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Managing Patients with Bipolar Disorder at Home

A Family Affair and A Psychiatric Challenge in Home Healthcare

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Medicare has covered psychiatric home care for many years, but the delivery of psychiatric services in the home continues to raise questions related to coverage and criteria. What services do psychiatric nurses provide in the home? What are the rules and regulations governing this service? This article presents information related to psychiatric nursing in home care and specifically bipolar disease. These questions are answered within Chapter 7 of the Medicare Benefit Policy Manual, April 2011. Section 40.1.2.15.

Box 1. Medicare Criteria for Psychiatric Nursing Services

Patient must have an Axis 1 psychiatric diagnosis:

- Anxiety disorders (e.g., panic disorder, social anxiety disorder, posttraumatic),
- Mood disorders (e.g., major depression, bipolar disorder)
- Eating disorders (e.g., anorexia nervosa, bulimia nervosa),
- Psychotic disorders (e.g., schizophrenia, schizoaffective disorder),
- Dissociative disorders, or
- Substance use disorders.

Patient must be referred by a physician (psychiatrist not required but backup a good idea).

Patient must be psychiatrically homebound.

Patient must need the skills of a psychiatric nurse: assessment, psychotherapeutic counseling, teaching, and medication management.

The Centers for Medicare & Medicaid Services (CMS) does not publish data regarding which psychiatric diagnoses are most frequently addressed in home care, nor is there data on how many home healthcare agencies (HHAs) provide psychiatric services. (See Box 1 for CMS criteria to receive psychiatric home care services.) Similarly, there are no statistics regarding how many patients receive psychiatric care at home. Depression among homebound older adults is the primary psychiatric diagnosis that receives attention in home care literature. There is a great deal of research on the incidence of depression in the homebound elderly and the role of home care agencies in responding to these needs. One of the most problematic diagnoses from a management perspective in home care is bipolar disorder (BD) and this has not been addressed in a systematic manner in home healthcare.

Literature Review on Depression and Psychiatric Home Care

The abundance of research on depression underscores the lack of research on other psychiatric disorders, including BD but also highlights the role that home healthcare can play in the management of all the psychiatric disorders. The incidence of depression among the homebound elderly is significant with studies reporting

statistics ranging from 13.5% to 46% (Bruce, 2002; Bruce & Ahrens, 2003; Bruce et al., 2002, 2011; Carson, 2001a, 2001b, 2007; Carson & Vanderhorst, 2010). In contrast, there are no statistics on the incidence of BD among the homebound older adults, even though BD is a lifelong illness characterized by exacerbations and remissions. The very nature of BD points to the safe assumption that BD exists in the typical home healthcare population.

Outcome and Assessment Information Set (OASIS)-C , which is the Medicare-required comprehensive assessment tool, is completed on every patient admitted to home healthcare services (CMS, 2011b). Using OASIS-C, clinicians are required to assess depression using the PHQ2 as a screening tool. When the clinician assesses the PHQ2 score as three or higher, the clinician is expected to complete a more thorough screening for depression using one of a variety of evidence-based assessment tools, including the PHQ9 (Kroenke et al., 2001) or the Geriatric Depression Scale-Short Version—GDS (Shiekh & Yesavage, 1986), and report the results to the physician. The rationale for this addition to the OASIS-C was the recognition that untreated depression increases readmission rates to inpatient facilities; is a barrier to patients' abilities to adhere to a prescribed treatment plan; and results in substantially higher medical costs (Bruce et al., 2011; Carson & Vanderhorst, 2010; Juurlink et al., 2004; Koenig & George, 1998; Ranga et al., 2002). There are no additional assessments included or recommended within the OASIS for clinicians to assess BD or any of the other debilitating psychiatric diagnoses. If the clinician is not required to assess for a problem, it is likely that the problem will not be addressed.

