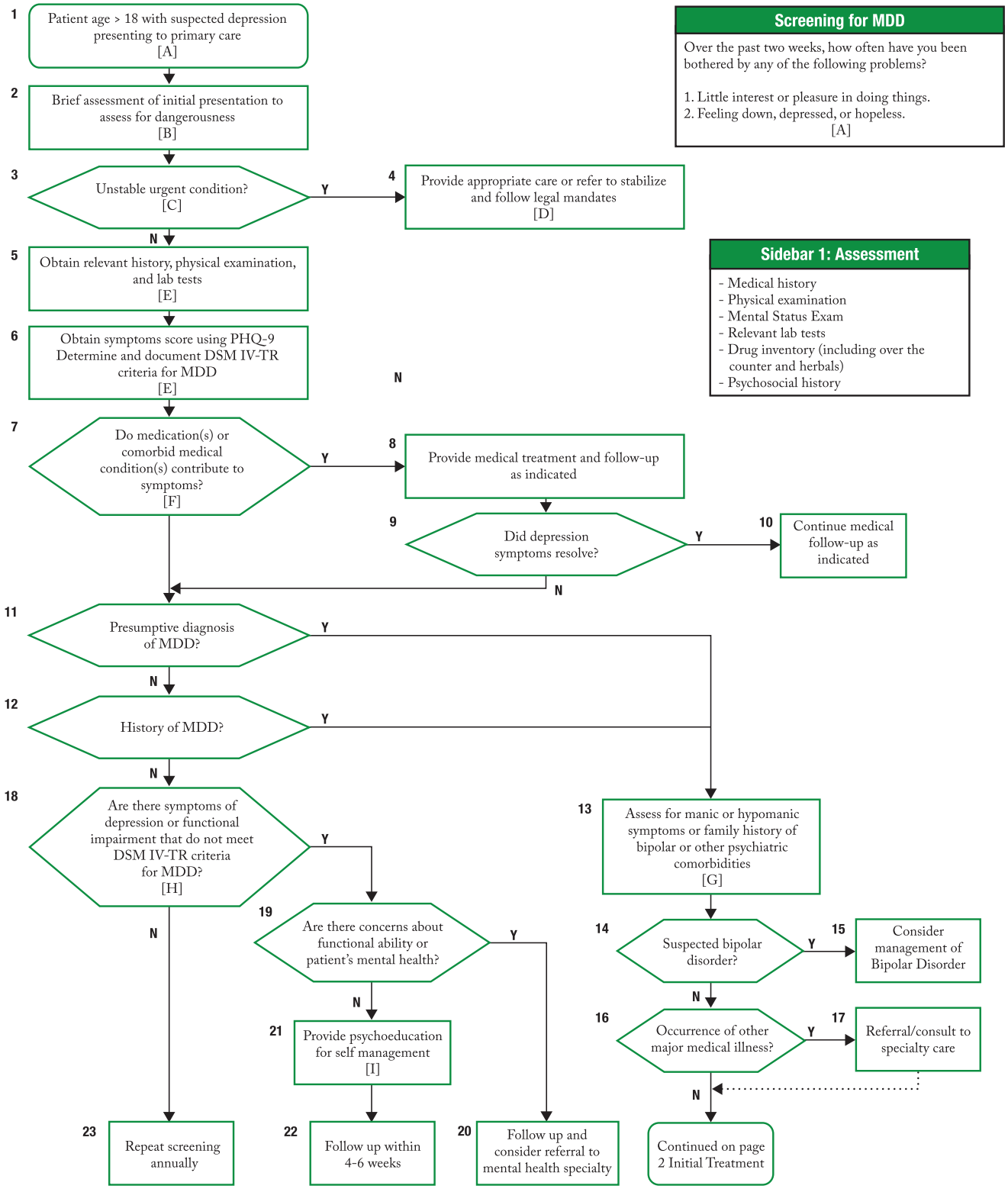
VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Assessment and Treatment Algorithm

