Institution Name: Al Masarra Hospital

Document Title: Clinical and Treatment Guidelines for Bipolar Affective Disorder

Approval Process

	Name	Title	Institution	Date	Signature
Written by	Dra. Muna Al Salmi	Consultant, Unit B Psychiatry	Al Masarra Hospital	25/1/23	
	Dr. Furqan Al Lawati	Consultant, Unit B Psychiatry	Al Masarra Hospital	25/1/23	
	Dr. Shaimaa Mohamed Abady	Specialist, Unit B Psychiatry	Al Masarra Hospital	25/1/2023	
	Maria Claudia M. Fajardo-Bala	General Nurse BSN, MSN	Al Masarra Hospital	25/01/23	
Reviewed by	Dr. Said Al Kaabi	Head of Psychiatry	Al Masarra Hospital	25/1/23	
Validated by	Kunooz Al Balushi	Document Manager	Al Masarra Hospital	Feb 2023	for Kunooz
Approved by	Dr. Bader Al Habsi	Executive Director	Al Masarra Hospital	Feb 2023	

Table of Contents

Acronyms

AMRH	Al Masarra Hospital
CBT	Cognitive Behavioral Therapy
ICD	International Classification of Diseases
BAD	Bipolar Affective Order
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
EEG	Electroencephalogram

Clinical and Treatment Guidelines for Bipolar Affective Disorder

1. Introduction

Bipolar affective disorder is a complex mental disorder characterized by episodes of depression and mania/hypomania/mixed states with inter-episodic phases of remission. Due to complexity and variability of this condition, plus a high rate of comorbidity with a multitude of psychiatric disorders and medical condition, it can negatively impact the patient's quality of life as well as his/her family. Well-timed and appropriate treatments are paramount for safe patient care and symptoms management.

This guideline provides a comprehensive, evidence based, clinical and treatment recommendations to assist clinicians in proper assessments and in providing a holistic, best, and safest treatment plans.

2. Scope

This guideline is applicable to all psychiatrists and all mental health professionals in Al Masarra Hospital. (AMRH)

3. Purpose

3.1. To increase awareness of all mental health care professionals regarding the proper diagnosing and disease management of bipolar affective disorder (BAD)

3.2. To improve clinical practices and provision of pharmacologic treatment among patients with bipolar affective disorder (BAD) based on best guidelines and evidences.

4. Definitions

4.1. International Classification of Diseases (ICD): is an international standard diagnostic tool published and maintained by World Health Organization in providing systematic analysis, interpretation, comparison for appropriate classification of diseases, despite presentations of wide range of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.

4.2. Diagnostic and Statistical Manual of Mental Disorder 5 Text Revision (DSM5- TR): was created by American Psychiatric Association, is the descriptive text that provides information about mental disorder to increase diagnostic reliability and distinguish specifiers and diagnostic features for mental illnesses.

4.3. Mania: a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy.

4.4. Hypomania: is a lesser degree of mania, but remains a persistent mild elevation of mood (for at least several days on end), increased energy and activity, and usually marked feelings of well-being and both physical and mental efficiency.

4.5. Depression: presents with symptoms of depressed mood, loss of interest or pleasure, decreased energy and fatigue, reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness, bleak and pessimistic views of the future, ideas or acts of self- harm or suicide, disturbed sleep and diminished appetite.

4.6. Psychosis: symptom of serious mental disorders which may be in form of hallucinations or delusions.

4.7. Hallucination: a sensory appearance/existence of the experience/ person/ object with person's conviction of its reality in the absence of a real object.

4.8. Delusion: false belief by a person, held with certainty, and additional properties.

4.9. Mono-therapy: The use of single drug to treat a disease or disorder.

5. Guidelines

5.1. International Classification of Diseases 10th Revision (ICD-10) is the diagnostic classification standard for all mental health disorders in Al Masarra Hospital, including the basis of all relevant clinical and research related purposes and activities within the area of hospital pertaining to mental health disorder. (*Refer to Policy & Procedure of Disease Classification and Coding Process AMRH/IHS/P&P/003/Vers02)*

5.2. Although ICD-10 is the hospital's standard basis for diagnostic classification and coding of diseases or of mental health disorders, diagnosing Bipolar Affective Disorder necessitates the utilization of the latest version, which is the ICD-11th revision.