In 2003, a study conducted by Zeltzer and Kohn (2006) underscored the lack of focus and direct care that home healthcare providers are prepared to deliver to patients with any psychiatric disorder, including BD. Zeltzer and Kohn examined the practices of HHAs and home care agencies licensed in Rhode Island. HHAs provided nursing services plus at least one other service such as occupational, physical, and speech therapies, medical and social services, and home health aides. Home care agencies were defined as those that provided supportive services such as housekeeping, meal preparation, personal assistance, live-in attendants, and companions, but not direct healthcare services. This study examined the management and treatment of homebound patients with behavioral issues including dementia and undiagnosed psychiatric disorders. Fifty-four agencies were queried and 53 responded. Eighteen of the respondents were home care agencies and 35 were HHAs. The results of this study demonstrated that there was no direct management of psychiatric disorders in either the home care agencies or the HHA providers. Less than 30% of both HHAs and home care agencies said that they would notify the patient's primary care physician. About 34% of both types of agencies said they would consider making a referral to a mental health provider, regardless of whether the provider made home visits. When confronted with behavioral problems such as yelling, hitting, and other forms of agitation, only 29% of the HHAs and 26% of the home care agencies referred the patient to the primary care physician for treatment. Twenty percent of the HHAs and 50% of the home care agencies stated they would notify only family without providing any referral recommendations. The researchers identified a bias against accepting patients who had a primary psychiatric disorder and were in need of mental healthcare. Thus, families were left to manage challenging behaviors without support of home healthcare providers.

A striking contrast to the Zeltzer and Kohn (2006) study is a research study conducted in 1998 (Vanderhorst et al., 1998) that examined the clinical- and cost-effectiveness of psychiatric home care compared to other treatment modalities. This study examined the clinical outcomes of 80 patients referred for psychiatric home care and looked at a sample with a variety of psychiatric diagnoses represented including major depression with and without psychotic features; schizophrenia; BD; dementia; schizoaffective disorder; anxiety disorders; substance abuse disorders; psychosis not otherwise specified), and intermittent explosive disorder. There were four interventions offered to these patients that included medication teaching and management; individual and family counseling; and psychoeducation about their illnesses and strategies to stay well. Sixty percent (n = 48) of the patients in this study were stable at discharge and had met the goals established for them in their plans of care. This is the only published work that has exam-

ined the home healthcare management along with clinical and financial outcomes of psychiatric diagnoses, other than depression. The remainder of this article addresses BD and the challenges inherent in this diagnosis.

Bipolar Disorder: An Overview

According to the *Diagnostic and Statistical Manual* (American Psychiatric Association [APA], 2000) there are two major subtypes of BD: BD I is considered the classic form of the illness and involves recurrent episodes of severe mood swings, from mania to depression—see Box 2 for a description of these symptoms; BD II involves milder episodes of mania called hypomania with depressive episodes. However, there are many variations on BD—see Supplemental Digital Content 1 (http://links.lww.com/HHN/A16) for codes and variations of BD.

BD is a lifelong disease frequently beginning in adolescence. In a 2011 international study funded by the National Institute of Mental Health (NIMH), the researchers also identified a third variation of BD named BD-NOS (i.e., bipolar disorder-not otherwise specified), which they described as a subthreshold BD with symptoms of both mania and depression leading to significant impairment in those who suffer with this disorder (Merikangas et al., 2011).

This same study reported worldwide prevalence rates of BD I, BD II, and BD-NOS as 0.6%, 0.4%, and 1.4%, respectively, with an overall bipolar spectrum rate of 2.4%. The highest prevalence was found in the United States at 4.4% with India having the lowest rate at 0.1%. Across the countries studied, 75% of those who had bipolar symptoms also suffered with at least one other psychiatric disorder. The most prevalent coexisting disorders were the anxiety disorders, with a high occurrence of panic disorders. The findings of this international study support the conclusion that BD is best described as a spectrum disorder that carries with it huge burdens to those unfortunate enough to be living with some variation of this disorder (Merikangas et al., 2011).