CARD 1

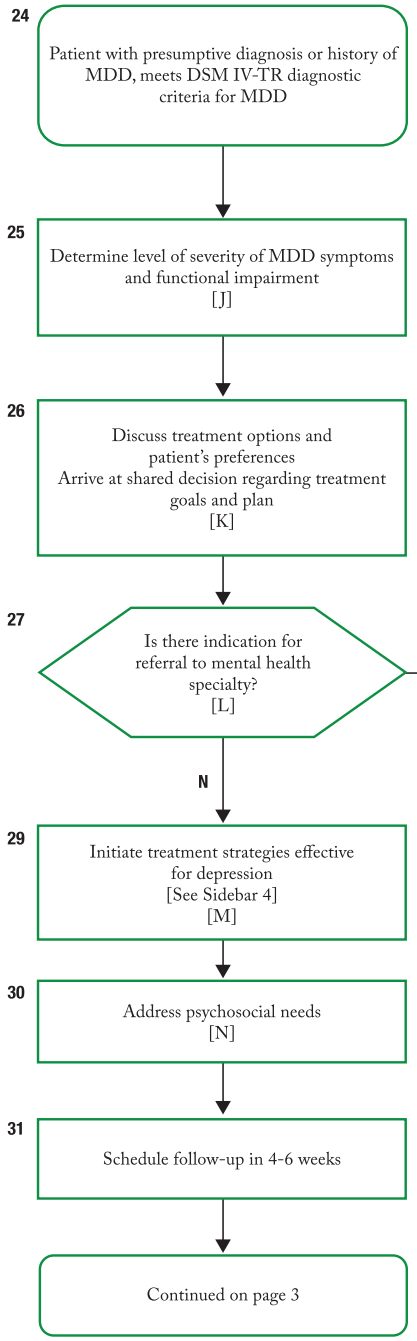
Management of Major Depressive Disorder (MDD) in Adults
Primary Care Initial Assessment and Diagnosis

1



VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Assessment and Treatment Algorithm (cont.)

Management of Major Depressive Disorder in Adults
Primary Care Initial Treatment **2**



Sidebar 2: DSM-IV-TR Diagnostic Criteria for MDD

MDD diagnosis requires the presence of symptom 1, 2, or both; and at least 5 of 9 symptoms that persist for at least 2 weeks:

1. Depressed mood nearly every day for most of the day, based on self report or observation of others.
2. Marked reduction or loss of interest or pleasure in all, or nearly all, activities for most of the day, nearly every day.
3. Significant non-dieting weight loss or weight gain (>5% change in body weight)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation (should be observable by others).
6. Fatigue/loss of energy nearly every day.
7. Feelings of worthlessness or excessive/inappropriate guilt nearly every day.
8. Diminished cognitive function (reduced ability to think or concentrate) nearly every day.
9. Recurrent thoughts of death and/or suicide, suicide planning, or a suicide attempt.

Sidebar 3: Indications for Referral to Mental Health

- Unclear diagnosis
- Evidence of psychotic features, past mania, or hypomania
- Signs of comorbid psychiatric conditions
- Unable to treat patient in primary care
- Need for psychosocial interventions
- Patient preference

