one Major Depressive Episode, Manic Episode, or Mixed Episode.
C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
Specify (for current or most recent episode):
Severity/Psychotic/Remission Specifiers
With Catatonic Features
With Postpartum Onset
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

Diagnostic criteria for 296.5x Bipolar I Disorder, Most Recent Episode Depressed (cautionary statement)
A. Currently (or most recently) in a Major Depressive Episode.
B. There has previously been at least one Manic Episode or Mixed Episode.
C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
Specify (for current or most recent episode):
Severity/Psychotic/Remission Specifiers
Chronic
With Catatonic Features
With Melancholic Features
With Atypical Features
With Postpartum Onset
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

Diagnostic criteria for 296.7 Bipolar I Disorder, Most Recent Episode Unspecified (cautionary statement)
A. Criteria, except for duration, are currently (or most recently) met for a Manic, a Hypomanic, a Mixed, or a Major Depressive Episode.
B. There has previously been at least one Manic Episode or Mixed Episode.
C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder

Not Otherwise Specified.
E. The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

Diagnostic criteria for 296.89 Bipolar II Disorder (cautionary statement)
A. Presence (or history) of one or more Major Depressive Episodes.
B. Presence (or history) of at least one Hypomanic Episode.
C. There has never been a Manic Episode or a Mixed Episode.
D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify current or most recent episode:
Hypomanic: if currently (or most recently) in a Hypomanic Episode
Depressed: if currently (or most recently) in a Major Depressive Episode
Specify (for current or most recent Major Depressive Episode only if it is the most recent type of mood episode):
Severity/Psychotic/Remission Specifiers Note: Fifth-digit codes specified on p. 377 cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
Chronic
With Catatonic Features
With Melancholic Features
With Atypical Features
With Postpartum Onset
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

General Goals of Treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms, and to restore function. For Bipolar Disorder, remission usually means that the patient's extreme mood swings will even out and they will be able to function more effectively at home, work, school, and in the community.

Summary of 1st, 2nd, and 3rd line treatment

Based on our own clinical experience and a review of the literature, the BHS clinicians feel that the first line treatment for Bipolar Disorder at this time involves medication management and family support. They are the mainstays of intervention. Early initiation of appropriate medication (s) is especially important in cases of severe depression and mania. It is critical to try to bring these symptoms under control as soon as possible. An evaluation by a psychiatrist or advanced nurse practitioner should be completed in a timely manner and appropriate medications prescribed.

Psychosocial interventions with families and patients are also very important. This can educate them about the illness and its expected course. It can also help them deal with their feelings about the disease and the problems it causes for everyone involved. This can be done as single family therapy and with multi-family groups. Family support is critical for the patient during the acute phase of the illness. It also helps with

post-episode management and is aimed at assuring medication compliance, relapse recognition/prevention and to assist with early intervention

Group therapy with effected individuals can also be very helpful. May of the patients have limited insight and impaired judgment. They are in denial of their symptoms and the functional impairment they cause. Group therapy can help them over come their denial and improve their understanding of the likely chronicity of their illness. Of course this is a second line treatment because they will not be able to participate in group therapy until their acute symptoms are under control.

As a third line intervention, individual psychotherapy might be helpful. When the patient begins to truly understand the severity and chronicity of the illness, and the impact it had and will have on his life, he might go through a grieving process. Individual psychotherapy can help him grieve the loss of his previous self and help him adjust and develop new coping skills. Additionally cognitive therapy may also help with medication compliance and increased social functioning. It may assist the client with identifying prodromal signs of relapse and help him to construct a plan of intervention with a team of supportive professionals and others.

For children and adolescents, psychoeducation is the primary intervention and must be appropriate to the stage of development. Interventions around social skills, family communication and peer relationships as well as school based interventions are helpful. Group therapy and Family Therapy are well suited to address these issues.