Treatment of Bipolar Disorder

Medications

BD is usually treated with an array of medications. Because individuals respond to medications differently, patients frequently need to try several different medications or combinations of medications in an effort to find the best course of treatment. It is common to find that patients with BD struggle to remain adherent to their medication regimen. Thus, the management of medications is a major issue for the psychiatric home

Box 2. Description of the Symptoms of Bipolar Disorder

Symptoms of Mania

- Feeling unusually "high" and optimistic **OR** extremely irritable
- Unrealistic, grandiose beliefs about one's abilities or powers
- Sleeping very little, but feeling extremely energetic
- Talking so rapidly that others can't keep up
- Racing thoughts; jumping quickly from one idea to the next
- Highly distractible, unable to concentrate
- Impaired judgment and impulsiveness
- Acting recklessly without thinking about the consequences
- Delusions and hallucinations (in severe cases)

Symptoms of Hypomania

- Hypomania is a less severe form of mania. People in a hypomanic state
- Feel euphoric, energetic, and productive: able to carry on with their day-to-day lives and they never lose touch with reality
- Appear in unusually good mood
- Hypomania can result in bad decisions that harm relationships, careers, and reputations
- Hypomania often escalates to full-blown mania or is followed by a major depressive episode

Symptoms of Bipolar Depression

- Feeling hopeless, sad, or empty
- Irritability
- Inability to experience pleasure
- Fatigue or loss of energy
- Appetite or weight changes
- Sleep problems
- Concentration and memory problems
- Feelings of worthlessness or guilt
- Thoughts of death or suicide

One of the risks of taking lithium is that the medication is sometimes linked to low thyroid levels and can lead to rapid cycling in some individuals with bipolar disorder (BD), especially women. Additionally, hypothyroidism is associated with changes in mood and energy, thus necessitating careful checks of thyroid levels in those with BD.

healthcare nurse as well as for the patient and family. The types of medications commonly prescribed include (a) mood-stabilizing medications, (b) antidepressant medications, and (c) antipsychotic medications. Teaching patients about the importance of medication adherence is a major role of the psychiatric home healthcare nurse (NIMH, 2008a). The following section describes the three types of medication management used for BD.

Mood-stabilizing medications are usually the first choice to treat BD. Because this disease is a chronic lifetime illness, these medications may be continued for years. Included in this category are lithium (brand names may include Eskalith and Lithobid) as well as anticonvulsants that are used not only to treat seizures but to help control a person's moods. Lithium was the first mood-stabilizing medication approved by the U.S. Food and Drug Administration (FDA) in the 1970s for treatment of mania, and it is very effective in controlling symptoms of mania and preventing the recurrence of manic and depressive episodes. One of the risks of taking lithium is that the medication is sometimes linked to low thyroid levels and can lead to rapid cycling in some individuals with BD, especially women. Additionally, hypothyroidism is associated with changes in mood and energy, thus necessitating careful checks of thyroid levels in those with BD. Hypothyroidism would necessitate the need for those with BD to also take thyroid medication to maintain healthy levels of thyroid hormone (Bowden et al., 2000). Because lithium is a naturally occurring salt, taking it poses risks for patients who also need antihypertensive and/or diuretic(s), especially thiazide diuretics. In these situations, the lithium concentration levels can reach dangerous levels and must be closely monitored (Handler, 2009). Lithium poisoning occurs frequently, since it is used in a population at high risk for overdose. The therapeutic dose is 300 to 2,700 mg/day with desired serum levels of 0.6 to 1.2 mEq/L. Lithium clearance is predominantly through the kidneys. Because it is minimally protein-bound, lithium is freely filtered at a rate that is dependent on the glomerular filtration rate. Consequently, dosing must be adjusted based on renal function. Individuals with chronic renal insufficiency must be closely monitored if placed on lithium therapy (Handler, 2009).