Sidebar 4: Initial Treatment Strategies for MDD

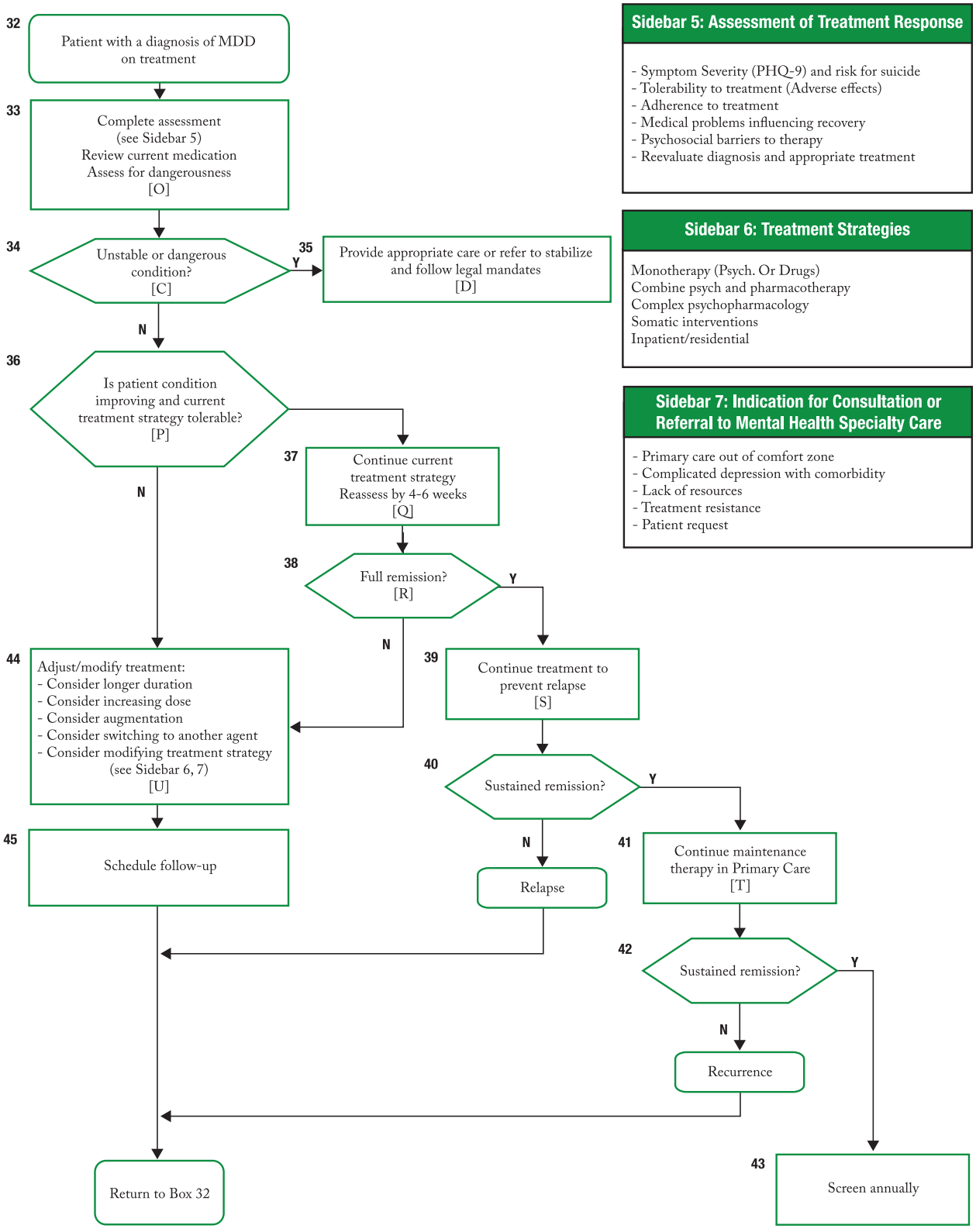
SEVERITY	PHQ-9 Score	FUNCTIONAL IMPAIRMENT	INITIAL STRATEGY
Mild	10-14	Mild	Monotherapy – antidepressants or psychotherapy – or, possibly combination
Moderate	15-19	Moderate	Antidepressants or psychotherapy, or combination
Severe	≥20	Severe	May start with antidepressants or psychotherapy but should prefer combination or multiple antidepressants

Psychoeducation and self-management should be provided for all severity levels.

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Assessment and Treatment Algorithm (cont.)