Although they may lack the formal structure and empirical validation of other treatment models, the Bipolar work group wishes to encourage clinicians at BHS to incorporate Alaska Native cultural idioms of care into the treatment of this disorder. For example, talking circles may be a specific group modality for providing core treatment components. Patience and respect are the key elements in engaging with native patients and their families to help them understand and come to terms with this bewildering illness.

Approaches for patients who do not respond to initial treatment

Bipolar disorder is a complex illness and recovery is rarely an orderly, linear process. If the patient is not progressing toward treatment goals, he should be re-evaluated by the clinician. It often takes time and patience to find the right combination of medications that can alleviate the symptoms. Also if the family is not adequately engaged and supportive, they might inadvertently undermine the patient's recovery. The patient must of course be frequently monitored for deterioration, and if his symptoms become sufficiently dangerous, he may need to be hospitalized either with his permission or involuntarily. In the acute phase of this illness, there can be a significant lack of insight, and the patient may need to be protected from his poor judgment. Manic patients in particular may like the feelings of grandiosity and be non compliant with treatment. Depressed patients may become suicidal and also need a safety plan that could include hospitalization.

Clinical and demographic issues that influence treatment planning

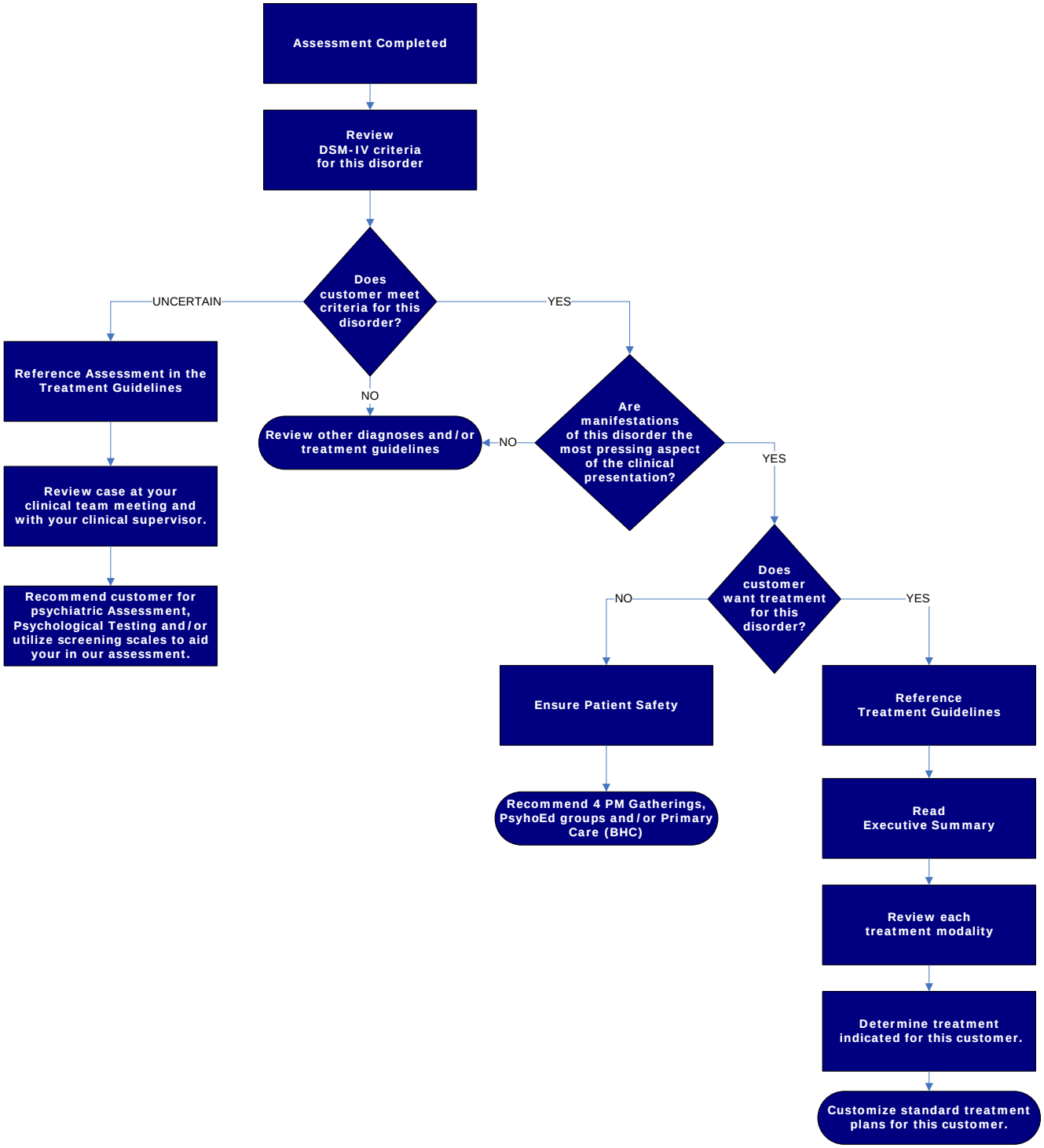
Comorbidity (the presence of more than one diagnosable condition) is the rule rather than the exception. Frequently patients with bipolar disorder may also have substance abuse problems. They may be suicidal or homicidal during the acute phase. They have poor judgment and limited insight. They usually have significant functional impairment. They may be having problems relating to family members, employers, teachers, and peers. They often have legal problems and are involved with the criminal justice system.. All of these difficulties can complicate our efforts to provide effective treatment. The critical factor is to overcome resistance and denial. We need to curb our impatience and frustration and realize that successful treatment might require a prolonged engagement with the patient and family.