An alternative to lithium is valproic acid or divalproex sodium (Depakote), which is an anticonvulsant drug that was approved by the FDA in 1995 for treating mania (Bowden et al., 2000; Calabrese et al., 2005). The anticonvulsant lamotrigine (Lamictal) is also prescribed for maintenance treatment of BD (Calabrese et al., 1999). Other anticonvulsant medications—including gabapentin (Neurontin), topiramate (Topamax), and oxcarbazepine (Trileptal)—are sometimes prescribed, although there are no large studies to demonstrate that these medications are more effective than lithium (NIMH, 2008b).

It is important to note that many of the anticonvulsant medications such as valproic acid and lamotrigine have an FDA warning that states that their use may increase the risk of suicidal thoughts and behaviors. A critical component of care involves monitoring patients who are taking anticonvulsant medications for bipolar or other illnesses for unusual changes in mood or behavior including new or worsening signs of depression, and suicidal ideation (NIMH, 2008b).

Antidepressant medications are also used to treat symptoms of depression in BD. People with BD who take antidepressants often take a mood

stabilizer as well to prevent a rapid switch to mania or hypomania (Thase & Sachs, 2000). Fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), and bupropion (Wellbutrin) are examples of antidepressants that may be prescribed to treat symptoms of bipolar depression (NIMH, 2008b).

Antipsychotic medications are sometimes used to treat symptoms of BD. These medications are taken along with other medications. Atypical antipsychotic medications are called "atypical" to set them apart from earlier medications, which are called "conventional" or "first-generation" antipsychotics. Included in this group of atypical antipsychotic medications are olanzapine (Zyprexa), aripiprazole (Abilify), quetiapine (Seroquel), risperidone (Risperdal), and ziprasidone (Geodon). Any of these atypical antipsychotics may also be prescribed for controlling manic or mixed episodes of BD. Table 1 presents information on dosing and side effects profile on the most commonly prescribe atypical antipsychotic medications used to treat the older adults.

The home healthcare clinician plays a significant role in educating the patient about the benefits and risks of taking these medications as prescribed and indeed maintaining a log on the therapeutic effects as well as the side effects experienced from taking these medications. The written log allows the patient and family to monitor both positive and negative changes and be able to keep the professional team of caregivers fully informed.

Psychotherapeutic Interventions

In addition to medications, psychotherapy, or "talk" therapy, is an essential component of treatment. The psychiatric home healthcare nurse may employ an eclectic approach to the management of BD. This may include providing support, education, and guidance to patients and families and a referral to psychotherapy. If the nurse is qualified as a psychotherapist, then this intervention can be provided in the home. However, not all psychiatric home care nurses possess this skill set. In situations in which the patient's and/or family's needs for psychiatric care exceed the agency's capacity to provide such care, it is important that home care clinicians have access to contact information for community-based

Table 1. Summary of Atypical Antipsychotic Medications Used in Elderly Patients

Drug	Dosage	Side Effects
Abilify (aripiprazole)	15 mg/day as monotherapy; 10-15 mg/day as an adjunct to lithium or valproate	Older adults with dementia-related psychosis treated with antipsychotic drugs are at an increased risk (1.6-1.7 times) of death compared to placebo (4.5% vs. 2.6%, respectively); can cause NMS, tardive dyskinesia, hyperglycemia and diabetes, leukopenia, seizures and convulsions, body temperature dysregulation, and dysphagia
Clozaril (clozapine)	6.5-75 mg/day	Tachycardia, hyperthermia, hypoglycemia
Geodon (ziprasidone)	40-80 mg twice daily.	QT prolongation, rash, hypertension; can cause NMS, tardive dyskinesia, hyperglycemia and diabetes, leukopenia, seizures and convulsions, body temperature dysregulation, and dysphagia tardive dyskinesia
Risperdal (risperidone)	0.25-3 mg/day	Extrapyramidal symptoms, hypotension
Seroquel (quetiapine)	12.5-200 mg/day	Hypotension, headache, weight gain, cataract formation
Zyprexa (olanzapine)	1.25-5 mg/day	Weight gain, hypotension, seizures, and hyperglycemia

Note: NMS = neuroleptic malignant syndrome.
Sources: Motsinger, Perron, and Lacy (2003); National Institute of Mental Health. (2008b). Mental health medications. Retrieved from; Zimbroff, Marcus, and Manos (2007).

