

Bipolar disorder

August 2009

Australian treatment guide
for consumers and carers



The Royal
Australian &
New Zealand
College of
Psychiatrists

© The Royal Australian and New Zealand College of Psychiatrists,
2009

Compiled by The Royal Australian and New Zealand College of Psychiatrists (RANZCP), this information and advice is based on current medical knowledge and practice as at the date of publication. It is intended as a general guide only, and not as a substitute for individual medical advice. The RANZCP and its employees accept no responsibility for any consequences arising from relying upon the information contained in this publication.

The Royal Australian and New Zealand College of Psychiatrists
309 La Trobe Street
Melbourne Victoria 3000
Australia
Telephone: (03) 9640 0646
Facsimile: (03) 9642 5652
Email: ranzcp@ranzcp.org

www.ranzcp.org



The Royal
Australian &
New Zealand
College of
Psychiatrists

Contents

Key points about bipolar disorder	3
Introduction	5
Treatment of mania and mixed episodes	10
Treatment of bipolar depression	19
Prevention of further episodes	25
Further treatment choices	30
Appendix 1: Mental health care teams	40
Appendix 2: Sources of information and support	42
Appendix 3: Terminology and acronyms	50
Appendix 4: Development of the guideline	53
Acknowledgements	56



Key points 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 impairment of function.
- 3 If you think you or someone you care about has bipolar disorder, check with your general practitioner. A referral to a psychiatrist or psychologist may be necessary.
- 4 Bipolar disorder is an illness for which there are effective treatments.
- 5 Those with bipolar disorder and their families can do positive things to reduce the impact of the illness, even though the illness can interfere with personal autonomy.
- 6 People with bipolar disorder can take control of their illness by working with a multidisciplinary team of doctors, psychologists and other health professionals, and utilising the support of family and friends.

Introduction

This guide was written by consumers, carers and mental health professionals to answer the most common questions consumers and carers 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 an updated 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.

The purpose of this guide is to provide consumers and carers with the information they need on the assessment, diagnosis and treatment of bipolar disorder. It is important that its recommendations are not taken as absolute. People with bipolar disorder and their carers 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 clinical treatment guidelines for consumers.

The guide covers the reasons why comprehensive assessment and diagnosis are so important. It then outlines treatments for the different phases of the illness:

- acute treatment of mania and mixed episodes
- acute treatment of depression
- prevention of further episodes of mania and depression.

Consumers, their partners, family, friends and other carers can locate further information about bipolar disorder and sources of support in Appendix 2.

What is bipolar disorder?

Bipolar disorder is a mood disorder. It is characterised by periods of mania or hypomania, depression and 'mixed episodes' (a mixture of manic and depressive symptoms). The illness is commonly subdivided into:

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

Most people with bipolar disorder experience multiple episodes at an average of one episode every 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.

Do I have bipolar disorder?

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

Bipolar I: occurrence over a lifetime of at least one manic episode

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

It is best to go to a general practitioner as early as possible if you have, or someone you know has, mood swings that concern you.

Recognising hypomania and mania (DSM-IV criteria)

Hypomania and mania are characterised by a distinct period of abnormally and persistently elevated, expansive or irritable mood.

Mania usually lasts at least one week and causes significant difficulties in carrying out normal roles such as job or family responsibilities.

Hypomania usually lasts at least four days and does not cause profound difficulties in job or family roles. During the period of mood disturbance, some of the following symptoms will be present to a significant degree:

- inflated self-esteem or sense of grandiosity, often of a spiritual nature
- decreased need for sleep (e.g. feels rested after only a few hours of sleep)
- more talkative than usual, or pressure to keep talking
- 'flight of ideas' or subjective experience that thoughts are racing
- distractibility (i.e. 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 (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

Recognising major depression (DSM-IV criteria)

People with major depression will experience some of the following symptoms for at least two weeks. These symptoms represent a change from previous functioning and at least one of the symptoms is either depressed mood or loss of interest or pleasure:

- depressed mood as indicated by either subjective reports (e.g. feels sad or empty) or observations made by others (e.g. 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 thoughts without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

Recognising mixed episodes (DSM-IV criteria)

People who have mixed episodes will experience symptoms of both mania and depression nearly every day for about one week.

Symptoms that may be concurrent with bipolar disorder

People with bipolar disorder often have symptoms of other mental health issues. These symptoms should be assessed as part of the comprehensive assessment and may need specific treatment, as they do not always get better even if the bipolar disorder is well controlled.

Alcohol and drug use is very common among people with bipolar disorder. They may consume alcohol or drugs to try to stop mood swings or to help cope with the impact of the mood swings on their work and family life. Sometimes it can be difficult to distinguish between alcohol-related problems and bipolar symptoms.

Anxiety disorders also commonly co-occur with bipolar disorder. These include Generalised Anxiety Disorder (characterised by excessive worry about the future), Social Anxiety Disorder (excessive concern about what others may think about you) and Panic Disorder (panic attacks).

During severe episodes of mania and depression, a person may have a psychotic experience such as hallucinations or delusions. Sometimes this can lead to an incorrect diagnosis of schizophrenia.

Treatment of mania and mixed episodes

Because there have been very few specific treatment studies on DSM-IV bipolar II disorder, our recommendations refer to bipolar disorder generally. Most studies have either described a group of people with bipolar I, or have not identified separate bipolar I and II subgroups. This guide discusses the initial clinical assessment, how bipolar disorder presents when people first experience it and the main treatment approaches including mood stabilising and anti-depressant medications.

How can I be sure that I have bipolar disorder?

In order to diagnose bipolar disorder, a health practitioner must undertake a detailed, comprehensive assessment. Referral to a psychiatric service is usually needed. However, some general practitioners have sufficient experience and expertise to assess, diagnose and treat bipolar disorder. Psychologists can also assist general practitioners in assessing and treating bipolar disorder.

During the assessment, you will typically be asked in detail about the type of symptoms, their severity and how they affect your work and relationships. You will typically also be asked about previous episodes of depression and mania/hypomania. With your permission, your family or carer will be asked for their perspective. In mania it is often others who notice the symptoms most, whilst the person experiencing the manic episode is usually unaware of the change in their behaviour. In contrast, a person with depression often tries to hide the symptoms – family and friends may not know the severity of the depression.

