STABLE

STAndards for **B**ipo**L**ar **E**xcellence

A Performance Measurement
& Quality Improvement Program

STABLE RESOURCE TOOLKIT

A resource toolkit designed to advance the quality of care for persons with depression and bipolar disorder through the support of clinical screening, assessing, monitoring and education.

Compiled by the STABLE National Coordinating Council Resource Toolkit Workgroup

STABLE Resource Toolkit: Table of Contents

Introduction to the STABLE Project and Resource Toolkit

The *Standards for Bipolar Excellence (STABLE) Project* is a clinician-led quality improvement initiative to advance the quality of care for persons with bipolar disorder.

- Evidence-based clinical performance measures were developed.
- A resource toolkit was compiled to support the key issues reflected in the performance measures.

What is a toolkit?

Toolkits are information sources that contain forms, scales, templates or other resource assistance. Toolkits are not meant to be prescriptive but to provide guidance and resource options that can be individually selected, shared within organizations or customized.

About the STABLE Resource Toolkit

The STABLE Resource Toolkit provides quality improvement resources to assist the clinician in the identification and management of bipolar disorder. Resources provided are brief, economical, and often can be used as self report tools in busy clinical practices.

The toolkit provides clinicians with optional resources for screening, assessing, monitoring and educating patients with bipolar disorder. Documentation templates and flow sheets, plus coding guidance are included. When required, permission has been granted by the owners of copyrights.

The STABLE National Coordinating Council declared that the STABLE Resource Toolkit should be provided in the public domain as a non-proprietary, non-branded, and cost-free resource for clinician use in primary care and psychiatric out-patient practice sites.

How to use the STABLE Resource Toolkit

- Each section of the toolkit has a brief introduction to the condition or issue that is covered. A list of tools in that section is summarized.
- Each tool within a section has an overview page that summarizes the purpose of the tool, its clinical utility, any scoring that is needed, psychometric properties that provide additional background for use of the tool, and key references.
- Separate pages are provided for each tool. The tools are formatted for office use and can be reproduced.

STABLE Resource Toolkit Contents - Overview

The STABLE Resource Toolkit contains validated tools and scales that aid in screening and assessment for the following states and conditions associated with bipolar disorder:

- Depression Screening
- Bipolar Disorder Screening
- Suicide Risk Assessment
- Substance Use Screening
- Level- of-Functioning Assessment

Forms and charting documents aid in obtaining a family history, monitoring bipolar symptoms over time and monitoring physical and lab findings associated with metabolic syndrome:

- Genogram for taking a Family History
- Bipolar Symptom and Function Monitoring Form
- Bipolar Clinical Self Report Form
- Metabolic Symptom Monitoring Form
- Mood Charting
- Side-effect Monitoring Form

Educational Resources:

- Educational Resources for Depression and Bipolar Disorder

Office Practice Resources:

- Depression & Bipolar Disorder Coding Reference
- Depressive Disorder Coding and Diagnostic Criteria
- Bipolar Disorder Coding and Diagnostic Criteria

Legal Disclosure

This STABLE Resource Toolkit is intended to provide informational material for clinicians for screening, assessment, monitoring and educating patients with bipolar disorder. This toolkit is not intended to provide medical advice to patients. The information provided here is general, and not intended as clinical advice for or about specific patients. Any management steps taken with patients should include a discussion of risks and benefits as well as patient preferences. The STABLE Resource Toolkit completion date is March 2007. Information contained in the Toolkit can become outdated as a result of new studies or developments.

Depression Screening

Depression

Depressive episodes are characteristic of both major depressive (unipolar) disorder and bipolar disorder. Studies show that bipolar depression is frequently misdiagnosed as unipolar depression:

- 30% of patients in a family practice setting who were determined to be depressed, anxious or both were identified as having bipolar disorder; mainly bipolar II disorder.[1]
- 56% of patients diagnosed with unipolar disorder in a primary care psychiatric sample were later found to have bipolar spectrum disorders.[2]
- In a low income primary care clinic, approximately 25% of the patients diagnosed with major depression had lifetime bipolar depression.[3]

The STABLE Resource Toolkit includes 2 depression screening tools.

The Patient Health Questionnaire-2 (PHQ-2): The PHQ-2 screen is a 2-item self report that inquires about the frequency of depressed mood and anhedonia over the last two weeks.

- The purpose of the PHQ-2 is to screen for depression in a "first step" approach.
- The PHQ-2 includes the first 2 items of the PHQ-9.
- Patients who screen positive with the PHQ-2 should be further evaluated with either the PHQ-9, other diagnostic instrument(s) or direct interview.

The Patient Health Questionnaire (PHQ-9): The PHQ-9 is an instrument that screens for and diagnoses depression based on DSM-IV criteria.

- The specific items included in the scale include the 9 diagnostic criteria for making a DSM-IV depression diagnosis.
- The brevity and self-report of PHQ-9 lends itself well to clinical practice settings.
- The PHQ-9 has the potential of being a dual-purpose instrument that can establish depressive disorder and assess depressive symptom severity. The PHQ-9 can also be used in serial fashion to monitor symptoms over time.
- The PHQ-9 also has questions that screen for the presence and severity of suicidal ideation and functional impairment based on depressive symptomotology.

1. *Manning JS, Haykal RF, Connor PD, Akiskal HS; On the nature of depressive and anxious states in a family practice residency setting: the high prevalence of bipolar II and related disorders in a cohort followed longitudinally; Compr. Psychiatry 1997; 38: 102-108*
2. *Ghaemi SN, Boiman EE, Goodwin FK, Diagnosing bipolar disorder and the effect of antidepressants: a naturalistic study, J. Clin Psychiatry 2000; 61: 804-808*
3. *Olfson M, Das AK, Gameroff MJ, Pilowsky D, Feder A, Gross R, Lantigua R, Shea S, Weissman MM, Bipolar depression in a low-income primary care clinic; Am J Psychiatry, 2005 Nov: 162 (11) 2146-51*

The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

Psychometric Properties[1]

Major Depressive Disorder (7% prevalence)				Any Depressive Disorder (18% prevalence)			
PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)	PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4	1	90.6	65.4	36.9
2	92.7	73.7	21.1	2	82.1	80.4	48.3
3	**82.9**	**90.0**	**38.4**	**3**	**62.3**	**95.4**	**75.0**
4	73.2	93.3	45.5	4	50.9	97.9	81.2
5	53.7	96.8	56.4	5	31.1	98.7	84.6
6	26.8	99.4	78.6	6	12.3	99.8	92.9

** Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.*

1. *Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care 2003, (41) 1284-1294.*

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

The Patient Health Questionnaire (PHQ-9) - Overview

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:

- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.
- A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's level of function.

Clinical Utility

The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

Scoring

See PHQ-9 Scoring on next page.

Psychometric Properties

- The diagnostic validity of the PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression.[1]

1. Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616

The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:
The clinician should rule out physical causes of depression, normal bereavement and a history of a manic/hypomanic episode

Step 1: Questions 1 and 2
Need one or both of the first two questions endorsed as a "2" or a "3"
(2 = "More than half the days" or 3 = "Nearly every day")

Step 2: Questions 1 through 9
Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a "2" or a "3"; Question 9 must be endorsed as "1" a "2' or a "3")

Step 3: Question 10
This question must be endorsed as "Somewhat difficult" or "Very difficult" or "Extremely difficult"

Use of the PHQ-9 for Treatment Selection and Monitoring
Step 1
A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive ("more than half the days" or "nearly every day") in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least "somewhat difficult"

Step 2
Add the total points for each of the columns 2-4 separately
(Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3
Review the Severity Score using the following TABLE.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation ***Patient Preferences should be considered***
5-9	Minimal Symptoms*	Support, educate to call if worse, return in one month
10-14	Minor depression ++ Dysthymia* Major Depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
>20	Major Depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

** If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")*
++ If symptoms present ≥ one month or severe functional impairment, consider active treatment

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Bipolar Disorder Screening

Bipolar disorder is an episodic illness with a variable course:

- It is generally a lifetime condition associated with significant disability.
- It is frequently unrecognized, under diagnosed, and inappropriately treated.
- Symptomatic bipolar disorder patients spend, on average, 33% of their time in a depressive phase compared with 11% in a manic/hypomanic phase.[1]
- Patients generally do not recognize or spontaneously report prior hypomania as they view these periods as normal happiness or well-being.[2]

The Mood Disorder Questionnaire (MDQ)

- The MDQ is designed to provide a tool to aid clinicians in the screening of present and past episodes of mania and hypomania.
- The MDQ includes 13 questions associated with the symptoms of bipolar disorder plus items assessing clustering of symptoms and functional impairment.
- The MDQ may be used in primary care settings to provide clinicians with an efficient way to identify patients most likely to have a bipolar disorder.

The Composite International Diagnostic Interview (CIDI) Bipolar Disorder Screening Scale

- The CIDI-based screening scale can accurately identify both threshold and sub-threshold bipolar disorder.
- The scale detected between 67-96% of true cases in clinical studies.[1]
- This compares very favorably with the widely-used MDQ screening scale for bipolar disorder, which was found in one study to detect only 28% of true cases in a general population sample, although higher sensitivity (58-73) has been reported in 3 studies using the MDQ in out-patient populations with depression.[3]

Differential Diagnosis of Bipolar Disorder I & II versus Major Depressive Disorders

This guide consists of questions that address factors that are found to be useful in differentiating bipolar disorder from major depressive disorder. The questions explore:

- Age of onset
- Frequency of previous depressive episodes
- Previous response to antidepressants
- Family history
- History of suicide attempts
- Substance abuse history

Obtaining a Family History through the use of a Genogram

Genogram can contribute to the assessment of bipolar disorder by[4]:

- Aiding in screening for and identifying familial patterns of major depressive disorder and bipolar disorder
- Allowing visualization of family relationships in other disease processes
- Contributing to disease prevention planning

1. *Post RM, Calabrese JR, Bipolar depression: the role of atypical antipsychotics; Expert Rev. Neurother. 2004 Nov; 4 (6 Suppl 2): S27-33.*
2. *Berk M, Dodd S, Bipolar II disorder: a review, Bipolar Disorders 2005:7; 11-21.*
3. *Kessler RC, et al; Validity of the assessment of bipolar disorder in the WHO composite international diagnostic interview; Journal of Affective Disorders 96 (2006) 259-269*
4. *Watson WJ, et al. Genograms: Seeing your patient through another window. Patient Care Canada 2005 16: 67-75.*

The Mood Disorder Questionnaire (MDQ) - Overview

The Mood Disorder Questionnaire (MDQ) was developed by a team of psychiatrists, researchers and consumer advocates to address the need for timely and accurate evaluation of bipolar disorder.

Clinical Utility

- The MDQ is a brief self-report instrument that takes about 5 minutes to complete.
- This instrument is designed for *screening purposes only* and is not to be used as a diagnostic tool.
- A positive screen should be followed by a comprehensive evaluation.

Scoring

In order to screen positive for possible bipolar disorder, all three parts of the following criteria must be met:

- "YES" to 7 or more of the 13 items in Question 1 **AND**
- "Yes" to Question number 2 **AND**
- "Moderate Problem" or "Serious Problem" to Question 3

Psychometric Properties

The MDQ is best at screening for bipolar I (depression and mania) disorder and is not as sensitive to bipolar II (depression and hypomania) or bipolar not otherwise specified (NOS) disorder.

Population /type	Sensitivity & Specificity
Out-patient clinic serving primarily a mood disorder population[1]	Sensitivity 0.73 Specificity 0.90
General Population[2]	Sensitivity 0.28 Specificity 0.97
37 Bipolar Disorder patients 36 Unipolar Depression patients[3]	Overall Sensitivity 0.58 (BDI 0.58-BDII/NOS 0.30) Overall Specificity 0.67
Primary care patients receiving treatment for depression[4]	Sensitivity 0.58 Specificity 0.93

1. *Hirschfeld RMA. et, al. Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire, Am J of Psychiatry, 2000, 157:1873-1875.*
2. *Hirschfeld RMA. The mood disorder Questionnaire: A simple, patient-rated screening instrument for bi-polar disorder. Journal of Clinical Psychiatry Primary Care Companion 2002; 4: 9-11.*
3. *Miller CJ et al, Sensitivity and specificity of the Mood Disorder Questionnaire for detecting bipolar disorder. J Affect Disorder 2004. 81: 167-171.*
4. *Hirschfeld RMA, et al. Screening for bipolar disorder in patients treated for depression in a family medicine clinic. JABFP 2005, 18: 233-239.*

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
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CIDI-based Screening Scale for Bipolar Spectrum Disorders - Overview

Version 3.0 of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) was validated as being capable of generating conservative diagnoses of both threshold and sub-threshold bipolar disorder. The CIDI Version 3.0 is a fully structured lay-administered diagnostic interview. DSM-IV criteria are used to define mania, hypomania, and major depressive episode. The referenced article states that for the purposes of the paper, bipolar spectrum was defined as a lifetime history of BP-I, BP-II or sub-threshold bipolar disorder. The results reported suggest that the prevalence of DSM-IV bipolar spectrum disorder is at least 4.0%[1].