Management of Major Depressive Disorder in Adults
Primary Care Treatment Strategy and Follow-Up

3



Sidebar 5: Assessment of Treatment Response

- Symptom Severity (PHQ-9) and risk for suicide
- Tolerability to treatment (Adverse effects)
- Adherence to treatment
- Medical problems influencing recovery
- Psychosocial barriers to therapy
- Reevaluate diagnosis and appropriate treatment

Sidebar 6: Treatment Strategies

Monotherapy (Psych. Or Drugs)
Combine psych and pharmacotherapy
Complex psychopharmacology
Somatic interventions
Inpatient/residential

Sidebar 7: Indication for Consultation or Referral to Mental Health Specialty Care

- Primary care out of comfort zone
- Complicated depression with comorbidity
- Lack of resources
- Treatment resistance
- Patient request

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Identification and Assessment

CARD 4

Depression Risk Factors

- Prior Episodes of Depression
- Family History of Depressive D/O
- Prior Suicide Attempt
- Female Gender
- Age of Onset Under 40
- Postpartum Period
- Medical Comorbidity
- Lack of Social Support
- Stressful Life Events
- Current Substance Abuse

Screening Using the Patient Health Questionnaire 2 (PHQ-2)

(see 2009 MDD CPG pp. 17-21)
Screening with PHQ-2 should be completed annually by all patients seen in primary care settings.

Over the past two weeks, how often have you been bothered by either of the following problems?
A) Little interest or pleasure in doing things. (0-3)
B) Feeling down, depressed, or hopeless. (0-3)

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Patients with a score of 3 or more should be followed up with the PHQ-9.

Score	% Prob. of MDD	% Prob. of Any Depressive Disorder
1	15.4%	36.9%
2	21.1%	48.3%
3	38.4%	75.0%
4	45.5%	81.2%
5	56.4%	84.6%
6	78.6%	92.9%

Assessment Using the Patient Health Questionnaire 9 (PHQ-9)

(see 2009 MDD CPG Appendix B pp. 149-153)
Purpose: The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of depressive disorders in primary care patients. For patients with a depressive disorder, a PHQ Depression Severity Index score can be calculated and repeated over time to monitor change.
Making a Diagnosis: Since the questionnaire relies on patient self-report, definitive diagnoses must be followed up on and verified by the clinician, taking into account any presenting functional impairments and/or the patient's understanding of the questions. The clinician should also consider relevant information obtained from the patient, their family, and other sources.

Over the last two 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 or 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 are 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
Add Columns:		+	+	
Total:				

10. If you checked off any problems, how difficult have these 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

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Identification and Assessment (cont.)

Assessment Using the Patient Health Questionnaire 9 (PHQ-9) (cont.)

Interpreting the PHQ to Make a Provisional Diagnosis: To facilitate interpretation of patient responses, all clinically significant responses are found in the columns farthest to the right. Any symptom endorsed as being present at least "more than half the days" counts toward a DSM-IV-TR diagnosis. (The only exception is for suicidal ideation which counts toward a DSM-IV-TR diagnosis if endorsed as being present "several days" or more.)
Major Depressive Disorder is suggested if Q#1 or 2 and five or more of Q#1-9 are at least "more than half the days" (count Q#9 if present at all).
Other Depressive Disorder is suggested if: Q#1 or 2 and two, three, or four of Q#1-9 are at least "more than half the days" (count Q#9 if present at all). To score the instrument, tally each response by the number value under the answer headings. Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the following guide:

PHQ-9 Score	DSM-IV-TR Criterion Symptoms	Depression Severity	Proposed Treatment Action
1–4	Few	None	None
5–9	< 5	Mild Depressive Symptoms	Watchful waiting; repeat PHQ-9 at follow-up
10–`4	5–6	Mild Major Depression	Treatment plan; Consider counseling, follow-up, and/or pharmacotherapy
15–19	6–7	Moderate Major Depression	Immediate initiation of pharmacotherapy and/or psychotherapy
20–27	> 7	Severe Major Depression	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Note: The diagnoses of Major Depressive Disorder and Other Depressive Disorder require ruling out normal bereavement (mild symptoms, duration less than two months), a history of a manic episode (Bipolar Disorder) and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

Additional Clinical Considerations

(see 2009 MDD CPG Appendix B pp. 149-153)
After making a provisional diagnosis with the PHQ, there are additional clinical considerations that may affect decisions about management and treatment:
- Have current symptoms been triggered by psychosocial stressor(s)?
- What is the duration of the current disturbance and has the patient received any treatment for it?
- To what extent are the patient's symptoms impairing his or her usual work and activities?
- Is there a history of similar episodes, and were they treated?
- Is there a family history of similar conditions?