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psychiatric providers to whom they can refer patients and families. Some psychotherapy treatments used to treat this disorder include:

1. *Cognitive behavioral therapy* (CBT), which helps people with BD learn to change harmful or negative thought patterns and behaviors. This is a skill that requires additional training, and not all psychiatric nurses possess this skill.
2. *Family-focused therapy*, which includes family members and is used to enhance family coping strategies, to improve communication and problem-solving, and to recognize impending new episodes of either mania or depression.
3. *Interpersonal therapy* assists those with BD improve their relationships with others and manage daily routines, which are essential in protecting against manic episodes.
4. *Psychoeducation* teaches people with BD about their illness and its treatment. This treatment helps people recognize signs of relapse so they can better manage their illness. This type of teaching is a major focus of the home healthcare nurse. Teaching patients strategies such as keeping a daily log to monitor mood changes, activity levels, amounts of sleep, and other indicators is an empowering technique. The following Web site provides extremely useful resources for managing Bipolar disorder: http://helpguide.org/toolkit/emotional_health.htm.

Case Study of Bipolar Disorder: Mr. Morris

The following case study of Mr. Morris's (pseudonym) care details not only the psychiatric interventions but medical ones as well provided to a homebound patient with BD.

Mr. Morris was a 72-year-old man admitted to home care with a primary diagnosis of bipolar, manic disorder, recurrent episode, moderate (296.12). He returned to his home from a skilled nursing facility after recovery from a three vessel coronary artery bypass graft (CABG) 2 months previously. Other diagnoses included hypertension, coronary atherosclerosis, and borderline diabetes, spinal stenosis, anxiety state, obesity, urinary incontinence, and a history of alcoholism. He was living with his wife of 45 years, who had filed and obtained a legal separation due to previous violent and "out-of-control" behavior. To continue living with his wife, he knew he had to maintain stable mental health behaviors and abstinence from alcohol consumption. Mr. Morris knew the alternative was permanent skilled nursing home placement.

The psychiatric nurse assessment revealed that Mr. Morris was a large man, weighing 240 pounds with a height of over 6 feet, and presented on the first visit with a labile mood—he was loud, irritable, and anxious. Mr. Morris' speech was very rapid and his thought content showed racing thoughts, limited concentration, and flight of ideas. He was a poor historian, yet interrupted when his wife attempted to answer the nurse's questions. His history included numerous mental health hospital admissions. He had a lengthy history of alcohol abuse and medication noncompliance. He admitted to feeling exhausted but reported he had little need for sleep. He slept intermittently, usually for 1 to 2 hours at a time, and wanted the attention of his wife, even when he was awake and she was sleeping in the middle of the night. Mrs. Morris was frustrated, angry, and exhausted. Although she wished to continue to live with her husband, she was ready to give up.

Safety was the immediate concern. Because of this, even deciding whether or not to proceed with admitting Mr. Morris to home care was in question. Mrs. Morris, though, wanted to give it a try. She recognized her husband's behaviors when he started escalating to the point of losing control or becoming violent. She was able to state an emergency plan and she had been instrumental in placing her husband into involuntary hospitalizations in the past. Mr. Morris had mobility problems and needed his wife's assistance when leaving home so it was thought that he posed no threat in the community. The safety plan also included the immediate departure of the nurse if she felt herself to be in danger.