Often the diagnosis is not clear at the first assessment. Sometimes this is because a person's symptoms overlap with other psychiatric conditions they may have (e.g. psychosis, schizophrenia or anxiety). For others, alcohol and drug use may distort or hide the symptoms of depression and mania.

There is no scan or blood test that can diagnose bipolar disorder. However, a doctor will often request some investigations to rule out physical diseases. Also, it is essential to know if a woman with bipolar disorder is pregnant.

During the comprehensive assessment (and during other assessments) the doctor or other health professional should assess any risk. A person with depression may have thoughts or plans of suicide. Mania sometimes leads to out-of-character and high-risk behaviour such as sexual indiscretion, over-spending or other financial recklessness or uninhibited and inappropriate disruptive behaviour. This can damage a person's reputation and standing in the community.

The doctor or health professional will also typically assess the person's level of insight and judgement. Some people with mania do not realise how unwell they are and lack insight into their condition. They may temporarily lose the capacity to judge appropriate behaviour. Occasionally they may develop false beliefs such as 'I am the saviour of the world'. This is called psychosis and is one of the signs of mania. An assessment of risk and insight is necessary so that your safety and the safety of others can be assured and appropriate treatment given. Most people with bipolar disorder can have treatment without needing admission to hospital. If there are severe symptoms, major risk issues and limited insight, involuntary treatment may be necessary.

Initial management

The charts on page 14 and 15 show the approach mental health professionals usually take in the initial management of a person who presents 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 relevant health legislation may be needed. Going to hospital can protect the person and their family from the damage that may result from the impaired judgement associated with the illness. The decision to go to hospital may be traumatic for the person with bipolar disorder and their family.

Acute treatment of manic episodes

As insight can be affected by both depression and mania (more commonly in mania than depression), often the person affected does not see a need for treatment. This can mean disagreement over the need for admission to hospital. Poor insight and judgement also lead to poor compliance with taking medication, and some people resort to hiding their medication.

This is not a wilful or defiant act, but is part of the impact of having bipolar disorder. It can be a challenging time for family and carers, who can often see the benefits of medication. Sometimes it can take several episodes of illness before the person with bipolar disorder agrees to take medication.

Medications are the main way of managing an acute manic episode. The aim of the medications is to stabilise mood and stop all symptoms.

There are two components to managing acute mania with medication. First, a mood stabiliser is prescribed, such as lithium, sodium valproate, carbamazepine or one of the new second-generation anti-psychotics. Mood stabilisers act upon the elevated mood but take about one week to start to take effect for most people.

Second, an anti-psychotic or benzodiazepine (or a combination of these) is prescribed, to be taken as well as the mood stabiliser. 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.

Research shows that lithium is effective as a mood stabiliser when compared to placebo. Studies show that carbamazepine and valproate are of similar value to lithium, although there have been few trials, particularly for carbamazepine. Research also shows that the second-generation anti-psychotic medications are also more effective than placebo.

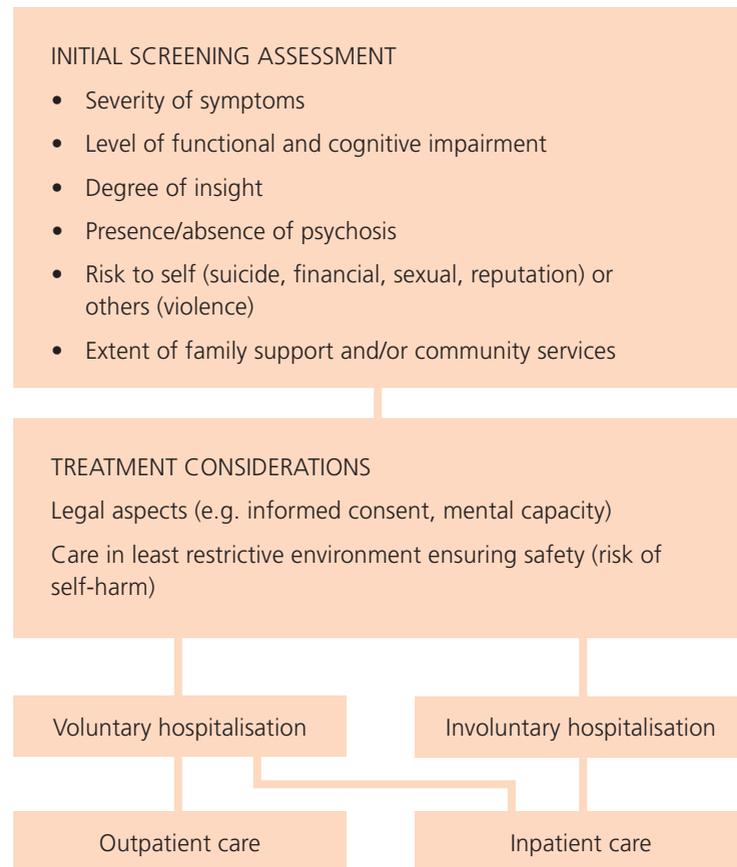
For lithium and sodium valproate, the therapeutic dosages for acute mania are reasonably well established. For carbamazepine, however, the dosage used is the same as the dosage for epilepsy (some people with epilepsy also take this medication). However, dosage is mainly determined by the assessment of your individual response to the medication.