In this published study, CIDI–based Bipolar Disorder screening scales were also evaluated. Evaluation of the sensitivity and positive predictive value showed that the CIDI screening scales met the desired requirement of detecting a high proportion of true cases while minimizing the number of false positives.

Clinical Utility

This is a clinician administered screening tool:

- The CIDI-based screening scale is capable of identifying both threshold and sub-threshold bipolar disorder with good accuracy.
- The scale detected between 67-96% of true cases.
- This compares very favorably with the widely-used MDQ screening scale for bipolar disorder, which was found in one study to detect only 28% of true cases in a general population sample, although higher sensitivity (58-73) has been reported in 3 studies using the MDQ in out-patient populations with depression.

Scoring

Scoring information is provided on the following two pages.

Psychometric Properties

- The positive predictive value (PPV) indicates that the proportion of true cases among the screened positives varies across populations as a function of prevalence. PPV may be high in general medical samples and considerably higher in specialty mental health outpatient samples.
- Estimates of PPV have been generated for a number of important sub-populations (e.g. primary care users weighted by number of visits in the past year; low-income residents of urban areas, etc.) and are posted on the NCS web site (www.hcp.med.harvard.edu/ncs/bpdscreen); PPV for 3 populations are provided, for reference, on the second page of the Scoring document.

1. *Kessler RC, et al; Validity of the assessment of bipolar disorder in the WHO composite international diagnostic interview; Journal of Affective Disorders 96 (2006) 259-269*

CIDI 3.0 Bipolar Screening Scales Scoring

The complete set of 12 Questions takes approximately three minutes to complete.

The Scale has 12 Questions

Note: To "endorse" = Answer "yes", in a yes-no response

2 Stem Questions: Question 1 & 2

Respondents who fail to endorse either of these first two questions are skipped out of the remainder of the question series.

1 Criterion B Screening Question: Question 3

- Respondents who fail to endorse this question after endorsing one of the first two stem questions (above) are skipped out of the remainder of the question series.
- Respondents who do endorse this question are then administered the 9 additional symptom questions.

Note: In a general population *sample, it can be expected that as many as 90% of the sample will skip out by the end of this third question.*

9 Criterion B Symptom Questions

- Each of the 9 symptom questions are administered

Note: the first question in this group is asked only if the first Stem Question (above) is endorsed, if this scenario occurs, then only the 8 remaining symptom questions would be administered.

- Based on positive endorsement of the 9 (or 8) questions in this category, the proportion of screened positives that are true cases are indicated in the tables on the following page. Again, positive predictive values vary across populations as a function of prevalence.

However, the author has indicated that scores may be collapsed for reference purposes, if desired, as follows:

- Very high risk (80% or more) 9 questions with positive endorsement
- High risk (50-79%) 7-8 questions with positive endorsement
- Moderate risk (25-49%) 6 questions with positive endorsement
- Low risk (5-24%) 5 questions with positive endorsement
- Very low risk (less than 5%) 0-4 questions with positive endorsement

Diagnoses based on the screening scales have excellent concordance with diagnoses based on the full WHO Composite International Diagnostic Interview (CIDI 3.0). CIDI Diagnoses, in turn, have excellent concordance with clinical diagnoses based on blinded SCID clinical appraisal interviews.

CIDI 3.0 Bipolar Screening Scales Scoring

The complete set of 12 Questions takes approximately three minutes to complete.

Positive Predictive Values in sub-populations for CIDI-based Screening Scales

Number of Questions Endorsed	For respondents who have seen a primary care physician at least 12 times in the year before the interview	For respondents who have seen a primary care physician at least once in the year before the interview	For respondents who have received specialty mental health treatment in the year before the interview.
0 Questions = Y	PPV = 0.0	PPV = 0.2	PPV = 0.0
1 Question = Y	PPV = 0.0	PPV = 0.2	PPV = 0.0
2 Questions = Y	PPV = 0.0	PPV = 0.2	PPV = 0.0
3 Questions = Y	PPV = 3.6	PPV = 3.0	PPV = 10.4
4 Questions = Y	PPV = 3.6	PPV = 3.0	PPV = 10.4
5 Questions = Y	PPV = 17.0	PPV = 20.8	PPV = 39.0
6 Questions = Y	PPV = 33.4	PPV = 37.2	PPV = 39.0
7 Questions = Y	PPV = 52.6	PPV = 50.2	PPV = 55.2
8 Questions = Y	PPV = 54.9	PPV = 53.7	PPV = 71.0
9 Questions = Y	**PPV = 100.0**	**PPV = 84.3**	**PPV = 88.2**
	AUC = .865	**AUC = .854**	**AUC = .800**

PPV = Positive Predictive Value: The proportion of screened positives that are true cases (of bipolar disorder for this scale)

*AUC = **A**rea **U**nder the Receiver Operating Characteristic **C**urve; the area measures discrimination, that is, the ability of the test to correctly classify those with and without the condition. [0.90-1 = Excellent; 0.80-0.90 = Good; 0.70-0.80 = Fair; 0.60-0.70 = Poor]*

Diagnoses based on the screening scales have excellent concordance with diagnoses based on the full WHO Composite International Diagnostic Interview (CIDI 3.0). CIDI Diagnoses, in turn, have excellent concordance with clinical diagnoses based on blinded SCID clinical appraisal interviews.

CIDI-based Bipolar Disorder Screening Scale

Stem Questions

Euphoria Stem Question

1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.

   Have you ever had a period like this lasting several days or longer?

   If this question is endorsed, the next question (the irritability stem question) is skipped and the respondent goes directly to the Criterion B screening question

Irritability Stem Question

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people?

Criterion B Screening Question

3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate.

   Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?

Criterion B Symptom Questions

Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

1. Were you so irritable that you either started arguments, shouted at people, or hit people?

   This first symptom question is asked only if the euphoria stem question (#1 above) is endorsed
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?
3. Did you do anything else that wasn't usual for you—like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?

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Interview Questions to be Considered in Differentiating Bipolar I and II Disorders versus Major Depressive Disorders

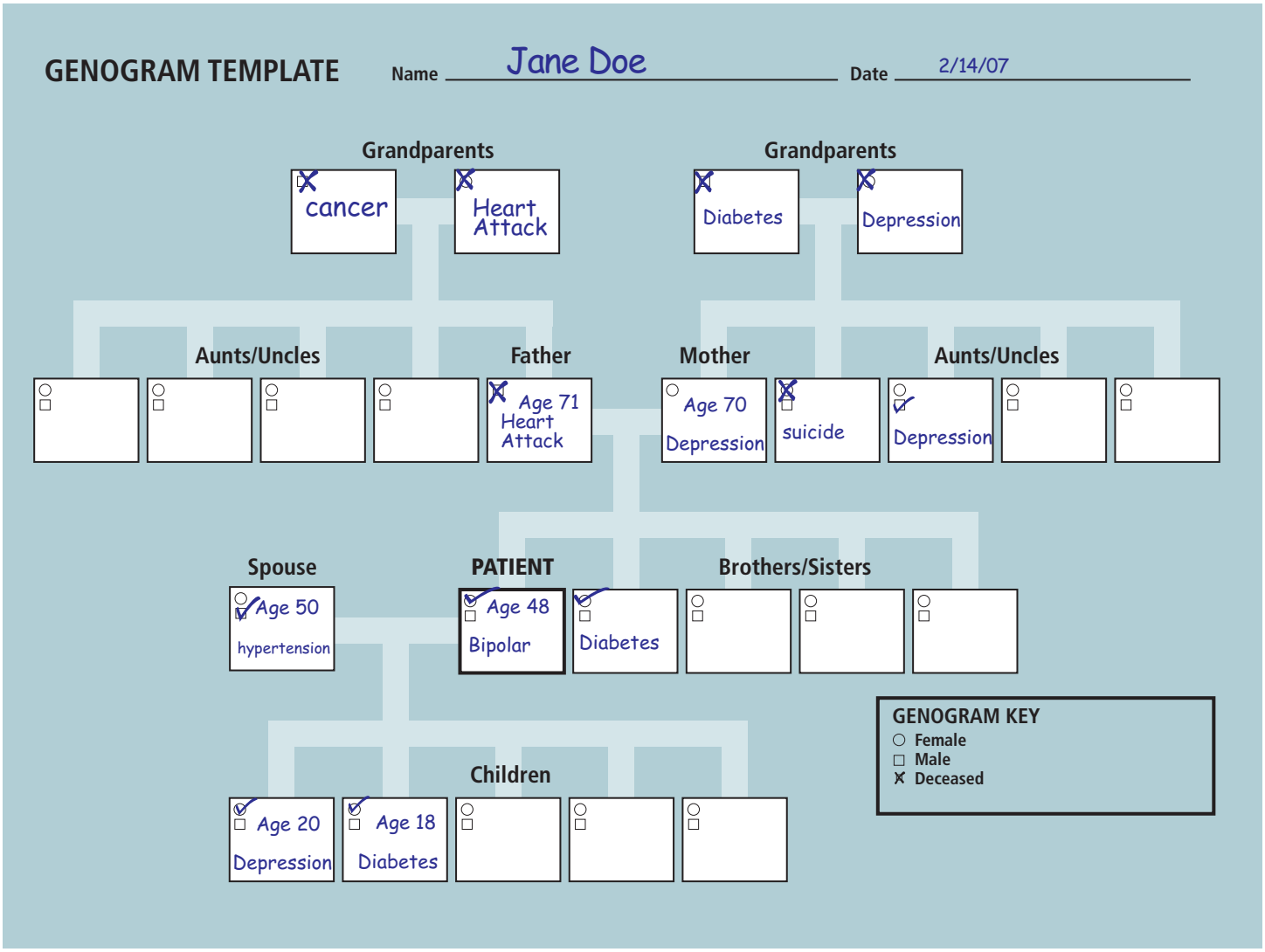
1. **What was the person's age at onset?**
   Literature suggests that the mean age of illness onset is earlier among bipolar patients (Mean = 21 with SD 9.6) than among those with major depressive disorder (Mean = 29 with SD 12.9 and 14.2).
2. **How frequent were previously recognized depressive episodes?**
   The number of prior depressive episodes was significantly greater among persons with bipolar disorder than with persons with major depressive disorder. In one published study, persons reported previous depressive episodes as "too numerous to count"; in another 52.8% reported > 25.
3. **What has been the previous response to antidepressants?**
   Treatment response to previous antidepressant therapy is a valuable distinguishing factor. Treatment-emergent manic/hypomanic symptoms strongly suggest the presence of bipolar illness and clinicians should query patients taking antidepressant about such symptoms, especially early in treatment and after dosage increases. Likewise, non-response to antidepressants, particularly a ceiling effect response or > two antidepressant failures should prompt further exploration for bipolar illness.
4. **Are there family members with episodes of mania/hypomania?**
   Family history of major depressive disorder has not been found to differ significantly between persons with bipolar disorder and persons with major depressive disorder; however, a family history of bipolar disorder has been determined to be more common among persons with bipolar disorder (41.9%) than among persons with major depressive disorder (5.2-8.3%).
5. **Has there been a history of attempted suicide?**
   Suicide risk is perhaps the most serious clinical consideration in patients with bipolar disorder. It has been reported that between 25% and 50% of patients with bipolar disorder will make a lifetime suicide attempt and that 8.6% to 18.9% will complete the attempt. The likelihood of a suicide attempt in bipolar disorder is higher than that in any other Axis I disorder, including major depression. Suicide risk, specifically making a severe suicide attempt, is associated with severe episodes of depression and dysphoric state in bipolar I and II disorder and not with manic or hypomanic states. In a review of suicide risk in a sample of 648 patients with bipolar I or bipolar II disorder in the Stanley Foundation Bipolar Network (2003), it was determined that 34% reported a history of suicide attempts. In another prospective system (2004) that followed a sample of 307 patients with bipolar I or bipolar II disorder for 7 years, 47% were found to have made a suicide attempt at some point in their lives.
6. **Is there comorbid substance use?**
   Estimates of co-occurring substance use disorders range from 40%-60% lifetime prevalence. Patients may use substances in an attempt to either counteract specific symptoms of depression (e.g., insomnia, depressed mood, lethargy) and hypomania/mania (agitation, anxiety) or to prolong hypomanic episodes. In a large national trial, the STEP-BD program, 20% of eligible subjects with bipolar I or bipolar II diagnosis were also diagnosed with a current substance use disorder.