5.2.1. ICD-11 has bridged the gap between the ICD-10 and DSM-5 that will be useful for psychiatrists to diagnose appropriately. In ICD-10, the bipolar disorder type II was not recognized as its specific category but is included in DSM5; also according to ICD-10, a single episode of mania was not considered for the diagnosis of bipolar disorder type 1 but was accepted in DSM-5.

5.2.2. In the ICD-11th revision, these contents have been added, and ICD-11 has defined the bipolar type 2 under its category, moreover accepted the single episode of mania as bipolar disorder type 1.

5.2.3. For the purpose of uniformity, ICD-11 will be the basis for diagnostic criteria of this guideline.

5.3. Bipolar and related disorders are episodic mood disorders defined by the occurrence of Manic, Mixed or Hypomanic episodes or symptoms, typically alternating over the course of these disorders with Depressive episodes or symptoms.

5.4. Generally, the types of Bipolar are divided into Bipolar type I, Bipolar type II disorder, Cyclothymic disorder, Other specified Bipolar or Related disorders, and Bipolar or Related disorders, Unspecified. The Bipolar type I and II are subdivided into more subtypes.

5.5. Bipolar type I disorder is an episodic mood disorder defined by the occurrence of one or more manic; or mixed episodes (As adopted from ICD 11-MMS, 2018)

5.5.1.A manic episode is an extreme mood state characterized by euphoria, irritability, or expansiveness, and by increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid or pressured speech, flight of ideas, increased self-esteem or grandiosity, decreased need for sleep, distractibility, impulsive or reckless behavior, and rapid changes among different mood states lasting at least one week unless shortened by a treatment intervention.

5.5.2. A mixed episode is characterized by either a mixture or very rapid alternation between prominent manic and depressive symptoms on most days during a period of at least 2 weeks.

5.5.3. Although the diagnosis can be made based on evidence of a single manic or mixed episode, typically manic or mixed episodes alternate with depressive episodes over the course of the disorder.

5.5.4. A hypomanic episode is a persistent mood state characterized by mild elevation of mood or increased irritability and increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid speech, rapid or racing

thoughts, increased self-esteem, an increase in sexual drive or sociability, decreased need for sleep, distractibility, or impulsive or reckless behavior lasting at least several days; but the symptoms are not severe enough to cause marked impairment in occupational functioning or in usual social activities Or relationships with others and does not necessitate hospitalization; with no accompanying delusions or hallucinations.

5.5.5. A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least 2 weeks accompanied by other symptoms such as changes in appetite or sleep, psychomotor agitation or retardation, fatigue, feelings of worthless or excessive or inappropriate guilt, feelings or hopelessness, difficulty concentrating, and suicidality.

5.5.5.1. Mild depressive episode- less intense, mild level of severity; with typically some, but not considerable, difficulty in continuing ordinary work, social, or domestic activities

5.5.5.2. Moderate depressive episode- lesser severity; with considerable difficulty in continuing work, social, or domestic activities, and is still able to function in at least some areas.

5.5.5.3. Severe depressive episode- with presence of many or most symptoms of a depressive episode to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree; and the individual is unable to function in personal, family, social, educational, occupational, or other important domains, except to a very limited degree .

5.5.6. with psychotic symptoms - with presence of delusions or hallucinations during the episode.

5.5.4. Sub-types of Bipolar type I disorder

5.5.4.1. *Bipolar type I with current episode manic, without psychotic* symptoms

5.5.4.2. Bipolar type I disorder, current episode hypomanic

5.5.4.3. *Bipolar type I disorder, current episode depressive, mild*

5.5.4.4. *Bipolar type I disorder, current episode depressive, moderate without psychotic symptoms*

5.5.4.5. *Bipolar type I disorder, current episode depressive, moderate with psychotic symptoms*

5.5.4.6. *Bipolar type I disorder, current episode depressive, severe without psychotic symptoms*

5.5.4.7. *Bipolar type I disorder, current episode depressive, severe with psychotic symptoms*

5.5.4.8. *Bipolar type I disorder, current episode depressive, unspecified severity*

5.5.4.9. *Bipolar type I disorder, current episode mixed, without psychotic symptoms*

5.5.4.10. *Bipolar type I disorder, current episode mixed, with psychotic symptoms*

5.5.4.11. *Bipolar type I disorder, currently in partial remission, most recent episode manic or hypomanic*

5.5.4.11.1. the definitional requirements for Bipolar type I disorder have been met and the most recent episode was a manic or hypomanic episode; however, the full definitional requirements for a manic or hypomanic episode are no longer met but some significant mood symptoms remain. In some cases, residual mood symptoms may be depressive rather than manic or hypomanic, but do not satisfy the definitional requirements for a depressive episode.