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

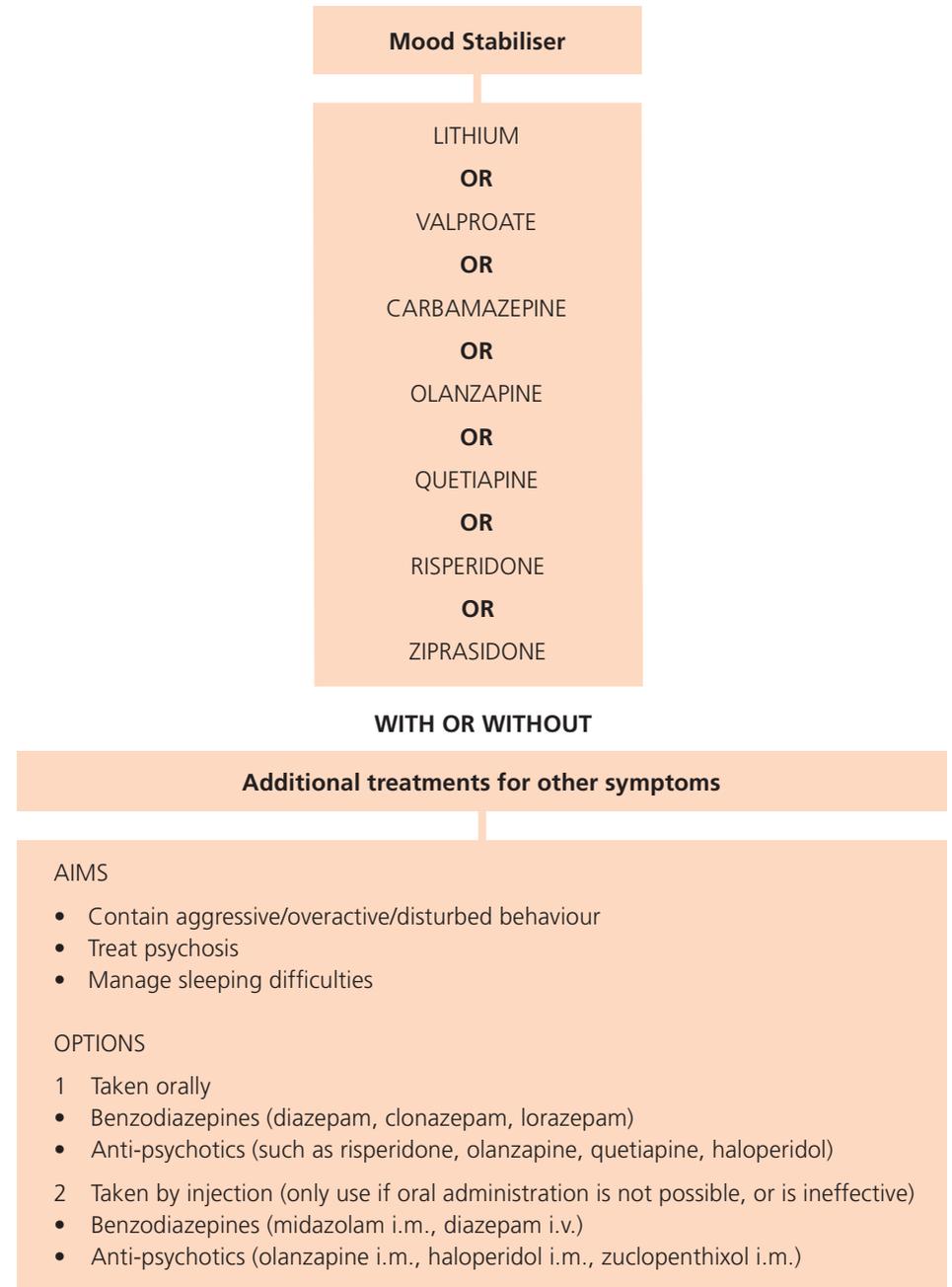
Timely treatment of mania can reduce disruption to your career, the likelihood of relationship problems, or risky financial mistakes being made during episodes of mania.

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

Initial clinical assessment hypomanic/manic episode



Treatment of a manic episode



How are mixed episodes (mania, depression) of bipolar disorder managed?

There is some weak research evidence for the benefit of the following treatments in mixed states of bipolar disorder: valproate, carbamazepine and all the second-generation anti-psychotics.

What if the manic episode does not respond to first-line treatment?

Your doctor or health professional may decide to alter your treatment if you are not experiencing any or sufficient improvement in your symptoms. There are several options if you do not respond to the initial medication chosen. Your doctor may:

- increase the dose and/or blood levels of the mood stabiliser
- switch mood stabilisers
- combine mood stabilisers
- add an anti-psychotic.

If you and your doctor have tried these strategies, and you have taken the medication correctly, and you still have no relief from symptoms, electroconvulsive therapy (ECT) may be considered.

What is electroconvulsive therapy (ECT)?

ECT is sometimes a life-saving treatment in severe cases where the person with bipolar disorder has not responded to other treatment, but is rarely used in contemporary practice.

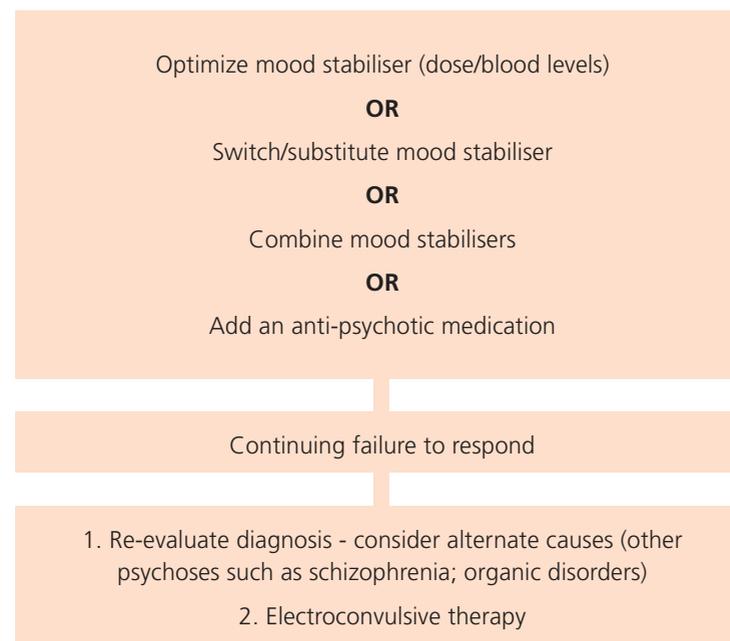
Electroconvulsive therapy involves the use of electricity to stimulate the brain and is administered on an inpatient or day treatment basis by psychiatrists who are specially trained to administer it. It is a physical treatment and is only able to be conducted after ensuring that no

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 covered again in the guideline on depression.

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 any side effects (such as short-term memory loss) are limited.

Each state has legislation to ensure that ECT is only used safely and appropriately.

Failure of manic episode to respond to treatment



What about ongoing treatment?

Following remission of an initial episode of mania, the mood stabiliser would typically 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.

In most cases, the benzodiazepine or anti-psychotic would be withdrawn once the acute episode has resolved and only the mood stabiliser continued.

