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Bipolar Disorder

New Zealand
Treatment Guide
for Consumers
and Carers



THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

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| | |
|---------------------------------------|-----|
| About Bipolar Disorder | 2/3 |
| Introduction | 5 |
| Treatment of Mania and Mixed Episodes | 9 |
| Treatment of Bipolar Depression | 19 |
| Prevention of Further Episodes | 28 |
| Further Treatment Choices | 34 |
| Appendix 1 | 42 |
| Appendix 2 | 45 |
| Appendix 3 | 47 |
| Appendix 4 | 48 |
| Authors and Acknowledgements | 52 |

Contents

Mate Hinengaro

“TINO HARAKOA, TINO POURI” ARA BIPOLAR DISORDER

1. Ka pangia ana te tangata e tenei mate ko nga tohu, i etahi wa he harakoa te ahua, mea rawa ake kua tau mai ko te tino pouri, a mea rawake kua harakoa ano.
2. Ka pangia ana te tangata e tenei mate kua haumate, kua poraruru tona ahua, a, kua kore e aata tau.
3. Mena ki o whakaaro, koinei to mate, e mohio ana ranei koe ki tetahi tangata ekene koinei tona mate, whakapa atu ki te Rata. Tera pea ka tonoa koe, te tangata ranei e mauititia ana ki te Tohunga wananga Hinengaro, ara psychiatrist, kia ata tirohia.
4. He rongoa pai kei te mohiotia hei awhina i tenei tumomo mate.
5. He ahuatanga kei te mohiotia hei awhina i nga turoro me nga whanau kia mama ai te kawae i nga raruru ka puta i roto i tenei tumomo mate.
6. Ma nga Tohunga e mohio ana ki te awhina i nga turoro penei, ma te mahi tahi hoki a te whanau me nga hoa, e mama ai te ora haere ake o te turoro.

ABOUT BIPOLAR DISORDER

1. Bipolar Disorder is a disorder of mood, in which a person has episodes of both elevated and depressed mood.
2. These episodes of major change of mood are associated with distress and disturbance of function.
3. If you think you have, or someone you care about has, Bipolar Disorder check with your family doctor who may refer to a psychiatrist.
4. Bipolar Disorder is an illness for which there are effective treatments.
5. Patients and their families can do positive things to reduce the impact of the illness, even though the illness can interfere with personal autonomy.
6. Working with a multidisciplinary team, and utilising the support of family and friends, patients with Bipolar Disorder can take control of their illness.

Key Points



INTRODUCTION

Aim and Purpose of the Guide

This guide was written by consumers and mental health professionals to answer the priority questions consumers have about treatments for bipolar disorder and living with the condition. It is a research summary of what is known about bipolar disorder and its treatment. It is also a plain English version of the *Australian and New Zealand Clinical Practice Guideline for the Treatment of Bipolar Disorder* (RANZCP, 2003) written for mental health professionals by the same authors.

What this Guide Covers

Its purpose is to provide consumers with information on best practice in the assessment, diagnosis and treatment of bipolar disorder. It might also assist their partners and carers. It is important that its recommendations are not taken as absolute. People with bipolar disorder should consult their mental health professionals before using information in this guide.

The guide has been written in accordance with the National Health and Medical Research Council recommendations for the development of treatment clinical guidelines for consumers.

First, we cover why comprehensive assessment and diagnosis is so important. We then outline treatments by each phase of the illness:

- Acute treatment of mania and mixed episodes
- Acute treatment of depression



- Preventative continuing treatment of mania and depression.

The appendices are intended to assist consumers, their partners, family/whanau and friends to locate further information about bipolar disorder.

What is Bipolar Disorder?

Bipolar disorder is a mood disorder. As detailed in Figure 1, it is characterised by periods of mania or hypomania, depression and 'mixed episodes' (or 'dysphoric mania' – a mixture of manic and depressed symptoms). The illness is commonly subdivided into:

- Bipolar I disorder – at least one lifetime manic episode or at least one mixed episode
- Bipolar II disorder – only periods of a major depression accompanied by at least one hypomanic (not manic) episode.

Most people experience multiple episodes at an average of one episode each two to three years, with each phase lasting about three to six months.

If a person has four or more episodes in a 12-month period, their condition is termed 'rapid cycling' bipolar disorder.

Figure 1: Do I have Bipolar Disorder?

The criteria for making a diagnosis of bipolar disorder, as defined by the Diagnostic and Statistical Manual (DSM), are:

Bipolar I: Occurrence over a lifetime of at least one manic episode or at least one mixed episode.

Bipolar II: One or more major depressive episodes accompanied by at least one hypomanic episode (not manic episodes).

Appendix 1 discusses these symptoms in more detail.

Recognising Hypomania and Mania (DSM-IV Criteria)

A distinct period of abnormally and persistently elevated, expansive or irritable mood. **Mania** lasts at least one week (or any duration if hospitalisation is necessary). **Hypomania** lasts at least four days. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (eg, feels rested after only three hours of sleep)
- More talkative than usual, or pressure to keep talking
- 'Flight of ideas' or subjective experience that thoughts are racing
- Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually, or a mental and physical restlessness)
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg, engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

Recognising Major Depression (DSM-IV Criteria)

Five or more of the following symptoms have been present during the same two week period and represent a change



It is best to go to a psychiatrist as early as possible if you have mood swings that concern you.

from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure:

- Depressed mood as indicated by either subjective report (eg, feels sad or empty) or observation made by others (eg, appears tearful)
- Markedly diminished interest or pleasure in activities
- Significant weight loss when not dieting, or weight gain or decrease or increase in appetite
- Insomnia or excessive sleep
- Mental and physical slowing or restlessness
- Fatigue or loss of energy
- Feelings of worthlessness, or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

Recognising Mixed Episodes (DSIM-IV Criteria)

The criteria are met both for mania and a major depressive episode nearly every day during at least a one week period.

TREATMENT OF MANIA AND MIXED EPISODES

Because there have been no specific treatment studies in bipolar II disorder, our recommendations refer to bipolar disorder generically. All studies have either described a group of people with bipolar I, or have not identified separate bipolar I and II subgroups. This chapter discusses the initial clinical assessment, how bipolar disorder presents when people first experience it and the main treatment approaches, mood stabilising and anti-depressant medications.

