OVERVIEW
Bipolar disorder is distinguished from depressive disorders by the occurrence of manic or hypomanic (mildly manic) episodes in addition to depressive episodes. Bipolar is an episodic, chronic cyclic disorder with an unpredictable course that can lead to severe functional impairment.

The goals of treatment in the Behavioral Health Homecare Program are:
1. Stabilization of mood.
2. Relapse prevention through symptom remission.
3. Prevent/identify symptoms of cycling into opposite pole.
4. Promote adherence to plan of care.
5. Return to pre-morbid level of functioning.
6. Develop patient centered self-management program to promote compliance and early symptom management.

EQUIPMENT:
None

Tool(s) to Determine Medical Necessity
An assessment tool should be administered to the patient at the initial visit and at recertification and discharge. Further, there is a need to re-administer the evaluation tool as a diagnostic assessment when the home care nurse identifies changes in patient condition. All patients will receive the Mania Rating Scale, depression scale and when anti-psychotics are ordered, the Abnormal Involuntary Movement Scale, etc. Where the score on a tool corresponds to an acuity level, interventions are implemented based on acuity.

1. Brief psychiatric rating scale (BPRS) – Rates psychiatric behaviors and symptoms for patients with major mental illness. The score corresponds to an acuity level.
2. Mania rating scale – Measures the severity of the behaviors exhibited during the manic phase of the disease. The score corresponds to an acuity level.
3. Geriatric depression scale (GDS) or Patient health questionnaire (PHQ9) – (See Depression visit guideline/clinical protocol.)
4. Abnormal involuntary movement scale (AIMS) – used for all patients who are on an anti-psychotic medication. The score corresponds to an acuity level.
5. SAD PERSONS suicide risk assessment – A scale used to assess the likelihood of a suicide attempt, based on risk factors.

Rapport
Patients with bipolar disorders are often ambivalent about treatment. They may minimize the destructive consequences of their behaviors or deny the seriousness of the disease. Some are reluctant to give up the increased energy, euphoria, and heightened sense of self-esteem of hypomania, before the devastating features of full-blown mania commence. Unfortunately, non adherence to the regimen of mood-stabilizing medication is a major cause of relapse. Therefore establishing a therapeutic alliance with the bipolar patient is crucial.

Associated Symptoms
1. Hypomania:
   a. Communication:
      (1) Talks and jokes incessantly, is the “life of the party”, gets irritated when not the center of attention.
      (2) Treats everyone with familiarity and confidentiality; often borders on crude.
      (3) Talk is often sexual-can reach obscene, inappropriate propositions to total strangers.
      (4) Talk is fresh; flits from one topic to the next, marked by pressure of speech.
   b. Affect and thinking:
      (1) Full of pep and good humor, feelings of euphoria and sociability, may show inappropriate intimacy with strangers.
      (2) Feels boundless self-confidence and enthusiasm. Has an elaborate scheme for becoming rich and famous. Initially schemes may seem plausible.
      (3) Judgment often poor. Gets involved with schemes in which job, marriage, or financial status may be destroyed.
      (4) May write large quantities of letters to rich and famous people regarding schemes or may make numerous worldwide telephone calls.
      (5) Decreased attention span to internal and external cues.
   c. Physical Behavior:
      (1) Overactive, distractible, buoyant, and busily occupied with grandiose plans (not delusions); goes from one action to the next.
      (2) Increased sexual appetite; sexually irresponsible and indiscreet. Illegitimate pregnancies in hypomanic women and venereal disease in both men and women common. Sex used for escape, not for relating to another human being.
      (3) Voracious appetite, eat on the run or gobble food during brief periods.
      (4) May go without sleeping; unaware of fatigue. However, may be able to take short naps.
      (5) Financially extravagant, goes on buying sprees, gives money and gifts away freely, can easily go into debt.

2. Mania:
   a. Communication:
      (1) May go suddenly from laughing to anger or depression. Mood is labile.
(2) Becomes inappropriately demanding of peoples attention, and intrusive nature repels others.

