# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

**Quality standard topic:** Bipolar disorder in adults

**Output:** Prioritised quality improvement areas for development.

**Date of Quality Standards Advisory Committee meeting:** 17 December 2014

## Contents

# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for bipolar disorder in adults. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

## *1.1 Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

## *1.2 Development source*

The key development source referenced in this briefing paper is Bipolar NICE guideline CG185 (2014).

# 2 Overview

## *2.1 Focus of quality standard*

This quality standard will cover recognition, assessment and management of bipolar disorder (including bipolar I, bipolar II, mixed affective and rapid cycling disorder) in adults (18 years and older) in primary and secondary care. Bipolar disorder in children and young people will be covered within the Psychosis and schizophrenia in children and young people quality standard which is currently being developed.

## *2.2 Definition*

Bipolar disorder is a potentially lifelong and disabling condition characterised by episodes of mania (abnormally elevated mood or irritability and related symptoms with severe functional impairment or psychotic symptoms for 7 days or more) or hypomania (abnormally elevated mood or irritability and related symptoms with decreased or increased function for 4 days or more) and episodes of depressed mood. It is often comorbid with other disorders such as anxiety disorders, substance misuse, personality disorders and attention deficit hyperactivity disorder (ADHD).

## *2.3 Incidence and prevalence*

The peak age of onset is 15–19 years, and there is often a substantial delay between onset and first contact with mental health services. Presentation to services is often initially with depression, ill-defined psychotic symptoms or an impulse control

problem, so the nature of the bipolar disorder is only diagnosed some years after the initial presentation. Bipolar disorder in children under 12 years is very rare.

The lifetime prevalence of bipolar I disorder (mania and depression) is estimated at 1% of the adult population, and bipolar II disorder (hypomania and depression) affects approximately 0.4% of adults. Bipolar disorder occurs approximately equally in both sexes. For some women, the experience of psychosis in the postnatal period may be the first indicator of bipolar illness and for those with an established illness; childbirth brings an increased risk of puerperal psychosis and represents a substantial clinical challenge.

There is evidence of an increased incidence and differences in the manner of presentation of bipolar disorder in people from black and minority ethnic groups.

## *2.4 Management*

Around 25% of people with bipolar disorder have never sought help from health services. Those who have sought help may not receive a correct diagnosis of bipolar disorder for at least 6 years from the first appearance of symptoms. People with bipolar disorder experience a range of difficulties in accessing services that meet their needs. Some of these include:

- lack of awareness and understanding about bipolar disorder in the community, leading to delays in seeking medical assessment
- the burden of illness is exacerbated by difficulties obtaining an accurate diagnosis and optimal treatment
- inappropriate crisis management
- difficulties accessing hospital care
- inappropriate exclusion of carers and families from management decisions
- frequent discontinuities of medical and psychological care

Most mental health organisations in England provide generic care for people with bipolar disorder as one form of severe mental illness along pathways outlined by National Health Service (NHS) tariffs for psychosis (clusters 10-17). These may involve community mental health teams, early intervention in psychosis (for people presenting in their first or second episode), dual diagnosis teams when there is a comorbid substance-use disorder, assertive outreach teams when people are difficult to engage and repeatedly require intensive input, and crisis resolution and home treatment teams as an alternative to mental health inpatient admission.

Pharmacological treatments are commonly used during episodes of mania and bipolar depression while manic episodes have been effectively treated with antipsychotic drugs often supplemented with a benzodiazepine. The treatment of

bipolar depression is more challenging and more diverse. Treatments used during acute episodes include antidepressants and some antipsychotic drugs but response to these agents both acutely and during maintenance treatment is often partial.

There are a number of types of psychological interventions for which there is a current evidence base. A common aim of these approaches is to provide the person with a set of mood regulation and self-management skills to address the challenges of living with bipolar disorder more effectively after the psychological intervention.

## *2.5 National Outcome Frameworks*

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

**Table 1 The Adult Social Care Outcomes Framework 2014–15**

| Domain | Overarching and outcome measures |
|---|---|
| 1 Enhancing quality of life for people with care and support needs | ***Overarching measure***<br>1A Social care-related quality of life**<br>***Outcome measures***<br>**People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.**<br>1B Proportion of people who use services who have control over their daily life<br>**Carers can balance their caring roles and maintain their desired quality of life.**<br>1D Carer-reported quality of life**<br>**People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.**<br>1F Proportion of adults in contact with secondary mental health services in paid employment**<br>1H Proportion of adults in contact with secondary mental health services living independently, with or without support*<br>1I Proportion of people who use services and their carers who reported that they had as much social contact as they would like* |
| 2 Delaying and reducing the need for care and support | ***Outcome measures***<br>**Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs**<br>**Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services**<br>2D The outcomes of short term services: sequel to services |

| | |
|---|---|
| 3 Ensuring that people have a positive experience of care and support | ***Overarching measure***<br>**People who use social care services and their carers are satisfied with the experience of care and support services**<br>3A Overall satisfaction of people who use services with their care and support<br>3B Overall satisfaction of carers with social services<br>3E Improving people's experience of integrated care**<br>***Outcome measures***<br>**Carers feel that they are respected as equal partners throughout the care process**<br>3C The proportion of carers who report that they have been included or consulted in discussion about the person they care for<br>**People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.**<br>3D Proportion of people who use services and carers who find it easy to find information about services |
| 4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm | ***Overarching measure***<br>4A Proportion of people who use services who feel safe**<br>***Outcome measures***<br>**Everyone enjoys physical safety and feels secure**<br>**People are free from physical and emotional abuse, harassment, neglect and self-harm.**<br>**People are protected as far as possible from avoidable harm, disease and injuries.**<br>**People are supported to plan ahead, and have the freedom to manage risks the way that they wish.**<br>4B Proportion of people who use services who say that those services have made them feel safe and secure |
| **Aligning across the health and care system**<br>* Indicator shared with Public Health Outcomes Framework<br>** Indicator shared with NHS Outcomes Framework | |

**Table 2 NHS Outcomes Framework 2014–15**

| Domain | Overarching indicators and improvement areas |
|---|---|
| 1 Preventing people from dying prematurely | ***Improvement areas***<br>**Reducing premature death in people with serious mental illness**<br>1.5 Excess under 75 mortality rate in adults with serious mental illness |
| 2 Enhancing quality of life for people with long-term conditions | ***Overarching indicator***<br>2 Health-related quality of life for people with long-term conditions**<br>***Improvement areas***<br>**Ensuring people feel supported to manage their condition**<br>2.1 Proportion of people feeling supported to manage their condition**<br>**Enhancing quality of life for carers**<br>2.4 Health-related quality of life for carers**<br>**Enhancing quality of life for people with mental illness**<br>2.5 Employment of people with mental illness*** |
| 4 Ensuring that people have a positive experience of care | ***Overarching indicators***<br>**Ensuring that people have a positive experience of care**<br>4a Patient experience of primary care<br>4b Patient experience of hospital<br>***Improvement areas***<br>**Improving hospitals' responsiveness to personal needs**<br>4.2 Responsiveness to in-patients' personal needs<br>**Improving experience of healthcare for people with mental illness**<br>4.7 Patient experience of community mental health services<br>**Improving people's experience of integrated care**<br>4.9 People's experience of integrated care** |
| **Alignment across the health and social care system**<br>* Indicator shared with Public Health Outcomes Framework (PHOF)<br>** Indicator shared with Adult Social Care Outcomes Framework (ASCOF)<br>*** Indicator shared with PHOF and ASCOF | |

**Table 3 Public health outcomes framework for England, 2013–2016**

| Domain | Objectives and indicators |
|---|---|
| 1 Improving the wider determinants of health | ***Objective***<br>Improvements against wider factors which affect health and wellbeing and health inequalities<br>***Indicators***<br>1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation**<br>1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services*** |
| 4 Healthcare public health and preventing premature mortality | ***Objective***<br>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities<br>***Indicators***<br>4.9 Excess under 75 mortality rate in adults with serious mental illness*<br>4.10 Suicide rate |
| * Indicator shared with NHS Outcomes Framework (NHSOF)<br>** Indicator shared with Adult Social Care Outcomes Framework (ASCOF)<br>******* Indicator shared with ASCOF and NHSOF | |

# 3 Summary of suggestions

## *3.1 Responses*

In total 11 stakeholders and 2 Specialist Committee Members responded to the 2-week engagement exercise 30th October – 13th November 2014.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

NHS England's patient safety submitted comments during stakeholder engagement, which are included in this paper and can be found in full in appendix 2.

Full details of all the suggestions provided are given in appendix 2 for information.

**Table 4 Summary of suggested quality improvement areas**

| Suggested area for improvement | Stakeholders |
|---|---|
| **Assessment and diagnosis** | |
| • Recognising bipolar disorder in primary care | BABCT |
| • Accurate diagnosis | SCM, Scotlandtherapy |
| • Identifying comorbidities | SCM, THORN |
| • Comprehensive & accessible care plans | O&L |
| **Managing bipolar disorder** | |
| • Preventing relapse | Scotlandtherapy |
| **Pharmacological interventions** | |
| • Lithium | CWPNHST, SCM, NHS England |
| • Antidepressants in mania | CWPNHST |
| • Olanzapine & fluoxetine or quetiapine in bipolar depression | CWPNHST |
| • Valproate in women of childbearing age | RCP |
| **Psychological interventions** | |
| • Specific & high intensity interventions | CWPNHST, RMI, SCM |
| **Managing crisis** | |
| • Community care in crisis | RMI |
| • Access to crisis care | Scotlandtherapy |
| • Preventing suicide | SCM |
| **Monitoring physical health** | |
| • Monitoring physical health | CWPNHST, O&L, SCM |
| • Responsibility for monitoring | RMI |

| Suggested area for improvement | Stakeholders |
|---|---|
| **Promoting recovery** | |
| • Employment, education and occupational activities | RMI |
| **Care across all phases of bipolar disorder** | |
| • Information and support | RMI, O&L |
| • Support for carers & involving relatives | BABCT, CWPNHST, O&L, THORN |
| • Family interventions | THORN |
| • Staff training | SCM |
| **Additional areas** | |
| • Antenatal and postnatal care | CWPNHST, RCP, THORN |
| • Access to psychological interventions | Scotlandtherapy |
| • Assessment of Implementation | CWPNHST |
| • Children and young people | LCNHSFT, SCM |
| • Complimentary therapies | LCNHSFT, SCM<br>BABCT |
| • Cross referencing | Scotlandtherapy |
| • Early intervention in psychosis | BABCT |
| • Inter-agency working | RMI |
| • Raising awareness | THORN |
| • Reviewing diagnosis | Scotlandtherapy |
| • Nutritional assessment | Scotlandtherapy |
| • Staff training in psychological interventions | HQT<br>BABCT |

BABCT- British Association for Behavioural and Cognitive Psychotherapies
CWPNHST - Cheshire & Wirral Partnership NHS Trust
HQT – HQT diagnostics
LCNHSFT - Lancashire Care NHS Foundation Trust
O&L - Otsuka and Lundbeck
RCP - Royal College of Psychiatrists
RMI – Rethink Mental Illness
SCM – Specialist Committee Member
THORN - The National THORN Steering Group

# 4 Suggested improvement areas

## *4.1 Assessment and diagnosis*

### 4.1.1 Summary of suggestions

**Recognising bipolar disorder in primary care**

Stakeholders highlighted that recognition of bipolar disorder in primary care is currently very poor. They also suggested that patients who present with depression and anxiety should be screened for possible mood disorders.

**Accurate diagnosis**

Stakeholders highlighted the importance of accurate diagnosis in receiving prompt and appropriate interventions. They also suggested that psychoeducation and mood management are key in managing the disorder.

**Identifying comorbidities**

Stakeholders highlighted that a large number of people with bipolar disorder also suffer from co-morbidities such as obsessive compulsive disorder, post-traumatic stress disorder, borderline personality disorder; and these may go untreated or mask the diagnosis of bipolar disorder.

**Comprehensive & accessible care plans**

Stakeholders highlighted the need to write and use a care plan in collaboration with people with bipolar disorder and their carers. They also highlighted the importance of care plans reflecting the full spectrum of needs, i.e. psychological, pharmacological and physical, as well as social needs such as housing and education and their impact on people's ability to achieve their recovery goals. The stakeholders also suggested that the care plan needs to be written in a language that is understandable to the service user and all those involved in supporting them.

### 4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

**Table 5 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Recognising bipolar disorder in primary care | **Recognising bipolar disorder in primary care and referral**<br>NICE CG185 Recommendation 1.2.1 |
| Accurate diagnosis | **Recognising bipolar disorder in primary care and referral**<br>NICE CG185 Recommendation 1.2.3<br>**Assessing suspected bipolar disorder in adults in secondary care**<br>NICE CG185 Recommendations 1.3.1, 1.3.2, 1.3.3 |
| Identifying comorbidities | **Assessing suspected bipolar disorder in adults in secondary care**<br>NICE CG185 Recommendation 1.3.2 |
| Comprehensive & accessible care plans | **Assessing suspected bipolar disorder in adults in secondary care**<br>NICE CG185 Recommendation 1.3.4<br>**Return to primary care**<br>NICE CG185 Recommendation 1.9.4 |

### Recognising bipolar disorder in primary care and referral

NICE CG185 – Recommendation 1.2.1

When adults present in primary care with depression, ask about previous periods of overactivity or disinhibited behaviour. If the overactivity or disinhibited behaviour lasted for 4 days or more, consider referral for a specialist mental health assessment.

NICE CG185 - Recommendation 1.2.3

Do not use questionnaires in primary care to identify bipolar disorder in adults.