Using a Genogram - Overview

A genogram is a visual multi-generational representation of familial relationships and patterns of behavior. Genograms:[1]

- Highlight family patterns of physical and mental health conditions
- Provide a visual reference of family patterns of disease
- Can be used as a patient self report form

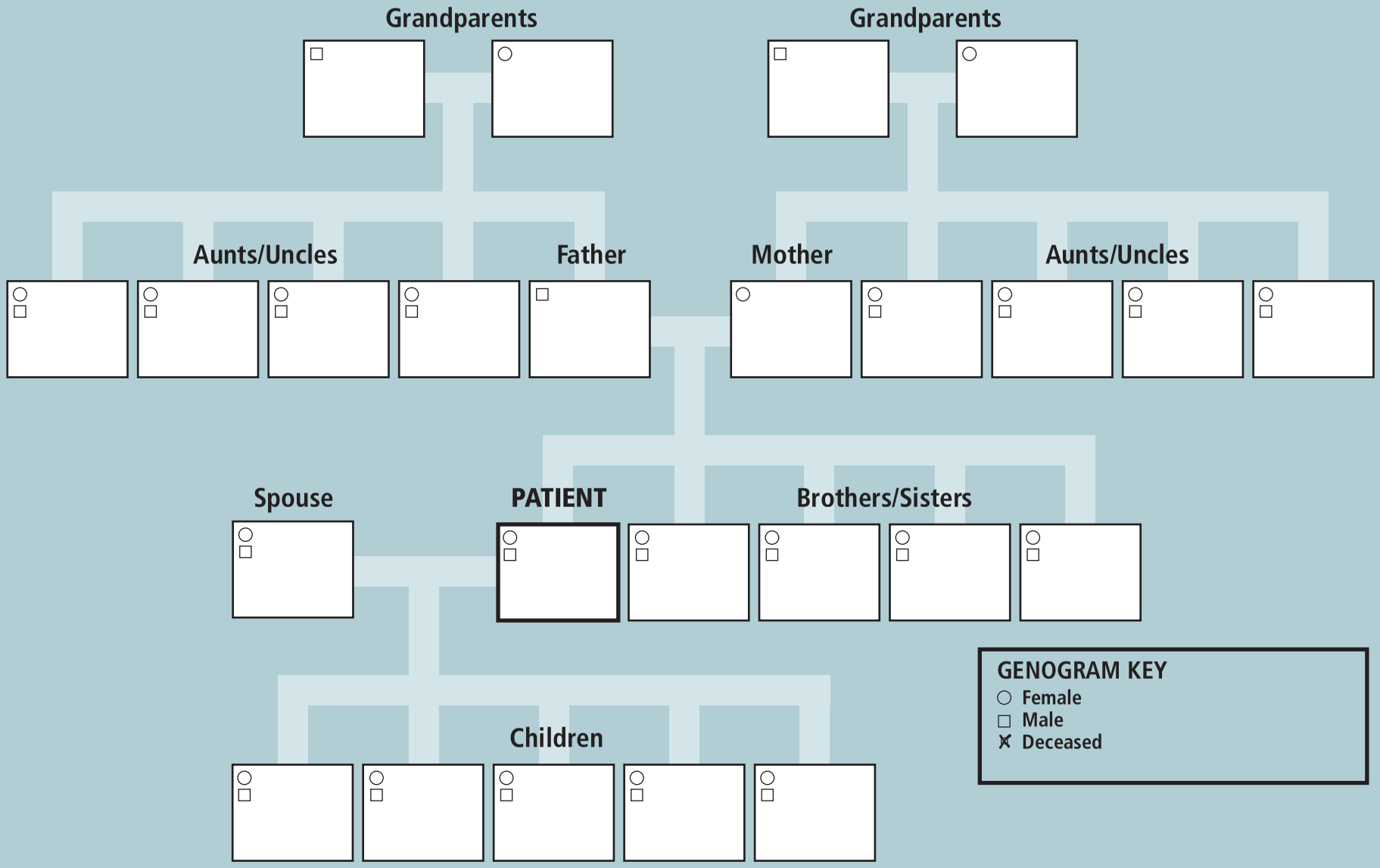
Example of a basic Genogram



1. *Watson WJ, et al; Genograms:Seeing your patient through another window. Patient Care Canada 2005 16: 67-75*

GENOGRAM TEMPLATE

Name _____ Date _____



Substance Use Screening and Assessment

Substance Use

- Between 40-70% of people with bipolar disorder have a history of substance use disorder.[1]
- A current or past comorbid substance use disorder may lead to worse outcomes for bipolar disorders, including more symptoms, more suicide attempts, longer episodes and lower quality of life.[1]
- Substance abuse may obscure or exacerbate mood swings that have no other apparent external cause.[2]
- Substance abuse may also precipitate mood episodes or be used by patients to self-treat in an attempt to improve the symptoms or episodes.[2]

The STABLE Resource Toolkit includes two tools for substance use screening.

AUDIT-C: Alcohol Use Disorder Identification Test – Consumption

- The AUDIT-C is a modified version of the AUDIT instrument that was developed by WHO to screen patients in primary health settings for hazardous or harmful drinking.
- The AUDIT-C is a 3 item instrument that screens for:
    - frequency of alcohol consumption
    - quantity of alcohol consumption
    - quantity of alcohol consumption on a single occurrence
- The AUDIT-C is a simple 3 question screen that can stand alone or be incorporated into general health history questionnaires.

CAGE-AID: Cut down; people Annoy you, feel Guilty; need Eye-opener – Altered to Include Drugs

- The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE alcohol use questionnaire was expanded to include alcohol and other drugs.
- The CAGE-AID is a simple 4 question self-report that is easily scored by the clinician.
- Advantage to using this screen is the ability to screen for alcohol and drug problems simultaneously rather than separately.

1. *Ostacher MJ, Sachs GS,. Update on Bipolar Disorder and Substance Abuse: Recent findings and treatment strategies, J Clin Psychology 2006; 67(9):e10.*
2. *American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Bipolar Disorder, Am J Psychiatry 159: 4, April 2002 Supplement.*

AUDIT-C - Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	Men[1]	Women[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

≥ 3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥ 4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. *Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Internal Med. 1998 (3): 1789-1795.*
2. *Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. Arch Internal Med Vol 163, April 2003: 821-829.*
3. *Frequently Asked Questions guide to using the AUDIT-C can be found via the website: www.oqp.med.va.gov/general/uploads/FAQ%20AUDIT-C*

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

CAGE-AID - Overview

The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include alcohol and other drugs.

Clinical Utility

Potential advantage is to screen for alcohol and drug problems conjointly rather than separately.

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited[1]:	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

1. *Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wisconsin Medical Journal. 1995:94(3) 135-140.*

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

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Suicide Risk Assessment

- Over their lifetime, the vast majority (80%) of psychiatric patients with bipolar disorder have suicidal ideation or ideation plus suicide attempt.[1]
- Suicide completion rates in patients with bipolar I disorder may be as high as 10%-15%, thus, a careful assessment of the patients risk for suicide is critical.[2]
- All patients should be asked about suicidal ideation, intention to act on these ideas, and extent of plans or preparation for suicide.2
- The instruments below may be useful in assessing suicidality but none have established predictive validity

Suicide Behaviors Questionnaire-Revised (SBQ-R)

- The SBQ-R is designed to assess suicide-related thoughts and behaviors. This instrument is made up of 4 items each assessing a different dimension of suicidality (or risk of suicide).

The Suicidal Ideation and Risk Level Assessment

- The clinician asks suicide screening questions, determines risk factors for suicide and then assesses suicide risk and action plan.
- The clinician asks questions that may elicit specific information relating to suicidal thoughts, plans and behaviors.

Assessing and Treating Suicidal Behaviors: A Quick Reference Guide

From the American Psychiatric Association (APA) treatment guidelines, which recommend that evaluation for suicide risk include:

- Presence of suicidal or homicidal ideation, intent, or plans
- Presence of alcohol or substance use
- Access to means for suicide and the lethality of those means
- History and seriousness of previous attempts
- Presence of psychotic symptoms, command hallucinations, or severe anxiety
- Family history of or recent exposure to suicide

1. *Valtonen H, Suominen K, Mantere O, et al., Suicidal ideation and attempts in bipolar I and bipolar II disorders, J Clin Psych, 2005 Nov; 66 (11): 1456-62*
2. *American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Bipolar Disorder, AM J Psychiatry 159: 4, April 2002 Supplement.*

The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:[1]

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]

	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	93%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

1. *Osman A, Bagge CL, Guitierrez PM, Konick LC, Kooper BA, Barrios FX., The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical and nonclinical samples, Assessment, 2001, (5), 443-454.*

SBQ-R - Scoring

Item 1: taps into *lifetime* suicide ideation and/or suicide attempts			
Selected response 1	Non-Suicidal subgroup	1 point	
Selected response 2	Suicide Risk Ideation subgroup	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 points	_____
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	**Total Points**

Item 2: assesses the *frequency* of suicidal *ideation* over the past 12 months			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	_____
	Very Often (5 or more times)	5 points	**Total Points**

Item 3: taps into the *threat of* suicide *attempt*		
Selected response 1	1 point	
Selected response 2a or 2b	2 points	_____
Selected response 3a or 3b	3 points	**Total Points**

Item 4: evaluates *self-reported likelihood* of suicidal behavior in the future			
Selected Response:	Never	0 points	
	No chance at all	1 point	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather Likely	5 points	_____
	Very Likely	6 points	**Total Points**

Sum all the scores circled/checked by the respondents.
The total score should range from 3-18.

_____
Total Score

AUC = Area Under the Receiver Operating Characteristic Curve; the area measures discrimination, that is, the ability of the test to correctly classify those with and without the risk. [.90-1.0 = Excellent; .80-.90 = Good; .70-.80 = Fair; .60-.70 = Poor]

	Sensitivity	Specificity	PPV	AUC
Item 1: a cutoff score of ≥ 2				
• Validation Reference: Adult Inpatient	0.80	0.97	.95	0.92
• Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R : a cutoff score of ≥7				
• Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: a cutoff score of ≥ 8				
• Validation Reference: Adult Inpatient	0.80	0.91	0.87	0.89

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

Evaluation of Suicide Risk for Clinicians - Overview

This screening tool was designed by the faculty and staff of South Texas Veterans Healthcare Systems and the University of Texas Health Care Service Center. (VERDICT UTHSCSA).

The screen requires a two step interview involving:

- Screening for a positive PHQ-9 question nine
- A structured interview investigating the severity of active ideation and specificity of the suicide plan

Clinical Utility

This suicide screening tool is unique because it first evaluates risk then categorizes the risk and recommends an action plan based on the risk.

Scoring

Not scored, rather risk categories are determined based on screening for suicidal ideation and assessing risk factors.

Psychometric Properties

This is not a validated tool, rather, it is a screen that has been reported by users to have good utility in determining suicide risk and providing action plans based on the identified risk.

Evaluation of Suicide Risk for Clinicians

Suicide Screening Questions

When you make a diagnosis of unipolar or bipolar depression, suicide risk requires assessment. Ask the following progressive questions. If question 1 is negative and suspicion is low, you can skip the subsequent questions.