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Assessment of Dangerousness

Assessing Homicidal Ideation

(see 2009 MDD CPG pp. 26-27)
Risk of violence towards others should be assessed by asking directly whether or not the patient has thoughts of harming anyone.
- Assess whether the patient has an active plan and method/means (e.g., weapons in the home)
- Assess whom the patient wishes to harm
- Assess whether the patient has ever lost control and acted violently
- Assess seriousness/severity of past violent behavior.

In the event of expressed dangerousness to self or others by a person with possible MDD, steps must be taken to ensure patient safety until further evaluation and a referral or consultation with a mental health professional has taken place.

Eliciting Suicidal Ideation, Intent, and/or Planning

(see 2009 MDD CPG Appendix C pp. 154-155)
Eliciting suicidal ideation, intent, and/or planning involves a free and honest exchange of information between the patient and clinician. Familiarity with the existing epidemiological and demographic data concerning suicide is useful in generating an index of suspicion. From there, direct questioning regarding suicidal ideation/intent/planning may be initiated. There are no data demonstrating an increased rate of suicide attempts or deaths following questioning about suicide.

Despite the lack of reliable measures of suicide risk among individuals, a basic assessment should:
1. Determine presence/absence of depression, delirium, and/or psychosis
2. Elicit patient's statements about his/her suicidality
3. Elicit patient's own ideas concerning what would help attenuate or eliminate suicidal ideation/intent/planning
4. Attempt to gather collateral data from a third party in order to confirm the patient's story
5. A suggested sequence of suicide questions to ask is:
   - Are you discouraged about your medical condition (or social situation, etc.)?
   - Are there times when you think about your situation and feel like crying?
   - During those times, what sorts of thoughts go through your head?
   - Have you ever felt that if the situation did not change, it would not be worth living?
   - Have you reached a point that you've devised a specific plan to end your life?
   - Do you have the necessary items for completion of that plan readily available?
6. Formulate an acute and chronic management plan. Encourage active patient participation in negotiating a plan for follow-up:
   - What epidemiological risk factors are present (may have to inquire about each one individually)?
   - What other psychiatric conditions are present (besides the ones mentioned above)?
   - What is the level of psychological defense functioning?
   - Has there been a will made recently?
   - Is there talk of plans for the future?
   - What is the makeup and condition of the patient's social support system? How can the patient be contacted?
   - Is there active suicidal ideation? "How strong is (your) intent to do this?"
   - "Can you resist the impulse to do this?" "Do you tend to be impulsive?"
   - "Have you ever rehearsed how you would kill yourself?"
   - "Have any family members or people close to you ever killed themselves?"

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Assessment of Dangerousness (cont.)

Gathering Data on Risk Factors for Suicide

(see 2009 MDD CPG Appendix C pp. 155-156)
The causes of suicide are multifactorial. The risk for suicide increases with the accumulation of risk factors in an individual. Clinician should be alert for suicide risk in patients with a sad or depressed mood, suicidal ideation and one or more of the following risk factors:

- History of previous suicide attempts
- Family history of completed suicide or suicide behavior
- Presence of psychiatric illness
- Psychosocial disruption
- Means for suicide completion readily available
- Active substance abuse and/or dependence
- Impulsivity or history of poor adaptation to life stress
- Serious medical illness
- Male sex
- Advanced age
- Caucasian race

There is no accepted standard screening instrument for suicidal risk. Recent publications including the VA Education Module, "Prevention of Suicide: Everyone's Concern," and the article by Hirschfeld and Russell provide examples of brief, thorough screening tools (Hirschfeld & Russell, 1997). Patients with evidence of intent for suicide should be offered mental health counseling and possibly hospitalization (U.S. PSTF, 1996). Patients with definite intent (suicidal/homicidal ideation, intent, and/or plan) to harm self or others require voluntary or involuntary emergency psychiatric treatment (APA, 1993; DHHS pub. no. 95- 3061, 1995). The endorsement of suicidal ideation or intent or morbid thoughts of death represent obvious risk factors for suicide completion, especially if intent exists with an active plan for carrying it out.