5.5.4.12. *Bipolar type I disorder, currently in partial remission, most recent episode depressive*

5.5.4.12.1. definitional requirements for Bipolar type I disorder are met and the current episode is depressive but the full definitional requirements for the episode are no longer met though some significant depressive symptoms remain.

5.5.4.13. *Bipolar type I disorder, currently in partial remission, most recent episode mixed*

5.5.4.13.1. the definitional requirements for Bipolar type I disorder have been met and the most recent episode was a mixed episode. The full definitional requirements for the episode are no longer met though some significant mood symptoms remain.

5.5.5.4.14. *Bipolar type I disorder, currently in partial remission, most recent episode unspecified*

5.5.4.14.1. the definitional requirements for Bipolar type II disorder have been met but there is insufficient information to determine the nature of the most recent mood episode. The full definitional requirements for a mood episode are no longer met though some significant mood symptoms remain.

5.5.4.15. *Bipolar type I disorder, currently in full remission*

5.5.4.15.1. full definitional requirements for Bipolar I disorder have been met in the past but there are no longer any significant mood symptoms.

5.5.4.16. *Other specified bipolar type I disorder*

5.5.4.17. *Bipolar type I disorder, unspecified*

5.6. Bipolar type II disorder. It is an episodic mood disorder defined by the occurrence of one or more hypomanic episodes and at least one depressive episode; without history of manic or mixed episodes

5.6.3. Sub-types of Bipolar type II disorder

5.6.3.1. *Bipolar type II disorder, current episode hypomanic*

5.6.3.2. *Bipolar type II disorder, current episode depressive, mild*

5.6.3.3. *Bipolar type II disorder, current episode depressive, moderate without psychotic symptoms*

5.6.3.4. *Bipolar type II disorder, current episode depressive, moderate with psychotic symptoms*

5.6.3.5. *Bipolar type II disorder, current episode depressive, severe without psychotic symptoms*

5.6.3.6. *Bipolar type II disorder, current episode depressive, severe with psychotic symptoms*

5.6.3.7. *Bipolar type II disorder, current episode depressive, unspecified severity*

5.6.3.7.1. the definitional requirements for Bipolar type II disorder have been met and the current episode is depressive, but there is insufficient information to determine the severity of the current depressive episode.

5.6.3.8. *Bipolar type II disorder, currently in partial remission, most recent episode hypomanic*

5.6.3.8.1. the definitional requirements for Bipolar type II disorder have been met and the most recent episode was a hypomanic episode; with unmet full definitional requirements for a hypomanic episode although some significant mood symptoms remain. In some cases, residual mood symptoms may be depressive rather than hypomanic, but do not satisfy the definitional requirements for a depressive episode.

5.6.3.9. *Bipolar type II disorder, currently in partial remission, most recent episode depressive*

5.6.3.9.1. the definitional requirements for Bipolar type II disorder have been met and the most recent episode was a depressive episode. The full definitional requirements for the episode are no longer met but some significant depressive symptoms remain.

5.6.3.10. *Bipolar type II disorder, currently in partial remission, most recent episode unspecified*

5.6.3.10.1. the definitional requirements for Bipolar type II disorder have been met but there is insufficient information to determine the nature of the most recent mood episode. The full definitional requirements for a mood episode are no longer met but some significant mood symptoms remain.

5.6.3.11 *Bipolar type II disorder, currently in full remission*

5.6.3.11.1. the definitional requirements for Bipolar type II disorder have been met but there are no longer any significant mood symptoms.

5.6.3.12. *Other specified bipolar type II disorder Bipolar type II disorder, unspecified*

5.7. Cyclothymic disorder: is characterized by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic and depressive symptoms that are present during more of the time than not.