Many patients have enormous reluctance to take medications. We need to be diligent in educating them about the strengths and limitations of various drugs and to obtain true informed consent. We need to understand that this is a frightening diagnosis to be given and we must be patient with the client and family as they struggle to come to terms with it. This illness usually has a prolonged and rocky course and we must be there for the long haul. There may be frequent relapses. This illness though distressing for all ages

may be particularly troublesome for children/adolescents and their families. Repetitive psychoeducation will be required.

The incidence of bipolar disorder may be increasing or perhaps we are getting better at recognizing and diagnosing it. It afflicts people of all nationalities and ethnic groups. Because of the unique history of Alaska Native peoples, the variation in levels of
acculturation, and the frequent differences in cultural background and experience between patients and clinicians in our setting, we shall be challenged to find ways of providing effective, efficient and relevant care. Although they may lack the formal evaluation and empirical validation of other treatment models, concurrent referral to a talking circle or a traditional healer may be appropriate for some patients and/or their families.

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed or manic	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 3 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above consider adult services

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

Family, Psychoeducation, CBT, Interpersonal, Social Rhythm

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

CBT, Interpersonal, Social Rhythm

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

Psychoeducation – Family Therapy should focus on psychoeducation for family members and emphasize need for medication compliance.

Individual Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available. ▪ Recommended concurrent with psychotherapy and/or psychoeducation	▪ Refuses Medication Management ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Documented history of medication non-compliance ▪ Disorder is caused by an untreated physiological disorder.

STRUCTURE

Duration	30 minutes
Frequency	Monthly

TREATMENT MODEL

There have been several attempts to create expert consensus or evidence based algorithms for global management of and medication choice for Bipolar Disorder. This is a rapidly evolving area of Psychiatric practice. Optimal treatment often requires more than one agent and a series of trials. This complexity makes direct recommendations beyond the scope of this guideline. Please see the TMAP (Texas Medication Algorithm Project) or the APA Guideline on the Management of Bipolar Disorder for specific guidelines and see the table below for a list of medications available on the ANMC formulary that have been used as mood stabilizers.