Evaluating the Available Data to Make Clinical Decisions About Safety

(see 2009 MDD CPG Appendix C pp. 156-157)
If suicide risk is present, a stratification system is useful in terms of formulating a strategy for intervention. One such system includes the following divisions: imminent (suicide may be attempted within the next two days); short-term (days to weeks); and long-term.

Imminent Risk – Suspect if patient endorses suicidal intent, an organized plan is presented, lethal means are available, signs of psychosis (especially command hallucinations) are present, extreme pessimism is expressed (despair, hopelessness, etc.), or several additional risk factors for suicide are present.
Management suggestions:
a. Immediate action is required. Hospitalize or commit. DO NOT leave the patient alone.

Short-Term Risk – Suspect if several risk factors for suicide are present, but no suicidal behaviors are present.
Management suggestions:
a. With patient's permission, involve family member or other person close to patient and advise them of the situation.
b. If potentially lethal means of suicide completion are available, initiate steps to make these items inaccessible.
c. Collaboratively generate a safety plan with the patient and/or family member (after obtaining patient consent). The plan should include emergency contact numbers for the national suicide hotline (1-800-SUICIDE) as well as information for local hospital(s) or emergency center(s).
d. Stay in contact with the patient (telephone calls, more frequent office visits, etc.). Frequently reevaluate risk. Document all contact and explain decision-making process for management.
e. Treat psychiatric conditions as appropriate, including substance abuse/dependence (may require consultation from mental health professional). Close follow-up will help to improve compliance and continue risk assessment.
f. Consider hospitalization as appropriate.

Long-Term Risk – The therapeutic goal is to eliminate or improve modifiable suicide risk factors. This may involve treatment of psychiatric illness (through pharmacotherapy or psychotherapy), treatment of substance abuse, etc. Frequent reassessment is still a useful guideline, and acute situations mandating psychiatric referral or hospitalization may arise. Thus, all of the aforementioned management suggestions should be considered even here.

Providing Appropriate Care or Referring to Stabilize and Follow Legal Mandates

(see 2009 MDD CPG p. 29)
Initial steps in assessing and caring for dangerous conditions in patients with MDD include the provision of appropriate care to stabilize the situation. Depending on the seriousness of the condition and the resources at hand, this will be accomplished on-site or through urgent/emergent referral to mental health. However, it is also essential that providers and their administrative staffs have an understanding of, and ability to access local, state and federal regulations/policies/procedures and guidelines relating to danger to self or others. If patients represent a risk to others, additional notifications may be required by state or federal laws and/or regulations. When making notifications, it is wise to consult a peer and/or medical law consultant on the legal and ethical requirements.

For VA patients, these procedures should also reflect the opinion and guidance of the VHA District Council. For DoD patients, these procedures are directed by DoD Directive 6490.1, "Mental Health Evaluation of Members of the Armed Forces," DoD Instruction 6490.4, "Requirements for Mental Health Evaluations of Members of the Armed Forces," and related Service regulations/instructions. These regulations/instructions may require a number of notifications (e.g., commanders) which would not be made in a civilian practice.

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Assessment Considerations

Common Presentations of Depression in Primary Care

- **Multiple Organ Systems** - Symptoms from multiple organ systems, especially neurologic, gastrointestinal, and cardiac that are difficult if not impossible to ascribe to a single medical condition.
- **Emotions** - Patients who are emotionally flat and verbally unproductive, tearful or who are worried or upset out of proportion to the apparent severity of the problem.
- **Visits** - Frequent, often unscheduled, patient-initiated visits to the physician or the emergency room for unclear reasons.
- **Sleep** - Sleep disturbance.
- **Dysfunction** - Patients who have cognitive or emotional dysfunction such as forgetfulness, irritability and loss of motivation or energy.
- **Family History** - A family history of psychiatric illness, suicide or abuse of any kind (sexual, physical, or substance).
- **Recurrence** - Past history of similar episodes or unspecified "breakdowns."
- **"Difficult"** - Patients labeled by health care providers as "difficult" or a "problem."
- **Chronic Pain Syndromes**

Pathologies Related to Depression

(see 2009 MDD CPG pp. 36-38).