### Assessing suspected bipolar disorder in adults in secondary care

NICE CG185 - Recommendation 1.3.1

Assessment of suspected bipolar disorder, and subsequent management, should be conducted in a service that can:

- offer the full range of pharmacological, psychological, social, occupational and educational interventions for people with bipolar disorder consistent with this guideline
- be competent to provide all interventions offered
- place emphasis on engagement as well as risk management

- provide treatment and care in the least restrictive and stigmatising environment possible, and in an atmosphere of hope and optimism in line with the NICE clinical guidance on service user experience in adult mental health.

This might be an early intervention in psychosis service, a specialist bipolar disorder team, or a specialist integrated community-based team.

NICE CG185 - Recommendation 1.3.2

When assessing suspected bipolar disorder:

- undertake a full psychiatric assessment, documenting a detailed history of mood, episodes of overactivity and disinhibition or other episodic and sustained changes in behaviour, symptoms between episodes, triggers to previous episodes and patterns of relapse, and family history
- assess the development and changing nature of the mood disorder and associated clinical problems throughout the person's life (for example, early childhood trauma, developmental disorder or cognitive dysfunction in later life)
- assess social and personal functioning and current psychosocial stressors
- assess for potential mental and physical comorbidities
- assess the person's physical health and review medication and side effects, including weight gain
- discuss treatment history and identify interventions that have been effective or ineffective in the past
- encourage people to invite a family member or carer to give a corroborative history
- discuss possible factors associated with changes in mood, including relationships, psychosocial factors and lifestyle changes

NICE CG185 - Recommendation 1.3.3

Take into account the possibility of differential diagnoses including schizophrenia spectrum disorders, personality disorders, drug misuse, alcohol-use disorders, attention deficit hyperactivity disorder and underlying physical disorders such as hypo- or hyperthyroidism.

NICE CG185 - Recommendation 1.3.2

When assessing suspected bipolar disorder

- undertake a full psychiatric assessment, documenting a detailed history of mood, episodes of overactivity and disinhibition or other episodic and

sustained changes in behaviour, symptoms between episodes, triggers to previous episodes and patterns of relapse, and family history

- assess the development and changing nature of the mood disorder and associated clinical problems throughout the person's life (for example, early childhood trauma, developmental disorder or cognitive dysfunction in later life)
- assess social and personal functioning and current psychosocial stressors
- assess for potential mental and physical comorbidities
- assess the person's physical health and review medication and side effects, including weight gain
- discuss treatment history and identify interventions that have been effective or ineffective in the past
- encourage people to invite a family member or carer to give a corroborative history
- discuss possible factors associated with changes in mood, including relationships, psychosocial factors and lifestyle changes

NICE CG185 - Recommendation 1.3.4

If bipolar disorder is diagnosed, develop a care plan in collaboration with the person with bipolar disorder based on the assessment carried out in recommendation 1.3.2 as soon as possible after assessment and, depending on their needs, using the care programme approach. Give the person and their GP a copy of the plan, and encourage the person to share it with their carers.

**Return to primary care**

NICE CG185 - Recommendation 1.9.4

When making transfer arrangements for a return to primary care, agree a care plan with the person, which includes:

- clear, individualised social and emotional recovery goals
- a crisis plan indicating early warning symptoms and triggers of both mania and
- depression relapse and preferred response during relapse, including liaison and referral pathways
- an assessment of the person's mental state

- a medication plan with a date for review by primary care, frequency and nature of monitoring for effectiveness and adverse effects, and what should happen in the event of a relapse.

Give the person and their GP a copy of the plan, and encourage the person to share it with their carers.

### 4.1.3 Current UK practice

#### Recognising bipolar disorder

In April and May 2012 an audit was conducted in secondary psychiatric services in Bedford among 112 bipolar patients, examining the course of their illness and diagnosis. The audit found that just over 28% of patients referred from primary care already had a diagnosis of bipolar disorder. It should be noted that this study only took into account definitive diagnoses, so some postulated diagnoses were excluded. However, only 59% of patients received a diagnosis of bipolar after seeing a psychiatrist. These results demonstrate that the difficulty with making this diagnosis is not confined to primary care, although specialists appear to do it more effectively[1].

#### Accurate diagnosis

No published studies on current practice were highlighted for this suggested area for quality improvement. This area is based on stakeholder's knowledge and experience.

#### Identifying comorbidities

No published studies on current practice were highlighted for this suggested area for quality improvement. This area is based on stakeholder's knowledge and experience.

#### Comprehensive & accessible care plans

According to QOF results for 2013-14 75% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, agreed between individuals, their family and/or carers as appropriate.

[1] Jonathan Rogers et al. Diagnosis of mental illness in primary and secondary care with a focus on bipolar disorder.

## *4.2 Managing bipolar disorder*

### 4.2.1 Summary of suggestions

**Preventing relapse**

Stakeholders highlighted that current care is too focused on crisis point intervention, and not enough on ongoing support and management to prevent relapse.

### 4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

**Table 6 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Preventing relapse | **Managing bipolar disorder in primary care**<br>NICE CG185 Recommendation 1.2.9<br>**Return to primary care**<br>NICE CG185 Recommendation 1.9.4 |

**Managing bipolar disorder in primary care**

NICE CG185 - Recommendation 1.2.9

If bipolar disorder is managed solely in primary care, re-refer to secondary care if any one of the following applies:

- there is a poor or partial response to treatment
- the person's functioning declines significantly
- treatment adherence is poor
- the person develops intolerable or medically important side effects from medication
- comorbid alcohol or drug misuse is suspected
- the person is considering stopping any medication after a period of relatively stable mood
- a woman with bipolar disorder is pregnant or planning a pregnancy.

**Return to primary care**

NICE CG185 - Recommendation 1.9.4

When making transfer arrangements for a return to primary care, agree a care plan with the person, which includes:

- clear, individualised social and emotional recovery goals
- a crisis plan indicating early warning symptoms and triggers of both mania and
- depression relapse and preferred response during relapse, including liaison and referral pathways
- an assessment of the person's mental state
- a medication plan with a date for review by primary care, frequency and nature of monitoring for effectiveness and adverse effects, and what should happen in the event of a relapse.

Give the person and their GP a copy of the plan, and encourage the person to share it with their carers.

### 4.2.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement. This area is based on stakeholder’s knowledge and experience.

## *4.3 Pharmacological interventions*

### 4.3.1 Summary of suggestions

**Lithium**

Stakeholders highlighted that lithium should be offered as first-line treatment in the longer term. However, they also highlighted the risk associated with lithium therapy and recalled the details of patient safety alert (2009) which advised close and regular monitoring of patients prescribed lithium including blood test necessary to obtain prescription. Stakeholders suggested the need to clarify a robust management of the lithium use and prophylaxis.

**Antidepressants in mania**

Stakeholders suggested that if patient develops mania, stopping antidepressants should be considered and haloperidol, olanzapine, quetiapine or risperidone should be offered.

**Olanzapine & fluoxetine or quetiapine in bipolar depression**

Stakeholders suggested that olanzapine together with fluoxetine or quetiapine should be offered in bipolar depression.

**Valproate in women of childbearing age**

Stakeholders highlighted that despite clear guidance from NICE that valproate should not be used in women of childbearing age, this advise is still not being followed. They suggested that many women in their childbearing years are still being exposed to this medication.

### 4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

**Table 7 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Lithium | **Pharmacological interventions**<br>NICE CG185 Recommendations 1.5.7, 1.6.4, 1.7.5, 1.7.6<br>**Using Lithium**<br>NICE CG185 Recommendations 1.10.14 - 1.10.26 |

| | |
|---|---|
| Antidepressants & mania | **Pharmacological interventions**<br>NICE CG185 Recommendations 1.5.2, 1.5.3, 1.5.6 |
| Olanzapine & fluoxetine or quetiapine in bipolar depression | **Pharmacological interventions**<br>NICE CG185 Recommendation 1.6.3 |
| Valproate in women of childbearing age | **Using valproate**<br>NICE CG185 Recommendation 1.10.28 |

## Pharmacological interventions

NICE CG185 - Recommendation 1.5.7 (hypomania)

If the person is already taking lithium, check plasma lithium levels to optimise treatment (see section 1.10). Consider adding haloperidol, olanzapine, quetiapine or risperidone, depending on the person's preference and previous response to treatment.

NICE CG185 - Recommendation 1.6.4 (bipolar depression)

If a person develops moderate or severe bipolar depression and is already taking lithium, check their plasma lithium level. If it is inadequate, increase the dose of lithium; if it is at maximum level, add either fluoxetine combined with olanzapine or add quetiapine, depending on the person's preference and previous response to treatment. If the person prefers, consider adding olanzapine (without fluoxetine) or lamotrigine to lithium. If there is no response to adding fluoxetine combined with olanzapine, or adding quetiapine, stop the additional treatment and consider adding lamotrigine to lithium. Follow the recommendations in section 1.10 on using lithium, antipsychotics and lamotrigine.

NICE CG185 - Recommendation 1.7.5 (bipolar disorder)

When planning long-term pharmacological treatment to prevent relapse, take into account drugs that have been effective during episodes of mania or bipolar depression. Discuss with the person whether they prefer to continue this treatment or switch to lithium, and explain that lithium is the most effective long-term treatment for bipolar disorder.

NICE CG185 - Recommendation 1.7.6 (bipolar disorder)

Offer lithium as a first-line, long-term pharmacological treatment for bipolar disorder and:

- if lithium is ineffective, consider adding valproate
- if lithium is poorly tolerated, or is not suitable (for example, because the person does not agree to routine blood monitoring), consider valproate or

olanzapine instead or, if it has been effective during an episode of mania or bipolar depression, quetiapine.

- Discuss with the person the possible benefits and risks of each drug for them.

**Using Lithium**

NICE CG185 - Recommendation 1.10.14

When starting lithium:

- advise the person that poor adherence or rapid discontinuation may increase the risk of relapse
- measure the person's weight or BMI and arrange tests for urea and electrolytes including calcium, estimated glomerular filtration rate (eGFR), thyroid function and a full blood count
- arrange an ECG for people with cardiovascular disease or risk factors for it ensure the person is given appropriate national information (or a locally available equivalent) on taking lithium safely
- establish a shared-care arrangement with the person's GP for prescribing lithium and monitoring adverse effects.

NICE CG185 - Recommendation 1.10.15

Measure plasma lithium levels 1 week after starting lithium and 1 week after every dose change, and weekly until the levels are stable. Aim to maintain plasma lithium level between 0.6 and 0.8 mmol per litre in people being prescribed lithium for the first time.

NICE CG185 - Recommendation 1.10.16

Consider maintaining plasma lithium levels at 0.8–1.0 mmol per litre for a trial period of at least 6 months for people who: have had a relapse while taking lithium in the past or are taking lithium and have sub threshold symptoms with functional impairment.

NICE CG185 - Recommendation 1.10.17

Advise people taking lithium to:

- seek medical attention if they develop diarrhoea or vomiting or become acutely ill for any reason
- ensure they maintain their fluid intake, particularly after sweating (for example, after exercise, in hot climates or if they have a fever), if they are immobile for long periods or if they develop a chest infection or pneumonia

- talk to their doctor as soon as possible if they become pregnant or are planning a pregnancy.

NICE CG185 - Recommendation 1.10.18

Warn people taking lithium not to take over-the-counter non-steroidal anti-inflammatory drugs and avoid prescribing these drugs for people with bipolar disorder if possible; if they are prescribed, this should be on a regular (not p.r.n.) basis and the person should be monitored monthly until a stable lithium level is reached and then every 3 months.

NICE CG185 - Recommendation 1.10.19

Measure the person's plasma lithium level every 3 months for the first year.

NICE CG185 - Recommendation 1.10.20

After the first year, measure plasma lithium levels every 6 months, or every 3 months for people in any of the following groups:

- older people
- people taking drugs that interact with lithium
- people who are at risk of impaired renal or thyroid function, raised calcium levels or other complications
- people who have poor symptom control
- people with poor adherence
- people whose last plasma lithium level was 0.8 mmol per litre or higher.

NICE CG185 - Recommendation 1.10.21

Measure the person's weight or BMI and arrange tests for urea and electrolytes including calcium, estimated glomerular filtration rate (eGFR) and thyroid function every 6 months, and more often if there is evidence of impaired renal or thyroid function, raised calcium levels or an increase in mood symptoms that might be related to impaired thyroid function.

NICE CG185 - Recommendation 1.10.22

Monitor lithium dose and plasma lithium levels more frequently if urea levels and creatinine levels become elevated, or eGFR falls over 2 or more tests, and assess the rate of deterioration of renal function. For further information see NICE's guidance on chronic kidney disease and acute kidney injury.

NICE CG185 - Recommendation 1.10.23

When discussing whether to continue lithium, take into account clinical efficacy, other risk factors for renal impairment and cardiovascular disease, and degree of renal impairment; if needed seek advice from a renal specialist and a clinician with expertise in managing bipolar disorder.

NICE CG185 - Recommendation 1.10.24

Monitor the person at every appointment for symptoms of neurotoxicity, including paraesthesia, ataxia, tremor and cognitive impairment, which can occur at therapeutic levels of lithium.

NICE CG185 - Recommendation 1.10.25

If stopping lithium, reduce the dose gradually over at least 4 weeks, and preferably up to 3 months, even if the person has started taking another antimanic drug.

NICE CG185 - Recommendation 1.10.26

During dose reduction and for 3 months after lithium treatment is stopped, monitor the person closely for early signs of mania and depression.

**Pharmacological interventions**

NICE CG185 – Recommendation 1.5.2

If a person develops mania or hypomania and is taking an antidepressant (as defined by the British national formulary [BNF]) as monotherapy:

- consider stopping the antidepressant and
- offer an antipsychotic as set out in recommendation 1.5.3, regardless of whether the antidepressant is stopped.