The physical assessment revealed a well approximated and healed surgical scar resulting from a three vessel CABG (coronary artery bypass graft); complaints of chest pain, bilateral lower leg, ankle and pedal edema, and urinary incontinence. His blood pressure was within his normal limits and blood glucose was 125.

The nurse developed a care plan to include the following interventions:

- Instruction on the importance of medication compliance (e.g., log and review of medication record and what medications were taken, what time, date);
- Management of BD;
- Improvement of communication;
- Counseling regarding marital relationship and related issues;
- Caregiver support and education;
- Observation and assessment of postoperative medical conditions including chest pains, pedal edema, and urinary incontinence; and
- Counseling regarding nutrition—specifically a low fat, low salt, and low sugar diet.

Mr. Morris was a college graduate who had worked in the healthcare system. In fact, he had worked at a hospital as well as the state health department and had been instrumental in developing immunization programs in the United States and other countries. Like many bipolar patients, it was not surprising that he would question the use of—and his need for—medication. He often altered, discontinued, and reinitiated his medication regimen, including lithium, the hypertension medication, and his diuretics. Although Mr. Morris understood that lithium was the drug of choice for stabilizing his mood, he reported that he hated the side effects. Mr. Morris experienced a fine line between stable mood and depression. He, like so many others with BD, preferred the elated feeling of mania to the overwhelming despair of depression. For example, he verbally agreed to take 300 mg of lithium, occasionally took 450 mg, but he never accepted 600 mg, which was the dose prescribed by the physician. Arguments with his psychiatrist centered on medication needs, and Mr. Morris fired the psychiatrist several times. Additionally, Mr. Morris argued with his primary care physician regarding compliance with his hypertension and diuretic medication. Mr. Morris sincerely thought that he did not need them, and wanted to see what would happen when he stopped. The primary physician repeatedly explained to Mr. Morris that because lithium is a salt, taking it, which was essential, could increase his blood pressure—thus increasing the need for his diuretic and careful monitoring of fluid intake. Mr. Morris refused to follow either of these suggestions. The end result was a dramatic increase in his blood pressure and in the edema in his legs. He also complained about side effects with most of the other medications. Because of this, finding interventions and solutions to Mr. Morris's impulsive medication management was crucial.

Specific skilled nurse interventions directed toward medication compliance included

1. Assess therapeutic response to medications and symptom control with his medication regimen;
2. Reinforce the importance of medication compliance to control symptoms of mania, stabilize blood pressure, and decrease the bilateral lower leg edema. More important, Mr. Morris needed to understand that medication compliance was directly related to his and his wife's goal for him to be able to stay at home. Additionally, he would also be less likely to exhibit impulsive or out of control behavior if he was compliant with taking lithium at the higher doses. Mr. Morris agreed that his wife could prepare, setup, and monitor his medication.
3. The nurse prepared a medication list and instructed Mr. and Mrs. Morris on medication indications, dosage, and frequency. Mr. Morris's mood dictated discussions of medication side effects since he felt so

strongly about that subject. He understood that stopping a diuretic equaled increased edema and stopping blood pressure medication increased blood pressure, but generally insight occurred only after nonadherence.

Management of Mr. Morris's BD was essential to his ability to remain at home, refrain from alcohol consumption, demonstrate medical stability, and live peacefully with his wife. Skilled nurse interventions included only a review of BD since both were very familiar with the disorder. Mr. Morris had been diagnosed when he was an undergraduate in college. There was a concentrated effort by the nurse to instruct about alcohol abstinence and the signs and symptoms of relapse. The nurse monitored patient safety and the potential for injury to Mr. Morris and others and used the SAD PERSONS Suicide Rating Scale (Juhnke, 1994; see Supplemental Digital Content 2, http://links.lww.com/HHN/A17) for information regarding suicide risk assessment. His score was a 3, based on age, being male, and clinically depressed. Self-esteem had been a problem for Mr. Morris since childhood. Many visits were spent in teaching him to praise himself and to avoid being critical. Because Mr. Morris found it impossible to sleep for more than 1 or 2 hours at a time, he was instructed about impediments to sleeping. These included no napping during the day, avoiding caffeine, limiting fluids for 3 hours before bedtime, and minimizing noise and other distractions. The nurse measured Mr. Morris's behavior severity utilizing the Young Mania Rating Scale (Young et al., 1978) (Figure 1). His score was 33, placing him in the moderate-to-severe degree of manic behaviors.