Questions to assess thoughts of suicide	YES	NO
1. Have these symptoms/feelings (of depression) we've been talking about led you to think you might be better off dead?	☐	☐
2. This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?	☐	☐
3. What about thoughts about hurting or even killing yourself? *If "YES", go to question 4. If "NO", stop.*	☐	☐
4. What have you thought about? Have you actually done anything to hurt yourself?	☐	☐

Risk factors for suicide[1] (VERDICT UTHSCSA)

- ☐ **Hopelessness**
- ☐ Caucasian race
- ☐ Male gender
- ☐ Advanced age
- ☐ Living alone
- ☐ **Prior suicide attempts**
- ☐ Family history of suicide attempts
- ☐ Family history of substance abuse
- ☐ **Access to means**
- ☐ **Substance abuse**
- ☐ Medical Illness
- ☐ Psychosis

Assessment of Suicide Risk and Action Plan

Description of Patient Symptoms	Level of Risk	Action
No current thoughts; no major risk factors (Major Risks are **BOLDED**)	Low	Continue follow-up visits and monitoring
Current thoughts, but no plans With or without risk factors	Intermediate	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent. Consult with mental health specialist as needed.
Current thoughts with plans	High	Emergency management by qualified expert

1. Suicide Risk as designated by the faculty and staff of South Texas Veterans Healthcare Systems and the University of Texas Health Care Service Center. (VERDICT UTHSCSA) http://verdict.uthscsa.edu/decal/htmlfiles/diagnosis/mod2faq2.htm

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Considerations When Interviewing Potentially Suicidal Patients

When interviewing a patient about suicidal thoughts, plans, and behaviors, the following should be considered:

1. The presence or absence of suicidal ideation
   - Feelings about living
   - Thoughts of death, self-harm or suicide
2. Prior thoughts or attempts of self-harm or suicide; lethality of past acts
3. The presence or absence of a suicidal plan
4. The degree of suicidality, including:
   - Presence of intent, plan or means; potential lethality
   - Potential for attempt to also harm others
5. Presence of alcohol or substance use
6. Presence of psychotic symptoms, command hallucinations, or severe anxiety
7. Family history of or recent exposure to suicide

Resources:

- Assessing and Treating Suicidal Behaviors, A Quick Reference Guide. American Psychiatric Association, 2003.(See Table 2 for illustrative interview questions.) www.psych.org/psych_pract/treatg/quick_ref_guide/Suibehavs_QRG.pdf
- Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. American Psychiatric Association, 2003. (See Table 3 for additional examples.) www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf

Side-effects Monitoring

- Patients with bipolar disorder should be regularly monitored for iatrogenic adverse effects of antipsychotic medication including extrapyramidal symptoms (EPS).[1]
- Studies indicate that tardive dyskinesia (TD) still occurs with atypical agents and that regular and specific examination for early signs of TD remains an appropriate monitoring plan.[2,3]
- Treatment with certain antipsychotic medications is associated with metabolic adverse events that can increase the risk for metabolic syndrome and related conditions such as pre-diabetes, type 2 diabetes, and cardiovascular disease.[4]

The STABLE Resource Toolkit includes tools that will aid monitoring of EPS, TD symptoms and the common side-effects associated with antipsychotic medication usage.

Abnormal Involuntary Movement (AIMS)

- The AIMS scale was designed to measure involuntary movements known as tardive dyskinesia. TD is a disorder that can develop as a side-effect of long term treatment with neuroleptic (antipsychotic) medication.

The Texas Medication Algorithm Project Side-effects Checklists

- Medication side-effect self-report checklists, created by the Texas Medication Algorithm Project, lists common side-effects that should be reported to the clinician.
- The two checklists include "Less Severe" and "More Severe" side-effects.

Antipsychotic Side-effects Checklist (ASC)

- The ASC was originally developed for use with schizophrenia on antipsychotic medication. The checklists are also useful in monitoring the side-effects of antipsychotics in the bipolar population.
- The ASC was not designed to screen for TD or acute dystonia.

Metabolic Monitoring Forms

- The STABLE Metabolic Monitoring Form was designed as a tool to help clinicians organize the results of tests required for monitoring metabolic syndrome. The form includes tables for recording serial test results and provides normal and abnormal laboratory reference ranges.

1. *Yatham LN, Kennedy SH, et al. Canadian Network for Mood and Anxiety Treatments of Bipolar Disorder (CANMAT) guidelines for the management of patients with bipolar disorder: consensus and controversies. Bipolar Disorders 2005: 7(Suppl 3): 5-69*
2. *Suppes T, Dennehy E, Hirschfeld R, et al. The Texas Implementation of Medication Algorithms: Update to the Algorithms for Treatment of Bipolar I Disorder, J Clin Psychiatry 2005 ; 66 :870-886.*
3. *Tarsy D, Baldessarini R, . Epidemiology of Tardive Dyskinesia: Is Risk Declining with Modern Antipsychotics? Movement Disorders Vil 21, No 5, 2006, 589-598*
4. *Newcomer JW, Haupt DW, The Metabolic Effects of Antipsychotic Medications. Can J Psychiatry, Vol 51, No 8, July 2006; 480-491*

Abnormal Involuntary Movement Scale (AIMS) - Overview

- The AIMS records the occurrence of tardive dyskinesia (TD) in patients receiving neuroleptic medications.
- The AIMS test is used to detect TD and to follow the severity of a patient's TD over time.

Clinical Utility

The AIMS is a 12 item anchored scale that is clinician administered and scored

- Items 1-10 are rated on a 5 point anchored scale.
  - Items 1-4 assess orofacial movements.
  - Items 5-7 deal with extremity and truncal dyskinesia.
  - Items 8-10 deal with global severity as judged by the examiner, and the patient's awareness of the movements and the distress associated with them.
- Items 11-12 are yes-no questions concerning problems with teeth and/or dentures, because such problems can lead to a mistaken diagnosis of dyskinesia.

Examination Procedure

The indirect observation and the AIMS examination procedure are on the following two pages.

Scoring[1]

1. A total score of items 1-7 (Categories I, II, III) can be calculated. These represent observed movements.
2. Item 8 can be used as an overall severity index.
3. Items 9 (incapacitation) and 10 (awareness) provide additional information that may be useful in clinical decision making.
4. Items 11 (dental status) and 12 (dentures) provide information that may be useful in determining lip, jaw and tongue movements.

Psychometric Properties

The AIMS is a global rating method. The AIMS requires the raters to compare the observed movements to the average movement disturbance seen in persons with TD. Such relative judgments may vary among raters with different backgrounds and experience.

1. Rush JA Jr., Handbook of Psychiatric Measures, American Psychiatric Association, 2000, 166-168.

AIMS Examination Procedure

Either before or after completing the AIMS on the following page, observe the patient unobtrusively at rest (e.g., in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

Questions

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the *current* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient *now*.
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they *currently* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.)
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice.

Abnormal Involuntary Movement Scale (AIMS)

Patient Name _____ Date of Visit _____

Code: 0 = None 1 = Minimal 2 = Mild 3 = Moderate 4 = Severe

Movement Ratings:
- Rate highest severity observed in category I, II, III.
- Rate movements that occur upon activation one point less than those observed spontaneously.
- Circle movements as well as code number that applies.

		RATER / DATE	RATER / DATE	RATER / DATE	RATER / DATE
I FACIAL & ORAL MOVEMENTS	**1. Muscles of Facial Expression** e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. Lips and Perioral Area e.g. puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. Jaw Biting, clenching, chewing, mouth opening , lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
II EXTREMITY MOVEMENTS	**5. Upper (arms, wrists, hands, fingers)** Include choreic movements (i.e. rapid objectively purposeless, irregular, spontaneous) athetoid movements. DO NOT INCLUDE TREMOR (i.e. repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) Lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
III TRUNK MOVEMENTS	**7. Neck, shoulders and hips** Rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
IV GLOBAL JUDGEMENT	**8. Severity of abnormal movements overall**	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. Patient's awareness of abnormal movements. Rate only patients report: No Awareness = 0 Aware, no distress = 1 Aware, mild distress = 2 Aware, moderate distress = 3 Aware, severe distress = 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
V DENTAL STATUS	**11. Current problems with teeth and/or dentures**	YES NO	YES NO	YES NO	YES NO
	12. Are dentures usually worn	YES NO	YES NO	YES NO	YES NO
	13. Endentia?	YES NO	YES NO	YES NO	YES NO
	14. Do movements disappear with sleep?	YES NO	YES NO	YES NO	YES NO

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The Texas Medication Algorithm Project (TMAP) Side-effects Checklists - Overview

The checklists are part of the patient and family education package created to support the Texas Medication Algorithm Project.

Side-effects Checklist #1: Less Severe Symptoms

- This document lists "Less Severe" symptoms and provides suggested actions to be taken by the patient to relieve the symptoms.

Side-effects Checklist #2: More Severe Symptoms

- This document provides a list of potential side-effects of medication that are more severe.
- The patient is instructed to "report these symptoms to your doctor right away."

Clinical Utility

Helpful self-reporting tools to aid the patient in identifying side-effects and communicating with the clinician.

Psychometric Properties

The checklists are non-scored educational aids.

TMAP Side-effects Checklist 1: Less Severe Symptoms

Take Appropriate Action and Report Symptoms to your doctor at your next visit

Symptom	Action to be taken
Eyes sensitive to strong sun or light	Wear sunglasses, hat or visor; avoid prolonged exposure
Dryness of lips and/or mouth	Increase fluid intake; rinse mouth often with water; keep hard candies or sugarless gum handy
Occasional upset stomach	Drink small amounts of clear soda water; eat dry saltines or toast. Do not take antacids without your doctor's permission
Occasional constipation	Increase water intake; increase physical exercise; eat leafy green vegetables or bran corals, etc; drink lemon juice in warm water; occasionally take milk of magnesia or other mild laxative if suggested by your doctor or pharmacist
Tiredness	Take a brief rest period during the day; consult physician about switching entire daily dosage to bedtime
Dryness of skin	Use mild shampoo and soap; use hand and body lotion after each bath; wear seasonal protective clothing
Mild restlessness, muscle stiffness or feeling slowed down	Exercise; take short walks; stretch muscles; relax to music
Weight Gain	Increase exercise; watch diet and reduce overeating

If no relief is obtained by following these suggestions, call your doctor.

Doctor's name and telephone number: _____

Nearest emergency room telephone number: _____

Local pharmacist's name and telephone number: _____

From the Texas Medication Algorithm Project website http://www.dshs.state.tx.us/mhprograms/PtEd.shtm

TMAP Side-effects Checklist 2: More Severe Symptoms

Report these symptoms to your doctor right away

Symptom	Explanation
Blurred vision	Difficulty focusing your eyes
Drooling or difficulty swallowing	Spasms of swallowing muscles
Body tremors or spasms	Involuntary shaking or tightening of muscles
Diarrhea	Liquid stools for more than 2 days
Severe constipation	Unable to move bowels for more than 2 days
Muscle rigidity	Difficulty moving (for example, mask-like face)
Nervousness, inability to lie or sit still or inner turmoil	Muscular restlessness in body, arms or legs
Rash	Skin eruptions; pimples on the body
Skin discoloration	Excessive pigmentation
Sexual difficulty or menstrual irregularity	Delayed ejaculation; impotence; breast changes; changes in menstrual periods
Sunburn	Sensitivity to sun's rays
Tardive dyskinesia	Slow, involuntary movements of mouth, tongue, hand or other parts of the body
Sleepiness during the day	Excessive sedation
Extreme difficulty urinating	Bladder tone relaxed

Doctor's name and telephone number: _____

Nearest emergency room telephone number: _____

Local pharmacist's name and telephone number: _____

From the Texas Medication Algorithm Project website http://www.dshs.state.tx.us/mhprograms/PtEd.shtm

Antipsychotic Side-effect Checklist (ASC) - Overview

- Communication with patients about side-effects improves medication adherence.
- The ASC was designed to assess for various side-effects of antipsychotic medication and the subjective distress associated with the side-effects.
- The ASC does not screen for tardive dyskinesia (TD) or acute dystonia.

Clinical Utility

The ASC is a checklist of common problems for which the patient is asked to check only the boxes that apply. The patient can complete the form in the waiting room or at home before seeing the clinician.