For those people with a well-established history of bipolar disorder, there are several recommended criteria for deciding if you are likely to benefit from ongoing medication treatment. Most of these guidelines are based on a consensus of medical opinions and clinical wisdom, taking into account how often illness happens, its severity and the level of disability that it causes.

Those medications that are effective in long-term treatment (either alone or in combination) are: lithium, valproate, carbamazepine, olanzapine and quetiapine.

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 section discusses assessment and management of episodes of bipolar disorder depression.

Your doctor or health professional would typically conduct a full psychiatric history, analysis of your mental state and a physical examination in order to:

- confirm diagnosis
- exclude underlying complications (such as the presence of any other illness)
- identify physical complications
- assess any risk of self-harm.

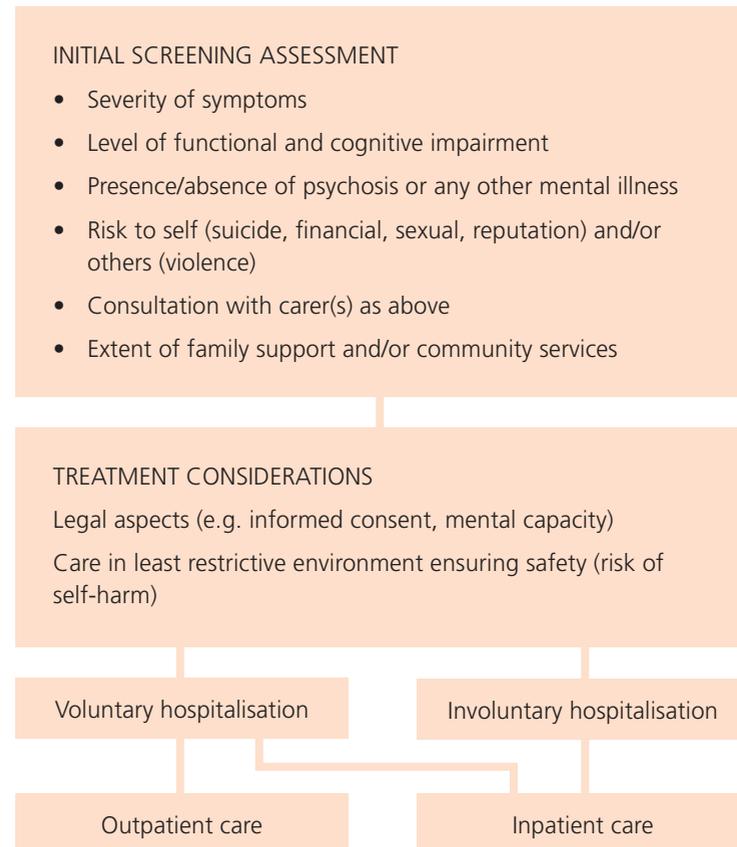
The reason for the assessment for risk of self-harm is that people with bipolar disorder have a higher rate of self-harm and suicide than the general population. This is usually due to depression, sometimes due to impulsivity, and at other times can result from accidents during periods of manic behaviour. Stopping medication too soon is a common cause of depressive relapse, so the assessment would typically involve a full medication history and review, and consultation with carers where appropriate.

Acute treatment of bipolar depression

There are two options that work for most people:

- a mood stabiliser (such as lithium, valproate, carbamazepine, lamotrigine, olanzapine and quetiapine) and anti-depressant combined; or
- a mood stabiliser alone. Those with proven efficacy in bipolar depression are lithium, olanzapine, quetiapine or lamotrigine.

Initial clinical assessment of bipolar depressive episode



If you are already on a mood stabiliser, your dose and/or blood levels should be optimised. If this is unsuccessful, your doctor may prescribe an anti-depressant, or a second mood stabiliser.

There are many effective anti-depressant medications available. If you have had a previously effective and well-tolerated anti-depressant before, this would typically be used again.

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

The preferred options for treatment are selective serotonin reuptake inhibitors (SSRIs) and serotonin-noradrenaline reuptake inhibitors (SNRIs such as venlafaxine, duloxetine or desvenlafaxine). Newer anti-depressants (mirtazapine or reboxetine) have not been well researched for the treatment of bipolar disorder, but may be reasonable second-line choices, if the first-line treatment proves ineffective. Monoamine oxidase inhibitors (MAOIs) and tricyclic anti-depressants (TCAs) should be considered a third-line treatment choice. Upon remission or recovery of the episode, anti-depressants should be gradually reduced so as to minimise the risk of switching moods while the mood stabiliser is continued.

Failure to respond to treatment

The chart on page 24 shows the treatment approach if your depressive episode does not respond to initial treatment.

First, it is important to be sure that your medication is at the right dosage and that it is being taken as prescribed. If there is still no improvement, other mood stabilisers or anti-depressants can be tried instead, on your doctor's advice.

A number of mood stabiliser combinations can be attempted in conjunction with anti-depressants. However, if despite all reasonable efforts you remain depressed or only partially respond, it is important

to re-evaluate the diagnosis and review your therapy. Organic causes need to be ruled out. Furthermore, the impact of any additional medical or psychiatric conditions should be thoroughly reassessed. Family circumstances, social networks, and carer circumstances should be examined.

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, the psychosocial factors in your life need to be assessed, such as how much support you have, and whether or not your living circumstances will promote your recovery.

Ongoing treatment

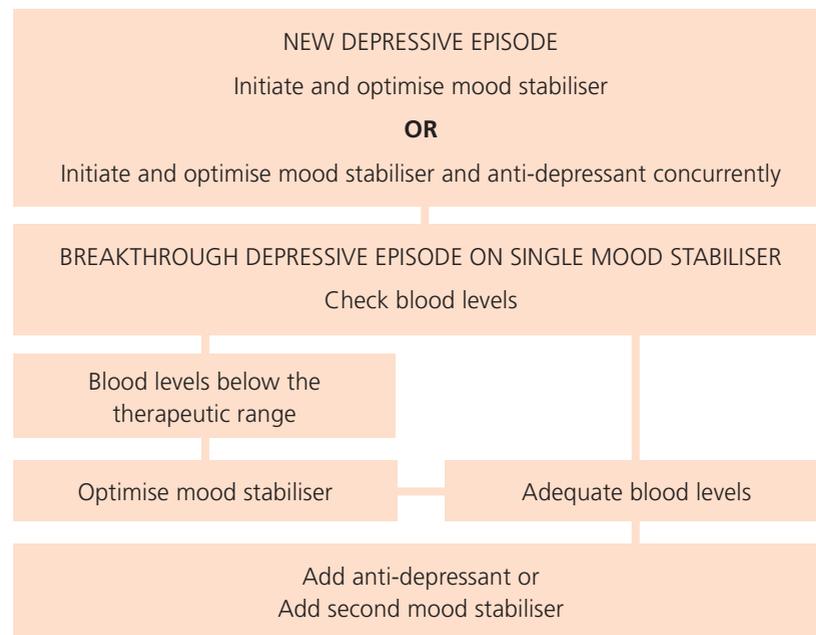
If you are in remission from the depressive episode, your doctor will usually withdraw anti-depressant treatment after two to three months to avoid causing mania and/or rapid cycling. However, in every individual, it is necessary to balance the need to treat bipolar depression versus the risk of precipitating mania. If you have recurrent depressive episodes, you can continue taking the anti-depressant along with a mood stabiliser.