NICE CG185 – Recommendation 1.5.3

If a person develops mania or hypomania and is not taking an antipsychotic or mood stabiliser, offer haloperidol, olanzapine, quetiapine or risperidone, taking into account any advance statements, the person's preference and clinical context (including physical comorbidity, previous response to treatment and side effects). Follow the recommendations on using antipsychotics in section 1.10.

NICE CG185 – Recommendation 1.5.6

If a person develops mania or hypomania and is taking an antidepressant (as defined by the BNF) in combination with a mood stabiliser, consider stopping the antidepressant.

NICE CG185 – Recommendation 1.6.3

If a person develops moderate or severe bipolar depression and is not taking a drug to treat their bipolar disorder, offer fluoxetine combined with olanzapine, or

quetiapine on its own, depending on the person's preference and previous response to treatment.

- If the person prefers, consider either olanzapine (without fluoxetine) or lamotrigine on its own.
- If there is no response to fluoxetine combined with olanzapine, or quetiapine, consider lamotrigine on its own.

Follow the recommendations on using antipsychotics and lamotrigine in section 1.10.

**Using valproate**

NICE CG185 – Recommendation 1.10.28
Do not offer valproate to women of childbearing potential for long-term treatment or to treat an acute episode.

### 4.3.3 Current UK practice

**All pharmacological interventions**

An audit of management of bipolar disorder against NICE guidelines in South Staffordshire NHS Trust (2011) found that twenty of twenty-eight patients (72%) were on mood stabilizers, either lithium or sodium valproate, with sodium valproate as the more preferred drug. Twelve of twenty-eight (43%) were on antipsychotics. Three of seven (43%) patients, who did not respond to combination treatment, were started on lamotrigine. Nine of the twenty-eight (32%) patients continued to be on antidepressants even after resolution of the depressive episode. The compliance of monitoring for physical side effects during the initial period of starting medications was not satisfactory with only:

- 19/24 (79%) monitored for renal disease
- 18/24 (75%) monitored for diabetes
- 15/24 (63%) monitored and advised about obesity
- 15/24 (63%) drug levels checked regularly

In 4/28 (15%), there was no documentation about any physical health monitoring. Only in 50-60% of patients had the monitoring done annually, but it was regardless of any recognised guidelines. In 19/26 (73%) the patient's preference of drug choices was recorded. In 21/28 (75%) patients, there was documentation about discussion of potential benefits and side effects of the medications. Five of twenty-eight (18%) patients who were prescribed valproate were of child bearing age; 4 were advised to use contraception and one had been sterilized.

**Lithium**

The Prescribing Observatory for Mental Health (POMH-UK) invited all National Health Service Mental Health Trusts in the UK to participate in a benchmarking audit of lithium monitoring against recommended standards. 436 clinical teams from 38 Trusts submitted data for 3,373 patients.

397 patients had been prescribed lithium for less than 1 year. Of these, 84% had a documented baseline test of renal function including creatinine; the respective figures for thyroid function and body weight were 82% and 37%. With respect to documentation regarding the provision of relevant information to patients, this was present for the side effects of lithium in 62% cases, the risk factors for toxicity in 42%, and the signs and symptoms of toxicity in 45% of cases.

2,976 patients had been prescribed lithium for more than a year. With respect to lithium serum levels, 68% of cases had 2 or more documented tests in the previous year, thus meeting the QOF standard, while 30% had 4 or more tests in the last year, reaching the NICE standard. With respect to tests of renal function, which included creatinine, 81% of cases had one or more documented tests in the last year, thereby meeting the QOF standard, while 55% had two or more documented tests and therefore met the NICE standard. The respective figures for thyroid function were 82% and 50%. For 206 (7%) patients there was no documented evidence that any of the recommended monitoring tests/measures had been conducted in the previous year.

Findings from this audit, along with reports of harm received by the National Patient Safety Agency, prompted a Patient Safety Alert mandating primary care, mental health and acute Trusts, and laboratory staff to work together to ensure systems are in place to support recommended lithium monitoring by December 2010[2].

Following on to the patient safety alert issued by the National Patient Safety Agency a Quality Improvement Programme (QIP) was implemented. Data were submitted for re-audit (n = 3,647) and supplementary audit (n = 5,683).

A re-audit was conducted at 18 months and a supplementary audit at three years. By supplementary audit, the proportion of patients having four serum lithium tests over the previous year had increased from 30% at baseline to 48%, and the respective proportions that had two tests of renal function from 55% to 70% and thyroid function from 49% to 66%. Elderly patients and those prescribed a drug known to interact with lithium were not more likely to be monitored in line with the audit standards. Between baseline and supplementary audit, the proportion of patients with a diagnosis of bipolar disorder prescribed an antidepressant increased from 36% to 41%.

Improvements in biochemical monitoring of lithium treatment were achieved over time, yet gaps remained between the standard and current practice. Antidepressants

[2] Noel Collins et al. Standards of lithium monitoring in mental health trusts in the UK

were frequently prescribed in patients with bipolar disorder despite a paucity of evidence supporting their efficacy[3].

**Valproate in women of childbearing age**

An audit carried out between August 2005 and October 2012 at Pennine Care NHS Foundation Trust assessed current practice in respect of valproate prescribing for bipolar disorder in women of childbearing age (under 46 years old). Prescribing data for 23 patients showed clinical discussion was carried out during initiation of valproate with 35% of patients and during follow up for 22% of patients.

South London and Maudsley NHS Foundation Trust carried out a baseline survey to determine adherence to the NICE guidance recommendations on the use of valproate for bipolar illness in women of childbearing potential which was followed by a quality improvement programme. The audit was performed in five stages: the baseline audit and feedback of results, implementation of a quality improvement programme, re-audit and feedback of results, a second quality improvement programme and final audit. Significant improvement was noted between baseline and final audit:

- information provision 10% v. 63%
- contraceptive use 15% v. 38%
- folate prescription 3% v. 35%

## *4.4 Psychological interventions*

### 4.4.1 Summary of suggestions

**Specific and high intensity interventions**

Stakeholders highlighted the importance of offering people with bipolar disorder psychological intervention specifically developed for bipolar disorder or high-intensity psychological intervention.

### 4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

[3] Carol Paton et al. Monitoring lithium therapy: the impact of a quality improvement programme in the UK

**Table 8 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Specific and high intensity interventions | **Managing bipolar disorder in primary care**<br>NICE CG185 Recommendation 1.2.5<br>**Psychological interventions**<br>NICE CG185 Recommendations 1.6.1, 1.7.2, 1.7.3 |

**Managing bipolar disorder in primary care**

NICE CG185 - Recommendation 1.2.5

Offer people with bipolar depression:

- a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or
- a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.

Discuss with the person the possible benefits and risks of psychological interventions and their preference. Monitor mood and if there are signs of hypomania or deterioration of the depressive symptoms, liaise with or refer the person to secondary care. If the person develops mania or severe depression, refer them urgently to secondary care.

**Psychological interventions**

NICE CG185 - Recommendation 1.6.1

Offer adults with bipolar depression:

- a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or
- a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.

Discuss with the person the possible benefits and risks of psychological interventions and their preference. Monitor mood for signs of mania or hypomania or deterioration of the depressive symptoms.

NICE CG185 - Recommendation 1.7.2

Offer a family intervention to people with bipolar disorder who are living, or in close contact, with their family in line with recommendation 1.3.7.2 in the NICE clinical guideline on psychosis and schizophrenia in adults.

NICE CG185 - Recommendation 1.7.3

Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder and has a published evidence-based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.

### 4.4.3 Current UK practice

**Psychological interventions**

Community Mental Health Survey (2013) asked people who use community mental health services about their experiences in accessing talking therapies, as defined in the questionnaire (i.e. included counselling, cognitive behavioural therapy (CBT), and anxiety management). Only 39% of respondents said that they had received talking therapy from NHS mental health services in the last 12 months.

Between 2012 and 2013 'We need to talk' coalition (a group of mental health charities, professional organisations, Royal Colleges and service providers) carried out research with people who have either used or tried to access psychological therapies on the NHS in England within the last two years. The research included:

- two focus groups with 10 people
- carrying out a survey of more than 1600 people with mental health problems who have used psychological therapies
- carrying out surveys with local MINDs, the British Psychoanalytic Council, UK Council for Psychotherapy and NHS psychological therapists

The survey results showed wide variation in people's experiences of psychological service provision, availability, access and quality. While many people are now getting access to their choice of psychological therapy within weeks, some still wait years for services that are not right for them; Key findings:

- one in 10 people have been waiting over a year to receive treatment
- over half have been waiting over three months to receive treatment

- 58% weren’t offered choice in the type of therapies they received
- three quarters were not given a choice in where they received their treatment
- half felt the number of sessions weren’t enough
- 11% said they had to pay for treatment because the therapy they wanted was not available on the NHS
- 40% had to request psychological therapies rather than being offered them
- one in ten, after being assessed, were not offered psychological therapies

## *4.5 Managing crisis*

### 4.5.1 Summary of suggestions

#### Community care in crisis

Stakeholders highlighted that people experiencing a mental health crisis often come into contact with the police and other emergency services, rather than mental health services. They suggested that appropriate, community-based crisis care and support needs to be incentivised so that people can access support earlier, avoiding detention under the Mental Health Act and inpatient care.

#### Access to crisis care

Stakeholders highlighted that crisis care and accessibility has been improving but is still inadequate. They stressed that it is vital for potential patients, families and partners to be able to access rapid assessment to prevent danger. The stakeholders suggested that bipolar disorder is often diagnosed post crisis, including admission to hospital with self-harm or suicide attempt, or via arrest in the justice system.

#### Preventing suicide

Stakeholders highlighted the need for effective management of suicide risks and preventative interventions in mental illnesses.

### 4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

**Table 9 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Community care in crisis | **Managing crisis, risk and behaviour that challenges in adults with bipolar disorder in secondary care**<br>NICE CG185 Recommendation 1.4.2 |
| Access to crisis care | **Managing crisis, risk and behaviour that challenges in adults with bipolar disorder in secondary care**<br>NICE CG185 Recommendation 1.4.1 |
| Preventing suicide | **Managing crisis, risk and behaviour that challenges in adults with bipolar disorder in secondary care**<br>NICE CG185 Recommendation 1.4.3 |

**Managing crisis, risk and behaviour that challenges in adults with bipolar disorder in secondary care**

NICE CG185 - Recommendation 1.4.1

Develop a risk management plan jointly with the person, and their carer if possible, covering:

- identifiable personal, social, occupational, or environmental triggers and early warning signs and symptoms of relapse
- a protocol for applying the person's own coping strategies and increasing doses of medication or taking additional medication (which may be given to the person in advance) for people at risk of onset of mania or for whom early warning signs and symptoms can be identified
- agreements between primary and secondary care about how to respond to an increase in risk or concern about possible risk information about who to contact if the person with bipolar disorder and, if appropriate, their carer, is concerned or in a crisis, including the names of healthcare professionals in primary and secondary care who can be contacted.

Give the person and their GP a copy of the plan, and encourage the person to share it with their carers.

NICE CG185 - Recommendation 1.4.2

Offer crisis services to support people with bipolar disorder who are in crisis, in line with recommendations 1.4.1.1–1.4.1.4 in the NICE clinical guideline on psychosis and schizophrenia in adults.

NICE CG185 - Recommendation 1.4.3

If people with bipolar disorder pose an immediate risk to themselves or others during an acute episode, see the NICE guidance on:

- violence and service user experience in adult mental health for advice on managing agitation, challenging behaviour and imminent violence, and on rapid tranquillisation or
- Self-harm for advice on managing acts of self-harm and suicide risk.

### 4.5.3 Current UK practice

#### Community care in crisis

According to a report "Listening to experience" produced by MIND based on independent inquiry into acute and crisis mental healthcare (2010/11) service user satisfaction with crisis resolution and home treatment (CRHT) was significantly higher than with inpatient services. However, there were still gaps connected with discontinuity in services, short follow-up care, staff shortages, long waiting times for care and a lack of information on an individual's mental health condition and/or medication.

The report presented feedback from people who criticised crisis resolution and home treatment services, people who had had traumatic experiences of hospital and people with a loved one who had taken their own life while in, or trying to access, the care of mental health services. While there were some very positive experiences of CRHTs, there were also major frustrations and problems to do with the capacity of teams, their responsiveness, the effectiveness of their help and their role in gatekeeping acute hospital admissions.

#### Access to crisis care

At the end of the 2013-14 reporting period (31 March 2014) there were a total of 23,531 people subject to The Mental Health Act. Of these, 18,166 were detained in hospital on longer term hospital orders and 5,365 were being treated in the community on Community Treatment Orders (CTOs). The figures show that the total number of Place of Safety Orders made has increased by 5% (1,166) to 23,343 since 2012-13. Of the 23,036 Place of Safety orders made using Section 136, the proportion where the individual went to a hospital rather than a police custody based Place of Safety increased from 64% (14,053) during 2012-13 to 74% (17,008) this reporting year (reflecting an 21% increase in uses of hospital based-, and a 24% decrease in police custody based-, Place of Safety Orders)[4].

CQC report "A safer place to be" (2014) highlights that in 2011/12 and 2012/13, people with mental health problems accounted for half of all deaths in or following police custody (seven out of 15 deaths in both years), and over a third in 2013/14 (four out of 11). The survey carried out by CQC found that some places of safety were operating effectively, with innovative examples of positive practice and organisational developments. However, the survey also found problems with capacity, staffing, delays in carrying out assessments, and unclear arrangements for multi-agency working. In addition, the survey found that it is not uncommon for health-based places of safety to operate with exclusion criteria, for example excluding people under a certain age, or people believed to be intoxicated.