How Can I be Sure that I have Bipolar Disorder?

When people with bipolar disorder experience acute mania, immediate referral to a specialist psychiatric service is usually necessary.

Diagnosing bipolar disorder can be very complex and the first assessment may not provide a definitive diagnosis. To confirm the diagnosis, a mental health professional (usually a psychiatrist) should undertake a comprehensive assessment. If you agree, this may include speaking with your family/whanau, partner or someone who knows your behaviour prior to, and after, the onset of the symptoms.

It is necessary to conduct a full psychiatric history, mental state assessment and physical examination to confirm the diagnosis. The doctor will exclude any underlying organic



Mania lasts at least one week (or any duration if hospitalisation is necessary). Hypomania lasts at least four days.

cause (such as a prescription drug or substance-induced manic state) and identify any physical complications (such as dehydration).

The doctor will also decide if there is any risk to the person's safety or to others, a key consideration in deciding how best to manage the condition.

Mania refers to elevated mood that is characterised by high-risk behaviour of either: aggression, excessive spending, or engaging in what is called, 'disinhibited behaviour'. This is behaviour that is likely to severely damage your reputation, such as sexual indiscretions.

Insight and judgment are usually impaired early in the episode of the illness. Some people may develop delusions, which are fixed false beliefs. These are symptoms of psychosis. The presence or absence of psychosis will be taken into account in treating bipolar disorder.

Initial Management

Figure 2 on page 13 shows the approach mental health professionals usually take in the initial management of a person when they present with acute mania. Although community or outpatient treatment is always preferable, and admission with the patient's consent is sometimes possible, involuntary hospitalisation under the Mental Health Act (Compulsory Assessment & Treatment) may be needed. Going to hospital can protect the person and their family/whanau from the damage that may result from the impaired judgment associated with the illness. The decision to go to hospital is often traumatic for the person with bipolar disorder and his or her family/whanau.

Comprehensive Clinical Assessment

Clinical assessment requires patient cooperation. This may not be possible if the patient is irritable or aggressive as a result of acute mania. The comprehensive assessment is carried out after the person is more settled.

Your full medical history will be taken and a mental state assessment will be performed. This includes a 'risk assessment', which assesses a person's potential for experiencing harms associated with mania. These may include aggression, financial harm, risky sexual behaviour or vulnerability to exploitation, and the possibility of contracting communicable diseases (such as HIV, Herpes or Hepatitis C) due to sexual behaviour.

This medical history will include past episodes of psychiatric problems. If the person has established bipolar disorder, the General Practitioner (GP) will also check the patient's compliance with mood stabiliser medications and cease any anti-depressants.

The GP will also perform a physical examination. Its purpose is to exclude organic causes of the manic behaviour, such as neurological disorder, systemic disease, the misuse of alcohol or drugs or other substances, or the use of prescription medication. The GP will also assess any physical consequences of mania (eg, dehydration, emaciation or injuries).

In addition, the GP will conduct a routine physical investigation (urea and electrolytes, full blood count, liver

function tests, thyroid function tests, therapeutic drug monitoring of mood stabiliser serum concentrations).

Finally, other investigations will be carried out if needed. For example, these may include a brain scan, cognitive/dementia screen, and an Electroencephalography (EEG).

Once this comprehensive assessment is carried out, a treatment plan is developed with the person to tailor the treatment of bipolar disorder to his or her individual needs.

Acute Treatment of Manic Episodes

Medications are the main way of managing an acute manic episode. The aim of the medications is to stabilise your mood.

There are two components to the drug management of acute mania. The first is the commencement of a mood stabiliser (lithium, sodium valproate, carbamazepine or olanzapine). Mood stabilisers act upon the elevated mood but take about one week to start working for most people.

The second component is the concurrent use of an anti-psychotic or benzodiazepine (or a combination of these). These medications calm or sedate the person with mania as a temporary procedure, until the mood stabiliser starts to help the person to feel better.

The research evidence that has evaluated the effectiveness of lithium when compared to placebo (a sugar pill used in experiments) is strong. Studies show that carbamazepine and valproate are of similar value to lithium, although there have been few trials, particularly for carbamazepine.



Olanzapine has also been studied and has been demonstrated in controlled trials to be more effective than placebo. It is possibly more effective than valproate.

For lithium and sodium valproate, therapeutic blood concentration levels for acute mania are reasonably well established. For carbamazepine however, the plasma therapeutic range used is that applied for epilepsy (some people with epilepsy also take this medication). However, dosage is mainly determined by the assessment of your individual response than the medication.

Figure 2: Initial Clinical Assessment Hypomanic / Manic Episode

INITIAL SCREENING ASSESSMENT

- Severity of symptoms
- Level of functional impairment
- Degree of Insight
- Presence/absence of psychosis
- Risk to self (financial, sexual, reputation) or others (violence)
- Amount/quality of family/whanau support and/or community services

INITIAL SCREENING ASSESSMENT

- Severity of symptoms
- Level of functional impairment
- Degree of insight
- Presence/absence of psychosis
- Risk to self (financial, sexual, reputation) or others (violence)
- Amount/quality of family/whanau support and/or community services

Voluntary hospitalisation

Involuntary hospitalisation

Outpatient

Inpatient

It is important to discuss with your mental health professional/s the risks you face if you do not get treatment for bipolar disorder.

Timely treatment of mania can reduce disruption to your career, the likelihood of relationship problems, or risky financial mistakes being made during episodes of mania.

Treatment may also help to prevent self-harm and suicidal thinking as a result of mania or depression.

Figure 3: Treatment of a Manic Episode

MOOD STABILISER

LITHIUM

Commence with 750 – 1000 mg daily. Determine serum level after 5 to 7 days of steady-dose treatment [Aim for serum concentration of 0.8 – 1.2 mmol/L]

OR

VALPROATE

Commence with 400 – 800 mg daily. Determine serum level after 5 days of steady-dose treatment, OR

Use loading dose strategy commencing at 20 – 30 mg/kg [Aim for serum concentration of 300 – 800 µmol/L]

OR

CARBAMAZEPINE

Commence with 200 – 400 mg daily. Determine serum levels after 5 to 7 days of treatment. [Aim for serum concentration of 17 – 50 µmol/L].