Barriers to taking medication

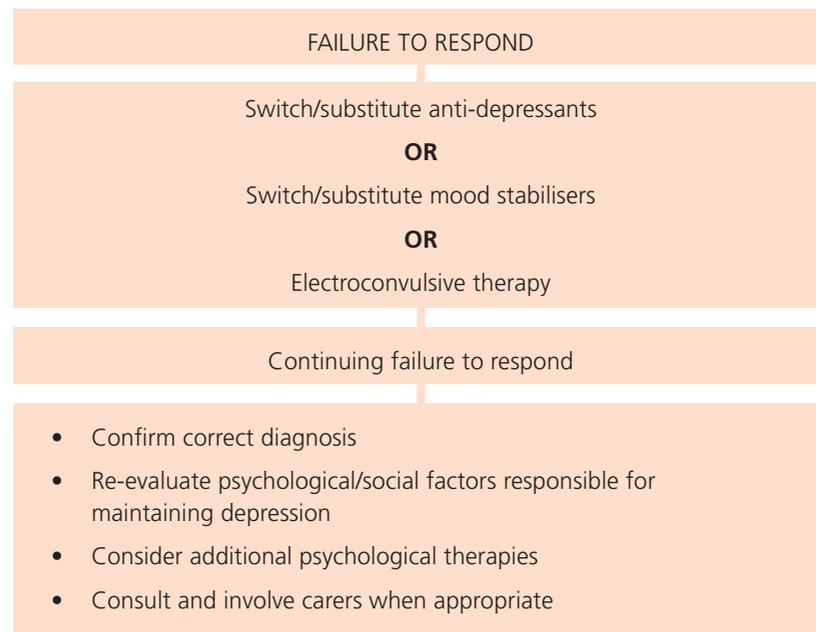
- **Doubt about the diagnosis, reluctance to accept the illness and willingness to risk another episode to confirm it.**
- **Possible side effects, including weight gain.**
- **Possible enjoyment of the experience of mania and a wish to experience it again.**
- **Not realising that mania and depression may involve negative consequences for you 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 doctor. Including carers in these discussions can be very helpful.

Pharmacological intervention - depressive episode



Failure of depressive episode to respond to treatment



Prevention of further episodes

People with bipolar disorder have different patterns of illness. Because the illness is episodic (at least 90% who experience one episode go on to have more episodes), 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 the experience will help you in future to better recognise the warning signs and to respond by initiating treatment again. This guide 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. If you haven't already done so, consider involving your carer(s) in your treatment.

Attitude to medication and coping with side effects

Deciding not to take your medication can lead to a relapse of mania or depression, which can result in severe social, financial and relationship loss.

There are many reasons why people do not take their medication. They may experience adverse side effects or lack of feelings of general health and wellbeing, successful social interaction and intellectual activity. 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. Your carer, friends and others may be able to help.

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

Not taking medication properly is the most common cause of relapse. Your mental health professional should discuss with you how you manage your medication, and your attitude and response to it, to try to prevent the possibility of your symptoms recurring. Approaches may include:

- providing you with education about the recurrent and disabling nature of this condition and potential side effects of medications
- providing methods by which you can manage or control the side effects e.g. diet and exercise
- 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 Australia and provide information about living with a mood disorder (see Appendix 2).

Continuity of care

The importance of continuity of care is an under-acknowledged issue in the long-term management of bipolar disorder. Ongoing contact with the same mental health professional increases the likelihood of early identification of recurrences, and helps raise 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. Your carer may also have much of this information and can assist.

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 help you maintain a stable mood and to prevent a relapse of mania or a depressive episode. Your GP or mental health professional would typically discuss with you, and your carer if appropriate, your pattern of illness and suggest what maintenance therapy is best for you.

There is strong evidence from clinical trials of the long-term effectiveness of lithium olanzapine and quetiapine (the latter only in combination with lithium or valproate) in treating the symptoms of bipolar disorder. Lamotrigine is effective in preventing bipolar depressive episodes, though it is only weakly effective in preventing mania. 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.

If you are taking lithium, your kidney function, serum creatinine and electrolytes should be monitored every three to twelve months. Your thyroid function, including Thyroid-Stimulating Hormone (TSH) should be monitored every six to twelve months, in addition to clinical assessment.

If you suddenly stop taking lithium you are likely to experience a relapse of mania (or, less likely, depression) within the next few months. Therefore, if you are going to stop taking lithium, your intake should gradually be reduced over at least one to two months.

If you are taking carbamazepine and valproate, your blood levels and liver function should be monitored at least every three to six months after treatment has begun. If you are taking anti-psychotics, your glucose, cholesterol and triglyceride levels should be monitored regularly.

Rapid cycling

So far, research has not shown that any of the mood stabilizers are very 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

There is some evidence that adding a second mood stabiliser 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.

Medications for long-term treatment of bipolar disorder

LITHIUM
OR
OLANZAPINE
OR
QUETIAPINE
(in combination with lithium or valproate)
OR
VALPROATE
OR
CARBAMAZEPINE
OR
LAMOTRIGINE
(For prevention of bipolar depressive episodes in particular)

Failure to prevent recurrences of bipolar disorder

- Exclude non-compliance
- Treat any additional 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)

Relapse prevention plans and mental health care plans

Relapses can be prevented and minimised for people with bipolar disorder. You and your doctor and carer can develop a plan that can identify situations where relapse is likely, early signs to lookout for, what you can do to minimise your symptoms (e.g. limiting alcohol use or using extra medication) and who you can contact if you experience any symptoms. This plan should be in writing and your family/carer and doctor and other health professional should have a copy.