The ASC is also designed for clinicians to use as a brief interview for side-effects during a regular treatment session. The ASC is an instrument that focuses only on common or bothersome side-effects. It does not cover uncommon but important side-effects such as acute dystonia, TD, neuroleptic malignant syndrome, urinary retention and seizures.[1]

Scoring

A guide to the ASC is on the following two pages. A more extensive training guide for using the ASC program can be accessed via the Journal of Psychiatric Practice website: www.psychiatricpractice.com

Psychometric Properties

- In a multi-center pilot study set up to evaluate the utility of checklists, 86% of patients responding considered the ASC to be useful in communicating their problems to psychiatrists and other members of the healthcare team.[2]
- 47% of healthcare team respondents reported that the ASC had assisted them in identifying side-effect problems not previously acknowledged.[2]

1. *Weiden P, Miller A, Which side-effects really matter?: Screening for common and distressing side-effects of antipsychotic medications. Journal of Psychiatric Practice, January 2001: 41-47*
2. *Dott SG, Weiden P, Hopwood P, Awad AG, Hellewell JS, Knesevich J, Kopala L, Miller A, Salzeman C,. An innovative approach to clinical communication in schizophrenia: the approaches to schizophrenia communication checklists. CNS Spect. 2001 (4): 333-338.*

Guide to the ASC-Clinician Version[1]

Extrapyradmidal Symptoms (EPS)

- Refers to the movement disorders that occur when there is a disruption of the brains extrapyramidal system
- Can be caused by antipsychotic agents, both 1st and, to a lesser extent, also by 2nd generation agents
- **Akathisia:** a motor restlessness; inability to resist the urge to move; pacing and inability to sit still are common
- **Drug-induced Parkinsonian symptoms:** tremor and muscle rigidity; also with extreme slowness of movements

Severe Extrapyradmidal Symptoms not captured by the ASC-C:

- **Acute Dystonia:** sudden muscular contractions; often produces neck or jaw spasms or cause eyes to roll up
- **Tardive Dyskinesia:** spasmodic involuntary movements; writhing-like movements are common in the face, mouth, tongue and hands. *Assess dyskinesia using the Abnormal Involuntary Movement Scale (AIMS) (available in STABLE Resource Toolkit)*

Item	Problem	Corresponding Side-effect
1	Loss of energy or drive	**Akinesia:** Also known as "bradykinesia" means slowing down of movements. A person with akinesia may appear listless or lifeless or the face may loose its usual range of expression. Item 1 covers the physical aspects of akinesia.
2	Feeling unmotivated or numb	**Akinesia:** A person with akinesia commonly complains of "feeling like a zombie" or having a subjective feeling of being "slowed down". Item 2 covers the internal aspect of akinesia.
3	Daytime sedation or drowsiness	**Sedation:** Common side-effect of some antipsychotic medications
4	Sleeping too much	**Sedation:** Common side-effect of some antipsychotic medications
5	Muscles too tense or stiff	**Muscle Rigidity:** (EPS) Antipsychotics can make a person's muscles too firm or tense. Muscle rigidity from EPS can cause a person to walk slowly with small steps.
6	Muscles trembling or shaking	**Tremor:** (EPS) A repeated shaking movement of the person's muscles; a side-effect of antipsychotic medication.

1. Using the ASC Program: A Training Guide. Journal of Psychiatric Practice, Jan 2001 64-68

Guide to the ASC-Clinician Version - continued

Item	Problem	Corresponding Side-effect
7	Feeling restless or jittery	**Akathisia (EPS):** Refers to a kind of restlessness or inability to sit still. People often describe akathisia as feeling like they want to "jump out of their skin". Item 7 refers to the subjective feeling of akathisia.
8	Need to move around and pace	**Akathisia (EPS):** Can cause people to pace repeatedly, get up and down from a chair or have fidgety leg movements. Item 8 covers the physical restlessness of akathisia.
9	Trouble getting to sleep or staying asleep	**Insomnia:** Although sedation is more frequent, sometimes psychiatric medications can cause insomnia.
10	Blurry vision	**Anticholinergic side-effect:** Associated with some antipsychotics and antidepressants Some medications used to treat the side-effects of antipsychotics (e.g., muscle stiffness) also have anticholinergic effects.
11	Dry mouth	**Anticholinergic side-effect:** Associated with some antipsychotics and antidepressants Some medications used to treat the side-effects of antipsychotics (such as muscle stiffness) also have anticholinergic effects.
12	Drooling	**Excessive salivation:** Often worse at night: associated with the antipsychotic clozapine
13	Memory and concentration	**Benzodiazepine side-effect:** Associated with some medications used to address anxiety
14	Constipation	**Anticholinergic side-effect:** Associated with some antipsychotics and antidepressants: can slow down bowel movements
15	Weight changes	**Weight gain:** Most antipsychotics cause some degree of weight gain, some more than others. Weight gain is a significant concern for patients who are overweight prior to treatment or have a weight-related problem such as hyperglycemia or hyperlipidemia.
16	Change is sexual function	**Sexual difficulty:** Sexual side-effects are common with antipsychotic medication. Difficulties include problems with erection in and ejaculation in males and lubrication and orgasm in women. Antipsychotic medications can also lead to loss of normal sex drive for both sexes.
17	Menstrual or breast problems	**Amenorrhea:** Some antipsychotics can cause missed or irregular menstrual periods. **Galactorrhea:** Some antipsychotics can elevate the hormone prolactin and cause abnormal breast milk leakage.

Antipsychotic Side-effects Checklist (ASC)

Problem	Report
1. **Loss of energy and drive:** Have you had trouble moving, getting going, or starting things? You may feel generally slowed down.	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
2. **Feeling unmotivated or numb:** Have you had trouble getting motivated or wanting to do the things you used to? Sometimes people describe this as "feeling like a zombie".	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
3. **Daytime sedation or drowsiness:** Are you tired or sleepy during the day? The tiredness could be a feeling you get throughout the day or only at certain times.	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
4. **Sleeping too much:** Do you sleep too much? Do you feel you sleep for too long? Do you have a problem getting out of bed in the morning, or do you need to go back to sleep for a large part of the day?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
5. **Muscles being too tense or stiff:** Do your muscles feel stiff or rigid? Sometimes people describe this as cramps or muscle pains in the arms, legs, or neck. Have you had this problem?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
6. **Muscles trembling or shaking:** Have you had any shaking or muscle-trembling?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
7. **Feeling restless or jittery:** Have you had any feelings of restlessness? There is an internal restlessness; people describe this experience as "feeling like I'll jump out of my skin". Have you had this problem?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
8. **Need to move around and pace; inability to sit still:** Do you have to get up and pace around? Do you have trouble sitting still? Do you rock from one leg to another?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
9. **Trouble getting to sleep or staying asleep (insomnia):** Do you have trouble falling asleep or getting to sleep when you want to? Do you wake up during the night, or wake up too early in the morning?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____

Antipsychotic Side-effects Checklist (ASC) - continued

Problem	Report
10. Blurry vision: Do you have blurry vision? Things may seem out of focus. People with blurry vision might have trouble with reading printed words in newspapers.	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
11. Dry mouth: Is your mouth too dry? Does it feel like you have cotton in your mouth? Does it seem like your tongue sticks to your mouth?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
12. Drooling: Do you have too much saliva? Some people have problems with drooling or may find that when they wake up their pillow is wet from saliva (spit).	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
13. Memory and concentration: Do you have any memory problems? Are you more forgetful? Is it hard to concentrate? Do you find it hard to follow a conversation or program on TV?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
14. Constipation: Do you have problems with constipation?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
15. Weight changes: Have you had any changes in weight? Do you feel that you are overweight? Do you gain weight quickly, or cannot seem to go on a diet? Are your clothes getting too big or too small for you?	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
16. Changes in sexual functioning: Do you have any sexual problems or difficulties? Sometimes people say they have problems with low sex drive. Some men say that they have difficulty with erections or ejaculation, and some women say they have difficulty achieving orgasm.	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____
17. Menstrual or breast problems: If you should have regular menstrual periods, have you had any menstrual problems lately? Sometimes women stop having their normal period, or have irregular periods. Have you had this problem recently? Sometimes there may be milk leakage from the breasts.	☐ **No** Not a problem ☐ **Yes** This is a problem Comments _____

Metabolic Monitoring

Metabolic Syndrome

Metabolic syndrome (MS) is the name given to the cluster of risk factors leading to cardiovascular disease. The criteria proposed by the National Cholesterol Education Program Adult Treatment Panel (ATPIII)[1] are widely used as a reference. According to the ATP III guidelines, a patient with any 3 of the risk factors in the chart (right) is considered to have MS.

ATP III Criteria for Clinical Identification of Metabolic Syndrome

Risk Factor	Defining Level
Abdominal Obesity • Men • Women	Waist Circumference • >102 cm (>40 inches) • >88 cm (>35 inches)
Triglycerides	≥150/dl
HDL Cholesterol • Men • Women	 • <40 mg/dl • <50 mg/dl
Blood Pressure	≥ 130/ ≥ 85 mmHg
Fasting Glucose	≥ 110 mg/dl

Correlation between Metabolic Syndrome and Second-Generation Antipsychotics (SGA)*

Many studies suggest that prevalence of diabetes and obesity among individuals with schizophrenia and affective disorders is 1-2 times higher than the general population. Treatment with some SGA's has been found to cause an increase in body weight which is associated with increased insulin resistance and concordant elevation of serum lipids.[2]

The currently available SGA's vary in liability for weight gain, risk for development of type II diabetes and worsening lipid profiles. Because of the variability, the ADA/APA/ACE/NAASO consensus guidelines:[3]

- Recommended scheduled monitoring of metabolic risk factors.
- Suggested clinicians switch the patient to a SGA medication with a lower weight gaining liability if the patient experiences a weight gain of > 5% of initial weight.

Recommended Schedule for Monitoring Patients on Second-Generation Antipsychotics

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 years
Personal/ Family History	X					X	
Weight (BMI)	X	X	X	X	X		
Waist Circumference	X					X	
Blood Pressure	X			X		X	
Fasting Plasma glucose**	X			X		X	
Fasting Lipid profile	X			X			X

** Second Generation Antipsychotics include: clozapine, olanzapine, ziprasidone, risperidone, olanzapine-fluoxetine (combination)*

*** Per recommendations from The Mount Sinai Conference: measurement of fasting plasma glucose level is preferred, but measurement of Hemoglobin A1C is acceptable if a fasting plasma glucose test is not feasible[4]*

1. *National Cholesterol Education Program. Executive Summary of the Third Report of the National Cholesterol Education Program (NCEP)Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATPIII). JAMA 2001;285: 2486-97*
2. *Newcomer JW, Haupt D,. The metabolic effects of antipsychotic medication. Can J Psychiatry 2006; 51:480-491*
3. *American Diabetes Association. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004;27:596-601*

Metabolic Syndrome Monitoring Form

Patient Name _____ Date of Visit _____

Metabolic Syndrome[1] considered positive for MS if 3 or more risk criteria present

Measure	Risk Criteria	Baseline	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Abdominal Obesity	Men > 40 inches Women > 35 inches						
Triglycerides	≥ 150 mg/dl						
HDL Cholesterol	Men < 40 mg/dl Women < 50 mg/dl						
Blood Pressure	≥ 130/≥85 mmHg						
Fasting Plasma Glucose*	≥ 100 mg/dl						

** Per recommendations from The Mount Sinai Conference: measurement of fasting plasma glucose level is preferred, but measurement of Hemoglobin A1c is acceptable if a fasting plasma glucose test is not feasible.[3]*

Weight/BMI[2]	BMI ≥ 30						

Lipid Monitoring Results

	Baseline	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Total						
LDL						
HDL						
TG						

Serum Lipid Levels Reference Ranges

	Optimal/Desired[1]	Near/Above Optimal	Borderline High	High	Very High
Total	< 200		200-239	≥ 240	
LDL	< 100	100-129	130-159		≥ 190
HDL	> 40 men > 50 women			≥ 60	
TG	<150		150-199	200-499	≥ 500

1. National Cholesterol Education Program. Executive Summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATPIII). JAMA 2001;285: 2486-97.

2. Other obesity indicators not in the ATP III recommendations: Actual Weight or BMI (Weight/height in kg/m2 overweight 25-29, Obese ≥30)

3. Marder SR, Essock SM, miller AL, et al. Physical health monitoring of patients with schizophrenia. Am J Psychiatry 2004;161:1334-1349

Symptom Monitoring

The STABLE Resource toolkit provides several options to aid in the measurement of the complex symptoms of bipolar disorder.

- The mood episodes of bipolar disorder are defined in DSM-IV by symptomatology; therefore, diagnosis and assessing response to treatment requires symptom monitoring.
- Recognizing and monitoring signs and symptoms of manic and depressive symptoms is critical in assessing patient status.[1]
- The use of a graphic display or timeline of life events and mood symptoms can be helpful in identifying early or recurrent signs or symptoms and in involving the patient in treatment.[2]

The STABLE Resource Toolkit contains 3 resources for monitoring symptomatology:

Altman Self-Rating Scale for Mania (ASRM)

The ASRM is a brief, self-rating mania scale compatible with DSM-IV criteria that can be used to measure the presence and severity of manic symptoms for research or clinical purposes.