[4] Health and Social Care Information Centre Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2013-2014, Annual figures

**Figure 1**

**People unable to access the place of safety - frequency**

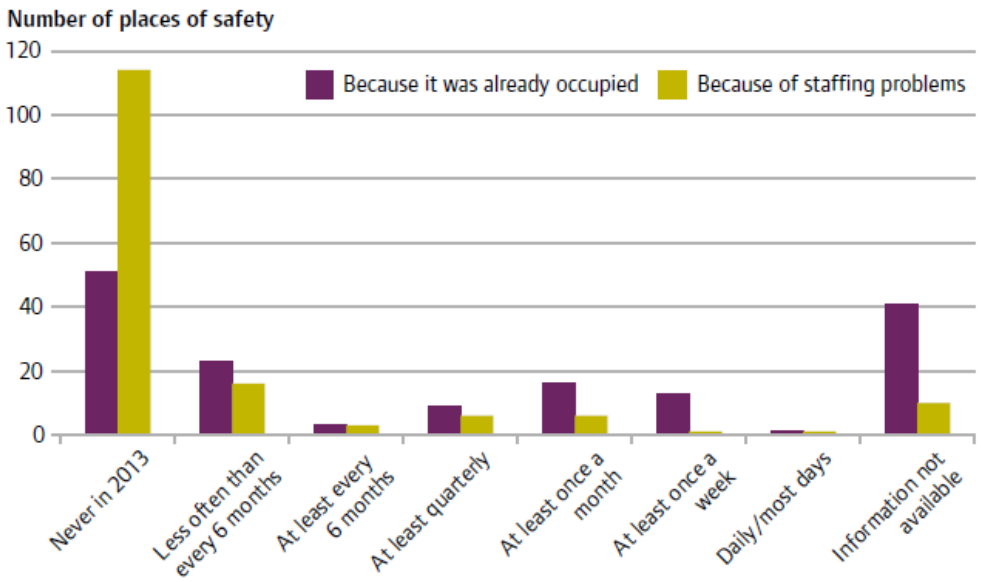
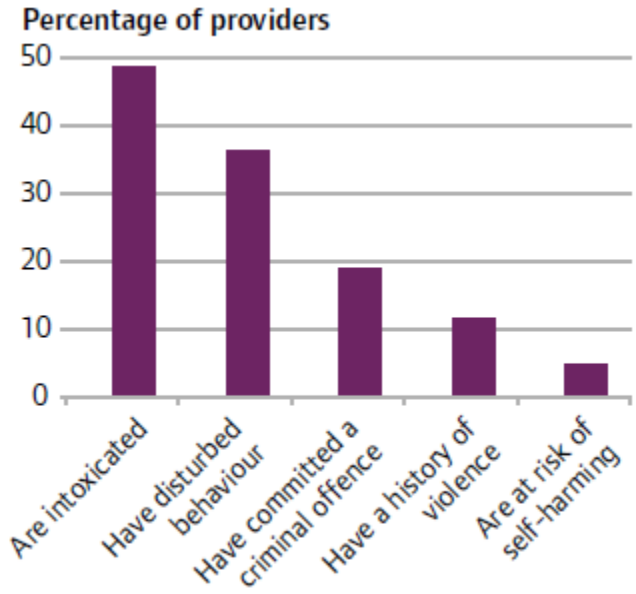



**Figure 2**

**Reasons for exclusion in provider or interagency policies**




The survey, conducted by the Royal College of Psychiatrists' Psychiatric Trainees' Committee (PTC), asked junior doctors working in psychiatry in the UK to talk about their experiences of working in mental health over the last six months. Of the 576 trainees that responded: 70% said they had experienced difficulty finding an appropriate bed for a patient at least once.

- 80% had sent a patient outside the local area for a bed, 15% doing this more than monthly.
- 37% said a colleague's decision to detain a patient under the Mental Health Act had been influenced by the fact that doing so might make the provision of a bed more likely, and 18% said their own decisions had been influenced in such a way.
- 28% have sent a critically unwell patient home because no bed could be found.

## *4.6 Monitoring physical health*

### 4.6.1 Summary of suggestions

**Monitoring physical health**

Stakeholders highlighted that achieving parity of esteem is a priority for people with mental illness and that it is essential for people with bipolar disorder to have their physical health thoroughly assessed. Stakeholders suggested that this should take place when people are first in contact with healthcare professionals and then regularly monitored, at least annually, by GPs and other healthcare professionals. This regular monitoring should include medication reviews and lipids measurement. Stakeholders also highlighted the importance of subsequent treatment to address any physical health needs that have been identified and data sharing between primary and secondary care.

**Responsibility for monitoring**

Stakeholders highlighted that lack of clarity around the role of mental health services in supporting physical health, inaccessible physical health services and poor integration between primary and secondary care are key barriers to good care for people with bipolar disorder.

### 4.6.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

**Table 10 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Monitoring physical health | **Monitoring physical health (primary care)**<br>NICE CG185 Recommendations 1.2.10, 1.2.12, 1.2.13<br>**Monitoring physical health (secondary care)**<br>NICE CG185 Recommendation 1.8.4 |
| Responsibility for monitoring | **Monitoring physical health (primary care)**<br>NICE CG185 Recommendation 1.2.11<br>**Monitoring physical health (secondary care)**<br>NICE CG185 Recommendations 1.8.1, 1.8.5 |

**Monitoring physical health (primary care)**

NICE CG185 - Recommendation 1.2.10

Develop and use practice case registers to monitor the physical and mental health of people with bipolar disorder in primary care.

NICE CG185 - Recommendation 1.2.11

Monitor the physical health of people with bipolar disorder when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, including all the checks recommended in recommendation 1.2.12 and focusing on physical health problems such as cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care records.

NICE CG185 - Recommendation 1.2.12

Ensure that the physical health check for people with bipolar disorder, performed at least annually, includes:

- weight or BMI, diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including fasting blood glucose, glycosylated haemoglobin (HbA1c)
- and blood lipid profile
- liver function
- renal and thyroid function, and calcium levels, for people taking long-term lithium.

NICE CG185 - Recommendation 1.2.13

Identify people with bipolar disorder who have hypertension, have abnormal lipid levels, are obese or at risk of obesity, have diabetes or are at risk of diabetes (as indicated by abnormal blood glucose levels), or are physically inactive, at the earliest opportunity. Follow NICE guidance on hypertension, lipid modification, prevention of cardiovascular disease, obesity, physical activity and preventing type 2 diabetes.

**Monitoring physical health (secondary care)**

NICE CG185 - Recommendation 1.8.1

Healthcare professionals in secondary care should ensure, as part of the care programme approach, that people with bipolar disorder receive physical healthcare

from primary care as described in recommendations 1.2.10–1.2.14 after responsibility for monitoring has been transferred from secondary care.

NICE CG185 - Recommendation 1.8.4

Routinely monitor weight and cardiovascular and metabolic indicators of morbidity in people with bipolar disorder. These should be audited in the annual team report.

NICE CG185 - Recommendation 1.8.5

Trusts should ensure that they take account of relevant guidelines on the monitoring and treatment of cardiovascular and metabolic disease in people with bipolar disorder through board-level performance indicators.

### 4.6.3 Current UK practice

**Monitoring physical health**

An audit carried out in 5 primary care centres in Northampton found that 96% of patients with Severe Mental Illness (SMI) had a record of a review within the last 15 months. However, just over 20% of people with SMI received a full CVD screen (blood glucose and cholesterol, BP and BMI) in comparison with 96% of those with diabetes. The results showed that out of people with SMI 57% were given smoking advice, 14% were given advice on exercise and 13% were given advice on diet. What is more, only 11% were given full lifestyle advice and 8% received full CVD screening and lifestyle advice[5].

An audit of physical health monitoring for patients with schizophrenia or bipolar disorder carried out in two urban GP practices found that the number of patients whose smoking history, alcohol consumption history, blood pressure and body mass index had been recorded in the preceding 15 months varied significantly by practice, whilst recording of blood cholesterol and diabetes status did not. Patients with a diagnosis of schizophrenia were significantly more likely to have had a diabetes status recorded in the preceding 15 months compared to patients with bipolar disorder[6].

Quality and Outcomes Framework (QOF) results for April 2013 - March 2014 illustrating monitoring of agreed physical health indicators among people with schizophrenia, bipolar affective disorder and other psychoses in England are presented by figure 3

[5] Sheila Hardy et l. (2013) Screening for cardiovascular risk in patients with severe mental illness in primary care
[6] Tom Ratcliffe et al. (2011) Physical healthcare for people with serious mental illness

## Figure 3

| QOF Indicator | Percentage of patients receiving intervention |
|---|---|
| MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17 | 82.9 |
| MH004: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months, NICE 2010 menu ID: NM18 | 68.0 |
| MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42 | 74.9 |
| MH006: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months, NICE 2010 menu ID: NM16 | 78.8 |
| MH007: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months, NICE 2010 menu ID: NM15 | 79.1 |
| MH008: The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years, NICE 2010 menu ID: NM20 | 72.27 |
| MH009: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, NICE 2010 menu ID: NM21 | 93.2 |
| MH010: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months, NICE 2010 menu ID: NM22 | 81.3 |

## *4.7 Promoting recovery*

### 4.7.1 Summary of suggestions

**Employment, education and occupational activities**

Stakeholders highlighted that employment can be a very important part of a person's recovery, yet employment rates amongst people affected by mental illness are lower than most other health conditions. Stakeholders suggested that mental health services do not always understand their role in supporting people's employment outcomes and that health professionals may avoid talking about it, concerned that it might be detrimental to their health.

### 4.7.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

**Table 10 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Employment, education and occupational activities | **Information and support**<br>NICE CG185 Recommendation 1.1.9<br>**Employment, education and occupational activities**<br>NICE CG185 Recommendation 1.9.6 |

**Information and support**

NICE CG185 - Recommendation 1.1.9

Consider identifying and offering assistance with education, financial and employment problems that may result from the behaviour associated with bipolar disorder, such as mania and hypomania. If the person with bipolar disorder agrees, this could include talking directly with education staff, creditors and employers about bipolar disorder and its possible effects, and how the person can be supported.

**Employment, education and occupational activities**

NICE CG185 - Recommendation 1.9.6

Offer supported employment programmes to people with bipolar disorder in primary or secondary care who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.

### 4.7.3 Current UK practice

**Employment, education and occupational activities**

According to the Centre for mental health data shows that mental health problems are keeping large numbers of people out of the workforce. In February 2013 over 724,000 people were claiming employment and support allowance (ESA) because of mental and behavioural disorders. Even when mental health professionals do believe that the people they are supporting are capable of work, this does not necessarily translate into encouragement to find work or referrals to employment services. An investigation of the employment status of clients using a London community mental health service, found that while mental health staff rated 18.9% of their clients as capable of open market employment, the percentage actually in work was only 5.5% (Lloyd-Evans et al., 2012).

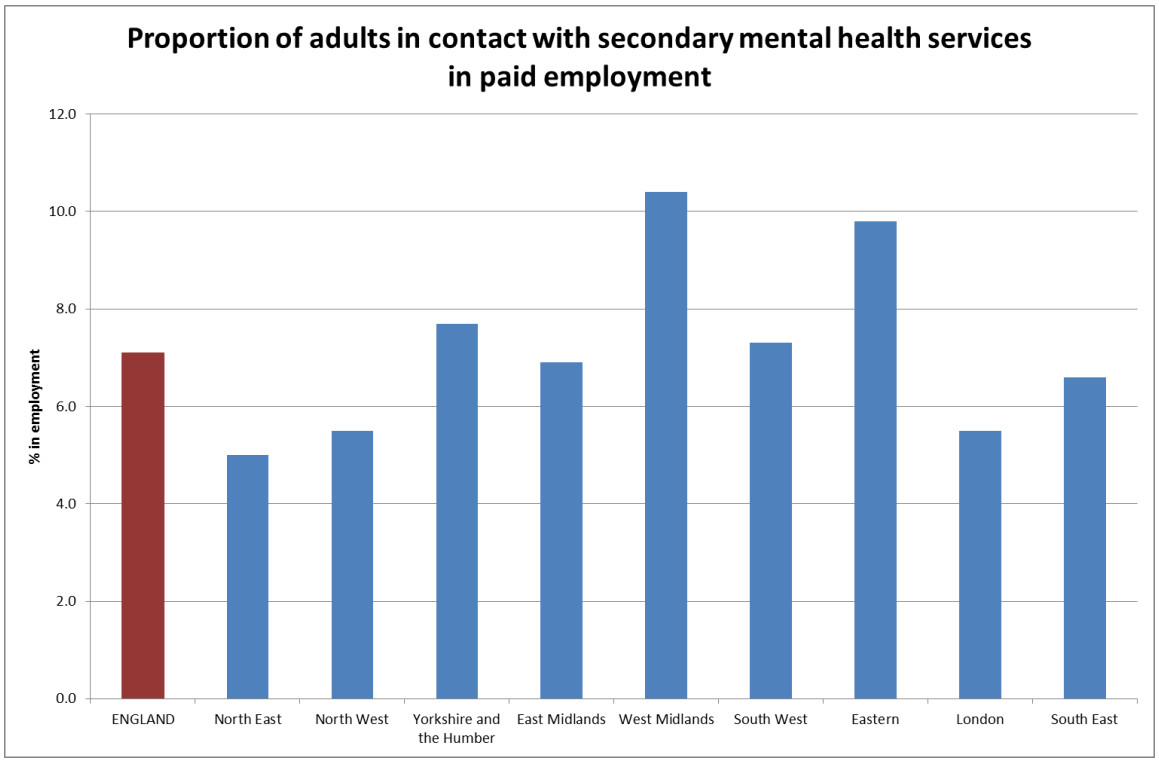
Community Mental Health Survey (2013) results suggest that some respondents would like more support in getting help with aspects of day to day living. Of those respondents who needed support:

- Almost a third (32%) of respondents on CPA and over half of those not on CPA (52%) said they did not receive support from someone in NHS mental health services in getting help with finding or keeping work but would have liked it.