OR

OLANZAPINE

5 – 20 mg daily

WITH OR WITHOUT

ADDITIONAL TREATMENTS FOR OTHER SYMPTOMS

AIMS

- Contain aggressive/overactive/disturbed behaviour
- Treat psychosis
- Manage sleeping difficulties

OPTIONS

i) Taken orally

- Benzodiazepines (diazepam, clonazepam, lorazepam)
- Anti-psychotics (risperidone, olanzapine, chlorpromazine, thioridazine, haloperidol)

ii) Taken by injection (only use if oral administration is not possible, or is ineffective)

- Benzodiazepines (lorazepam IM, Clonazepam IV)
- Anti-psychotics (Olanzapine IM, haloperidol IM, zuclopenthixol IM)
- Cease adjunctive treatments prior to discharge.

How are Mixed Episodes of Bipolar Disorder Managed?

The best evidence for the treatment of mixed states of bipolar disorder is for valproate. However, this finding is based on only one study of valproate and lithium in mania.

The evidence for carbamazepine is weak and, although there are no specific studies of lithium in mixed episodes, some GPs recommend its use if anti-convulsants have not worked.

Olanzapine, an anti-psychotic medication, has been shown to be effective in studies that included people with both mania and mixed episodes.

Figure 4: Medication Options for the Treatment of a Mixed Episode

Accordingly, the treatment of mixed episodes involves the choice of any of these medications:

- Valproate
- Carbamazepine
- Lithium
- Olanzapine

What if the Manic Episode Does Not Respond to First Line Treatment?

The timing of the decision to change treatment will depend on both clinical urgency and the degree of response, which varies from person to person. There are several options when a person does not respond to the initial medication chosen:

- Increase the dose and/or blood levels of the mood stabiliser
- Switch mood stabilisers
- Combine mood stabilisers
- Add an additional anti-psychotic such as risperidone, olanzapine or haloperidol.

If you and your doctor have tried these strategies, and you still have no relief from symptoms, Electroconvulsive Therapy (ECT) may be considered.

What is Electroconvulsive Therapy?

ECT is administered on an inpatient or day treatment basis by psychiatrists especially trained to administer it. It is a physical treatment and is only able to be conducted after ensuring no physical complications could arise from its use in a particular patient's case. It has a variety of uses in the treatment of bipolar disorder and is discussed again on page 25 in relation to depression.

It involves the use of electricity to stimulate the brain. It is a safe and painless procedure and can be life-saving for severe depression. It is now administered to very specific target areas of the brain so that side effects (such as short-term memory loss) are limited and/or of very short duration.

You will be asked to sign a specific consent form for this procedure to be carried out.

Figure 5: Failure of Manic Episode to Respond to Treatment

Optimize mood stabiliser (dose/blood levels)

OR

Switch/substitute mood stabiliser

OR

Combine mood stabilisers

OR

Augment mood stabiliser with olanzapine,
risperidone or haloperidol

Continuing failure to respond

1. Re-evaluate diagnosis – consider alternate causes (other psychoses; organic disorders)
2. Electroconvulsive therapy

What About Continuation Treatment?

Following remission of an initial episode of mania, the mood stabiliser should be continued for at least six months. This is because experience with most patients shows that this is the best way to prevent another episode.

The benzodiazepine or anti-psychotic should be withdrawn once the acute episode has resolved and just the mood stabiliser should be continued.

For those people with a well-established history of bipolar disorder, there are several recommended criteria for deciding if the person is likely to benefit from ongoing medication

treatment. Most of these guidelines are based on medical consensus opinions and clinical wisdom, taking into account how often illness happens, its severity and the level of disability that it causes.

Figure 6: Criteria for Continuation and Maintenance Treatment

FIRST MANIC EPISODE

- Continue treatment for at least six months.

MANIC EPISODE IN ESTABLISHED BIPOLAR ILLNESS

Various criteria for long-term treatment:

- Grof and Angst: At least two episodes of mania or depression (including current episode) in two years
- NIMH Consensus development panel guidelines: Single manic episode or both hypomanic and depressed episode. Also consider past suicide attempts, psychotic episodes and functional disability associated with episodes
- Goodwin and Jamison: Two major episodes of mania and/or depression, irrespective of frequency.

TREATMENT OF BIPOLAR DEPRESSION

Assessment of Bipolar Depression

The treatment for bipolar depression is sometimes different to how people with depression, but without bipolar disorder, are treated for depressive symptoms. This chapter discusses assessment and management of these episodes in relation to bipolar disorder depression. In established bipolar disorder, depression arises:

- In the absence of ongoing medication – a new depression
- During ongoing treatment – called ‘breakthrough depression’.

As shown in Figures 7 and 8 (see pages 21 and 22), a full psychiatric history, mental state and physical examination should be conducted to:

- Confirm diagnosis
- Exclude underlying complications (such as the presence of any other illness)
- Identify physical complications
- Assess any risk of self-harm.

The reason for the latter is that people with bipolar disorder have much higher rates of self-harm and suicide than the general population. This is usually due to depression, sometimes due to impulsivity, and at other times can result from accidents during periods of manic behaviour. Stopping medications too soon is a common cause of depressive



relapse, so the assessment will involve a full medication history and review.

New Depressive Episode

The first step in managing a new depressive episode is for appropriate anti-depressant treatment to be started. There are two options that work for most people: using a mood stabiliser alone or mood stabiliser and anti-depressant combined.

Mood stabiliser alone

Lithium is recommended as the first-line treatment unless it has been unsuccessful in the past or is poorly tolerated. If it has not worked before, lamotrigine (an anti-epileptic drug) or valproate should be tried. The administration of a mood stabiliser minimises the risk of switching (from depression into mania). For patients who are not psychotic, suicidal or hospitalised, this may be sufficient.

However, the anti-depressant effect of mood stabilisers can take several weeks to work. Where there is a risk of self-harm, simultaneous anti-depressant use is advisable.

Mood stabiliser treatment should be tailored to each individual to ensure that it is working effectively. Side effects must be reported to your GP so that they are minimised.

Mood stabiliser medication is tailored to each individual by monitoring blood levels to ensure that the dosage of medication is adequate. Lithium is the preferred choice because it has been shown by research to be very effective. However, it has a slow onset of action and it is not as effective as anti-depressant medications.