Self Report Form for Mood Episodes (SRF-ME)

- The SRF-ME form is designed to be completed in the waiting room, prior to the office visit.
- The SRF-ME includes self-reported frequency of DSM-IV symptoms of mood elevation and depression which, collected over time, allows for tracking of symptoms in response to treatment.

The Symptom Documentation Form

- The Symptom Documentation form lists usual DSM-IV criteria symptoms exhibited with depression and mania/hypomania and 3 domains where impaired function may occur.
- Changes in symptomatology and function can be monitored by recording a baseline and evaluating on subsequent visits whether the condition is better, worse or the same.

1. *Keck PE, Defining and Improving Response to Treatment in Patients with Bipolar Disorder; J Clin Psychiatry 2004; 65 (sip 15) 25-29.*
2. *Post RM, Roy-Byrne PP, Uhde TW: Graphic representation of the life course of illness in patients with affective disorder. AM J Psychiatry 1988; 145: 844-848*

Altman Self-Rating Mania Scale (ASRM) - Overview

- The ASRM is a 5-item self rating mania scale, designed to assess the presence and/or severity of manic symptoms.
- The ASRM may be used in an inpatient or outpatient setting to screen for the presence of and/or severity of manic symptoms for clinical or research purposes.
- Because it is compatible with DSM-IV criteria, and correlates significantly with Clinician-Administered Rating Scale for Mania (CARS-M), Young Mania Rating Scale (YMRS), it can be used effectively as a screening instrument to facilitate diagnostic assessment in patients with hypomanic symptoms.

Clinical Utility

- In outpatient settings the ASRM may be used as a psycho-educational tool to help patients recognize and monitor their own symptoms.
- It may be used reliably as a self-report measure of efficacy for patients receiving clinical treatment.
- It may be used in combination with self-rating depression scales to assess mixed states of mania and depression.

Scoring

1. Sum items 1-5
   - A cutoff score of 6 or higher indicates a high probability of a manic or hypomanic condition (based on a sensitivity rating of 85.5% and a specificity rating of 87.3%).
   - A score of 6 or higher may indicate a need for treatment and/or further diagnostic workup to confirm a diagnosis of mania or hypomania.
   - A score of 5 or lower is less likely to be associated with significant symptoms of mania.

2. As a self-report measure of clinical efficacy, items 1-5 should be summed to give a total score, which then may be compared to subsequent total scores during and after treatment.

Psychometric Properties

Specificity of 85.5

Sensitivity of 87.3[1]

1. Altman EG, Hedeker D, Peterson JL, Davis JM. The Altman self-rating mania scale. Society of Biological Psychiatry 1997; 42:948-955.

Altman Self-Rating Mania Scale (ASRM)

Name _____ Date _____

Instructions:

1. There are 5 statements groups on this questionnaire: read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

Question 1

- ☐ 0 I do not feel happier or more cheerful than usual.
- ☐ 1 I occasionally feel happier or more cheerful than usual.
- ☐ 2 I often feel happier or more cheerful than usual.
- ☐ 3 I feel happier or more cheerful than usual most of the time.
- ☐ 4 I feel happier or more cheerful than usual all of the time.

Question 2

- ☐ 0 I do not feel more self-confident than usual.
- ☐ 1 I occasionally feel more self-confident than usual.
- ☐ 2 I often feel more self-confident than usual.
- ☐ 3 I feel more self-confident than usual.
- ☐ 4 I feel extremely self-confident all of the time.

Question 3

- ☐ 0 I do not need less sleep than usual.
- ☐ 1 I occasionally need less sleep than usual.
- ☐ 2 I often need less sleep than usual.
- ☐ 3 I frequently need less sleep than usual.
- ☐ 4 I can go all day and night without any sleep and still not feel tired.

Question 4

- ☐ 0 I do not talk more than usual
- ☐ 1 I occasionally talk more than usual.
- ☐ 2 I often talk more than usual.
- ☐ 3 I frequently talk more than usual.
- ☐ 4 I talk constantly and cannot be interrupted

Question 5

- ☐ 0 I have not been more active (either socially, sexually, at work, home or school) than usual.
- ☐ 1 I have occasionally been more active than usual.
- ☐ 2 I have often been more active than usual
- ☐ 3 I have frequently been more active than usual.
- ☐ 4 I am constantly active or on the go all the time.

Self-Report Form for Mood Episodes (SRF-ME) - Overview

- The SRF-ME form is a tool through which the patient can become an active partner in their disease management by actively monitoring and recording changes in symptoms and mood.[1]
- The SRF-ME form is designed to be completed in the waiting room, prior to the office visit.
- The SRF-ME includes self-reported frequency of DSM-IV symptoms of mood elevation and depression.
- Collecting information at each visit allows for better tracking of symptoms and response to treatment.
- Answering standard questions before the MD visit allows for more productive office visit time with the clinician.

Validation

The SRF-ME demonstrates excellent sensitivity and specificity for hypomania, mania and for depression as compared with the treating clinician diagnosis derived from the Clinical Monitoring Form.[2]

	Sensitivity	Specificity	PPV*	NPV**
Mania/hypomania	0.83	0.97	0.80	0.98
Mixed	0.77	1.0	1.00	0.97
Depressed	0.71	0.92	0.77	0.91
Recovered	1.00	0.75	1.00	0.53
Subsyndromal	0.55	0.94	0.80	0.82

**PPV-Positive Predictive Value, **NPV-Negative Predictive Value*

Use of the SRF-ME

The SRF-ME is intended to aid the clinician in comparing and monitoring changes from one office visit to the next.

1. *Information regarding the SRF-ME form can be obtained through the Massachusetts General Hospital Bipolar Clinic & Research Program at : http://www.manicdepressive.org/selfreport*
2. *Farrelly N, Tran TB, Borrelli DJ, et al. The self report form for mood episodes in bipolar disorder. Program and abstracts of the American Psychiatric Association 2006 Annual Meeting; May 20-25, 2006: Toronto, Ontario, Canada. Poster NR 212.*

Clinical Self-Report Form

Name: _____ ID# _____ Clinician: _____ Date ____/____/_____

Since your last appointment:

	Circle	
Has there been a period of time when you were feeling down or depressed most of the day nearly everyday?	Yes	No
If Yes: Did it last as long as two weeks?	Yes	No
What about being a lot less interested in most things or unable to enjoy things you usually enjoy?	Yes	No
If Yes: Did it last as long as 2 weeks?	Yes	No
Has there been a period of time when you were feeling so good or so hyper people thought you were not your normal self or you were so hyper you got in trouble?	Yes	No
If Yes: Was it more than just feeling good?	Yes	No
Did anyone say you were manic?	Yes	No
What about a period of time when you were so irritable that you would shout at people or start fights or arguments?	Yes	No
Have you experienced a major stress that you feel has caused your mood to change?	Yes	No
If Yes, (describe)_____		
Have you experienced other medical problems?	Yes	No
If Yes, (describe)_____		

Used additional psychiatric care/treatment ☐ Yes ☐ No **Other medical treatment** ☐ Yes ☐ No **Onset of last menses** __ __/__ __/__ __

Over the past 10 days how many days have you been/had…

…depressed **most** of the day _____/10 days …unable to experience pleasure **most** of the day _____/10 days

…any period of abnormal mood elevation _____/10 days …any period of abnormal irritability _____/10 days

…any period of abnormal anxiety _____/10 days

During the past week . . .

What is the least you have slept in any one day? _____ hrs What is the most you have slept any one day? _____hrs

Have you had: Panic Attacks __ Binge/Purge __ Headaches __ **Your Weight? _____**

Indicate your use of: Caffeine ___ cups/day Nicotine ___ packs/day Alcohol ___ drinks/week Drugs _____

For each item, rate this week compared to your usual (when well)	<----------Decreased					Well ↓	Increased ---------->				
	Constant and Severe		Nearly Every Day	Often	Rarely and/or mild		Rarely and/or mild	Often	Nearly Every Day		Constant and Severe
Sleep						Normal					
Ability to enjoy pleasant things / usual interests						Normal					
Self confidence/Self Esteem						Normal					
Energy						Normal					
Ability to Concentrate						Normal					
Distractibility						None					
Appetite						Normal					
Physical restlessness/agitation						None					
Rate of speech or thoughts						None					
Feel life isn't worth living or suicidal thoughts						None					
Talking						Normal					
Racing thoughts						None					
Making plans or getting new projects started						Normal					
Behaviors others regard as excessive, foolish or risky						None					

Please complete for all medications used since your last visit

Medication	Total daily dose	Mg missed this week	Comments / adverse effects ☐ Check if no adverse effects
	Mg	Mg	
	Mg	Mg	
	Mg	Mg	
	Mg	Mg	
	Mg	Mg	
	Mg	Mg	
	Mg	Mg	
	Mg	Mg	

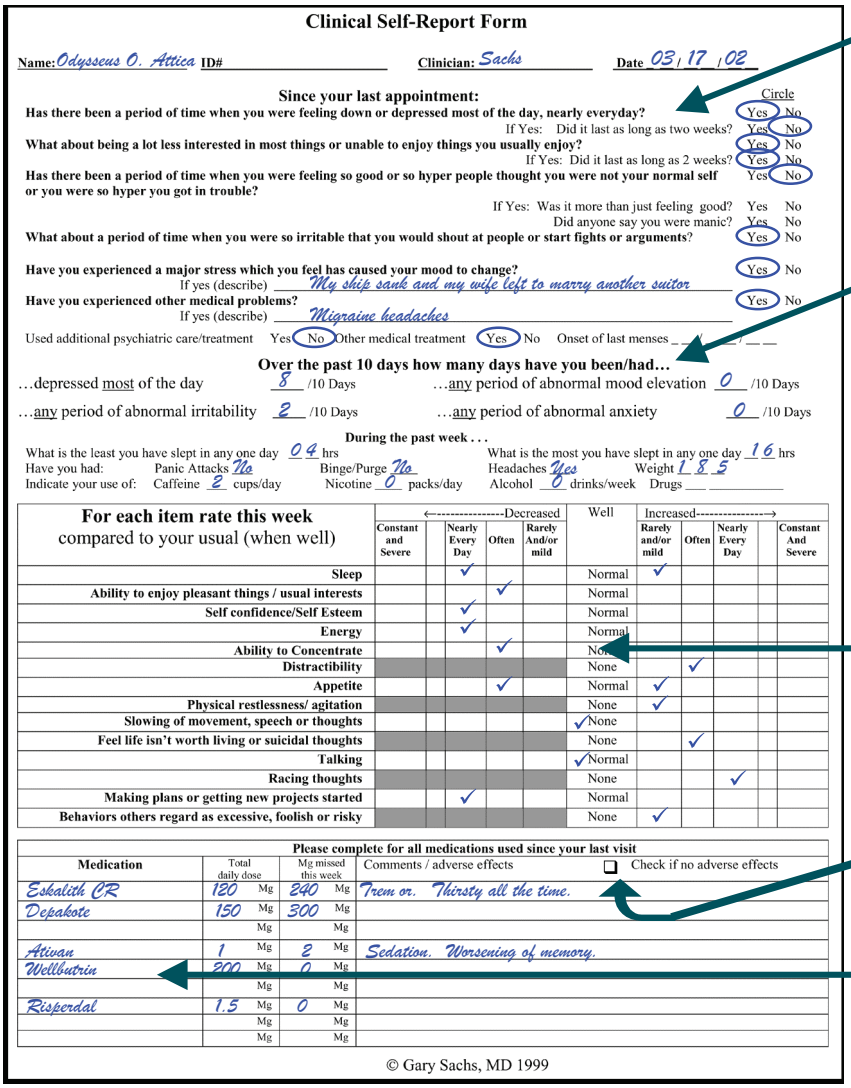
Clinical Self-Report Form - Directions

Should I complete the Clinical Self-Report Form?

YES

The Clinical Self-Report Form was designed to systematically collect information about the symptoms commonly experienced by patients with mood disorders. Collecting information at each visit allows your doctor to better track the course of your symptoms and your response to treatment. Answering standard questions before your visit allows for more productive time with your doctor. We strongly recommend filling one out at each visit.