As several doctors and health professionals may be involved in your care, it is important to have a care plan. This can be co-ordinated through your GP who may refer you to a psychiatrist or psychologist.

Your care plan should cover:

- **situations that are stressful and may cause symptoms (e.g. family Christmas gatherings)**
- **what I can do to stay well (e.g. get at least 7 hours sleep at night, stop drinking alcohol)**
- **what signs might indicate that my depression or mania may be recurring (e.g. arguing with my boss)**
- **what change I can make to my medication (e.g. increase my sedating medication for the next week)**
- **who I can talk to (e.g. let my partner know)**
- **when I will contact my doctor/health care worker (e.g. phone my doctor if symptoms last longer than two days)**

Further treatment choices

So far the guide has outlined the range of medications available for treating bipolar disorder that have been shown to be effective. There are further treatment choices, such as psychological and psychosocial therapies, which can be a valuable part of a treatment plan. These therapies are most effective in preventing recurrences if you have treatment when you are not currently depressed or manic. Psychological and psychosocial treatments work best when used in conjunction with medication.

What is the role of psychosocial treatments?

In some other psychiatric illnesses, there is often an 'either/or' choice between taking a medication OR using a psychological treatment. However, in bipolar disorder medication remains essential rather than optional. Psychological treatments are called 'adjunctive', which means that they are effective but should be used in addition to medications.

Learning to live with a continuous, episodic illness is a huge challenge for people with bipolar disorder and their families. Education about the illness leads to better coping strategies and fewer relapses.

People with bipolar disorder often express embarrassment because of the inappropriate behaviour, or sexual indiscretions, which might have happened when they were manic. Counselling about the trauma of embarrassing behaviour and coming to terms with the diagnosis is often needed.

Repeated episodes of mania and depression tend to lead to greater risk of divorce and family breakdown, unemployment, a break in social networks and education, and financial difficulties. Support and

counselling to help you deal with these issues can reduce the impact of having bipolar disorder.

Developing a balanced lifestyle can also help you to minimise the risk of relapse. In particular, establishing a regular sleep pattern is very important in helping you avoid further episodes.

Psychologists have an important role in all of these treatments. They can also provide specific treatments for depression, including cognitive behavioural therapy or CBT (looking at how we think and what we do), which can ease depression. One aspect of this treatment involves identifying patterns of early warning signs and triggers that precede episodes, and developing strategies to minimise them. Some psychological treatments are now covered by Medicare (through the Better Access initiative). Interpersonal and social rhythms therapy focuses on the roles of relationship difficulties and changes in daily patterns for those with bipolar disorder.

If you have problems with substance abuse and anxiety disorders as well as bipolar disorder, medications can help, but psychological treatments, especially CBT, are the most effective. These therapies are often undertaken with a psychologist.

The role of psychological treatments is to help you cope with the experience of bipolar disorder and its effects. Better outcomes can be achieved with these additional therapies. Many other medical conditions can also improve with psychological treatment.

Coping strategies

People who are living with bipolar disorder 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 and friends to also be able to identify those early signs
- staying in treatment and being aware of anything that may prevent you from taking your medication
- 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 keep track of your treatment progress and any side effects of any medications you are taking
- using exercise, proper diet, vitamin supplements, yoga and meditation to manage stress levels which can potentially trigger an episode
- keeping support around you from family and friends.

Support from family and friends is vitally important but it cannot always shield you from the effects of life stresses. Increased levels of support may be necessary if you have to cope with the death of a family member or close friend, loss of or interruption to your career, or experience 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, but the results have been mixed.

St John's Wort (*hypericum perforatum*) is being studied as a treatment for depression, but there is some evidence that it can reduce the effectiveness of some medications (such as the oral contraceptive pill), 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.

How to improve the quality of your care

- **Participate in active ways in your treatment planning.**
- **Write a relapse plan with your clinician.**
- **Identify the symptoms or signs that precede an episode.**
- **Discuss concerns about the quality of your care with your doctor.**
- **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 non-government agencies.**
- **Give yourself permission to talk about your feelings, your symptoms etc. with carers, friends and others. Don't forget: laughter is a good medicine.**

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

Support groups

While types of support groups vary widely, this section looks at 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 bipolar disorder. Being part of a support group can help you recognise and satisfy your need for practical and experiential information about the illness, and the need to keep taking your medications. A support group can also help you cope with the interpersonal difficulties you may experience 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 groups had helped them in communicating with their doctor, 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 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 Australia (see Appendix 2).

Speak with your case manager about how you can join the consumer workforce and network as a representative, advisor, consultant or advocate. This is a way of being actively involved in making a difference and learning at the same time about the many services and resources in the mental health sector.

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 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 that you can use if you are unhappy about the quality of your mental health care.

Cultural needs

Health professionals should always respect and cater for the wide diversity of cultural groups in our community. Depending on your cultural background or religious beliefs, when you are seeking treatment, or helping a person you care for get treatment, you may have special requirements that you need to communicate to the health professionals you encounter. You may need to request:

- a translator if your first language or that of the person you care for is not English
- explanations of medical or other terms that may not be clear
- respect for your religious practices and understanding of the roles of males and females in your culture

- treatment provided in a particular setting (you may have a cultural preference for home or hospital treatment)
- special food or access to a prayer room if you need to go to hospital
- understanding of your family's expectations of treatment.

It is very important to discuss cultural issues with your health care provider to enable them to better understand you and so that your religious beliefs and cultural practices can be incorporated into your treatment plan.

What does treatment cost?

It is important to discuss all potential costs involved in your treatment with your health professional.

In Australia, some GPs bulk bill, which means that Medicare will cover the full cost of any visit. If your GP does not bulk bill, partial rebates are available through Medicare and you will need to pay any difference. There will also be an additional cost for any medication that may be prescribed.

Your GP may refer you to appropriate services, such as for psychological services provided by a psychologist or an appropriately trained social worker or occupational therapist. Any treatment provided by these health professionals will only be rebated by Medicare if you have previously claimed a rebate for a GP Mental Health Treatment Plan. A GP Mental Health Treatment Plan will be developed by your GP and tailored to your needs to find the treatment that is right for you, monitor your progress and assist you in achieving your goals for recovery.