Pathology	Disease
Cardiovascular	Coronary Artery Disease, Congestive Heart Failure, Stroke, Vascular Dementias
Chronic Pain Syndrome	Fibromyalgia, Reflex Sympathetic Dystrophy, Low Back Pain (LBP), Chronic Pelvic Pain, Bone or Disease Related Pain
Degenerative	Hearing Loss, Alzheimer's Disease, Parkinson's Disease, Huntington's Disease, Other Neurodegenerative Diseases
Immune	HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosis (SLE), Sarcoidosis
Metabolic/Endocrine Conditions (includes renal and pulmonary)	Malnutrition, Vitamin Deficiencies, Hypo/Hyperthyroidism, Addison's Disease, Diabetes Mellitus, Hepatic Disease (Cirrhosis), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, Kidney Disease
Neoplasm	Of any kind, especially pancreatic or central nervous system (CNS)
Trauma	Traumatic Brain Injury, Amputation, Burn Injuries

Depression Diagnostic Considerations in Primary Care

(see 2009 MDD CPG pp. 30-33, 40-41)

- **Symptom-Sign Mismatch** - Suspect depression in cases of many seemingly severe symptoms, a negative physical exam, and an increasingly long list of normal laboratory tests. Caution: maintain the usual vigilance for undiagnosed medical disease.
- **History** - Establish duration of illness, history of prior episodes, family history, history of prior manic/hypomanic episodes, substance abuse and/or other comorbid disorders.
- **Physical Examination** - Screen for anemia, liver/renal dysfunction and thyroid disease, if indicated.
- **Evaluate** - the severity of depressed symptoms, suicidal tendencies and psychotic features (if present).
- **Laboratory Testing** - Laboratory tests have value in ruling out medical conditions that might mimic the symptoms of depression.
- **General Medical Illnesses Associated with Depression** - Myocardial infarction, stroke (particularly left frontal lobe), cancer, major trauma, multiple sclerosis, or any major new diagnosis, particularly if hospitalization is involved.
- **Unexplained Treatment Failure** - Clinical depression can interfere with effective treatment of the primary medical condition, delay recovery and significantly increase morbidity.

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
Comorbid and Related Conditions

Signs of Comorbid Psychiatric Conditions

(see 2009 MDD CPG pp. 38-39)
Other common psychiatric conditions may complicate treatment or put the patient at increased risk for adverse outcomes. It is recommended that patients presenting to primary care with evidence or suspicion of a co-occurring psychiatric disorder be referred to a mental health specialty for evaluation and treatment. Conditions that should prompt the provider to consider referral may include, but is not limited to:

- Dangerousness to self and/or others.
- Frequent and disabling nightmares or flashbacks suggestive of Post-Traumatic Stress Disorder (PTSD).
- Frequent use or binging of alcohol and/or other drugs despite negative consequences (Substance Use Disorder).
- An extensive history of childhood abuse, unstable or broken relationships, or criminal behavior starting before or during adolescence, that is suggestive of a personality disorder.
- Extreme weight loss suggestive of Anorexia Nervosa or a pattern of binge-eating and purging, suggestive of Bulimia Nervosa.
- The presence of a psychotic disorder (e.g., Schizophrenia) which is likely to significantly complicate the primary care management of depression symptoms.
- The presence of unexplained physical symptoms suggestive of a Somatoform Disorder.
- The presence of Bipolar Disorder, since initiating or titrating routine antidepressant medication can precipitate a manic episode.

Screening for Alcohol Dependence Using AUDIT-C

The Alcohol Use Disorders Test-Consumption (AUDIT-C) is a shorter version of the AUDIT test designed to measure consumption. Only three questions, it differs from other tests in that it is not yes/no but a multiple-choice test (with scoring for each response).