- Many more would like to try out work yet are discouraged from seeking employment. Some are told by health professionals ‘you’ll never work again’ or warned to postpone their job search because they are ‘not ready’. 43% of those who have wanted help with employment never received it.

Latest data from the Mental Health Minimum Dataset (2013-14) illustrated by figure 3 shows that the proportion of working age adults (aged 18-69) who were receiving secondary mental health services and who were on the Care Programme Approach who were in paid employment varied across England. Over 10% of adults in contact with secondary mental health services were in paid employment in the West Midlands, which compared with 5% of those in the North East. National average was just over 7%.

**Figure 4**




The low priority given to employment by mental health professionals combined with the low expectations of people with mental health problems themselves in being able to gain employment may partly account for these low employment rates. These low expectations are reinforced by the attitudes of an overwhelming number of professionals, with only 8% of community mental health teams' (CMHTs) case notes addressing vocational needs and mental health professionals holding the belief that the majority of people on their case-loads are only capable of sheltered or voluntary work.[7]

Centre for Mental Health promotes Individual Placement and Support (IPS) as the most well-established method of 'place then train' in mental health. IPS has been shown to be more effective the more closely it follows these eight principles:

- It aims to get people into competitive employment
- It is open to all those who want to work
- It tries to find jobs consistent with people's preferences
- It works quickly
- It brings employment specialists into clinical teams

[7] Miles Rinaldi et al. (2011) Increasing the employment rate for people with longer-term mental health problems.

- Employment specialists develop relationships with employers based upon a person's work preferences
- It provides time unlimited, individualised support for the person and their employer
- Benefits counselling is included.

Implementation of the Individual Placement and Support (IPS) approach in the UK has been patchy and few places have achieved high fidelity to the model.

13 sites have been selected to be new Centres of Excellence in supporting people who use mental health services into employment. The sites that have committed to being partners in the programme are in Central and North West London, Coventry, Devon, Essex, Manchester, North Staffordshire, Nottingham, Shropshire, Somerset, Stafford, Sussex, Walsall and Worcestershire. They will act as exemplars of how can be implemented in localities across England. These areas will demonstrate how to base employment services for people with mental health problems on the evidence of what works best. In each site, the local mental health trust will work with partners in employment services, local authorities and other agencies to offer people effective support to get into paid work. The learning from these sites will be shared with other areas of England.

## *4.8 Care across all phases of bipolar disorder*

### 4.8.1 Summary of suggestions

**Information and support**

Stakeholders highlighted the importance of presenting people with bipolar disorder with information about their condition, potential treatment options (the risks and benefits of different approaches) and encouraging them to make an informed choice. They also highlighted the need to collect data on service user experience.

**Staff training**

Stakeholders suggested that all mental health professionals should be trained in specific biopsychosocial skills for working with people with bipolar disorder. They highlighted that service users and carers have been vocal in demanding better and more compassionate, respectful care.

**Family interventions**

Stakeholders highlighted the critical role of the family in maintaining wellness and long-term stability for the individual with a diagnosis of mental illness, acknowledging the impact the condition can have on the family. They also suggested that despite strong evidence, people with bipolar disorder and their families still find it difficult to access family intervention therapies.

**Support for carers & involving relatives**

Stakeholders highlighted the importance of involving relatives in care and shared decision making where appropriate. They raised the issue of difficulties in engagement particularly during acute phases of illness as their relative suffering from the disorder might lack capacity of consenting for information sharing.

### 4.8.2 Selected recommendations from development source

Table 11 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 11 to help inform the Committee's discussion.

**Table 11 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Information and support | **Discussing long-term treatment**<br>NICE CG185 Recommendations 1.7.1 |
| Staff | **Managing bipolar disorder in primary care**<br>NICE CG185 Recommendation 1.2.6<br>**Psychological interventions (secondary** |

| | |
|---|---|
| | **care)**<br>NICE CG185 Recommendation 1.6.2 |
| Family interventions | **Support for carers of people with bipolar disorder**<br>NICE CG185 Recommendation 1.1.18,<br>**Psychological interventions (secondary care)**<br>NICE CG185 Recommendation 1.7.2 |
| Support for carers & involving relatives | **Information and support**<br>NICE CG185 Recommendations 1.1.10, 1.1.11<br>**Support for carers of people with bipolar disorder**<br>NICE CG185 Recommendations 1.1.15, 1.1.17 |

**Discussing long-term treatment**

NICE CG185 - Recommendation 1.7.1

After each episode of mania or bipolar depression, discuss with the person, and their carers if appropriate, managing their bipolar disorder in the longer term. Discussion should aim to help people understand that bipolar disorder is commonly a long-term relapsing and remitting condition that needs self-management and engagement with primary and secondary care professionals and involvement of carers. The discussion should cover:

- the nature and variable course of bipolar disorder
- the role of psychological and pharmacological interventions to prevent relapse and reduce symptoms
- the risk of relapse after reducing or stopping medication for an acute episode
- the potential benefits and risks of long-term medication and psychological
- interventions, and the need to monitor mood and medication
- the potential benefits and risks of stopping medication, including for women who may wish to become pregnant
- the person's history of bipolar disorder, including:
    - the severity and frequency of episodes of mania or bipolar depression, with a focus on associated risks and adverse consequences
    - previous response to treatment
    - symptoms between episodes

    - potential triggers for relapse, early warning signs, and self-management strategies

- possible duration of treatment, and when and how often this should be reviewed.

Provide clear written information about bipolar disorder, including NICE's information for the public, and ensure there is enough time to discuss options and concerns.

**Managing bipolar disorder in primary care**

NICE CG185 - Recommendation 1.2.6

Psychological therapists working with people with bipolar depression in primary care should have training in and experience of working with people with bipolar disorder.

**Psychological interventions (secondary care)**

NICE CG185 - Recommendation 1.6.2

Psychological therapists working with people with bipolar depression should have training in, and experience of, working with people with bipolar disorder.

**Support for carers of people with bipolar disorder**

NICE CG185 - Recommendation 1.1.18

Offer a carer-focused education and support programme, which may be part of a family intervention for bipolar disorder, as early as possible to all carers. The intervention should:

- be available as needed

- have a positive message about recovery

**Psychological interventions**

NICE CG185 - Recommendations 1.7.2

Offer a family intervention to people with bipolar disorder who are living, or in close contact, with their family in line with recommendation 1.3.7.2 in the NICE clinical guideline on psychosis and schizophrenia in adults.

**Information and support**

NICE CG185 - Recommendation 1.1.10

Encourage people with bipolar disorder to develop advance statements while their condition is stable, in collaboration with their carers if possible.

NICE CG185 - Recommendation 1.1.11

Explain and discuss making a lasting power of attorney with adults with bipolar disorder and their carers if there are financial problems resulting from mania or hypomania.

**Support for carers of people with bipolar disorder**

NICE CG185 - Recommendations 1.1.15

As early as possible negotiate with the person with bipolar disorder and their carers about how information about the person will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the person's perspective. Foster a collaborative approach that supports both people with bipolar disorder and their carers, and respects their individual needs and interdependence.

NICE CG185 - Recommendations 1.1.17

Include carers in decision-making if the person agrees.

### 4.8.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement. This area is based on stakeholder’s knowledge and experience.

## *4.9 Additional areas*

### 4.9.1 Summary of suggestions

**Access**

Stakeholders highlighted the need for greater access to psychological therapies. They suggested that capacity could be increased by either expanding the remit of IAPT services or increasing the number of therapists with skills to work with people with bipolar disorder. Family interventions were also highlighted as a type of therapy particularly difficult to access. This area of quality improvement is not supported by recommendations within the guideline. However, if psychological therapies are prioritised as an area for quality improvement, improved access could be one of the outcomes of the statement.

**Antenatal and postnatal care**

Stakeholders highlighted various aspects of antenatal and postnatal care for women of childbearing age. This area of quality improvement is not within the remit of this quality standard as it will be addressed by a specific quality standard on antenatal and postnatal mental health which has been referred to the Quality Standards Topic Library.

**Assessment of Implementation**

Stakeholders highlighted the importance of psychological therapies developed specifically for bipolar disorder but raised concerns that access to these therapies remains poor. Stakeholders highlighted the importance of collecting data on implementation of the recommendations included in NICE CG185 regarding psychological therapies. This area of quality improvement is not supported by recommendations within the guideline. However, if psychological therapies are prioritised as an area for quality improvement measuring compliance would be a standard part of quality statement on psychological therapies.

**Children and young people**

Stakeholders highlighted various issues around diagnosing children and young people with bipolar disorder. This area of quality improvement is not within the remit of this quality standard as bipolar disorder in children and young people will be addressed within a quality standard Psychosis and schizophrenia in children and young people which is currently being developed.

**Complimentary therapies**

Stakeholders highlighted that managing bipolar disorder should be much more flexible. They suggested that complimentary therapies such as psychotherapy, psychoanalysis, mindfulness, hypnotherapy, life coaching, nutritional therapy, exercise therapy and many more could be added to the management approach agreed with and overseen by GP's and CMHTs . This suggestion is recommending

an approach rather than action that would lead to quality improvement and includes therapies that are not supported by recommendations within the guideline.

### Cross referencing

Stakeholders highlighted that the guideline repeatedly refers readers to other guidelines and raised specific issues around using recommendations from Psychosis and schizophrenia in adults: treatment and management (CG178). This area comments on the way the guidelines are written which is out of the scope of this quality standard.

### Early intervention in psychosis

Stakeholders highlighted the importance of providing Early Intervention in Psychosis (EIP) services to people experiencing a first episode of psychosis. This area of quality improvement will be better addressed within the Psychosis and schizophrenia in adults quality standard which is currently being developed.

### Inter-agency working

Stakeholders suggested that the needs of the patient and family are best met through collaboration of motivated and engaged stakeholders from all relevant sectors, including people with mental disorders, carers, family members, in prevention, treatment and recovery. This suggestion is not supported by recommendations within the guideline

### Nutritional assessment

Stakeholders suggested nutrition assessment and supplementation for 3 months before starting medication (measuring fatty acids and improving Omega-3 Index and Omega-6/3 ratio as well as Vitamin D supplement to 100 nmol/L). This suggestion includes an approach that is not supported by guideline recommendations.

### Raising awareness

Stakeholders suggested the need to raise awareness of mental health and mental illness to increase understanding and reduce fear and stigma. This area of quality improvement is not within the remit of this quality standard as it is already addressed within the quality standard for service user experience in adult mental health (QS14).

### Reviewing diagnosis

Stakeholders highlighted that patients present with one mental health condition, and then over time are re-diagnosed. With bipolar this may present as depression, then bipolar, or one bipolar type then another. There is an issue around delays in changes to care once new diagnosis is in place. This suggestion is not supported by recommendations within the guideline.

### Staff training

Stakeholders highlighted that it is not clear what bipolar specific training and manuals should be accessed and how. Stakeholders suggested that the quality standard should specify and direct people to the appropriate training and evidence based manuals mentioned in the guideline The training and competencies section within the quality standard addresses staff training expectations and no additional areas are supported by recommendations within the guideline.

## Appendix 1: Key priorities for implementation (CG185)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

### *Care for adults, children and young people across all phases of bipolar disorder*

#### Support for carers of people with bipolar disorder

- As early as possible negotiate with the person with bipolar disorder and their carers about how information about the person will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the person's perspective. Foster a collaborative approach that supports both people with bipolar disorder and their carers, and respects their individual needs and interdependence.[recommendation 1.1.15]

### *Recognising and managing bipolar disorder in adults in primary care*

#### Managing bipolar disorder in primary care

- Offer people with bipolar depression:

  - a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or

  - a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.

Discuss with the person the possible benefits and risks of psychological interventions and their preference. Monitor mood and if there are signs of hypomania or deterioration of the depressive symptoms, liaise with or refer the person to secondary care. If the person develops mania or severe depression, refer them urgently to secondary care.[recommendation 1.2.5]

### *Managing mania or hypomania in adults in secondary care*

#### Pharmacological interventions

- If a person develops mania or hypomania and is not taking an antipsychotic or mood stabiliser, offer haloperidol, olanzapine, quetiapine or risperidone, taking into account any advance statements, the person's preference and

clinical context (including physical comorbidity, previous response to treatment and side effects). Follow the recommendations on using antipsychotics in section 1.10. [recommendation 1.5.3]

- If the person is already taking lithium, check plasma lithium levels to optimise treatment (see section 1.10). Consider adding haloperidol, olanzapine, quetiapine or risperidone, depending on the person's preference and previous response to treatment.

## *Managing bipolar depression in adults in secondary care*

### Psychological interventions

- Offer adults with bipolar depression:

  - a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or

  - a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression.

Discuss with the person the possible benefits and risks of psychological interventions and their preference. Monitor mood for signs of mania or hypomania or deterioration of the depressive symptoms.[recommendation 1.6.1]

### Pharmacological interventions

- If a person develops moderate or severe bipolar depression and is not taking a drug to treat their bipolar disorder, offer fluoxetine combined with olanzapine, or quetiapine on its own, depending on the person's preference and previous response to treatment.

  - If the person prefers, consider either olanzapine (without fluoxetine) or lamotrigine on its own.

  - If there is no response to fluoxetine combined with olanzapine, or quetiapine, consider lamotrigine on its own.

Follow the recommendations on using antipsychotics and lamotrigine in section 1.10. [recommendation 1.6.3]

- If a person develops moderate or severe bipolar depression and is already taking lithium, check their plasma lithium level. If it is inadequate, increase the dose of lithium; if it is at maximum level, add either fluoxetine[3] combined with olanzapine[4] or add quetiapine, depending on the person's preference and previous response to treatment.

- If the person prefers, consider adding olanzapine (without fluoxetine) or lamotrigine to lithium.

- If there is no response to adding fluoxetine combined with olanzapine, or adding quetiapine, stop the additional treatment and consider adding lamotrigine to lithium.