(3) Speech may be marked by profanities and crude sexual remarks to everyone (nursing staff in particular).

(4) Speech marked by flight of ideas, in which thoughts race and fly from topic to topic. May have clang associations.

b. Affect and Thinking:
   (1) Good humor gives way to increased irritability and hostility, short-lived period of rage, especially when not getting his or her way or when controls are set on behavior. May have quick shifts of mood from hostility to docility.
   (2) Grandiose plans are totally out of contact with reality. Thinks he or she is a musician, prominent business man, great politician, or religious figure, without any basis in fact.
   (3) Judgment is extremely poor.
   (4) Decreased attention span and distractibility are intensified.

c. Physical Behavior:
   (1) Extremely restless, disorganized and chaotic. Physical behavior may be difficult to control. May have outbursts, such as throwing things or becoming briefly assaultive when crossed.
   (2) No time for sex-too busy, poor concentration, distractibility and restlessness are severe.
   (3) No time to eat-too distracted and disorganized.
   (4) No time for sleep-psychomotor activity too high; if unchecked can lead to exhaustion and death.
   (5) Financially extravagant; same as in hypomania, but in the extreme.
   (6) Acute phase of illness: This patient is not appropriate for homecare; and most often these patients are hospitalized.
   (7) If any of these indicators are present call the Primary Care Physician (PCP), your Nursing Manager, and the patient’s psychiatrist and inform them of your findings. It may be necessary to call 911. The most important goal is to maintain safety until EMS arrives.

3. Depression:
   a. For patients with depressive episodes please follow guidelines for depression.

4. Psychoses:
   a. These symptoms are often mood congruous reflecting the extreme mood state at the time. For example, delusions of grandiosity, such as believing one is the President or has special powers or wealth, may occur during mania; delusions of guilt or worthlessness, such as believing that one is ruined and penniless or has committed some terrible crime, may appear during depression.

**Phases of Treatment and Associated Treatment Goals**

1. **Acute (0-2 months).** The goal is symptom reduction and stabilization. When mania is acute, hospitalization is usually the safest place for the patient. Continue to monitor for breakthrough acute mania in the homecare setting.
   a. Upon discharge patient can be considered for a behavioral health admission. Assumptions inherent in this document are that the behavioral health patient (BHP) will be admitting patients from a psychiatric in-patient unit who will be at the end of the acute phase and the early portion of the continuation phase, or medically ill patients with a concurrent diagnosis of bipolar disorder with an acute symptom exacerbation of the chronic mental illness.

2. **Continuation (2-6 months).** After acute phase symptoms resolve. Planning focuses on maintaining compliance with the medication regimen and preventing relapse. The goal is to prevent relapse or cycling into the opposite pole.
   a. In this phase the mental health patient will most likely continue to provide services for a defined period of time. For example, 1-2 episodes followed by a referral to out patient psychiatric services for on-going monitoring and treatment.

3. **Maintenance (begins at about 6 months)-Planning focuses on preventing relapse and limiting the severity and duration of the episodes.** Goal is to sustain remission and prevent new episodes. Patients with bipolar disorders require medications over long periods of time, if not a lifetime. Specific psychosocial therapies, support or psycho educational groups, and periodic evaluations all help patients maintain their family and social lives continue employment and minimize relapse rates.

**Co-Morbid Illness or Risks Associated with Bipolar Disorders**

1. Substance use/abuse.
2. Anxiety disorders.
3. High risk lifestyle factors as a direct result of the disorder.
4. Weight gain during antipsychotic treatment leads to predictable disturbances in glucose and lipid metabolism and increased cardiovascular risk. Be cognizant of hypertension, lipid abnormalities, clinical symptoms of diabetes, fasting glucose, hemoglobin A1c levels.

**Emergent Care Issues/Risk Assessment Associated with Bipolar Disorders**

Depression and its treatment in the presence of Hypomania: Some antidepressants can precipitate a manic episode, particularly the following drugs (tricyclics...
> selective serotonin reuptake inhibitors > monoamine oxidase inhibitors) and if cycling occurs it will often be necessary either to add a mood stabilizer or to avoid antidepressants altogether.