Questions	0	1	2	3	4	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10+	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
			AUDIT-C Score (add items 1-3)			

In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Differentiating Mania from Major Depression

(see 2009 MDD CPG pp. 39-40)
Some depressed patients manifest periods of mania. A past history of mania (lasting at least one week) or hypomania (lasting at least four days) excludes a patient from a diagnosis of MDD.

According to DSM-IV-TR, a manic episode is a distinct period of persistently elevated, expansive, or irritable mood, lasting at least four days (hypomanic episode) or at least one week (manic episode), that is clearly different from the usual nondepressed mood and is observable by others.

During this period of abnormal mood, at least three of the following symptoms need to be present and persistent to a significant degree.

- Inflated Self-Esteem or Grandiosity
- Decreased Need for Sleep
- Pressure to Keep Talking
- Excessive Involvement in Pleasurable Activities that Have a High Potential for Painful Consequences
- Flight of Ideas or Subjective Experience that Thoughts are Racing
- Increase in Goal-Directed Activity or Psychomotor Agitation
- Distractibility

These symptoms need to be severe enough to cause marked impairment in social or occupational functioning or require hospitalization. The clinician also needs to determine that symptoms are not secondary to a substance use or general medical condition. Hypomania is characterized by a manic episode without accompanying impairment or psychosis.

These patients may require referral to a mental health professional. These patients often need a specialist's treatment and follow-up, since initiating or titrating routine antidepressant medication can precipitate a manic episode.

VA / DoD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD

Comorbid and Related Conditions (cont.) and Consultation/ Referral Considerations

Evidence of Psychosis

(see 2009 MDD CPG pp. 27-28)
Psychosis is defined as a mental state in which the patient is significantly out of touch with reality to the extent that it impairs functioning. Patients with psychotic symptoms may present in an acutely agitated state with a recent onset of disturbing symptoms. However, patients may also present with enduring, chronic symptoms which are long-standing and to which patients have made a reasonably comfortable adaptation.

In particular, paranoid concerns that others wish to harm the patient and voices (especially command hallucinations) telling the patient to hurt him or herself or someone else, are indications for an immediate mental health consultation or referral. Patients who have longstanding psychotic illness and who are able to attend to present circumstances without responding to their psychosis may be evaluated and treated for a comorbid depression in the primary care setting.

It is important to bear in mind that psychotic symptoms may be the direct result of an underlying medical condition, toxic state, alcohol or substance use disorder, or may be associated with a mental health condition such as schizophrenia or affective illness.

Patients with a possible diagnosis of MDD who exhibit any of the following characteristics related to psychosis need to be referred for urgent/ emergent mental health intervention as these are inappropriate for care in the primary care setting:

- Serious Delusions (fixed false beliefs)
- Visual or (typically) Auditory Hallucinations
- Incoherence
- Confusion
- Catatonic Behavior (motor immobility or excessive agitation)
- Extreme Negativism or Mutism or Peculiar Voluntary Movement
- Inappropriate Affect of a Bizarre or Odd Quality
- Paranoia

Overview of Appropriate Conditions for Consultation or Referral

A. Refer to an intensive outpatient recovery program for persistent substance abuse.

B. Refer to Behavioral Health for suicidal ideation, plan or intent, or depression with vegetative symptoms (insomnia, fatigue, or impaired attention).

C. Refer to Behavioral Health for psychotic disorders.

D. Refer to Behavioral Health for non-compliance with or abuse of psychopharmacological medication.

E. Refer to Behavioral Health for persistent or disabling psychiatric conditions or dysfunction without resolution of symptoms.

F. Refer to Behavioral Health for personality disorders or dissociative identity disorders.

G. Refer to Behavioral Health for patient request for consultation.

H. Refer to Behavioral Health for the presence of mania indicative of Bipolar Disorder.

** For additional information on Bipolar Disorder please refer to the VA/DoD Clinical Practice Guidelines for Bipolar Disorder.

***Consultations and/or referrals should be made based upon provider experience and expertise.**

****Consult Behavioral Health for hospitalization considerations, psychological testing, medication issues, psychotherapy, etc.**