5.7.1. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a hypomanic episode as with bipolar II and/or there is no history of manic or mixed episodes as with bipolar I.

5.7.2. The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode as with bipolar II but the symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

5.8. Other specified bipolar or related disorders Bipolar or related disorders, unspecified

5.9. Bipolar or related disorders, unspecified

5.10. <u>Treatment Plans and Management</u>. This guideline highlights the pharmacologic approach although still with some emphasis on other non-pharmacologic treatment approach.

5**.**11. This guideline will focus on five major steps in initiating treatment for patients with bipolar disorders based on presenting symptoms or state; whether on manic state, depressive state, mixed, and/or with psychosis.

5.12. The choice of drugs is grouped into three: the first line, the second, and the third line of drug treatment while the treatment categories are mainly the mono-therapy, the combination, and the treatment-resistant.

5.13. **Pharmacologic treatment of Acute Bipolar mania** (with or w/out psychosis, as per applicability)

5.13.1. The First line of drugs of choice are: lithium, divalproex or an atypical antipsychotic, preferably Olanzapine; Second line: carbamazepine and oxcarbazepine; the combination of lithium plus divalproex; or electroconvulsive therapy (ECT). Third line: haloperidol, chlorpromazine or perphenazine in combination with lithium or divalproex ; lithium plus carbamazepine; and clozapine

5.13.2. Steps for treatment initiation.

5.13.3. *Review general principles and assess medication status*. The patient should be immediately assessed for risk of aggressive behavior/violence to others, suicide, degree of insight and the ability to adhere to treatment.

5.13.3.1. A physical examination with appropriate lab investigations should be conducted, but may be deferred until the patient is more cooperative. Based on the overall assessment the type of treatment setting (e.g. ambulatory or inpatient) should be established.

5.13.3.2. Antidepressants should be discontinued and steps taken to rule out factors that may be perpetuating manic symptoms, such as prescribed medication, illicit-drug use/abuse or an endocrine disorder. Substance abuse should be identified and treated.

5.13.3.3. Patients should also be strongly encouraged to discontinue using stimulants such as caffeine and alcohol and gradually discontinue nicotine.

5.13.3. *Initiate or optimize therapy and check adherence*. The decision to treat with mono-therapy or a combination of medications is influenced by current and prior medication use, as well as patient factors that may influence prognosis or safety.

5.13.3.1. For untreated manic patients or those receiving a medication other than a first-line agent, therapy should be initiated with one or more of the first-line agents: lithium, divalproex or an atypical antipsychotic

5.13.3.2. For patients who are uncontrolled on mono-therapy with a first-line medication, the first option before adding or switching therapies is to optimize the dose of current medication and to identify issues of non-adherence.

5.13.4. *Add-on or switch therapy (alternate first-line therapies*). If therapy with one of the first-line agents (lithium, divalproex or an atypical antipsychotic) at optimal doses is inadequate or not tolerated, the next step should involve switching to or adding-on an alternate first-line agent. The use of second- and third-line agents is only recommended after these first-line classes of agents have been tried alone or in combination.

5.13.5. *Add-on or switch therapy (second- and third- line therapies).* For Second-line options: In patients who are inadequately responsive to first-line agents, second-line choices would include other anticonvulsants such as carbamazepine and oxcarbazepine, the combination of lithium plus divalproex, or electroconvulsive therapy (ECT).

5.13.5.1. Third-line options. A variety of agents including the conventional antipsychotics, haloperidol, chlorpromazine or perphenazine in combination with lithium or divalproex;

lithium plus carbamazepine; and clozapine are recommended as third-line options for therapy.

5.13.5.2. Although clozapine may have efficacy for acute mania, it should be reserved for treatment-resistant patients.

5.13.6. *Add-on novel or experimental agents*. Phenytoin and levetiracetam have some anti-manic efficacy but should preferably only be used as add-on therapies in those patients who have shown partial refractoriness to all the standard treatments reviewed above.

5.13.7. *When patients are stabilized, behavioral and educational strategies should be applied*.