1. In the presence of the above antidepressants, the nurse should monitor for episodes of hypomania and transition to mania.

2. Manic episodes:
   a. Provide protective measures for patients with poor judgment and impulsivity who engage in high risk behavior.
   b. Assess for risk to others during severe manic episodes.

3. Suicide Risk
   a. 10-15% complete suicide.
   b. Risk may increase.
      (1) During depressive episodes.
      (2) During mixed episodes.

4. Medications
   a. Lithium toxicity-Moderate and Severe toxicity.
   b. Valproate and carbamazepine may be lethal if high doses are ingested.

Commonly used Medications: (not a complete list)
1. Salts: Lithium Carbonate (Lithane, Eskalith, Lithonate) monitor for Lithium toxicity.
2. Antiepileptic drugs Divalproex (Depakote), Carbamazepine (Tegretol), Valproate (Depakene), Lamotrigine (Lamictal), Gabapentin (Neurontin), Topiramate (Topamax).
3. Anxiolytics: Clonazepam (Klonopin), Lorazepam (Ativan), Carbamazepine (Equetro).
4. Antipsychotics: Olanzapine (Zyprexa), Quetiapine (Seroquel), Risperidone (Risperdal), Aripiprazole (Abilify), Ziprasidone (Geodon).
5. Antidepressants: (may trigger manic episode): Sertraline (Zoloft), Citalopram (Celexa), Amitriptyline, Duloxetine (Cymbalta), Venlafaxine (Effexor), Selegiline (Emsam), plus others not listed here.

Specific and actual teaching/training interventions are defined below:
These interventions are inclusive of categories that will ensure overall safe and quality care for the patient with bipolar disorder and are defined by a recommended visit occurrence.

Visit recommendations are based upon the necessity and urgency of the information provided and the ability of the patient to learn and understand the information.

Management Transition from Acute to Maintenance Phase: Nurse will make between 5-18 visits for a period of one (1) to two (2) episodes. The visit frequency most likely will be once a week (QW) or twice a week (BIW) initially for more symptomatic patients.

1. Interventions:
   a. Patient Assessment History:
      (1) Number of prior psychiatric hospitalizations
      (2) Length of stay in the hospital
      (3) Length of time between hospitalizations (possible insight into how quickly patient cycles).
      (4) Symptoms exhibited prior to hospitalization (depression vs. mania, aggression, withdrawal etc).
      (5) Inquire what patient understands as to why he/she was hospitalized (insight into causation; non-compliance with meds, substance abuse, poor coping skills?).

   b. Every Visit:
      (1) Mental status evaluation.
      (2) Vital signs.
      (3) Weight.
      (4) Presence/severity of symptoms impairing functioning (e.g., self care deficits):
         a. Symptoms of mania- irritability, fatigue and potential for harming self or others.
         b. Symptoms of depression.
         c. Suicide ideation/risk.
      (5) Identify target symptom(s):
         a. Have patient score target symptoms on a scale of 0-10 each visit.
         b. Observe for resurgence of symptoms.
      (6) Assess for treatment non adherence behaviors.
      (7) Medication compliance with anti-psychotic and adjunctive medication.
      (8) Lab test results:
         a. Monitor lithium carbonate level, narrow therapeutic range (0.4-1.3 mEq/L).
         b. Frequency of draws determined by MD.
      (9) Subjective distress due to side effects of the medication-this impacts on adherence to treatment (see below).
      (10) Extrapyramidal (EPS) side effects
         b. Acute dystonic reactions: acute contractions of tongue, face, neck and back (tongue and jaw first).
         c. Akathisia: motor inner-driven restlessness (foot tapping incessantly, rocking forward and backward in chair, shifting weight from side to side).
      (11) Tardive Dyskinesia:
         a. Facial: protruding and rolling tongue, blowing, smacking, licking, spastic facial distortion, smacking movements.
         b. Limbs:
            • Choreic: rapid, purposeless, and irregular movements.
            • Athetoid: slow, complex, and serpentine movements.