MOOD STABILIZERS

- Lithium (Eskalith, Lithobid) 300mg immediate release tabs and caps, 300mg SR tabs (liquid special order)

ANTI-EPILEPTIC DRUGS

- No levetiracetam (Keppra), tiagabine (Gabitril), Zonisamide (Zonegran)
- Carbamazepine (Tegretol) – tablets: 200mg, 100mg chewable, XR tabs 100mg, 400mg. Oral suspension
- Divalproex/valproate (Depakote/Depakene) – valproic acid liquid:
  - Depakote sprinkles 125mg, Depakote tablets 125mg, 250mg, 500mg,
  - Depakote ER tablets 250mg, 500mg (dose QD ~20% higher than regular Depakote) **DEPAKOTE ER (EXTENDED RELEASE) MUST BE DOSED ONCE DAILY OR THE DELAYED RELEASE MUST BE DISPENSED**
- Gabapentin (Neurontin) – tablets: 100mg, 300mg, 400mg. Solution 250mg/5ml
- Lamotrigine (Lamictal) – chew tab: 5mg. Regular tab: 25mg, 100mg, 150mg
- Topiramate (Topamax) – sprinkle caps: 15mg, 25mg. Tabs: 25mg, 100mg, 200mg.
- Oxcarbazepine (Trileptal) – tablets 150mg, 300mg. Liquid

ANTIPSYCHOTICS - ATYPICAL

- We do not stock the fluoxetine/olanzapine combination Symbyax
- Aripiprazole (Abilify) – tablets: 10mg, 15mg, 20mg, 30mg (**SECOND LINE ATYPICAL**)
- Clozapine (Clozaril) – tablets: 25mg, 100mg
- Olanzapine (Zyprexa) – tablets: 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg (no IM) **NO ZYDIS**
- Quetiapine (Seroquel) – tablets: 25mg, 100mg, 200mg, 300mg

- Risperidone (Risperdal) – tablets; 0.5mg (for 0.25mg dose only) 1mg, 2mg, 3mg, 4mg. Oral solution 1mg/ml., Risperdal Consta depot (every 2 weeks) injection 25mg, 37.5mg, 50mg
- **RISPERDAL TABLETS OF ALL STRENGTHS SHOULD BE SPLIT WHENEVER POSSIBLE
- Ziprasidone (Geodon) – capsules: 20mg, 40mg, 60mg, 80mg (no IM)

ANTIPSYCHOTICS – TYPICAL (NEUROLEPTICS)

- No loxapine, mesoridazine, molindone
- Chlorpromazine (Thorazine) – tablets: 25mg, 50mg, 100mg. Oral solution 100mg/ml. IM injection.
- Fluphenazine (Prolixin) – tablets: 1mg, 2.5mg, 5mg. Regular IM injection 2.5mg/ml. Decanoate IM injection 25mg/ml.
- Haloperidol (Haldol) – tablets: 1mg, 2mg, 5mg. Oral solution 2mg/ml. Regular IM injection 5mg/ml. decanoate IM injection and 100mg/ml
- Perphenazine (Trilafon) – tablets: 2mg, 4mg, 8mg, 16mg
- Thioridazine (Mellaril) – tablets: 10mg, 25mg, 50mg, 100mg. Oral solution 30mg/ml
- Trifluoperazine (Stelazine) – tablets: 1mg, 2mg, 5mg, 10mg

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ No child care available ▪ Severe untreated hyperactivity	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

Duration	▪ 90 minutes ▪ 8 to 12 weeks for customer over 17 years old
Frequency	Once a week
Size	8 to 10 customers per clinician
Open vs. Closed	Open

TREATMENT MODEL
No proposed model at this time. See individual medication management section for additional information.

Psychoeducational Groups

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
Bipolar Disorder

Diagnosis: Bipolar disorder category is divided into two subdivisions: Bipolar I and Bipolar II. The cardinal symptoms of either group are similar with Mania and Depression cycling. Intensity, duration and frequency of these two symptom clusters are the points of differentiation. In childhood and adolescences, the definitions of both mania (grandiosity, lack of need for sleep, pressured speech, flight of thoughts, etc) and depression (apathy, subjective depression, amotivation, etc) are different. Irritability, hyperkinesis, rapid cycling of moods, defiant agitation and hypersomnia are some of the different childhood manifestation of the symptoms.