Medicare rebates are also available for assessment and treatment by a psychiatrist. A psychiatrist may also refer you for Medicare-subsidised treatment with a psychologist, an appropriately trained social worker

or occupational therapist. You may receive up to 12 individual/and or group therapy sessions in a year. An additional six individual sessions may be available in exceptional circumstances.

Your GP may also refer you to other government funded providers of psychological services depending on what is available in your local area.

Living with bipolar disorder

This guide has covered what recent 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. There are many examples of ordinary people and high-profile people successfully managing their condition and leading satisfying lives.

The wider community is now more aware and understanding of bipolar disorder, there is support and there are highly effective treatments now available. If you choose to, you can help spread this awareness.

While there remains no cure, there is good reason to think that treatments will 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, and constant monitoring, it is possible to achieve a good quality of life if you have bipolar disorder.

Appendix 1

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.

Case manager - The health care provider whom you see the most for your mental health care in the public mental health system. The case manager co-ordinates 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. With your agreement, carers may also consult case managers and vice versa.

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).

GP / General practitioner / Local doctor/ Family doctor -

Registered medical practitioners who have a general training in all areas of medicine, including psychiatry, and manage your general health care.

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.

Psychiatric nurse - A person specially 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.

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 psychiatry 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 wellbeing.

Social worker - A person with specialised training in individual and community work, group therapies, family 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 and accommodation.

Appendix 2

Sources of information and support

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

The list of organisations and information sources provided in this Appendix, whilst not exhaustive, may further support you in learning about and managing bipolar disorder. Inclusion of these organisations and information sources does not imply RANZCP endorsement but rather aims to help people find information and to encourage communication about mental illness.

These organisations and resources are not intended as a replacement for formal treatment but as an adjunct to it. If you are unsure about any of the information you find or would like to know if a treatment you read about may be appropriate for you, you should speak with your mental health care professional.

Many of the organisations that provide information and support for those with bipolar disorders and their carers are community-managed and not-for-profit associations. They provide support, information and referral services for health, housing, rehabilitation, employment, and 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.

Try looking 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: 13 11 14

Kids Help Line

Freecall: 1800 55 1800

National Organisations

beyondblue

Phone: (03) 9810 6100

Website: www.beyondblue.org.au

SANE Australia

Phone: (03) 9682 5933

Email: info@sane.org

Helpline: 1800 187 263

Helpline email: helpline@sane.org

Website: www.sane.org

Black Dog Institute

Phone: (02) 9382 4523

Email: blackdog@blackdog.org.au

Website: www.blackdoginstitute.org.au

Mental Illness Fellowship of Australia

Phone: (03) 8486 4200

Helpline: (03) 8486 4222

Email: enquiries@mifellowship.org

Website: www.mifellowship.org

Mind Australia

Phone: (03) 9455 7900

Email: info@mindaustralia.org.au

Website: www.mindaustralia.org.au

Multicultural Mental Health Australia

Phone: (02) 9840 3333

Email: admin@mmha.org.au

Website: www.mmha.org.au

Carers Australia

Phone: (02) 6122 9900

Email: caa@carersaustralia.com.au

Website: www.carersaustralia.com.au

Queensland Organisations**Mental Health Association (QLD) Inc**

Phone: (07) 3271 5544

Website: www.mentalhealth.org.au

Mental Illness Fellowship of North Queensland Inc

Phone: (07) 4725 3664

Email: fellowship@mifng.org.au

Website: www.mifng.org.au

Mental Illness Fellowship of Queensland

Brisbane:

Phone: (07) 3358 4424

Email: admin@sfq.org.au

Gold Coast:

Phone: (07) 5591 6490

Email: sfbranch@bigpond.net.au

Website: www.sfa.org.au

Western Australia Organisations**Mental Illness Fellowship of Western Australia**

Phone: (08) 9228 0200

Email: info@mifwa.org.au

Website: www.mifwa.org.au

Western Australian Association for Mental Health

Phone: (08) 9420 7277

Website: www.waamh.org.au

Victoria Organisations**Mental Illness Fellowship of Victoria**

Phone: (03) 8486 4200

Helpline: (03) 8486 4265

Email: enquiries@mifellowship.org

Website: www.mifellowship.org

New South Wales Organisations**Schizophrenia Fellowship of NSW**

Phone: (02) 9879 2600

Email: admin@sfnsw.org.au

Website: www.sfnsw.org.au

Mental Health Association NSW Inc

Phone: 1300 794 991 / (02) 9399 6000

Email: info@mentalhealth.asn.au

Website: www.mentalhealth.asn.au

South Australia Organisations**Mental Illness Fellowship of South Australia**

Phone: (08) 8221 5160

Email: mifsa@mhrc.org.au

Website: www.mifsa.org

ACT Organisations**Mental Illness Fellowship of ACT Inc**

Phone: (02) 6205 1349

Email: admin@mifact.org.au

Website: www.mifact.org.au

Mental Health Foundation ACT

Phone: (02) 6230 5789

Website: www.mhf.org.au

Northern Territory Organisations

Mental Health Association of Central Australia

Phone: (08) 8950 4600

Email: info@mhaca.org.au

Website: www.mhaca.org.au

Mental Health Carers NT

Phone: (08) 8948 2473

Website: www.mentalhealthcarersnt.org

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

ARAFMI Australia

Phone: (08) 9427 7100

Email: arafmi@arafmi.asn.au

Website: www.arafmiaustralia.asn.au

ARAFMI New South Wales

Central Coast ARAFMI: (02) 4369 4233

ccarafmi@bigpond.net.au

ARAFMI Illawarra: (02) 4254 1699

arafmi_i@bigpond.net.au

ARAFMI Hunter: (02) 4961 6717

arafmihunter@exemail.com.au

ARAFMI North Ryde: (02) 4961 6717

fcmhp@arafmi.org

Support: 1800 655 198 (NSW rural); (02) 9332 0700 (Sydney)