Last Update 9/10
2. Teaching/Training Topics:
   a. Disease process.
      (1) Course and outcome.
      (2) Causation several accepted models.
         (a) Chronobiologic theories-sleep disturbance.
         (b) Sensitization and kindling.
         (c) Genetic.
         (d) Psychobiological and social.
   b. Psychopharmacologic agents include drug action, dosage, frequency, possible adverse effects and importance of adherence.
      (1) Antipsychotic medications.
      (2) Mood stabilizers.
      (3) Anti depressants—may trigger manic episode.
      (4) Benzodiazepines.
   c. Patient self management strategies.
      (1) Identify antecedents to mood episodes, prevent progression into full blown episodes.
         (a) Monitor physical and mental state.
      (2) Link positive effects of medications with patients goals.
      (3) Prevent/reverse weight gain (anti psychotics, mood stabilizers and anti depressants can all cause weight gain).
      (4) Teach behavioral strategies (e.g. portion control, increase activity).
      (5) Assess need for Nutrition consult.
      (6) Enhance general coping strategies.
      (7) Establish regular sleep routine.
      (8) Monitor amount of sleep.
         (a) Report decrease of more than 1 hour/night (precursor to manic episode).
      (9) Identify high risk times for manic episodes.
         (a) Avoid changes in work schedule (day to night).
         (b) Shift work.
         (c) Avoid working excessively long hours.
         (d) Avoid night flying and flying across time zones.
   3. Perform Skilled CBT/Psychotherapy Techniques:
      CBT is typically used as an adjunct to pharmacotherapy and involves identifying maladaptive cognitions and behaviors that may be barriers to a person’s recovery and ongoing mood stabilization.
      a. Establish a strong therapeutic alliance.
         (1) Acceptance support, collaboration.
      b. Develop and prioritize problem list.
         (1) Target Symptoms.
         (2) Treatment goal—management of symptoms.
      c. Educate and normalize symptoms:
         (1) Disease process.
         (2) Medication acceptance/adherence.
      (3) Early detection and intervention.
      (4) Identify prodromal features of manic or depressive episodes.
      (5) Introduce self-management approach to symptoms.
      (6) Decrease mental illness stigma through education.
   d. Educate about CBT:
      (1) Links between thoughts, feelings and behaviors.
      (2) Identify themes from the problem list.
      (3) Share formulation and cognitive focus with patient.
      (4) CBT for “at risk” situations related to recognition of prodromes.
   e. CBT for Mania (Continuation Phase):
      (1) Test and re-frame beliefs.
      (2) Weigh the evidence.
      (3) Alternative explanations.
      (4) Behavioral experiments.
      (5) Elicit self-beliefs.
      (6) Investigate hierarchy of fears and suspicions.
      (7) Use images.
      (8) Use role playing.
      (9) Coping strategies.
   f. CBT for Depressive Episodes:
      (1) Adapt standard strategies for anxiety and depression.
      (2) Test and reframe beliefs related to anxiety and depression.
      (3) Focus on misinterpretations.
      (4) Use relaxation exercises.
      (5) Use activity exercises.
   g. Relapse Prevention:
      (1) Communication and problem solving skills training.
      (2) Identify and address occurrence of life stresses and events that increase the risk of relapse or are obstacles to returning to previous levels of functioning.
      (3) Identify triggers/hi risk situations, stressors.
      (4) “Rehearse” the action plan.
      (5) Compliance with medication regimen.
         Teach patient:
            (a) Report side effects ASAP.
            (b) Benefit of medication to decrease symptoms.
            (c) Regimen simplification.
            (d) To obtain family assistance in monitoring adherence.
            (e) Teach family benefit of pill counting to monitor medication compliance.
      (6) Assess responsiveness of supports (formal and informal).
      (7) Refer to Support groups: psycho educational groups, interpersonal, family-focused therapies.
h. Establish step-by-step action plan to deal with setbacks.