Valproate should be considered in rapid cycling bipolar disorder.

Figure 7: Initial Clinical Assessment Bipolar Depressive Episode

INITIAL SCREENING ASSESSMENT

- Severity of symptoms
- Level of functional and cognitive impairment
- Presence/absence of psychosis
- Risk to self (suicide)
- Extent of family/whanau support and/or community services

TREATMENT CONSIDERATIONS

- Legal aspects (eg, informed consent, mental capacity)
- Care in least restrictive environment ensuring safety (risk of self-harm)

Voluntary hospitalisation

Involuntary hospitalisation

Outpatient care

Inpatient care

Mood stabiliser and anti-depressant combined

The concurrent use of a mood stabiliser and anti-depressant may enhance and accelerate anti-depressant effectiveness and reduce the likelihood of switching moods.

Figure 8: Comprehensive Clinical Assessment Bipolar Depressive Episode

COMPREHENSIVE CLINICAL ASSESSMENT

Clinical assessment requires patient cooperation and may not be possible if the patient is severely slowed physically and mentally.

It is essential to obtain corroborative information especially in cases where cognitive impairment is suspected:

- Suicide risk assessment
- Exclude organic causes (neurological disorder, systemic disease, substance misuse, drug induced)
- Sophisticated appraisal of possible psychotic symptoms – especially pathological/delusional guilt and hallucinations
- Check compliance with mood stabilisers
- Conduct routine haematological and biochemical investigations (urea and electrolytes, full blood count, thyroid function tests, therapeutic drug monitoring)
- Additional investigations if indicated (eg, brain scan, cognitive/ dementia screen).

Breakthrough Depression on a Single Mood Stabilizer

First, the dose and/or blood levels of the mood stabiliser should be optimised. If this is unsuccessful the addition of an anti-depressant, or a second mood stabiliser should be considered.

Add an anti-depressant

Anti-depressant therapy on its own may induce mania or rapid cycling, and should therefore be avoided.

Monoamine Oxidase Inhibitors (MAOIs) are suited to people with bipolar depression who lack energy or activity, but like Tricyclic Anti-depressants (TCAs), they can induce mood instability. Therefore, Selective Serotonin Reuptake Inhibitors (SSRIs) and venlafaxine form the first-line choice of treatment.

MAOIs and TCAs should be considered the second-line treatment choice.

Newer anti-depressants (mirtazapine, nefazodone or reboxetine) have not been adequately researched for the treatment of bipolar disorder.

Upon remission or recovery of the episode, anti-depressants should be tapered so as to minimise the risk of switching moods while the mood stabiliser is continued.

Add second mood stabiliser

Adding a second mood stabiliser is as effective as adding an anti-depressant, but can have significant side effects in some people.

Lithium, valproate and carbamazepine combinations are used routinely but convincing research is only available to suggest that the combining of lithium and carbamazepine is the better option.

Therefore, overall, the addition of an anti-depressant is the preferred choice but a second mood stabiliser can be tried, especially if combination therapy is likely to continue long-term.

Choice of Anti-depressant

The SSRIs are the anti-depressants of choice in the treatment of bipolar depression because research shows they are superior and they seldom cause mood switching. Venlafaxine is a suitable alternative.

The MAOIs and TCAs are of limited use in the long-term because of associated side-effects and the increased risk of switching moods. Nevertheless, your psychiatrist may prescribe MAOIs especially if you have low energy, or if you have melancholic or atypical depressive features such as increased sleep or appetite.

- SSRIs
- MAOIs
- TCAs
- Venlafaxine.

Choice of Mood Stabiliser

The choice of mood stabiliser is made between you and your GP depending upon your preferences and clinical indication:

- Lithium
- Olanzapine/fluoxetine combination.

However, the research evidence clearly shows that lithium is superior.

Failure of Depressive Episode to Respond to Treatment

Figure 10 on page 27 shows the treatment approach if the depressive episode does not respond to initial treatment.

First, it is important to be sure that your individual treatment is at the right dosage and that it is being taken as prescribed. If there is still no improvement, either or both mood stabilisers and anti-depressants can be tried instead or yet another mood stabiliser added. By this stage, lithium should have been tried.

Any number of mood stabiliser combinations can be attempted in conjunction with anti-depressants. However, if despite all reasonable efforts the patient remains depressed or only partially responds, it is important to re-evaluate the diagnosis and review therapy. Organic causes need to be ruled out. Furthermore, the impact of any additional medical or psychiatric conditions should be thoroughly re-assessed.

Continuation Treatment

Most experts agree that electroconvulsive therapy is the most effective anti-depressant therapy for bipolar depression. It should therefore be used when indicated and especially if it has been previously effective or there are psychotic symptoms.

Finally, consideration needs to be given to psychosocial factors, such as how much support the person has, and whether or not their living circumstances are such that recovery will be promoted.

Following remission of the depressive episode it is appropriate to withdraw anti-depressant treatment after two to three months to avoid causing mania and/or rapid cycling. However, in every individual, it is necessary to balance the need to treat bipolar depression versus the risk of precipitating mania. It is usual to withdraw anti-depressant treatment after two to three months to avoid precipitating mania / rapid cycling. If the person has recurrent depressive episodes, the anti-depressant can be continued if administered with a mood stabiliser.