DIRECTIONS



Clinical Self-Report Form

Name: Odysseus O. Attica ID# Clinician: Sachs Date 03 / 17 / 02

Since your last appointment: Circle

Has there been a period of time when you were feeling down or depressed most of the day, nearly everyday? Yes No
If Yes: Did it last as long as two weeks? Yes No
What about being a lot less interested in most things or unable to enjoy things you usually enjoy? Yes No
If Yes: Did it last as long as 2 weeks? Yes No
Has there been a period of time when you were feeling so good or so hyper people thought you were not your normal self or you were so hyper you got in trouble? Yes No
If Yes: Was it more than just feeling good? Yes No
Did anyone say you were manic? Yes No
What about a period of time when you were so irritable that you would shout at people or start fights or arguments? Yes No
Have you experienced a major stress which you feel has caused your mood to change? Yes No
If yes (describe) My ship sank and my wife left to marry another suitor
Have you experienced other medical problems? Yes No
If yes (describe) Migraine headaches
Used additional psychiatric care/treatment Yes No Other medical treatment Yes No Onset of last menses __/__/__

Over the past 10 days how many days have you been/had…

…depressed most of the day 8 /10 Days …any period of abnormal mood elevation 0 /10 Days
…any period of abnormal irritability 2 /10 Days …any period of abnormal anxiety 0 /10 Days

During the past week . . .

What is the least you have slept in any one day 04 hrs What is the most you have slept in any one day 16 hrs
Have you had: Panic Attacks No Binge/Purge No Headaches Yes Weight 185
Indicate your use of: Caffeine 2 cups/day Nicotine 0 packs/day Alcohol 0 drinks/week Drugs ___

For each item rate this week compared to your usual (when well)	←Decreased: Constant and Severe		Nearly Every Day	Often	Rarely And/or mild	Well	Increased→: Rarely and/or mild	Often	Nearly Every Day	Constant And Severe
Sleep			✓			Normal	✓			
Ability to enjoy pleasant things / usual interests				✓		Normal				
Self confidence/Self Esteem			✓			Normal				
Energy			✓			Normal				
Ability to Concentrate				✓		Normal				
Distractibility						None		✓		
Appetite				✓		Normal	✓			
Physical restlessness/ agitation						None	✓			
Slowing of movement, speech or thoughts						✓None				
Feel life isn't worth living or suicidal thoughts						None		✓		
Talking						✓Normal				
Racing thoughts						None			✓	
Making plans or getting new projects started			✓			Normal				
Behaviors others regard as excessive, foolish or risky						None	✓			

Please complete for all medications used since your last visit

Medication	Total daily dose	Mg missed this week	Comments / adverse effects	☐ Check if no adverse effects
Eskalith CR	120 Mg	240 Mg	Trem or. Thirsty all the time.	
Depakote	150 Mg	300 Mg		
	Mg	Mg		
Ativan	1 Mg	2 Mg	Sedation. Worsening of memory.	
Wellbutrin	300 Mg	0 Mg		
	Mg	Mg		
Risperdal	1.5 Mg	0 Mg		
	Mg	Mg		
	Mg	Mg		

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For each question, circle "YES" or "NO". READ CAREFULLY!
Keep in mind the time frame of each question

These questions refer to the past 10 days only

What is…?

- **Depressed Mood -** feeling sad, blue, down, being unable to enjoy most things you usually find pleasurable
- **Elevated Mood -** feeling high, up, more capable than usual, feeling invulnerable - out of proportion to circumstances
- **Abnormal irritablility -** feeling more easily annoyed, angry, or hostile than normal for the circumstances
- **Abnormal anxiety -** feeling more nervious, anxious, worried than normal for the circumstances

All remaining questions refer to this past week only

- **Rate each item referring to this past week only.**
- **Check "Normal" or "None" if symptom has not been present.**
- **Check appropriate box to rate each item.**
- **You may check more than one box.**
- **Ask your doctor if you are unsure of an item**

- **Check here if you have not had any noticeable side effects from your medications.**

- **Please indicate all medications you have taken since your last visit.**
- **If you can't remember how many milligrams (mg) you take, consult your doctor about your dose.**
- **List any side effects or comments you have about your treatments.**

PLEASE GIVE THIS FORM TO YOUR DOCTOR AT THE BEGINNING OF YOUR APPOINTMENT

After filling out the Self-report Form once or twice, you'll find that it's much easier than it first appears, and you will be able to make better use of your appointment time.

Bipolar Disorder Symptoms & Functioning Monitoring Form

From the STABLE Resource Toolkit.
Identify symptoms during initial assessment and then update at each visit
Update: "✓" if still present & mark as "same (S)" – "better (B)" – "worse (W)"

If a symptom has two opposite selections (xx OR xx); circle as assessed at initial evaluation

	Initial Assessment Date:	Date:	Date:	Date:	Date:
DEPRESSIVE SYMPTOMS **Criteria for Major Depressive Episode >**	APA Practice Guideline for the Treatment of Patients with Bipolar Disorder: Symptom List from Diagnostic Criteria for a Major Depressive Episode; *[Core Symptoms in BOLD] 5 or more symptoms for same 2-week period and at least one symptom is a Core symptom*				
Depressed mood (sad, empty; tearful; hopeless; most of day, nearly every day)					
Diminished interest/pleasure (all or almost all activities; most of day, nearly every day)					
Weight: loss & not dieting OR gain Appetite: decrease OR increase					
Sleeping; too much OR too little					
Psychomotor Agitation OR Psychomotor Retardation					
Fatigue; Loss of energy					
Feelings of worthlessness; excessive/inappropriate guilt					
Inability to think/concentrate; indecisiveness					
Recurrent thoughts of death; suicidal ideation					
MANIC/HYPOMANIC SYMPTOMS **Criteria for Manic/Hypomanic Episode >**	APA Practice Guideline for the Treatment of Patients with Bipolar Disorder: Symptom List from Diagnostic Criteria for a Manic or Hypomanic Episode; *[Core Symptoms in BOLD] Mania = For at least 1 week; a Core Symptom plus 3 or more symptoms (4 if core symptom is only irritable) Hypomania = For at least 4 days; a Core symptom plus 3 or more symptoms (4 if core symptom is only irritable)*				
Period of elevated or expansive mood					
Period of an irritable mood					
Inflated self-esteem or grandiosity					
Decreased need for sleep (< 3 hrs)					
More talkative than usual or pressure to keep talking					
Flight of ideas / Feels that thoughts are racing					
Distractibility (too easily drawn to unimportant / irrelevant items)					
Increase in goal-directed activities (socially; school; work; sexually) or psychomotor agitation					
Excessive involvement in pleasurable activities with high potential for painful consequences (financial; sexual; etc.)					
LEVEL-OF-FUNCTIONING	Document response; Consider use of Sheehan Disability Scale				
Work / School					
Social Life / Interpersonal					
Family Life / Home Responsibilities					

Note: DSM-IV-TR Criteria for a Mixed Bipolar Disorder Episode: The criteria are met for both a manic episode and for a major depressive episode (except for duration) nearly every day during at least a 1-week period.

Level-of-Function Assessment

A functional assessment provides the clinician with a means to quantify the patient's impairment.

- Level-of-functioning instruments measure a person's ability to interact with others, form relationships and handle day-to-day tasks.[1]
- Self-report of level-of-functioning has been found to have an important role in treatment as it encourages patient participation and collaborative dialogue.[1]
- Monitoring response to treatment in bipolar disorder should extend beyond symptom reduction to include a focus on a person's improvement in functioning.[2]

The STABLE Resource Toolkit contains a single scale, the Sheehan Disability Scale. This scale is a highly validated instrument developed to assess functional impairment which can be used to assess response to treatment.

Sheehan Disability Scale (SDS)

- The SDS is a self-rated scale that evaluates 3 inter-correlated domains. The patient rates the extent to which his or her work, social life, and home life or family responsibilities are impaired by his or her symptoms on a 10 point visual analog scale.
- This anchored visual analog scale uses spatiovisual, numeric, and verbal descriptive anchors simultaneously to assess disability.

1. *O'Malia L, McFarland B, et al. A Level-of Functioning Self Report Measure for consumers with severe mental illness. Psychiatric Services, March 2002, Vol 53, No 3 26-331*
2. *Keck PE, Defining and Improving response to treatment in patients with bipolar disorder. J Clin Psychiatry 2004; 65 (suppl 15) 25-29.*

Sheehan Disability Scale (SDS) - Overview

The Sheehan Disability Scale (SDS) was developed to assess functional impairment in three inter-related domains; work/school, social and family life. It is used by researchers and practicing clinicians.

Clinical Utility

- The SDS is a brief self-report tool.
- The patient rates the extent to which work/school, social life and home life or family responsibilities are impaired by his or her symptoms on a 10 point visual analog scale.
- This 10 point visual analog scale uses spatiovisual, numeric and verbal descriptive anchors simultaneously to assess disability.
- The author indicates that this range of anchor options addresses the various ways that individuals approach rating a continuum.

Scoring[1]

- The numerical ratings of 0-10 can be translated into a percentage, if desired.
- The 3 items can also be summed into a single dimensional measure of global functional impairment that rages from 0 (unimpaired) to 30 (highly impaired).
- There is no recommended cutoff score; however, change-over-time in scores will be of interest to clinicians in monitoring response to treatment
- It is recommended that clinicians pay special attention to patients who score 5 or greater on any of the three scales, because such high scores are associated with significant functional impairment.

Psychometric Properties

The following sensitivity and specificity is for patients with any of the following six mental disorders (alcohol dependence, drug dependence, general anxiety disorder, major depressive disorder, obsessive compulsive disorder and panic disorder).[1]

Sensitivity	83%
Specificity	69%

1. Rush JA, et al. Handbook of Psychiatric Measures, 2000 American Psychiatric Association, 113-115.

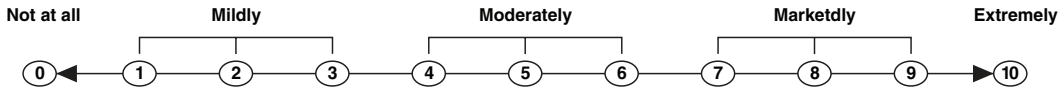
Sheehan Disability Scale

A brief, patient rated, measure of disability and impairment.

Please mark ONE circle for each scale.

WORK* / SCHOOL

The symptoms have disrupted your work / school work:

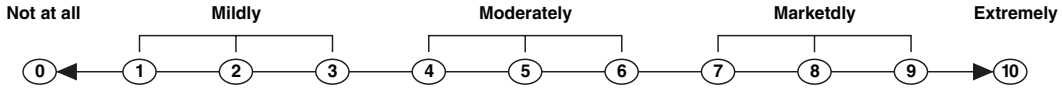


☐ I have not worked / studied at all during the past week for reasons unrealted to the disorder.

* Work includes paid, unpaid volunteer work or training

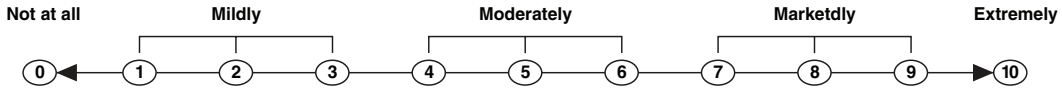
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:



Days Lost

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

Days Unproductive

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

Education

- Patients who do not believe or understand that they have a serious illness are less likely to adhere to long-term treatment regimens that can improve their health status.[1]
- Specific goals of psychiatric treatment for bipolar disorder include providing education to assist the patient in understanding and accepting their illness and to reinforce the patient's collaborative role in the treatment of this persistent condition.[1]
- Printed materials can assist in reinforcing education provided by the health care provider.[1]

To enhance bipolar disorder education the STABLE Resource Toolkit provides:

- A mood chart
- A clinical educational resource guide

Mood Charting

- Mood charts are self monitoring tools used to gather information about changes in mood over time.
- Recording this information on a chart generates a simple graph from which an emerging pattern can be seen that might be difficult to identify.
- Although all patients will not elect to participate in mood monitoring, those who do may find it a valuable tool to report changes to their clinician or identify early signs of relapse.

Educational Reference Guide

The Educational Reference Guide provides an up-to-date listing of guides and brochures that are available through mental health advocacy and support organizations.

1. *Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4 April 2002 Supplement*

Mood Charting

Long-term monitoring is valuable in bipolar disorder to facilitate recognition of the variability in the mood swings associated with the condition, including identification of symptom-free intervals. Ongoing monitoring also provides an "early-warning" system and a method to recognize any patterns of stressful life events that may act as triggers.

Various approaches that provide graphic representations of mood variability have been developed that include 2, 3, or 4 levels of depressive or mania-related severity. The levels are operationalized by indicating functionality in everyday life or its impairment due to mood symptoms.