The development of a therapeutic relationship with the Morrises and the necessity of a strategy that addressed the marital concerns of both were critical aspects of the plan of care. Insight driven statements such as, "Is stopping your medication so important that you are willing to lose your wife and home?" were often used. Mr. and Mrs. Morris tolerated extremely difficult conversations once a strong therapeutic relationship was developed. It was important that such conversations be based on mutual respect and trust.

Basic communication was difficult, and conversations often digressed into arguments. Mr. Morris insisted that his wife drop all of her responsibilities to listen to him, cook, buy things, take him to the store, and clean up after him. He interrupted most if not all conversations. Mrs. Morris responded with frustration and anger and yelled at her husband just to be heard. The nurse explained the importance of listening to one another. This instruction included paying attention, maintaining eye contact, and trying to really hear what the other person was saying. Stress was placed on the importance of respecting the other's opinion and speaking calmly.

Mrs. Morris also had medical and functional problems. She had bilateral knee replacements, hypertension, and needed rotator cuff surgery. She admitted that she was becoming less and less patient with her husband. She was unable to get a full night's sleep because she was often disturbed by her husband directly or indirectly when he was making noise while cooking or playing music and by the pain from her rotator cuff injury. The lack of sleep and constant caregiving led to her feeling angry and irritable. Mrs. Morris was encouraged to verbalize her concerns and caregiver stress was acknowledged. Mrs. Morris revealed that over the years she had tried support groups such as Alanon but found them to be minimally helpful because the support focused primarily on his drinking and not on how to respond to her husband's BD. The home care nurse instructed Mrs. Morris strategies to manage symptoms and problems, and was taught specific coping strategies. She learned that yelling and arguing only escalated the situation. She was also encouraged to concentrate on her own physical and mental health, and take time out for herself.

Mr. Morris's physician determined that the chest pain he experienced was muscular and associated with his surgical site healing. Lasix was ordered for the bilateral lower leg edema. His wife was instructed in how to test for his blood glucose, check blood pressure, and monitor weight. Mr. Morris was encouraged to see both his psychiatrist for monitoring of his lithium levels and electrolytes and his primary care physician, who monitored his alcohol use, ordered laboratory tests to evaluate liver enzymes, and closely monitored his cardiovascular status.

Poor impulse control resulted in excessive food and fluid intake, and weight gain. The skilled nurse assessed Mr. Morris' diet, eating patterns, and hydration. Mr. Morris routinely consumed whole bowls of candy and a carton of ice cream in a day.

Figure 1. Young Mania Rating Scale.

Instructions: The Mania Rating Scale is a measure of the severity of the behaviors exhibited during the manic phase of bipolar disease. Scoring may range between the whole numbers (e.g., 1.5, 2.8) when defining gradations of a particular behavior. Individual indicators may be used to focus on specific behavior improvement targets.