Figure 9: Pharmacological Intervention – Depressive Episode

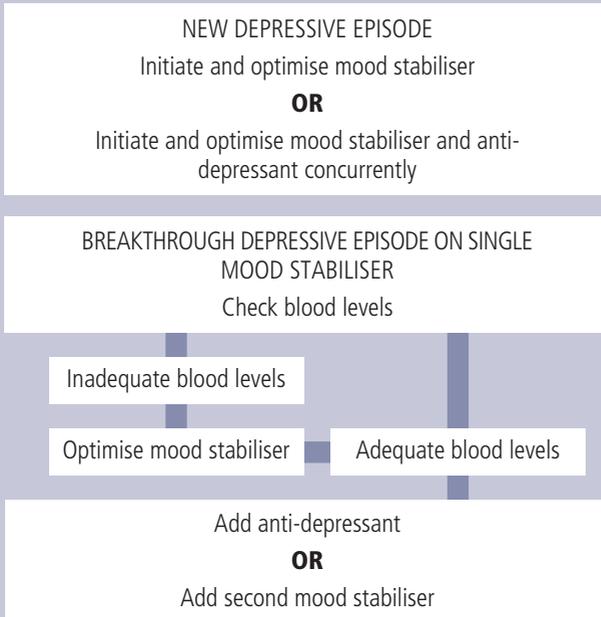
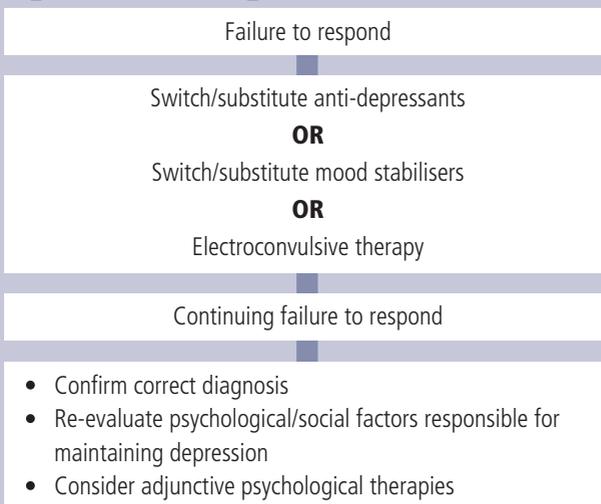


Figure 10: Failure of Depressive Episode to Respond to Treatment



BARRIERS TO TAKING MEDICATION

Doubt about the diagnosis and willingness to risk another episode to confirm it.

Possible side effects

Possible enjoyment of the experience of mania and a wish to experience it again.

Not realising that mania and depression may involve negative consequences for them or for others.

Concerns over pregnancy or interactions with medications used for other health problems.

All medications cause side effects. These cause many people to stop taking medications. It is important to discuss all side effects you experience with your GP.

PREVENTION OF FURTHER EPISODES

Everyone with bipolar disorder has different patterns of illness. Because the illness is episodic, it can be very hard at times to tell when you are well, or to distinguish between symptoms and the normal emotional experiences of daily life. It can be hard to judge when to stop or when to continue treatment.

If you stop taking medication (thinking you are well) and you relapse, it does not mean that your attempts to stay well are a complete failure. It is possible that this experience will help you in future to better recognise the warning signs and to respond by initiating treatment again. This booklet provides some strategies for minimising the possibility of a full relapse and aims to help you monitor your treatment outcomes and to prevent new episodes.

Attitude to Medication and Coping with Side Effects

Non-acceptance of medication can lead to relapse of mania or depression, which can result in severe social, financial and relationship loss.

Adverse side effects are not the only cause of nonacceptance of medication. The lack of feelings of general health and well being, successful social interaction and intellectual activity are important considerations. People who manage to live well with bipolar disorder tend to agree that even when treatment is seemingly effective, all other life issues must be taken into account.

Weight gain is often a significant problem for people taking medication for bipolar disorder. This is especially so for lithium, sodium valproate or anti-psychotics. Diet and exercise help lift depression and managing weight gain.

Not taking medication properly is the most common cause of relapse. A good mental health professional will discuss with you how you manage your medication and your attitude and response to it, to try to prevent the possibility of relapsing.

These approaches may include:

- Providing you with education about the recurrent and disabling nature of this condition and potential side effects of medications
- Addressing the fear people with bipolar disorder often have about the potential sudden loss of control of their behaviour and the embarrassing consequences (it is sometimes only after several episodes that many individuals come to accept the diagnosis and need for ongoing medication or treatment)
- Helping you to locate support groups – these operate in most parts of New Zealand and Australia provide written material about living with a mood disorder (see Appendix 4).

Continuity of Care

An under-acknowledged issue in the long-term management of bipolar disorder is that of continuity of care. Ongoing contact with the same mental health professional increases the likelihood of early identification of recurrences, and facilitates awareness of the impact of the illness. Unfortunately, mental health professionals change often.

Research suggests that the best outcomes are achieved if you consult with the same mental health professionals who know you well and know the pattern of your illness episodes.

How do I Tell if I Need Long-term Treatment?

Long-term treatment is often called the 'maintenance' phase of treatment or 'relapse prevention'. The goal of long-term treatment for bipolar disorder is to maintain stable mood and to prevent a relapse of mania or a depressive episode. Your GP or mental health professional will discuss with you your pattern of illness and will suggest what maintenance therapy is best for you.

Non rapid cycling

There is strong evidence from clinical trials of the long-term effectiveness of lithium for bipolar disorder. While there have been studies indicating that carbamazepine works to about the same extent as lithium, there have been no long-term studies of either carbamazepine or valproate confirming their superiority over placebo.

For individuals on lithium, kidney function, serum creatinine and electrolytes should be monitored every three to six months. Thyroid function (including Thyroid-Stimulating Hormone (TSH)) should be monitored every six to twelve months, in addition to clinical assessment.

Abrupt stopping of lithium leads to relapse of mania (or, less likely, depression) in many people with bipolar disorder within the next few months. Therefore, if lithium is to be stopped, this should be undertaken slowly over at least one to two months.

For carbamazepine and valproate, haematological and hepatic function should be monitored at least each three to six months after treatment has begun.

Rapid cycling

There is no convincing evidence from randomized controlled trials that any of the mood stabilizers are robustly effective in the treatment of rapid-cycling bipolar disorder.

Valproate has been reported to be effective in some studies but this finding is yet to be confirmed by further research.

Failure to Prevent Recurrences of Bipolar Disorder

Lamotrigine was found to have mood stabilising properties in one rigorous study of a mixed group of people who had unipolar and rapid-cycling forms of bipolar disorder. However, no breakdown of therapeutic response by diagnostic subgroup was provided. There have been no specific studies of lithium in this population.

Failure to Prevent Recurrences of Bipolar Disorder

Non-rapid cycling

There is some evidence that adding a second mood stabiliser (particularly using the combination of lithium and valproate) enhances long-term mood stability.

Rapid cycling

First, potential causes of rapid-cycling bipolar disorder should be excluded and managed. These may include substance misuse, anti-depressant medications, and possible physical conditions such as hypothyroidism.