General Information: This review searched the following data bases: Cochrane Reviews, American Psychological Association, American Psychiatric Association, The Journal of Empirical Mental Health, British Medical Journal, Medscape (online), The National Guideline Clearinghouse, The Texas Algorithm Project, The Harvard Algorithm Project and SAMHSA, and NIMH. The keywords for this search were: bipolar disorders, manic-depression, group therapy, psychosocial interventions, evidence-based, empirically supported treatments/therapies/interventions, reviews, and Boolean combinations of such terms.

This search resulted in a large number of hits on the general subject. The selection process was around reviews, guidelines and any psychosocial intervention that used between group research designs. The general consensus of all of the literature is the primacy of medication intervention in these disorders especially acute mania and deep depression. Most of psychosocial interventions focused on one of two attendant issues: 1) prodromal symptom recognition and containment and 2) post-episode interventions aimed at medication compliance, relapse recognition and prevention and early intervention in breadth and structure of adult onset. Nevertheless, medication management and family support remain the mainstays of interventions. (See Rivas-Vazquez, 2002)

Group Therapy and Bipolar Disorders: There were no hits directly for psychological group therapy for this category. A form of group intervention was noted extensively: family therapy and family psychoeducation. Rea et al, 2003, produced a randomized clinical trial using family-focused treatment. The results were that psychosocial interventions with family and clients reduced the incidence of re-hospitalizations and decrease in symptom relapse more than individual sessions. The effects were noted only post treatment (not during the active therapy stage). This was a 21 week/nine month course (on the edge of brief therapy) based on a structured composition of illness education, communication enhancement and problem-solving skills. There is a manual by Miklowitz and Goldstein (1997) for this method. Family Focused therapy was administered by a wide range of professionals including trained individuals with bachelors' degrees. The strict supervision and Manualized nature of this program did not differentiate between the levels of credentials and the positive outcomes (Miklowitz, et al., 2003)

Individual Therapy and Bipolar Disorders: Lam et al., 2003 noted that cognitive therapy produces a positive effect in helping with medication compliance and increasing social functioning. This model has a manual published by Lam (1999). Perry et al., 1999 identified a psychoeducation model that bridged the brief therapy parameter of 12 sessions. This method increased social functioning, medication compliance and reducing in mania symptoms but not depressive symptoms. This method dealt with identifying prodromal signs of relapse and helped the client to construct a plan of intervention with a team of supportive professionals and others. She posits that it is not necessary for a highly credentialed clinician be the interventionist. Finally, Frank et al., 2000, noted the individual model of Interpersonal and Social Rhythm Therapy as a positive intervention for bipolar disorder. This model is, more or less, an extension of the above models with some emphasis on sleep patterns and social routine maintenance. It, too, is a psychoeducation model.

For children and adolescents, education becomes more important paralleling developmental stages. Interventions around social skills, family communication and peer relationships as well as school based skills interventions are noted as positive (McClure, 2002)

Brief Therapy Models and Psychotic Disorders: Brief therapy models probably are not very effective. All the limited psychoeducation models noted above have an extended period of time for affiliation, are usually post episodic and include a team approach with medication management being primary. No evidence based practices were noted in this limited search for brief therapy.

Professional Status in (Brief) Therapy: All of the above cited studies indicated that a wide range of trained professional could administer the psychoeducation and support training to clients and staff. Medication management and possibly attending co-occurring disorder would necessitate more credentials and training.

Structure of most (Brief) Therapy: The uses of individual CB or Interpersonal therapy in combination with medications are most cited. One study utilized a community professional team approach. Education and skill development formats were the most cited and researched. These included the family or primary support systems as well as the client. It is conceivable by extension, that some of these could be done in multi-family groups settings or in group educational formats.

