Hospitalization for Bipolar Disorder At A Glance

Hospitalization of persons with bipolar disorder aims to stabilize the person served and reduce the risks of mania, depression and suicide.

It is imperative to evaluate for:

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

Because suicide rates in persons with bipolar disorder are as high as 15%, assessment of suicide risk is critical. The overwhelming majority of suicide attempts are associated with depressive episodes or depressive features during mixed episodes.

Child abuse, domestic violence, or other violent behavior may occur during a severe manic episode and/or when psychotic symptoms are present.

The risk of recurrence of a manic episode increases with the number of previous episodes and failure to adhere to treatment increases the frequency of hospitalization. Factors associated with suboptimal clinical outcomes are previous treatment failure, failure to adhere to prescribed medication regimen, rapid cycling, poor work adjustment and limited social supports.

Frequently used medications in the acute treatment of mania are lithium, Tegretol (carbamazepine) and valproate. Lithium dosing must be monitored for clinical evidence of neurotoxicity. Adjunctive treatments to lithium and Tegretol include use of benzodiazepines, clonazepam, verapamil, clonidine and antidepressants including MAOIs to treat the depressive pole as well as neuroleptics to control agitated behavior and psychosis. Treatment with lithium alone has significantly better overall outcomes than in combination with neuroleptics.

The essential components of effective management are supportive therapy, education about the illness, prophylactic medications to prevent relapses, coupled with closely monitored lithium levels, kidney and thyroid function tests.

Structured settings exert a therapeutic effect on manic patients, promoting quicker recompensation; hospital admission may be indicated if the person served displays:

- Homicidal, assaultive, and destructive behavior;
- Suicidal or self-mutilative behavior;
- Suicidal ideation with poor impulse control;
- Sustained agitation with high risk of violence against persons or property.
- Psychotic features, including hallucinations or delusions, when the patient is gravely disabled; and/or
- Severe impairment in occupational functioning and interpersonal relationships.

Hospitalization

Order laboratory tests: blood and urine drug screen tests, testing for substance intoxication and EEG for persons served age 40 and older who are started on lithium.
Consider medications to reduce mania and manage out-of-control behavior.

Complete medical, psychosocial and psychiatric evaluation for medications.

It is imperative that treatment planning emphasize discharge planning and relapse prevention including supportive therapy, education, family intervention and medication monitoring. Initiate and continue individual psychotherapy, family psychotherapy, group therapy and other milieu therapies as mania symptoms subside.

Most psychiatric hospitalizations are brief with longer stays generally associated with co-occurring disorders.

Consider transfer to open, less-restrictive unit if person served is managing behaviors.

Educational programs should be reinforce that adherence to treatment, especially medications, is vital.

Discharge should be to the least restrictive environment. Consider residential treatment centers, day treatment or return home with outpatient treatment.

Followup includes adherence to medications and individual and family psychotherapy as indicated. Medication adherence should be confirmed by monitoring for therapeutic blood levels.