Follow the recommendations in section 1.10 on using lithium, antipsychotics and lamotrigine. [recommendation 1.6.4]

## *Managing bipolar disorder in adults in the longer term in secondary care*

### Psychological interventions

- Offer a structured psychological intervention (individual, group or family), which has been designed for bipolar disorder and has a published evidence-based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.[recommendation 1.7.3]

### Pharmacological interventions

- Offer lithium as a first-line, long-term pharmacological treatment for bipolar disorder and: if lithium is ineffective, consider adding valproate if lithium is poorly tolerated, or is not suitable (for example, because the person does not agree to routine blood monitoring), consider valproate or olanzapine instead or, if it has been effective during an episode of mania or bipolar depression, quetiapine.

Discuss with the person the possible benefits and risks of each drug for them. [recommendation 1.7.6]

## Appendix 2: Suggestions from stakeholder engagement exercise

| ID | Section number | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 1 | 4.1 | Donna Swinden | SCM | Key area for quality improvement 2: Clearer guidance for making a diagnosis of bipolar disorder. | There is good evidence that if people receive the correct diagnosis they will receive prompt and appropriate interventions, with psychoeducation and mood management being key. | A paper by Jan Scott (?2004) highlighted that 46% of people with bipolar disorder are either undiagnosed or misdiagnosed. Early Intervention services can be very effective for newly diagnosed people with bipolar disorder. | NICE guidelines for Bipolar Disorder (2014) |
| 2 | 4.1 | Stuart Morgan-Ayrs | Scotlandtherapy | Key area for quality improvement 2 Screening | Screening of patients with presentations of depression and anxiety for possible mood disorders. | Currently many patients present with anxiety, depression or co-morbidity (depression and alcohol use for example). Only later is a mood disorder suspected, often after a crisis phase or an anti depression medication causes switching. | Highly recognised in studies on co-morbidity. Both NHS wide and Scottish government documents. |

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| 3 | 4.1 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Bipolar Disorder in Primary Care | Recognition of BD in primary care is currently very poor. | We have collected some evidence on this in the North West in which we conducted a mapping exercise across the footprint of the Cumbria and Lancashire Clinical Research Network (CRN), using the FARSITE tool. Data was collected across 50 GP surgeries covering a total patient population of 320,947 people. Only 34 surgeries identified ANY people with a diagnosis of Bipolar Disorder. The total number of people with this diagnosis was across all surgeries was 788 people. This is a prevalence rate of 0.24 % which we is significantly lower than the national reported prevalence rates of 1-1.5%.To address this, we would like to monitor how many people reporting depression in primary care, are asked specifically about experiences of high mood, as indicated should happen in the guideline. We hypothesise this would greatly increase the rates identified. | |
| 4 | 4.1 | Alison Lawrence & Andy Hockey | Joint response Otsuka and Lundbeck | 1. Provision of an accessible and relevant care plan | The Government's principle of 'no decision about me, without me' should be a key priority for mental health services. In practice this can be achieved by ensuring people with bi-polar and their carers are informed about the full range of treatment | In the development of NICE guideline 185 the Guideline Development Group (GDG) judged that the recommendation for care planning for people with schizophrenia and psychosis was relevant to people with bipolar disorder. The GDG also considered that the care programme approach might be appropriate for some people with multiple and complex needs as not infrequently seen with people with bipolar disorder. Care plans must reflect the full | Bipolar Disorder: The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. NICE Clinical Guideline 185 http://www.nice.org.uk/guidance/cg185/evidence/cg185-bipolar- |

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| | | | | | options, are involved in care planning and can, therefore, exercise informed choice. It is crucial that effective care planning is undertaken in collaboration with healthcare professionals and produced following a holistic assessment, which promotes recovery and sets out long-term outcomes. The need to write and use a care plan in collaboration with the service user is recommended in the NICE clinical guideline 185 and is consistent with other mental health guidance as a key element of high quality care. | spectrum of needs, ie psychological, pharmacological and physical, as well as social needs such as housing and educations, as these have an impact on people's ability to achieve their recovery goals. The necessity of care plans being accessible must also be reflected in the quality standard. This will help to ensure that care plans remain understandable and user-friendly for healthcare professionals, people with schizophrenia and their carers. | disorder-update-full-guideline3 |

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| 5 | 4.1 | Donna Swinden | SCM | Key area for quality improvement 3: Better identification of co-morbidities | A large number of people with bipolar disorder also suffer from co-morbidities e.g. OCD, PTSD, borderline personality disorder; and these may go untreated or mask the diagnosis of bipolar disorder. There is good evidence to support effective treatment for anxiety disorders. | When people with bipolar disorder do have identified co-morbidities, they often get them treated by separate services and/or individual professionals, leading to lack of a co-ordinated approach and also delay in treatment whilst being transferred between services and/or held on waiting lists. | NICE guidelines for Bipolar Disorder (2014) |
| 6 | 4.1 | Fiona Martin | The National THORN Steering Group | Key area for quality improvement 2 Early intervention | Engagement in a biopsychsocial model of assessment, treatment and wellness enhances outcomes as does the use of evidence-based protocols and practices, I such as early intervention. | Building the knowledge and skills of general and specialised health workers to deliver evidence-based, culturally appropriate mental health and social care services, by introducing mental health into primary, secondary and tertiary curricula; and through training and mentoring health workers particularly in non-specialised settings. | Mental Health Action Plan 2013-2020 (WHO) |
| 7 | 4.2 | Stuart Morgan-Ayrs | Scotlandtherapy | Key area for quality improvement 1 Condition Management | Management of persons with mood disorders including Bipolar Disorder | Current care is focused too much on crisis point intervention, and not enough on ongoing support and management to prevent relapse. | High incidence of relapse into front line NHS and CMHT services, often with suicide attempts or criminal behaviour. |
| 8 | 4.3 | Professor Ian Jones | Royal College of Psychiatrists | Key area for quality improvement 1 The prescription of sodium valproate to women with | The evidence base is clear implicating sodium valproate as having significant reproductive safety issues. Exposure | Despite clear guidance from NICE in the last bipolar guidelines that valproate should not be used in woman of childbearing potential clinical experience and a number of local audits have shown | |

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| | | | | bipolar disorder of childbearing age | to valproate in pregnancy is associated with a range of abnormalities and with long term problems with cognitive development in children | that this advise is still not being followed. Many women in their childbearing years are still being exposed to this dangerous medication. | |
| 9 | 4.3 | Richard Morriss | SCM | Drug treatment for adult bipolar depression | 2014 NICE guideline for bipolar depression in adults a change of practice from the 2006 guideline based on network meta-analysis of randomised controlled trials and economic assessment. The 2014 guideline recommends the use of one antidepressant with olanzapine some antipsychotic and anticonvulsant drugs rather than any antidepressant with any anti-mania drug. | The recommendation goes against traditional teaching on the management of depression in adults taught by the Royal College of Psychiatrists and the Royal College of General Practitioners. Differences between the management of bipolar depression and unipolar depression are poorly understood by clinicians. There are important differences in the agents used their effectiveness both in primary and secondary treatment recommendations, and the potential harm from such medication. | POMHS audit suggests high use of antidepressants in people with bipolar disorder: .Paton C, Adroer R, Barnes TRE. Monitoring lithium therapy: the impact of a quality improvement programm e in the UK. Bipolar Disorder 2013: 15: 865–875. Previous NICE Guideline in 2006 recommended management of bipolar depression using an antidepressant and an anti-mania drug. Recent surveys of prescribing for bipolar depression ( 2011-14) in Australia, Canada, China and Germany also show high prevalence of antidepressant |

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| | | | | | | | prescribing in bipolar disorder. |
| 10 | 4.3 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | Additional developmental areas of emergent practice- 1 Olanzapine together with fluoxetine or quetiapine are offered in bipolar depression 2 Psychological intervention specifically developed for bipolar disorder or high-intensity psychological intervention is offered in bipolar depression or in the longer term; | Important variation of practice from NICE guidance on medication use and access to psychological therapies. | http://www.nice.org.uk/guidance/CG185 | |

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| 11 | 4.3 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | Key area for quality improvement 4 | Clarifying a robust management of the lithium use and prophylaxis. Specifically; -If patient suffering from mania or depression on lithium; check level; -If lithium level are inadequate; dose increase; -If lithium at maximum dose and depression; add olanzapine together with fluoxetine or quetiapine on its own;-Lithium offered as first-line treatment in the longer term; | Lithium is subject to a shared national monitoring between primary and secondary care, involving the use of a booklet. | http://www.nice.org.uk /guidance/CG185 |
| 12 | 4.3 | Frances Healey | NHS England Patient Safety Domain | Ensuring the QS development group is mindful of potential for safety risk related to treatment for bipolar disorder | It is important to be aware that one particular treatment for bipolar disorder needs safeguards in place to ensure it does not cause unintended harm | The National Patient Safety Agency issued a Patient safety Alert Safer lithium therapy in 2009 to alert the NHS to a range of risks affecting patients on lithium therapy. The Alert stated:<br>Some patients taking lithium have been harmed because they have not had their dosage adjusted based on recommended regular blood tests. If patients are not informed of the known side effects or symptoms of toxicity, they cannot manage their lithium therapy safely.<br>Regular blood tests are important.<br>Clinically significant alterations in lithium blood levels occur with commonly | http://www.nrls.npsa.n hs.uk/alerts/?entryid45 =65426 |

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| | | | | | | prescribed and over-the-counter medicines. The blood level of lithium is dependent on kidney function and lithium has the potential to interfere with kidney (renal) and thyroid functions.<br>All healthcare organisations in the NHS where lithium therapy is initiated, prescribed, dispensed and monitored are asked to ensure that by 31 December 2010:<br>• patients prescribed lithium are monitored in accordance with NICE guidance;<br>• there are reliable systems to ensure blood test results are communicated between laboratories and prescribers;<br>• at the start of lithium therapy and throughout their treatment patients receive appropriate ongoing verbal and written information and a record book to track lithium blood levels and relevant clinical tests;<br>• prescribers and pharmacists check that blood tests are monitored regularly and that it is safe to issue a repeat prescription and/or dispense the prescribed lithium;<br>• systems are in place to identify and deal with medicines that might adversely interact with lithium therapy. | |

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| 13 | 4.3 | Richard Morriss | SCM | Lithium as first line long-term drug treatment of bipolar disorder with high quality lithium monitoring. | 2014 NICE Guideline reaffirmed that the best clinical and economic evidence for long-term drug treatment of bipolar disorder is still lithium. Changes to frequency and nature of lithium monitoring have been made. Valproate prescribing high in women of childbearing age when lithium is an alternative | The proportion of people prescribed lithium for long-term management of bipolar disorder has risen slightly over time and seems confined to older people while there have been large increases in prescriptions for valproate, quetiapine and olanzapine, especially in younger people. Lithium monitoring is not carried out as frequently as recommended in NICE 2006 Guideline although these recommendations have now changed. Valproate is associated with high teratogenicity | Hayes J, Prah P, Nazareth I, King M, Walters K, Petersen I, Osborn D: Prescribing trends in bipolar disorder: cohort study in the United Kingdom THIN primary care database 1995–2009. PLoS One 2011, 6:e28725. POMHs audit of lithium monitoring www.rcpsych.ac.uk/quality/nationalclinicalaudits/prescribingpomh: Paton C, Adroer R, Barnes TRE. Monitoring lithium therapy: the impact of a quality improvement programme in the UK.Bipolar Disord 2013: 15: 865–875. © |
| 14 | 4.3 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | If patient suffering of mania; 1. Consideration to stop the antidepressant; 2. haloperidol, olanzapine, quetiapine or risperidone are offered | Individual relapsing in mania require prompt and cohesive interventions from practitioners would it be in primary or secondary care. | http://www.nice.org.uk/guidance/CG185 | |

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| 15 | 4.4 | Pam Tester | Lancashire Care NHS Foundation Trust | Key area for quality improvement 2 | Inclusion of provision of psychological therapies | This appears to be a national issue and so having a quality standard should support us to drive up the quality of care for people with bipolar disorder | National audit of psychological therapy, IAPT for SMI recognises difficulty in providing family intervention therapy, despite strong evidence base on outcomes. |
| 16 | 4.4 | Richard Morriss | SCM | Psychological treatment for bipolar disorder | Psychological treatments developed for bipolar disorder shown to be clinically effective in meta-analysis for both bipolar depression and long-term management and may be cost effective in terms of long-term prevent of relapse and hospitalisation | Psychological treatment is not available routinely through Improving Access to Psychological Treatment (IAPT) although the need to develop such treatment was recognised in 2010 with the setting up of National Demonstration sites. Workforce has not been developed nor services commissioned. | There are no routinely delivered IAPT services for bipolar disorder in England and only two national demonstration sites according to the IAPT website: http://www.iapt.nhs.uk/smi- |
| 17 | 4.4 | Stuart Morgan-Ayrs | Scotlandtherapy | Key area for quality improvement 3 Talking therapies | Recognition of the importance of psychological and talking therapies in managing distress and related trauma. | Focus tends to be biomedical and functional only using CBT based techniques. Most long term sufferers have issues around relationships, lifestyle, development and other experiences that benefit from self awareness and understanding. Psychoanalysis, psychotherapy, counselling or methods like MBCT, mindfulness and hypnotherapy are helpful in these cases. | Feedback and comments from bipolar clients and widely available comment by sufferers on support group forums and meetings. Additional research would be beneficial. |

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| 18 | 4.4 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | Additional developmental areas of emergent practice- 1 Olanzapine together with fluoxetine or quetiapine are offered in bipolar depression 2 Psychological intervention specifically developed for bipolar disorder or high-intensity psychological intervention is offered in bipolar depression or in the longer term; | Important variation of practice from NICE guidance on medication use and access to psychological therapies. | http://www.nice.org.uk/guidance/CG186 | |