Figure II: Medications for Long-term Treatment of Bipolar Disorder

NON-RAPID CYCLING

LITHIUM

(Aim for serum concentration of 0.6 – 0.8 mmol/L)

OR

VALPROATE

(Usual dose range 1000 – 2500 mg; serum concentration 350 – 700 µmol/L)

OR

CARBAMAZEPINE

(Usual dose range 600 – 1200 mg; serum concentration 17 – 50 µmol/L)

RAPID CYCLING

VALPROATE

(Usual dose range 1000 – 2500 mg; serum concentration 350 – 700 µmol/L)

OR

LAMOTRIGINE

(Usual dose range 50 – 300 mg; serum concentration not useful)

OR

CARBAMAZEPINE

(Usual dose range 600 – 1200 mg; serum concentration 17 – 50 µmol/L)

OR

LITHIUM

(Aim for serum concentration of 0.6 – 0.8 mmol/L)

Figure 12: Failure to Prevent Non-rapid Cycling Recurrences of Bipolar Disorder

NON-RAPID CYCLING

- Exclude non-compliance
- Treat any co-morbid substance misuse
- Trial alternative mood stabiliser alone or in combination with current mood stabiliser (strongest evidence is for lithium+valproate)

RAPID CYCLING

- Exclude non-compliance
- Treat any comorbid substance misuse
- Exclude anti-depressant-induced affective instability
- Exclude subclinical hypothyroidism
- Trial alternative mood stabiliser alone or in combination with current mood stabiliser (strongest evidence is for lithium+valproate)

FURTHER TREATMENT CHOICES

So far we have reported the research evidence for the effectiveness of medications. There are further treatment choices, such as psychological and psychosocial approaches, which may also improve health outcomes. These may be used at all phases of illness along with medication. Here we discuss the role of these approaches in relation to medications, and other treatment issues.

What is the Role of Psychosocial Treatments?

Learning to live with a continuous illness that is episodic is a major issue for people with bipolar disorder and their families.

Repeated episodes of mania and depression tend to lead to increased rates of divorce, family/whanau breakdown, unemployment, a break in social networks and education, and financial difficulties. Therefore suffering can be reduced if other steps, over and above medication, are taken to manage the condition.

While in other psychiatric illnesses, there is often an 'either/or' choice between taking a medication OR using a psychological treatment, in bipolar disorder medication remains essential rather than optional. The psychological treatments here are called, 'adjunctive', which means that they can be used in addition to medications.

Psychological Treatments

People with bipolar disorder often express embarrassment because of the inappropriate behaviour, or sexual indiscretions, which might have happened when they were manic. Education about the illness and cognitive therapy can help to deal with the psychological and social stresses that the illness can cause.

These strategies therefore play an important role in any treatment plan. Cognitive therapy appears to assist people with bipolar disorder to understand the disorder and improve coping strategies, but might also improve self-esteem. The main psychological treatments that are used are:

- Psycho-education (education about the illness provided in groups, individually, or with family/whanau)
- Cognitive Behaviour Therapy (CBT)
- Interpersonal and Social Rhythm Therapy (IPSRT).

Coping Strategies

Consumers tend to agree that there are several strategies that you can try to improve how you cope with the illness. These are:

- Being educated about how to identify the early signs and symptoms of either mania or depression
- Encouraging family/whanau and friends to also be able to identify such early signs
- Staying in treatment and being aware of anything that risks you not taking your medication



The role of psychological treatments is to help you cope with the experience of bipolar disorder and its treatments. Better outcomes can be achieved with these additional therapies.

- Remembering to focus upon the achievement of your goals, rather than letting the illness take over your life
- Keeping a mood diary to help you to keep track of your treatment progress and any side effects of any medications you are taking
- Keeping support around you from family/whanau and friends.

However, support from family/whanau and friends, does not always shield you from the effects of life stresses. Increased levels of support may be necessary when people are required to cope with the death of family/whanau or close friends, loss or interruption to careers, or psychological and social distress of other kinds.

Complementary (Non Prescribed) Medications

Herbal remedies and other natural supplements have not been well studied and their effects on bipolar disorder are not fully understood.

Omega-3 fatty acids (found in fish oil) are being studied to determine their usefulness for long-term treatment of bipolar disorder.

St John's Wort (*hypericum perforatum*) is being studied in regard to depression, but there is some evidence that it can reduce the effectiveness of some medications, can react with some prescribed anti-depressants, or may cause a switch into mania.

Pregnancy and Breastfeeding

The period following childbirth for all women is an extremely emotional period but for women with bipolar disorder the risk of mania, depression or psychosis is particularly high. About 30% of women with pre-existing bipolar disorder will experience a manic or depressive episode following childbirth.

During pregnancy and breastfeeding the goal of treatment is to use the minimum effective dosage of medications and to limit the total number of medications while sustaining the mother's mental health.

Ensuring adequate social, emotional and psychological support is also important.

Support Groups

While types of support groups vary widely, here we discuss groups run by people who themselves have experienced bipolar disorder and its treatments.

There is now a growing awareness of the benefits of support groups for people with a bipolar disorder. They have been found to influence positively: the person's recognition of a need for practical and experiential information about the illness; the awareness of need for medications; and they have been found to assist with the interpersonal difficulties associated with this condition.

A large survey of people with bipolar disorder by the United States National Depressive and Manic-Depressive Association found that 95% stated that their participation in support

HOW TO IMPROVE CARE QUALITY

- Participate in active ways in your treatment planning.
- Discuss concerns about care quality with your GP.
- Raise suggestions for improvement with management or with a consumer consultant in the service.
- Participate in policy, advocacy and planning of mental health services through nongovernment agencies.

For major complaints, each jurisdiction has a confidential health care complaints tribunal through which complaints can be discussed and mediated.



groups had helped them in communicating with their GP, being motivated to follow medical instructions, being willing to take medication, making the treatment plan less complex, and/or making follow-up visits to their GP or health professional.

Such groups may also help people to cope with hospitalisation, understanding mental health legislation and finding other important mental health information. Some provide support over the telephone and professional referral services.

Some groups also enable partners, relatives and friends to attend groups with the person experiencing bipolar disorder. Separate groups for partners, relatives and friends are also available in New Zealand and Australia (see Appendix 4).