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: “there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations” (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more “pluralistic” methodology in developing evidence based and culturally sensitive treatments.
Meaning and context of the symptoms as well as cultural support mechanisms must be included in the models of support, education and intervention.
Pharmacological Interventions: Am. Psychiatric Assoc treatment guide for Bipolar Disorder, the National Guideline Clearinghouse guides all note that psychotropic medications are the first line of interventions with these disorders. The combination of Mood Stabilizers or Lithium is the most researched and effective. Some limited use of newer antipsychotics like Olazapine was cited for acute mania. Antidepressants were only used post initiation of mood stabilizers and with much caution. Side effects and quality of life issues must be considered in order to facilitate employment, school, relationships and social rhythms.

Manuals: Two noted: Miklowitz and Goldstein (Family Focused Therapy) and Lam et al, 1999

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Appendix C: Sample Treatment Plans

Treatment Plan for Bipolar Disorder

Problem #1:
Increased motor activity or agitation (put in clients own words), or flight of ideas or thoughts racing.

Goal:
Achieve controlled behavior, moderated mood, and more deliberative speech and though process through psychotherapy and medication.

Objectives:
1. Arrange for psychiatric evaluation. Take psychotropic medications as prescribed.
2. Begin to demonstrate trust in the therapy relationship by sharing fears about dependency, loss and abandonment. Explore signs of classic mania: pressured speech, impulsive behavior, euphoric mood, flight of ideas, reduced need for sleep, inflated self-esteem, and high energy.
3. Achieve mood stability, becoming slower to react with anger, less expansive, and more socially appropriate and sensitive.
4. Explore potential feelings of loss associated with diminished euphoric mood as a result of psychotropic medication.
5. Terminate self-destructive behaviors such as promiscuity, substance abuse, and the expression of overt hostility or aggression.
6. Repeatedly focus on the consequences of behavior to reduce thoughtless impulsivity.

Treatment Plan for Bipolar Disorder Adult Group

Problem #1:
"I can't cope – I'm so tired of living like this" – cycles of depression and hypomania

As evidenced by:
"Either I'm keyed up or completely empty" – psychomotor agitation and retardation, repeated cycle of weight loss and gain, difficulty concentrating, sleep disturbance.

Goals:
To decrease the frequency, severity, and/or consequences of bipolar disorder symptoms.

Objectives:
1. Verbally express awareness of disorder, associated symptoms, and treatment goals
2. Verbally express awareness of emotional and physical symptoms that identify new episodes early
3. Identify and implement 3 behavioral strategies to resolve problems arising from symptomatic behaviors.
4. Verbally identify interpersonal difficulties, including marital and parent-child issues, arising from symptomatic behaviors
5. Take all psychotropic medications as prescribed 100% of the time.

Treatment Plan for Bipolar Disorder (Child/adolescent)

Problem #1:
Hypomania and mania

As evidenced by:
- High energy levels, exaggerated talkativeness, racing thoughts, decreased need for sleep, inappropriate silliness,
- Overly-friendly with others; pressured speech, etc.

Goals:
Increase knowledge of mania/hypomania symptoms, increase coping skills and improve relationships affected by BPD

Objectives:
1. Identify 3+ BPD symptoms and 3+ triggers that may escalate mood beyond appropriate levels
2. Develop and implement 1-3+ coping skills & methods of symptom management (meds, behavioral, supportive, etc
3. Develop & implement 1-3+ coping & communication skills that help to improve family/peer relationships affected by BPD

Problem #2:
Depression

As evidenced by:
Sad or flat affect; social withdrawal from family and/or peers; marked change in sleep patterns; reduced appetite; low energy; lack of interest in previously-enjoyed activities; low self-esteem, etc.

Goals:
Increase knowledge of BPD depressive symptoms, increase coping skills and improve relationships affected by BPD

Objectives:
1. Identify 3+ BPD symptoms and 3+ triggers that may depress mood beyond normal ups & downs of daily life
2. Develop and implement 1-3+ coping skills & methods of symptom management (meds, behavioral, supportive, etc.)
3. Develop & implement 1-3+ coping & communication skills that help to improve family/peer relationships affected by BPD