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| 19 | 4.4 | Paula Reid | Rethink Mental Illness | Key area for quality improvement 4 Psychological therapies | Psychological therapies are widely recognised as effective treatments for a range of mental health problems. The NICE guidelines recommend structured psychological interventions designed for bipolar disorder, supported by an evidence-based manual for how to deliver it. Rethink Mental Illness also supports the ongoing IAPT for SMI pilots, including a pilot site focusing specifically on bipolar disorder | Recently Rethink Mental Illness published a report on access to talking therapies as part of a coalition of mental health organisations. There has been investment made in recent years to extend access to psychological therapies. However two-thirds of people with severe mental illness wait more than three months, and one in five wait for more than a year to access these therapies.[11] | We Still Need to Talk – a report from the We Need to Talk on access to talking therapies http://www.rethink.org/media/869903/We_still_need_to_talk.pdf Investing in Recovery - making the business case for effective interventions for people with psychosis http://www.rethink.org/media/1030280/investing_in_recovery.pdf IAPT for SMI programme http://www.iapt.nhs.uk/smi-/ |
| 20 | 4.4 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Delivery of Psychological Interventions | In relation to the delivery of psychological interventions, the guideline refers to “appropriate training” and use of “manualised” psychological interventions. | However, these terms are not defined, and clinicians are not given any information about how to access either the training or the manuals. Our experience is that specialist Bipolar training is not generally available, and that most of the manuals referenced in the evidence base for psychological interventions are not generally available to the public. Therefore the quality standard should specify and direct people to these resources, and work to make sure they are available | |

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| 21 | 4.5 | Stuart Morgan-Ayrs | Scotlandtherapy | Key area for quality improvement 5 Crisis care | Crisis care and accessibility is improving but is still inadequate. It is vital that potential patients, families and partners can access rapid assessment to prevent danger. | It is commonplace for bipolar to be diagnosed post crisis, including admission to hospital with self harm or suicide attempt, or via arrest in the justice system. Better access may reduce this, and the resultant trauma. | Statistics on suicide attempt and criminal justice system. |
| 22 | 4.5 | Paula Reid | Rethink Mental Illness | Key area for quality improvement 3 Crisis care | Too often, people experiencing a mental health crisis come into contact with the police and other emergency services, rather than mental health services. The Health and Social Care Information Centre has shown that people affected by mental illness disproportionately access acute and emergency services, approximately twice as often as people not affected by mental illness.[5] Appropriate, community-based crisis care and support needs to be incentivised so that people can access support earlier, avoiding detention under the Mental Health Act and | The number of people being detained under the Mental Health Act is increasing – it has risen 12% in the past five years.[8] This points towards a system where people are not getting the necessary support until they reach the point of crisis and hospitalisation. People are also not being given the necessary support and information to access appropriate services in a crisis. Crisis planning is one of the quality statements in NICE's Service User Experience in Adult Mental Health Services quality standard.[9] However just 58% people on CPA say that their NHS care plan 'definitely' covers what to do in a crisis. This drops to 49% for people not on CPA.[10] | Quality standard for service user experience in adult mental health (QS14) http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14 Mental Health Crisis Care Concordat https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf Investing in Recovery - making the business case for effective interventions for people with psychosis http://www.rethink.org/media/1030280/investing_in_recovery.pdf |

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| | | | | | inpatient care. Economic analysis shows that this is more cost-effective than inpatient care – crisis resolution and home treatment teams could lead to a 30% reduction in costs for people experiencing a mental health crisis.[6] The crisis house model as an alternative to admission also shows cost-savings and is viewed more favourably by people affected by mental illness.[7] | | Care Quality Commission - National Summary of the Results for the 2013 Community Mental Health Survey http://www.cqc.org.uk/sites/default/files/media/documents/20130911_mh13_national_summary_final.pdf Monitoring the Mental Health Act in 2012/13 http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2012_13_07_update.pdf |
| 23 | 4.5 | Donna Swinden | SCM | Key area for quality improvement 5: Reduce the suicide rates and risks for people with bipolar disorder and their families. | There is good evidence to support the effective management of suicide risks and preventative interventions in other mental illnesses. | There is a high suicide risk for people with bipolar disorder and also their family members who are affected by the impact of the illness. | Spectrum Centre for mood disorders, Lancaster. |

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| 24 | 4.6 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | Key area for quality improvement 2 | Promote annual measurement of lipids, not only cholesterol. People with rapid or excessive weight gain, abnormal lipids levels or problem with blood glucose; are offered interventions in line with NICE guidance on obesity, lipid modification or preventing type 2 diabetes. | A trust audit outlined that the majority of individual suffering from bipolar disorder present or develop metabolic syndromes with increased weight and lipids. There is considerable morbidity associated with metabolic disturbances and comorbid related physical conditions. | http://www.nice.org.uk /guidance/PH53 Global Burden of Bipolar Disorder Murray and colleagues (2012) |
| 25 | 4.6 | Alison Lawrence & Andy Hockey | Joint response Otsuka and Lundbeck | 4. Assessment and treatment of physical health | Achieving parity of esteem is a priority for people with mental illness. In this context it is essential that people with bipolar have their physical health thoroughly assessed when first in contact with healthcare professionals and regularly monitored, at least annually, by GPs and other healthcare professionals. Subsequent treatment to address any physical health needs that have been identified is then | The evidence set in the NICE bipolar clinical guideline supports the case for the focus on physical health needs of people with bipolar disorder. “People with bipolar disorder seem to be at increased risk of physical health problems, particularly from cardiovascular disease. Overall, 38% of people with bipolar disorder die from cardiovascular disease, about twice the expected standardised mortality rate, compared with 18% by suicide in a national sample from Sweden (Westman et al., 2013)” Moreover weight gain and obesity further contribute to stigma and discrimination and may explain unplanned discontinuation of antipsychotic medication leading to relapse. | Bipolar Disorder: The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. NICE Clinical Guideline 185 http://www.nice.org.uk /guidance/cg185/evide nce/cg185-bipolar-disorder-update-full-guideline3 |

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| | | | | | vital, in addition to ongoing assessment and treatment. In this context regular, annual, medicines reviews are important to ensure the right treatment at the right time to avoid unnecessary adverse events which may have detrimental effect on an individual's physical health. | | |
| 26 | 4.6 | Richard Morriss | SCM | Poor physical health monitoring and information sharing across primary and secondary care. | People with bipolar disorder have twice the standardised mortality ratio for dying for cardiovascular and respiratory disease. | Lower rates of cardiovascular monitoring in serious mental illness including bipolar disorder in primary care than for other high risk groups. | Martin JL, Lowrie R, McConnachie A, McLean G, Mair F, Mercer SW, Smith DJ Physical health indicators in major mental illness: analysis of QOF data across UK general practice.Br J Gen Pract. 2014 Oct;64(627):e649-56. |
| 27 | 4.6 | Paula Reid | Rethink Mental Illness | Key area for quality improvement 1 Physical health | People affected by mental illness die, on average, 20 years earlier than the general population. A number of national initiatives have recently highlighted the specific health challenges faced by this group. | The new national CQUIN offers a significant opportunity to improve the physical health outcomes of people using mental health services, particularly in inpatient care. However it is essential that all health services, including primary care, understand their role in supporting the physical health of people affected by mental illness. This is particularly | Integrated Physical Health Pathway from Rethink Mental Illness and the Royal Colleges of Nursing, General Practitioners and Psychiatrists https://www.rethink.org/media/304426/integr |

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| | | | | | These include the Living Well For Longer strategy[1] and the 2014/15 physical health CQUIN for mental health services.[2] Key barriers include a lack of clarity around the role of mental health services in supporting physical health, inaccessible physical health services and poor integration between primary and secondary care. We support the strengthened recommendations around physical health in the updated NICE guidance on bipolar disorder. We particularly welcome the clarity around who is responsible for physical health monitoring, and when it transfers between secondary and primary care (rec 1.10.9). | important for people taking antipsychotic medication. Health professionals must ensure routine monitoring takes place and that problems are flagged and followed up on appropriately. | ated_physical_health_pathway1.pdf CQUIN 2014/15 guidance for commissioners http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/09/CQUIN-Guidance-2014-15-PDF-751KB.pdf Lethal Discrimination – a report from Rethink Mental Illness highlighting the health inequalities faced by people affected by mental illness http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf Department of Health's Living Well For Longer strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf |

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| 28 | 4.6 | Fiona Martin | The National THORN Steering Group | Additional developmental areas of emergent practice Physical health; sexual health, personal safety, monitoring of drug treatment; access to psychological treatments; support with education and employment. Continuing professional development of all practitioners | Health workers must also attend to the physical health care needs, because of the high rates of co morbid physical and mental health problems and associated risk factors, for example, alcohol use; drug use, sexual behaviour, risky lifestyle choices, that go often unaddressed. Having competent, sensitive and appropriately skilled health practitioners/workers is central to the achievement of better outcomes for individuals with a diagnosis of bipolar disorder. | Address the mental well-being of children when parents have a serious illness such as bipolar affective disorder are presenting for treatment at health services Employment/career implication cost a lot in upset for people with bi-polar affective disorder and for their families. Livelihood opportunities, education, employment and options of flexible working to keep people in employment is more protective for the individual and the family. A recovery, enabling culture enhances outcomes, this will be more successfully realised by a valued workforce who have developed the required competencies. | National Audit of Schizophrenia (1 and 2) Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health (RCPsych, 2013) Mental Health Action Plan 2013-2020 (WHO) MIND Dame Sally Davies (CMO) Transforming and scaling up health professionals' education and training (WHO, 2013) |
| 29 | 4.7 | Paula Reid | Rethink Mental Illness | Key area for quality improvement 2 Employment | Employment can be a very important part of a person's recovery. However employment rates amongst people affected by mental illness are lower than most other health conditions.[3] We are pleased to see employment support | A recent Care Quality Commission survey showed that nearly a third of people (32%) on the Care Programme Approach (CPA) had not received the support they wanted around employment.[4] This rose to 52% for people not being supported through CPA. | Care Quality Commission - National Summary of the Results for the 2013 Community Mental Health Survey http://www.cqc.org.uk/sites/default/files/media/documents/20130911_mh13_national_summary_final.pdf |

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| | | | | | recommended in the guidelines (rec 1.9.6) Many more people would like to work but face considerable barriers in doing so. As with physical health, mental health services do not always understand their role in supporting people's employment outcomes. Health professionals may avoid talking about it, concerned that a person is not yet ready or that it might be detrimental to their health. | | |
| 30 | 4.8 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Choice | The guideline rightly presents all treatments as a choice, and recommends that service users are presented with the risks and benefits and encouraged to make an informed choice. | We would like to see data collected on the extent to which this reflects the experience of the service users. | |
| 31 | 4.8 | Alison Lawrence & Andy Hockey | Joint response Otsuka and Lundbeck | 2. Provision of information about the condition, treatment options | Consistent with high quality care planning and ensuring the principle of 'no decision about me, without me' is a reality for people with bipolar is the accessibility of | Throughout the NICE Clinical Guideline 185 there are references to the benefits of providing of information and there are recommendations to do so at various stages in the pathway. Provision of information enables people to stay central to their care making informed decisions | NHS, The NHS Constitution, March 2013, available at: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the- |

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| | | | | | information about the illness and available treatment and care. For people with bipolar and their carers the provision of high quality information underpins the principle of patient choice, which is enshrined in the NHS Constitution. Information should cover the illness itself, the complete range of treatment options available, pharmaceutical and psychological therapies, including all the benefits and any risks, and how to get help in a crisis. Information should be provided and discussed as early as possible in the pathway and presented in an accessible format. In addition and where appropriate carers and family members should be part of the discussion and have information made available to them. | about their treatment options. | nhs-constitution-for-england-2013.pdf |

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| 32 | 4.8 | Donna Swinden | SCM | Key area for quality improvement 4: Train all mental health professionals in specific biopsychosocial skills for working with people with bipolar disorder. | Service users and carers have been vocal in demanding better and more compassionate, respectful care. There is good evidence to support collaborative care as being effective in improving patient outcomes. It would also be useful to further research the ability of mental health professionals to manage people with bipolar disorder, particularly looking at confidence and attitudes. | Nurses often feel limited in how they manage patients with bipolar disorder, particularly when they are in a manic episode. This probably applies to other professionals also. | NICE guidelines for Bipolar Disorder (2014) Spectrum Centre for mood disorders, Lancaster. |
| 33 | 4.8 | Fiona Martin | The National THORN Steering Group | Key area for quality improvement 5 Family interventions and psychoeducation | Evidence identifies the critical role of the family in maintaining wellness and long-term stability for the individual with a diagnosis of mental illness. Acknowledging the impact the condition can have on the family | Greater collaboration with "informal" mental health care providers, | Open Dialogue Approach (Finland) Public Health England (Gregory Henderson) |

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| 34 | 4.8 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Involvement of relatives | The NICE Guideline does a good job of highlighting the importance of involving relatives in care where appropriate. | Again, our experience is that this is poorly implemented. Reasons given often include "there was no relative involved", "the relatives didn't want to come", "the relatives couldn't make the time". Relatives report they are not invited to take part, and/or are not given the range of options of ways they can be involved that the guideline highlights. Therefore we need an assessment of a. The number of service users in contact with a family / member or relative for support b. The number of relatives invited to be involved in the care team c. The nature of the relatives' involvement | |
| 35 | 4.8 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | Key area for quality improvement 3 | Promoting documentation of information sharing with carers. | Carers have reflected on the difficulty to engage in a productive dialogue with treating team during acute phases of illness as their relative suffering from the disorder might lack capacity of consenting for information sharing. | http://www.nice.org.uk /guidance/CG185 |
| 36 | 4.8 | Alison Lawrence & Andy Hockey | Joint response Otsuka and Lundbeck | 3. Shared decision-making and support for carers | The provision of information and effective care planning underpins shared decision-making. Timely and accurate information on treatment and care options is vital to supporting people and enable them to be at the centre of decisions about | Many people with the illness require regular support from family members and carers. These people have always played an important role supporting people with mental illness including bipolar disorder. Recognition of the role is embedded in mental health policy and included in NICE cinical guidelines. Families who are carers save the public purse £1.24 billion per year but are not receiving sufficient support. Evidence suggests that families are often | Bipolar Disorder: The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. NICE Clinical Guideline 185 http://www.nice.org.uk /guidance/cg185/evide nce/cg185-bipolar- |