Website: www.arafmi.org

ARAFMI Queensland

Phone: (07) 3254 1881

Email: info@arafmiqld.org

Website: www.arafmiqld.org

ARAFMI Western Australia

Perth: (08) 9427 7100

Rural Freecall: 1800 811 747

Hillarys: (08) 9427 7100

Midland: (08) 9347 5741

Mandurah: (08) 9535 5844

Broome: (08) 9194 2665

Canarvon: (08) 9941 2803

Website: www.arafmi.asn.au

ARAFMI Tasmania (Carer support)

Phone (North): (03) 6331 4486

Phone (South): 03) 6228 7448

Email (North): north@arafmitas.org.au

Email (South): south@arafmitas.org.au

Website: www.arafmitas.org.au

ARAFMI (Victoria)

Phone: (03) 9810 9300

Carer Helpline: 1300 550 265

Email: admin@arafemi.org.au

Useful Websites

NATIONAL, STATE AND TERRITORY		
Organisation	Website	What is the website useful for?
<i>beyondblue</i>	www.beyondblue.org.au	Information on depression, anxiety and bipolar disorder.
Youth-beyondblue	www.youthbeyondblue.com	<i>beyondblue's</i> youth website providing information on depression and anxiety.
The Black Dog Institute	www.blackdoginstitute.org.au	Information on depression and bipolar disorder.
Depression Services.org.au	www.depressionservices.org.au	Information and online forums with 24 hour peer support and moderation for people living with depression.
headspace	www.headspace.org.au	Information and advice regarding mental health problems and where young people can find help and support.
SANE Australia	www.sane.org	Information on mental health including factsheets; also includes an online helpline.
Reach Out	www.reachout.com.au	Youth information portal on mental health.

Organisation	Website	What is the website useful for?
Multicultural Mental Health Australia	www.mmha.org.au	Website on general mental health
itsallright.org	www.itsallright.org	Website for young people dealing with mental illness in their family.

INTERNATIONAL		
Child and Adolescent Bipolar Foundation	www.bpkids.org	Information regarding bipolar disorder in children and adolescents
Depression and Bipolar Support Alliance	www.dbsalliance.org	Information for those with depression and bipolar disorder
Depression-afterdelivery.com	www.depressionafterdeliery.com	Information on postnatal depression
National Mental Health Information Centre	www.mentalhealth.samhsa.gov	Information on general mental health
Mental Health Insight	www.mentalhealthinsight.org	Information on general mental health

Appendix 3

Terminology and acronyms

Common terms

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. The different mental health professionals and their roles are also defined.

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 ineffective and detrimental. An RANZCP Self-Harm guideline exists for those who have self-harmed.

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 wellbeing (persistent symptoms such as headaches or digestive disorders that do not respond to treatment).

Flight of ideas - 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 themselves 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 leading to change in functioning, sometimes associated with transient psychotic periods.

Pressure of speech or to keep talking - A compulsion in which 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 - Loss of touch with reality, characterised 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.

Acronyms

CAT	Crisis Assessment Team
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-Stimulating Hormone

Appendix 4

Development of the guideline

This guide is a research-based clinical practice guideline based on a thorough review of the medical and related literature. It was written in association with people who have bipolar disorder and those working with them.

In 2009, the content of this guide was revised and expanded by an expert advisory panel comprising mental health professionals, and consumer and carer representatives. The purpose of the revision was to ensure the information contained in the booklet was current and comprehensive in terms of treatment best-practice and therefore remained relevant for people with bipolar disorder and their carers, families, and friends.

Authors

The authors of the original edition, and their affiliations at the time, were:

Philip Mitchell - Chair, Clinical Practice Guideline Development Team, Scientia Professor of Psychiatry, School of Psychiatry, University of New South Wales, Prince of Wales Hospital, Randwick, NSW.

Gin Malhi - Senior Lecturer, School of Psychiatry, University of New South Wales, Prince of Wales Hospital, Randwick, NSW.

Bernette Redwood - Research Officer, Clinical Practice Guideline Development Team, Prince of Wales Hospital, Randwick, NSW.

Jillian Ball Research - Psychologist, Prince of Wales Hospital, Randwick, NSW.

The original edition was funded by Australia's National Mental Health Strategy and New Zealand's Ministry of Health.

The expert advisory panel for the 2009 revision comprised:

Philip Mitchell - Chair, Scientia Professor and Head, School of Psychiatry, University of New South Wales, Prince of Wales Hospital, Randwick, NSW.

Anne Camac - Psychiatrist at St George Hospital, Sydney and Conjoint Lecturer at University of New South Wales.

Diahann Lombardo - Multicultural Mental Health Australia (MMHA) consumer advocate and national reference group member.

Eugene Schlusser - Filmmaker/carer with diverse experience of mental illness.

Quality statement

The original edition of this guide was consulted upon bi-nationally and drafts were available for comment on www.ranzcp.org. It was appraised using DISCERN by a national workshop of consumer consultants, and meets NHMRC criteria for presenting information on treatments for consumers. The 2009 revision sought to maintain the integrity of this process by incorporating updated information supported by research findings published in recent medical and other scientific literature.

Acknowledgements

The original edition of this booklet was edited by Jonine Penrose-Wall, Consultant Editorial Manager, RANZCP Clinical Practice Guideline (CPG) Program.

The authors acknowledge the following people for their contribution to this guide: Ms Yvette Cotton, Mr George Dibley, Ms Sharon Kohn, Ms Larissa Mariner, Mr Michael Martin, Ms Jan Monson, Ms Anna Saminsky and Ms Penny Mitchell.

This guide was commissioned by the Royal Australian and New Zealand College of Psychiatrists and was funded by Australia's National Mental Health Strategy, via the Commonwealth Department of Health and Ageing.

The authors used research that was developed with input by the wider Clinical Practice Guideline team that developed the guideline for use by professionals. Members of that team other than the authors included:

Associate Professor Meg Smith - School of Applied Social and Human Sciences, University of Western Sydney, Australia.

Dr Bronwyn Gould - General Practitioner.

Professor Peter Joyce - Head, Department of Psychological Medicine, University of Otago, Christchurch, New Zealand.

Professor Ken Kirkby - Head, Department of Psychiatry, University of Tasmania, Hobart, Australia.

The RANZCP drew on material published by the Medical Practitioner's Board of Victoria and the American Psychiatric Association in preparing this brochure.

The 2009 revision of this booklet was undertaken with funding provided by the Commonwealth Department of Health and Ageing.



The Royal
Australian &
New Zealand
College of
Psychiatrists