Standards of Care – What Should I Expect?

People with any kind of mental illness should expect to be treated with courtesy and compassion by health professionals. There are published National Standards for Mental Health Services available in both New Zealand and Australia which are a guide to what to expect from services.

Currently, all public mental health services are aiming to achieve these standards over time. There are some key ideas to keep in mind:

- Evidence-based treatments have the best chance of working if delivered by skilled staff who have up-to-date training
- You have a right to quality care and you also have a responsibility to work with your health professionals to get the best care outcomes

- There are complaints processes in mental health services which you can use if you are unhappy about the quality of your mental health care.

Conclusion

This guide has covered what the latest research and expert and consumer opinion tells us about living with bipolar disorder and its treatments according to each phase of illness.

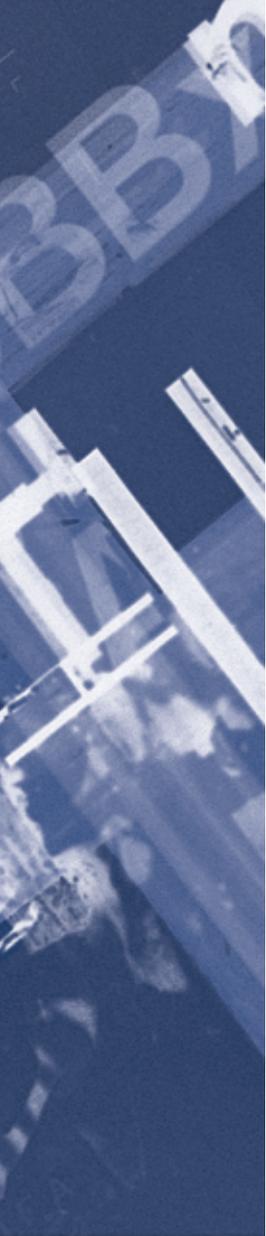
People who manage their bipolar disorder well provide assurance and hope that living with it and achieving a good lifestyle is now possible.

The wider community is now more aware and understanding of bipolar disorder, there is support and there are highly effective treatments now available.

While there remains no cure, there is no reason to think that treatments will not improve even further in the future. This guide has also discussed where research is limited or remains uncertain. Future research will aim to reduce the side effects of existing treatments and to develop better ones.



With treatment, it is possible to lead a good quality of life if you have bipolar disorder.





Appendices

APPENDIX I

Can You Explain that Term?

Some of the words or expressions that describe symptoms or treatment processes may require further explanation. The symptoms of mania and depression are particularly hard to describe and they have been further explained here so that you may see if they relate to you, or, if you are a carer, to the person you are concerned about. We also explain the different mental health professionals and their roles.

Deliberate self-harm – an act intended to cause injury or self-poisoning, to relieve distress, and sometimes to cause death. It can be used to try to cope with a mental illness or stress of some kind but is considered maladaptive coping. Two RANZCP guidelines exist for consumers who have self-harmed: *Coping without self-harm – Treatment guide for young people* and *Coping without self-harm – Treatment guide for consumers and carers*.

Depression – A mood disorder ranging from passing sad moods to a serious disabling illness requiring medical and psychological treatment. Major depression is a ‘whole body’ disorder impacting on emotions (feelings of guilt and hopelessness or loss of pleasure in once enjoyed activities), thinking (persistent thoughts of death or suicide, difficulty concentrating or making decisions), behaviour (changes in sleep patterns, appetite, or weight), and even physical well being (persistent symptoms such as headaches or digestive disorders that do not respond to treatment).

Flight of ideas – this refers to the experience of ideas entering the mind at a very rapid pace. The thoughts may be positive or negative, but their pace is such that few make much sense or can be reasonably acted upon.

Hypomania – periods of pathologically elevated mood without delusions. This is quite different to normal enthusiasm.

Inflated self esteem or 'grandiose ideas' – during mania, a person may experience or think of him or her self as being more capable, energetic and competent in activities than they do normally, or competent or superior in areas which they consider themselves not to be particularly skilled at when they are well. Others would not see them as being this capable in a particular area, so the inflated self-esteem is out of proportion to reality and is potentially socially embarrassing.

Mania – periods of pathologically elevated mood with transient psychotic periods.

Pressure of speech or to keep talking – this refers to a compulsion where the person may, or may not be aware they are talking too much, but feels unable to slow or stop speaking, even though it is not socially appropriate to be so outspoken.

Psychosis – This is a loss of touch with reality, characterized by delusions (fixed false beliefs) and/or hallucinations (a false or distorted perception) of objects or events, including sensations of sight, sound, taste, touch and smell, typically with a powerful sense of their reality. Psychosis can be experienced as part of mania or as part of psychotic depression and is treatable with anti-psychotic medications.

Psychotherapy/Psychological intervention – A form of treatment for mental disorders based primarily on verbal communication between the patient and a mental health professional, often combined with prescribed medications. Psychotherapy can be conducted in individual sessions or in a group.

Symptom – A feeling or specific sign of discomfort or indication of illness.

What do these Acronyms Stand for?

| | |
|--------------|---|
| CBT | Cognitive Behavioural Therapy |
| DSM | Diagnostic and Statistical Manual |
| ECT | Electroconvulsive Therapy |
| EEG | Electroencephalography |
| GP | General Practitioner |
| IPSRT | Interpersonal and Social Rhythm Therapy |
| MAOI | Monoamine Oxidase Inhibitor |
| SSRI | Selective Serotonin Reuptake Inhibitor |
| TCA | Tricyclic Anti-depressant |
| TSH | Thyroid-Simulating Hormone |

APPENDIX 2

Who are the Members of Mental Health Care Teams?

Services provided to people with bipolar disorder and their families, if delivered through the public health system may include a range of professionals at different stages of community or hospital-based treatment. The psychiatrist or a 'case manager' usually co-ordinates care provided to you by this team. Consumer consultants may also be employed to provide support and advocacy.

Crisis team member – Mental health professionals from a wide range of professions, who work in teams to provide assistance, during periods of high stress including after hours (sometimes called Crisis Assessment Team).