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| | | | | | their treatment. Shared decision-making should be based on shared information and agreeing jointly the best treatment plan to enable people with bipolar to achieve their personal recovery goals. Healthcare professional have a vital role in supporting people with bipolar to be involved actively in shared decision making to make fully informed choices about their treatment and care that reflects what is important to them. The importance of people with bipolar having the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals, is recognised in NICE clinical guideline 185. Furthermore carers have a vital role to play in shared decision-making and it is important that | not treated as partners in mental health care. This is contrary to existing NICE guidance (185), which emphasises the need to support carers and the benefits this has for people with the condition. If health professionals and carers work in partnership, the care of people with bipolar is likely to be optimised. | disorder-update-full-guideline3 |

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| | | | | | they too are supported to fulfil this role with provision of the necessary inform | | |
| 37 | 4.8 | Pam Tester | Lancashire Care NHS Foundation Trust | Key area for quality improvement 2 | Inclusion of provision of psychological therapies | This appears to be a national issue and so having a quality standard should support us to drive up the quality of care for people with bipolar disorder | National audit of psychological therapy, IAPT for SMI recognises difficulty in providing family intervention therapy, despite strong evidence base on outcomes. |
| 38 | 4.9 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Assessment of Implementation | Psychological interventions are recommended by NICE, but in our experience are very poorly implemented in the NHS. | We would like to see meaningful data collected to assess implementation. Specifically data on the percentage of people with Bipolar depression entering the service who have been offered a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or a high-intensity psychological intervention in line with the NICE clinical guideline on depression. In addition, in secondary care the percentage of people with Bipolar Disorder in contact with their families who are offered a family intervention, and the percentage of people with Bipolar Disorder and not in an acute episode who are offered a structured, evidence based intervention designed for individuals with Bipolar Disorder. It is important that this data is not just from | |

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| | | | | | | providers, but is also collected from service users. | |
| 39 | 4.9 | Dr Michelin e Tremblay | Cheshire & Wirral Partnership NHS Trust | Key area for quality improvement 1 Perinatal considerations for adults suffering from bipolar disorder | There are complex considerations in assisting women contemplating pregnancy, being pregnant or breast feeding with the medication used for effective management of bipolar disorder. | There is a general interest from individuals concerned, their carers, and general practitioners to offer a safe and efficient management of bipolar disorder in the perinatal period. | http://www.nice.org.uk /guidance/CG45 |
| 40 | 4.9 | Professor Ian Jones | Royal College of Psychiatrists | Key area for quality improvement 2 The access women with bipolar disorder of childbearing age have to preconception counselling | Childbirth is a very potent trigger for severe bipolar episodes with 50% of deliveries to women with bipolar disorder being followed by a mood episode. Women with bipolar disorder need to have access to counselling with regard to the risks associated with pregnancy and childbirth and the difficult decisions that must be made regarding such aspects of care as continuing or stopping medication at this time. | Despite recommendations from numerous guidelines including NICE that women with bipolar disorder should have access to preconception counselling still this is the exception around the UK. Most women still find it difficult to access the information they need. | |

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| 41 | 4.9 | Fiona Martin | The National THORN Steering Group | Key area for quality improvement 4 High risk groups e.g. pre-conception and postnatal, family history, life style | A diagnosis of bipolar affective disorder causes increased vulnerability to: recurrence of acute episode of illness, risk around prescribed medication; pre and post-natal risk of relapse; potential for unplanned pregnancy, sexual health and consequences of disinhibited behaviour and long-term trauma. | The DoH maternal mental health pathway clearly highlights this period as one of increased vulnerability for mothers; in addition it provides guidance/strategy on how to ensure a person centred seamless service is offered. | DoH |
| 42 | 4.9 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Bipolar Disorder Diagnosis with Children | We are concerned about the use of Bipolar Disorder diagnosis with children. | We feel there is a strong need for more evidence regarding the utility of this label, and the effectiveness of the interventions that follow this. The guideline outlines stringent criteria which should be met before this diagnosis is used. We query the extent to which these criteria is currently followed, and would like to see a requirement that clinicians report detailed rationale that includes all of these criteria before the diagnosis is given. Related to this, the guideline suggests that treatment following this diagnosis is as for adults. However, these interventions have not been tested on children and therefore we would like to see data collected on the effectiveness of these interventions when used with children. | |

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| 43 | 4.9 | Pam Tester | Lancashire Care NHS Foundation Trust | Key area for quality improvement 1 | 3.1 Population and topic to be covered does not currently include children | The bipolar group believe there is an equality issue with this. If bipolar is the same disorder across the age range, children and young people with bipolar would be disadvantaged by being covered within the psychosis quality standard due to lack of prioritisation of quality improvements for children and young people with bipolar disorder due to their categorisation within the psychosis/sz group. We think you either need a separate QS for children and young people (CYP) with bipolar disorder, or have specific standards for CYP in this QS. Bipolar is not a subtype of psychosis. | |

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| 44 | 4.9 | Richard Morriss | SCM | Underdiagnosis of bipolar disorder in young people | Fifty per cent of people with bipolar disorder may present their first symptoms between ages 13 and 19 years of age. Early presentation of bipolar disorder is usually comorbid with impulse control, anxiety or substance use disorders or present with psychotic symptoms that are diagnosed rather than comorbid bipolar disorder. Evidence suggests that the early diagnosis and management of bipolar disorder may be clinically and cost effective with the potential to reduce suicidality. | CAMHS and early intervention in psychosis services sometimes do not develop expertise in assessing and managing bipolar disorder in young people. | Hardoon S, Hayes JF, Blackburn R, Petersen I, Walters K, Nazareth I, Osborn DP. Recording of severe mental illness in United Kingdom primary care, 2000-2010. PLoS One. 2013;8:e82365. This papers shows diagnosis of bipolar disorder at peak age of onset 16-24 years is between 39-59% lower than in 25-34 and 35 -44 age groups. In contrast in schizophrenia the diagnosis in schizophrenia is up to 60% higher in 16-24 age group than the other age groups and similar in prevalence across all three age groups in females. |

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| 45 | 4.9 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Use of Guidelines for Psychosis | The NICE Guideline repeatedly refers readers to Guidelines for Psychosis, and suggests these guidelines will suffice. | Whilst there are many overlaps between experiences of people with these diagnoses, and we are aware of the limitations of diagnostic classification per se, there is a lack of consistency in using these different diagnoses, but then giving people with Bipolar Disorder, interventions not developed to meet their needs, and based on evidence from a different population. People with Bipolar Disorder are often seen in services designed for psychosis, supported by people with knowledge and expertise in psychosis, using interventions developed for psychosis. If Bipolar Disorder is presented as a different diagnostic group, then they should be offered interventions tailored to their specific needs | |
| 46 | 4.9 | Fiona Lobban | British Association for Behavioural and Cognitive Psychotherapies | Cross referencing | Bipolar Guideline makes cross reference to many other guidelines. | Whilst we recognise the need to keep repetition to a minimum, we wonder whether people actually navigate through this rather complicated process. Could this be looked at using web analytics to see the extent to which people do visit the recommended hyperlinks as directed? | |
| 47 | 4.9 | Paula Reid | Rethink Mental Illness | Key area for quality improvement 5 Early Intervention in Psychosis | Early Intervention in Psychosis (EIP) services make a significant difference to people experiencing a first episode of psychosis. We are pleased to see these | In spite of this strong evidence, EIP provision across the country is currently under threat. A report from Rethink Mental Illness shows that 50% of EIP services have had budget cuts in the last year. 53% of services believe the quality of their service has decreased due to staff | Lost Generation – report from Rethink Mental Illness including data from national EIP survey http://www.rethink.org/media/973932/LOST% |

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| | | | | | services recommended as one of the specialist services where people can be assessed and supported if diagnosed with bipolar disorder. There is a wealth of evidence about the clinical- and cost-effectiveness of EIP. People who receive EIP care have better employment outcomes, reduced suicide rates, lower rates of detention under the Mental Health Act and better experiences of care.[12] Timely access to these services is crucial – research shows that if someone receives EIP support within two months, their prospects of recovery are significantly improved. However a delay of longer than six months leads to poorer outcomes and reduces their chances of recovery.[13] Research has also shown that | shortages, loss of specialist support and high caseloads.[15] There is also a business case for improving EIP access and provision. Recent economic analysis from the LSE suggests that for every £1 invested in EIP services, £15 costs are avoided.[16] | 20GENERATION%20-%20Rethink%20Mental%20Illness%20report.pdf Investing in Recovery - making the business case for effective interventions for people with psychosis http://www.rethink.org/media/1030280/investing_in_recovery.pdf |

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| | | | | | progress 14 months into a person's illness will dictate their trajectory over 7.5 years.[14] It is therefore essential that these services are available as early as possible to anyone who needs them. | | |
| 48 | 4.9 | Rufus Greenbaum | HQT Diagnostics | Measure Fatty Acids and improve Omega-3 Index and Omega-6/3 Ratio for 3 months before starting medication | Trials have been done that show an improvement in Bipolar Disorder after Fatty Acids levels have been adjusted | It is worth testing and modifying Fatty Acids to achieve Omega-3 Index > 8% Omega-6/3 ratio < 3:1 before starting pharmaceutical drugs | www.expertomega3.com/omega-3-study.asp?id=38 www.hqt-diagnostics.com |
| 49 | 4.9 | Rufus Greenbaum | HQT Diagnostics | Measure Vitamin D and supplement to 100 nmol/L for 3 months before starting medication | Many people with mental illnesses have an imbalance in their body chemistry and a deficiency of Vitamin D | It is worth testing and supplementing Vitamin D to 100 nmol/L before starting pharmaceutical drugs | www.vitamindwiki.com/44X+increase+in+Bipolar+Disorder+in+youth+in+a+decade+%E2%80%93+Sept+2007 |

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| 50 | 4.9 | Fiona Martin | The National THORN Steering Group | Key area for quality improvement 1 Increased Public Health awareness | There is evidence that increased public knowledge and understanding about mental health and mental illness increases understanding and reduces fear and stigma. Knowledge about mental illness such as bipolar disorder potentially increases resilience of the individual with the illness by exploring lifestyle choices and coping strategies | Public mental health includes interventions to prevent mental health problems, promote good mental health and ensure good physical health for people with mental health issues. Young people in particular need better access to support, as half of adults with mental health problems develop them before the age of 15 and three-quarters by 18. | Mental Health, resilience and inequalities (WHO, 2009) Dame Sally Davies (CMO) |
| 51 | 4.9 | Donna Swinden | SCM | Key area for quality improvement 1: Greater access to psychological therapies e.g. by expanding the remit of IAPT services for people with bipolar disorder; by increasing the number of psychological therapists with specific skills for treating bipolar disorder. | There is good evidence that appropriate and effective psychological therapies can drive significant improvements in the quality of life and health status of people with bipolar disorder, particularly via self management techniques. Psychological therapies are recommended within NICE guidance. | There is wide variation in the provision of psychological therapies for people with bipolar disorder, and many trained therapists lack confidence in treating patients as they have not received specific training. | NICE guidelines for Bipolar Disorder (2014) |

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| 52 | 4.9 | Stuart Morgan-Ayrs | Scotlandtherapy | Key area for quality improvement 4 Diagnostic labels | Reduction of inflexibility of diagnostic labels. | From my professional experience, and from networking with local psychiatrists, it is clear that patients present with one mental health condition, and then over time are re-diagnosed. With bipolar this may present as depression, then bipolar, or one bipolar type then another. Once labelled it requires reassessment or a paradigm shift for the medical professionals and often there is a time lag between the condition morphing and the provided care adapting. More open diagnosis of “mood disorder” may be more appropriate. | Clinical observation by myself and others. Research indicates morphing and re-diagnosis over time. |
| 53 | 4.9 | Stuart Morgan-Ayrs | Scotlandtherapy | Additional developmental areas of emergent practice | Integration of different talking therapies and complementary therapies into a more holistic approach. | Bipolar management is not a “one size fits all” area. Each patient has subtle differences, and often massive life experience differences and developmental issues that make flexibility vital. A core agreed management approach overseen by GP's, CMHTs and respected by therapists is required around which other therapies could be bolted on according to the individual client needs. Therefore a CBT based psychological therapy management package with medication, could be added to with psychotherapy, psychoanalysis, mindfulness, hypnotherapy, life coaching, nutritional therapy, exercise therapy and many more. | Incidence of patients seeking additional support in the private sector. |

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| 54 | 4.9 | Fiona Martin | The National THORN Steering Group | Key area for quality improvement 3 Inter-agency working | The needs of the patient and family are best met through Stakeholder collaboration. Motivated and engaged stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in prevention, treatment and recovery. | The role of specialised mental health professionals needs to be expanded to encompass supervision and support of general health workers/practitioners in providing mental health interventions for the individual and support for the family. Crisis care, in particular family crisis ; addictions; sexual health; financial; | Open Dialogue approach (Finland) |
| 55 | | Margaret Ojo | Royal College of Nursing | This is to inform you that the Royal College of Nursing have no comments to submit to inform on the Bipolar disorder in adults topic engagement. Thank you for the opportunity and we look forward to participating in the next stage | | | |