Detailed documentation of medication provides information about adherence and the relationship of the medication type and schedule to the mood swings.

The National Institute of Mental Health's prospective Life Chart Method (NIMH-LCM™) uses daily ratings by the person with bipolar disorder. The ratings specify the polarity and severity of manic and depressive episodes and their course; also recording the concomitant use/ impact of medication and life events that may precipitate episodes.

In a study to validate the NIMH-LCM™ instrument, researchers found that depression rates correlated highly with the Inventory of Depressive Symptomatology –clinician rated scale (IDS-C) ($r = -0.785$) and manic rates correlated highly with the Young Mania Rating Scale (YMRS) ($r = 0.656$)[1]

Mood Charts

Mood Charting is a simplified patient self-report technique derived from the more extensive Life Chart approach. The participation of the patient in providing input to the daily documentation has been found to promote a more involved and collaborative therapeutic alliance with the clinician.

Patient participation serves to reinforce education and information about the condition and how to manage lifestyle (sleep habits, etc.) and promotes active involvement in the management of the disorder.

1. *Denicoff KD, et al, Validation of the prospective NIMH-Life-Chart Method (NIMH-LCM™-p) for longitudinal assessment of bipolar illness. Psychological Medicine Volume 30 (6) 2000, 1391-1397.*

Daily Mood Chart

How to use the Mood Chart

- At the end of each day rate your mood –the "Highest" or "Lowest" that you felt that day
- Place a dot in the box that best describes your mood
- If you have had High and Low moods on the same day place two dots
- List the number of hours you slept each day
- Weigh yourself on the 14th & 28th day of each month and record
- Rate any anxiety or irritability that you may have on a scale from 0-3 (3=high) and record daily
- List your medications and place a check mark daily if you took your medicine
- Place an "A" if you drank Alcohol or a "D" if you used any drug that was not prescribed by a doctor

HIGH MOOD	+3																													
	+2																													
	+1																													
NORMAL																														
LOW MOOD	-1																													
	-2																													
	-3																													
	DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HOURS SLEPT																														
WEIGHT ON DAY 14 & 28																														
ANXIETY																														
IRRITABILITY																														
MEDICATION (name/mg)	Place a checkmark if medication was taken each day																														
ALCOHOL/DRUGS																														

Name _____ Month/Year _____

Educational Resources for Persons with Depression or Bipolar Disorder

The recommended educational offerings listed below are available through the organization's website as listed.

American Psychiatric Association (APA)
APA is a medical specialty society with over 35,000 physicians working together to ensure humane care and effective treatment for all persons with mental disorders.

Recommended educational offerings:
- Let's talk Facts About Depression
- Let's talk Facts About Bipolar Disorder

American Psychiatric Association
1000 Wilson Blvd.
Suite 1825
Arlington, VA 22209

www.psych.org
703-907-7730

Depression and Bipolar Support Alliance (DBSA)
DBSA is the nations leading patient-directed organization focusing on the most prevalent mood-related mental illnesses, depression and bipolar disorder.

Recommended educational offerings:
- Myths and Facts about Depression and Bipolar Disorder
- Just Diagnosed? You are not alone
- Introduction to Depression and Bipolar Disorder
- Dual Diagnosis and Recovery

Depression and Bipolar Support Alliance
730 N. Franklin Street, Suite 504
Chicago, IL 60610-7224

www.dbsalliance.org
Toll Free 800-826-3632

Mental Health America (MHA)
Formerly The National Mental Health Association
MHA is the nations oldest non-profit advocacy organization.

Recommended educational offerings:
- Bipolar Disorder – What you need to know
- What is Bipolar Disorder? – A Guide to Hope and Recovery in African Americans
- Mood Disorders

Mental Health America
2000 N. Beauregard St, 6th Floor
Alexandria, Virginia 22311

www.nmha.org
Toll Free 800-969-6642

National Alliance on Mental Illness (NAMI)
NAMI is the nation's largest grassroots mental health organization dedicated to improving the lives of persons with serious mental illness and their families.

Recommended educational offering:
- Understanding Bipolar Disorder – What you need to know about this medical illness

National Alliance on Mental Illness
Colonial Place Three
2107 Wilson Blvd. Suite 300
Arlington, VA 22201-3042

www.nami.org
Toll Free: 1-800-950-6264

National Institute of Mental Health (NIMH)
NIMH is the leading federal agency for research in mental and behavioral disorders

Recommended educational offering:
- A Story of Bipolar Disorder

National Institute of Health
Public Information &
Communication Branch
6001 Executive Blvd.
Room 8184, MSC 9663
Bethesda, MD 20892-9663

nimh.nih.gov
Toll Free 1-866-615-6464

Office Practice Coding Assistance - Overview

Three office coding assistance resources are provided in the STABLE Resource Toolkit.

Depression & Bipolar Disorder Coding Reference:

- Provides ICD9CM and DSM-IV-TR codes
- Provides description for each code

Depressive Disorder Coding and Diagnostic Criteria

- Major Depressive Disorders code
- Dysthymic Disorder code
- Depression Disorder NOS code
- DSM-IV-TR criteria to support selection of each code

Bipolar Disorder Coding and Diagnostic Criteria

- Bipolar I Disorder codes
- Bipolar II Disorder code
- Cyclothymic Disorder code
- Bipolar Not Otherwise Specified (NOS) code
- Detailed DSM-IV-TR criteria to support selection of each code

Depression & Bipolar Disorder Coding Reference

Depression	
ICD-9 and DSM IV-TR Code	**Diagnosis Code Description**
296.2x	Major depressive disorder, single episode
296.3x	Major depressive disorder, recurrent episode
300.4x	Dysthymic disorder, depression with anxiety; depressed reaction
311	Depressive disorder, NOS, not elsewhere classified

Bipolar Disorder	
ICD-9 and DSM IV-TR Code	**Diagnosis Code Description**
296.0x	Bipolar I disorder, single manic/hypomanic episode
296.40	Bipolar I disorder-most recent episode hypomanic
296.4x	Bipolar I disorder-most recent or current episode manic
296.5x	Bipolar I disorder-most recent episode or current episode depressed
296.6x	Bipolar I disorder-most recent episode or current episode mixed
296.7x	Bipolar I disorder-most recent episode or current episode unspecified
296.80	Bipolar disorder-Not Elsewhere Classified-includes Bipolar Disorder NOS Manic-Depressive Syndrome NOS Manic-Depressive reaction NOS
296.89	Bipolar II disorder
301.13	Cyclothymic disorder

Valid ICD-9 codes but not included in DSM-IV coding	
296.1x	Includes any condition in 296.0x which is now stated to be recurrent.
296.81	Atypical manic disorder
296.82	Atypical depressive disorder

X = a 5th digit used to specify severity			
0	Unspecified severity		
1	Mild severity	4	Severe-with mention of psychosis
2	Moderate severity	5	In partial or unspecified remission
3	Severe-without mention of psychosis	6	In full remission

Depressive Disorder Coding And Diagnostic Criteria

Major Depressive Disorders	The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities.	
296.2x	Single Episode	■ Presence of a single major depressive episode ■ Diagnostic criteria 1&2.
296.3x	Recurrent Episode	■ Presence of two or more major depressive episodes. Note: to be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a major depressive episode. ■ Diagnostic criteria 1&2.
Dysthymic Disorder	**A mild depression that lasts for two years without a break**	
300.4	Dysthymic Disorder	■ Depressed mood for most of the day, for more days than not, as indicated by subjective account or observation by others. ■ Presence, while depressed of two or more of the following: Poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration, feelings of hopelessness. ■ During the 2-year period the person has not been without symptoms ■ Diagnostic Criteria 2. ■ The disturbance does not occur during the course of a chronic Psychotic disorder. ■ The symptoms are not due to the direct physiological effects of a substance (drug abuse or medication) or of a general medical condition. ■ The symptoms cause clinically significant distress or impairment in social, occupational or other area of function.
Depressive Disorder NOS	**The Depressive Disorder Not otherwise Specified (NOS) category includes disorders with depressive features that do not meet criteria for Major Depressive Disorder or Dysthymic Disorder**	
311	Depressive Disorder NOS	■ Premenstrual dysphoric disorder ■ Minor depressive disorder – episodes of at least 2 weeks but with fewer than the 5 items required for MDD. ■ Recurrent brief depressive disorders ■ Post psychotic depressive disorder ■ A MDD superimposed on delusional disorder, Psychotic Disorder NOS or the active phase of Schizophrenia ■ Situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.

DSM-IV-TR Diagnostic Criteria:

1. The depressive episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
2. There has never been a manic episode, a mixed episode, or a hypomanic episode. Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

American Psychiatric Association, 2000: Diagnostic and Statistical Manual of Mental Disorders, Forth Edition, Text Revision, Washington, DC

Bipolar Disorder Coding And Diagnostic Criteria

Bipolar I Disorder	Diagnosis of Bipolar I disorder requires at least one manic or mixed episode, but there may be episodes of hypomania or major depression	
296.0x	Single Manic Episode	■ Presence of only one manic episode and no past major depressive episodes. ■ Diagnostic criteria 1.
296.40	Most Recent Episode Hypomanic	■ Currently or most recently in a hypomanic episode ■ Diagnostic criteria 1 & 2.
296.4x	Most Recent Episode Manic	■ Currently or most recently in a manic episode. ■ There has previously been at least one major depressive episode, manic episode or mixed episode. ■ Diagnostic criteria 1.
296.5x	Most Recent Episode Depressed	■ Currently or most recently in a major depressive episode ■ There has previously been at least one manic episode or mixed episode ■ Diagnostic criteria 1.
296.6x	Most Recent Episode Mixed	■ Currently or most recently in a mixed episode. ■ There has previously been at least one major depressive episode, manic episode or mixed episode. ■ Diagnostic Criteria 1.
296.7x	Most Recent Episode Unspecified	■ Criteria, except for duration, are currently or most recently met for a manic, a hypomanic, a mixed, or a major depressive disorder. ■ There has previously been at least one manic episode or mixed episode ■ Diagnostic criteria 1, 2 and 3.

DSM-IV-TR Diagnostic Criteria:

1. The mood episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
2. The mood symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
3. The mood symptoms are not due to the direct physiological effects of a substance (a drug of abuse, a medication, or other treatment) or a general medical condition.

American Psychiatric Association, 2000: Diagnostic and Statistical Manual of Mental Disorders, Forth Edition, Text Revision, Washington, DC

Bipolar Disorder Coding And Diagnostic Criteria - continued

Bipolar II Disorder	**The diagnosis of this bipolar disorder requires neither a manic or a mixed episode, but does require at least one episode of hypomania in addition to an episode of major depression**	
296.89	Bipolar II Disorder	■ Presence or history of one or more major depressive episode. ■ Presence or history of at least one hypomanic episode. ■ There has never been a manic episode or a mixed episode ■ Diagnostic criteria 1 & 2.
Cyclothymic Disorder	**Diagnosis of this bipolar disorder requires a history of numerous hypomanic episodes intermingled with numerous episodes of depression that do not meet criteria for major depressive episodes.**	
301.13	Cyclothymic Disorder	■ A 2 year history of numerous of hypomanic and depressive symptoms that do not meet criteria for a major depressive episode and the patient has not been without symptoms for more than 2 months. ■ No major depressive disorder, manic or mixed episode has been present during the first 2 years of the disturbance ■ Diagnostic criteria 1, 2 and 3.
Bipolar Disorder Not Otherwise Specified	**The Bipolar Disorder Not Otherwise Specified category includes disorders with bipolar features that do not meet criteria for any specific bipolar disorder.**	
296.80	Bipolar Disorder NOS	■ Vary rapid alteration between manic and depressive symptoms that meet symptom threshold criteria but not minimal duration criteria. ■ Recurrent hypomanic episodes without intercurrent depressive symptoms. ■ A manic or mixed episode superimposed on delusional disorder, residual schizophrenia or psychotic disorder NOS. ■ Hypomanic episodes along with chronic depressive symptoms, that are too infrequent to qualify for a diagnosis of cyclothymic disorder. ■ Situations where bipolar disorder is present but the clinician is unable to determine whether it is primary or secondary to a general medical condition or substance abuse.

DSM–IV-TR Diagnostic Criteria:

1. The mood episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
2. The mood symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
3. The mood symptoms are not due to the direct physiological effects of a substance (a drug of abuse, a medication, or other treatment) or a general medical condition.