Case manager – The health care provider whom you see the most for your mental health care in the public mental health system. They co-ordinate all your care with other members of the team. They can be medical doctors, or allied health specialists such as psychologists, social workers, occupational therapists or trained mental health nurses.

GP – General practitioner / Local doctor/ Family doctor – Registered medical practitioners who have a general training in all areas of medicine, including psychiatry, but manage your general health care.

Psychiatric nurse – A person especially trained to provide promotion, maintenance, and restoration of mental health, including crisis and case management. Nurses can administer medications but cannot prescribe them, whereas other allied health professionals can neither prescribe nor administer medications.

Occupational therapist (OT) – A person trained to provide therapy through creative or functional activities that promote recovery and rehabilitation.

Pharmacist – A person licensed to sell or dispense prescription drugs.

Psychiatrist – A medical doctor who specialised in psychiatry. Psychiatry is a branch of medicine that deals with the study, treatment and prevention of mental illness and the promotion of mental health. A registrar is a trainee psychiatrist.

Psychologist – A person usually trained at a post-graduate level who works to apply psychological principles to the assessment, diagnosis, prevention, reduction, and rehabilitation of mental distress, disability, dysfunctional behaviour, and to improve mental and physical well-being.

Social worker – A person with specialised training in individual and community work, group therapies, family/whanau and case work, advocacy and the social consequences of disadvantage and disability, including mental disorders. They can provide psychosocial treatments for mental disorders and assist with welfare needs such as finance, legal matters or accommodation.

APPENDIX 3

Websites Containing Information about Bipolar Disorder

| | |
|--|--|
| BALANCE - NZ Bipolar Network | www.balance.org.nz |
| Mental Health Foundation of New Zealand | www.mentalhealth.org.nz |
| SPINZ – Suicide Prevention in New Zealand | www.spinz.org.nz |
| Mental Health Insight | www.mentalhealthinsight.org.nz |
| The Bipolar Manic Depression Society | www.bipolar.org.nz |
| Mood Disorders Association (SA) Inc | www.moodsa.info |
| Depression and Mood Disorders Association, Mental Health Association of NSW Inc | www.dmda.mentalhealth.asn.au |
| DepressioNet | www.depressionet.com.au |
| Sane Australia | www.sane.org |
| Australian National Resource Centre for Consumer Participation in Health | www.participateinhealth.org.au |
| Mental Health Council of Australia | www.mhca.com.au |
| Mental Health Co-ordinating Council | www.mhcc.org.au |
| Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing | www.health.gov.au |
| PubMed (search here for latest medical research) | www.ncbi.nlm.nih.gov |
| Mood Disorders Support Group of New York City | www.mdsg.org |
| US National Mental Health Information Centre | www.mentalhealth.org |
| Depression After Delivery Inc | www.depressionafterdelivery.com |
| Child and Adolescent Bipolar Foundation | www.bpkids.org |
| Depression and Bipolar Support Alliance | www.dbsalliance.org |

APPENDIX 4

Where Can I Find More Information and Support in New Zealand?

For further information on this guideline and other Clinical Practice Guidelines see www.ranzcp.org

Many of these organisations are community-managed non-profit associations. They provide mutual support, information, and referral services for clinical, housing, rehabilitation, employment, legal or advocacy services. They may also assist partners, relatives and friends of people with bipolar disorder over the telephone, or in mutual support groups.

New Zealand

SPINZ – Suicide Prevention in New Zealand

PO Box 10 318, Dominion Rd, Auckland

Phone: 09 300 7035

Fax: 09 300 7020

Email: info@spinz.org.nz

Website: www.spinz.org.nz

BALANCE - NZ Bipolar Network

PO Box 13266, Christchurch

Phone: 03 366 3631

Email: bipolar@balance.org.nz

Website: www.balance.org.nz

Manic Depressive Support Group

Wellington Adult Mental Health Service

Phone: 04 385 5802

The Bipolar Manic Depression Society

PO Box 25 068, Christchurch

Phone: 03 366 5815

Email: bipolarmd@xtra.co.nz

Website: www.bipolar.org.nz

Information and Support in Australia

Also look in the front pages of your telephone book for a mental health information and referral service in your state or territory and for clinical mental health services in your area.

Your GP may also know the local mental health service nearest to you.

Lifeline Australia conducts a referral service for rural Australia combining the databases of Mental Health Associations, Lifeline Centres, Kids Help Lines and Mental Health Branches of State and Territory Health Departments.

Lifeline Australia

Phone: +61 13 11 14

Just Ask Mental Health Information & Referral Service

Phone: +61 1300 1311 14

Depression and Mood Disorder Association of NSW

Phone: +61 2 9816 5688

Freecall: 1800 674200 (only in Australia)

Mental Health Association (QLD) Inc

Phone: +61 7 3271 5544

Email: association@mentalhealth.org.au

Website: www.mentalhealth.org.au

NEW ZEALAND

Also contact Platform, the peak non-government organisation in New Zealand for mental health policy, advocacy and referral to non-government housing, rehabilitation and support services or the Mental Health Foundation of New Zealand. These are listed in the front pages of your phone book.

Clinical mental health services are provided by the Ministry for Health and are listed in the front pages of the phone book.

Tasmanian Association for Mental Health

Phone: +61 3 6233 4049

Western Australian Association for Mental Health

Phone: +61 8 9420 7277

Email: *waamh@waamh.org.au*

Website: *www.waamh.org.au*

SANE Australia

Phone: +61 3 9682 5944

Email: *sane@sane.org*

Website: *www.sane.org*

**Associations for the Relatives and
Friends of the Mentally Ill (ARAFMI)**

ARAFMI New South Wales

Phone: +61 2 9887 5897

Helpline: +61 2 9805 1883

Email: *arafmi@webtime.com.au*

Website: *www.arafmi.org.au*

ARAFMI Queensland

Phone: +61 7 3254 1881

Email: *arafini@irvnet.org.au*

ARAFMI Western Australia

Phone: +61 8 9228 0577

ARAFMI South Australia

Phone: +61 8 8221 5166

ARAFMI Tasmania

Phone: +61 3 6326 9251

ARAFMI Northern Territory

Phone: +61 8 8942 2811

ARAFEMI (VIC) Inc

Phone: +61 3 9889 3733

Email: *admin@arafemi.org.au*

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