Descriptor	Scoring Range	Score
1. Elevated Mood	0 = Absent 1 = Mildly or possibly increased on questioning 2 = Definite subjective elevation, optimistic, self-confident, cheerful, appropriate content 3 = Elevated, inappropriate to content, humorous 4 = Euphoric, inappropriate laughter, singing	
2. Increased Motor Activity - Energy	0 = Absent 1 = Subjectively increased on questioning 2 = Animated, gestures increased 3 = Excessive energy, hyperactive at times, restless (can be calmed) 4 = Motor excitement, continuous hyperactivity (cannot be calmed)	
3. Sexual Interest	0 = Normal, not increased 1 = Mildly or possibly increased 2 = Definite subjective increase on questioning 3 = Spontaneous sexual content, elaborates on sexual matters, hypersexual by self-report 4 = Overt sexual acts (toward others)	
4. Sleep	0 = Reports no decrease in sleep 1 = Sleeping less than normal amount by up to one hour 2 = Sleeping less than normal by more than one hour 3 = Reports decreased need for sleep 4 = Denies need for sleep	
5. Irritability	0 = Absent 2 = Subjectively increased 4 = Irritable at times during interview, recent episodes of anger or annoyance 6 = Frequently irritable during interview, short, curt throughout 8 = Hostile, uncooperative, interview impossible	
6. Speech (Rate and Amount)	0 = No increase 2 = Feels talkative 4 = Increased rate or amount at times, verbose at times 6 = Push, consistently increase rate and amount, difficult to interrupt 8 = Pressured, uninterruptible, continuous speech	
7. Language-Thought Disorder	0 = Absent 1 = Circumstantial, mild distractibility, quick thoughts 2 = Distractible, loses goal of thought, changes topic frequently, racing thoughts 3 = Flight of ideas, tangentiality, difficult to follow, rhyming, echolalia 4 = Incoherent, communication impossible	
8. Content	0 = Normal 1 = Questionable plans, new interests 2 = Special projects, hyper religious 3 = Grandiose or paranoid ideas, ideas of reference 4 = Delusions, hallucinations	
9. Disruptive-Aggressive Behavior	0 = Absent, cooperative 2 = Sarcastic, loud at times, guarded 4 = Demanding, threats 6 = Threatens interviewer, shouting, interview difficult 8 = Assaultive, destructive, interview impossible	
10. Appearance	0 = Appropriate dress and grooming 1 = Minimally unkempt 2 = Poorly groomed, moderately disheveled, overdressed 3 = Disheveled, partly clothed, garish makeup 4 = Completely unkempt, decorated, bizarre garb	
11. Insight	0 = Present, admits illness, agrees with need for treatment 1 = Possibly ill 2 = Admits behavior change, but denies illness 3 = Admits possible change in behavior, but denies illness 4 = Denies any behavior change	

Reproduced from: A rating scale for mania: reliability, validity and sensitivity. R.C. Young, J.T. Biggs, V.E. Ziegler & D.A. Meyer, *British Journal of Psychiatry* (1978), **133,** 429-435. © 1978 The Royal College of Psychiatrists.

In situations in which the patient's and/or family's needs for psychiatric care exceed the agency's capacity to provide such care, it is important that home care clinicians have access to contact information for community-based psychiatric providers to whom they can refer patients and families.

He felt compelled to drink large amounts of fluid late into the night. His wife frequently found him cooking meals in the middle of the night. He insisted that he was going to strictly follow a new weight loss book he recently read, but was unable to make even the smallest changes to improve his diet due to his impaired judgment, thinking, and insight. He was instructed in the importance of a low-fat, low-salt, and low-sugar diet to have a stable cardiac status and to lose weight. Mr. and Mrs. Morris were taught to read labels, add more vegetables and fruits to his diet, and to stay away from high-calorie, high-salt, and processed foods.

Although Mr. Morris was followed by the psychiatric home care nurse for 18 months, he became more and more stable in his mental and physical condition. He remained sober and had no hospital admissions for his BD. He resided with his wife and remained in his home until he passed away from an unrelated medical problem at the age of 74.

A comprehensive and holistic approach is necessary when providing care and direction to those with mental health problems. The psychiatric home care nurse guides the patient/caregiver through assessments, education (instruction), counseling, and therapeutic approaches using psychiatric and medical knowledge/interventions. Short- and long-term goals can be achieved when loved ones and family are included. The mental health patient, even one as ill as Mr. Morris, can be managed cost-effectively and in the home through persistence, hard work, and caring. ☗

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