5.14. **Pharmacologic treatment of Acute Bipolar depression** (with or w/out psychosis, as per applicability

5.14.1. First line of drugs of choioce: Lithium, lamotrigine, lithium or divalproex + SSRI, olanzapine + SSRI, lithium + divalproex, lithium or divalproex + bupropion; Second line: Quetiapine, quetiapine + SSRI; Third line : Carbamazepine, olanzapine, divalproex, lithium + carbamazepine, lithium + pramipexole, lithium or divalproex + venlafaxine, lithium + MAOI, ECT, lithium or divalproex or AAP + TCA

5.14.2. Steps for treatment initiation.

5.14.3. *Review general principles and assess medication status*. The patient should be assessed for a risk of suicide/self-harm behavior, ability to adhere to treatment plan, psychosocial support network, and the ability to function. Based on these factors, a decision can be made as to whether the patient requires admission to hospital or can be safely managed in an outpatient setting.

5.14.4. *Initiate or optimize therapy and check adherence*. In managing an acute depressive episode, the decision to choose mono-therapy or combination therapy is based on current and prior medication use, as well as patient factors that may influence prognosis or safety.

5.14.4.1. In the drug-free patient, therapy should be initiated with one or more of the first-line agents. *(Refer to 5.16.1.)*

5.14.4.2. For patients who relapse into a depressive episode while on divalproex or atypical antipsychotic monotherapy, additional SSRI, bupropion, lamotrigine or lithium, or a switch to lamotrigine or lithium would be appropriate.

5.14.4.3. For patients on lithium or lamotrigine which have established antidepressant efficacy, the first option before adding or switching therapies is to optimize the dose of these medications.

5.14.5. *Add-on or switch therapy*. These include adding or switching to alternate first-line agents or considering second-line options. Quetiapine with or with- out an SSRI is recommended as an alternate or as add-on to first-line therapies.

5.14.6. *Add-on or switch therapy (alternate first- or second-line therapies).* Establish further therapeutic choices being based on current medication for efficacy and relative safety of first- and second-line agents. The use of third-line agents is not recommended until first or second-line classes of agents have been tried alone or in combination.

5.14.7. *Add-on or switch therapy (third-line therapies).* In patients who failed to respond to first- and second-line agents, third-line choices would include mono-therapy or add-on therapy with olanzapine, divalproex or carbamazepine; combination therapy with lithium or divalproex plus pramipexole or venlafaxine, lithium plus a monoamine oxidase inhibitor (MAOI) or carbamazepine and lithium, divalproex or an atypical antipsychotic plus a TCA, as well as Electroconvulsive therapy (ECT).

5.14.8. ECT can be considered earlier in patients with severe psychotic bipolar depression, those at risk of significant medical complications secondary to poor oral intake, and those with a past history of non-response to antidepressants.

5.14.9. Behavioral and educational strategies are important supportive treatment to improve symptoms and prevent relapse.

6. Responsibilities

6.1. Psychiatrists

6.1.1. Adhere to safe management of patients with bipolar affective disorder according to the guideline.

6.1.2. Take full history including all necessary relevant information significant in establishing diagnosis and treatment planning.

6.1.3. Perform necessary assessments, order laboratory and/or other diagnostic procedures as needed,

6.1.4. Assess baseline initial and comprehensive risk assessment, and initiate integrated team intervention with proper monitoring of patient's progress.

6.2. Nurses

6.2.1. Establish patient's rapport and trust and maintain therapeutic communication and provision of needs.

6.2.2. Monitor and ensure patient's safety in all aspects of patient care.

6.2.3. Promote compliance and monitoring of drug therapy.

6.3. Clinical Pharmacist.

6.3.1. Serves as therapeutic leaders for the appropriate and safe use of medication through performance of medication reconciliation; medication and prescription review; and safe dispensing of drugs.

6.3.2. Initiate medication counseling for patients and patient's family for optimized use of medication and proper monitoring of any possible adverse effect from medication for timely and appropriate management.

6.3.3. Analyze patient's laboratory and diagnostic data in collaboration with concerned multidisciplinary team towards decision on medication modifications.

6.4. Clinical Psychologist.

6.4.1. To provide safely an appropriate and effective psychotherapeutic and psycho-education sessions to patient and their families/relatives as applicable.

6.5. Social Worker (adopted from Social Services P&P; AMRH/SSD/P&P/001/Vers01)

6.51. Contact the patient's family for professional purposes as complementary to their roles (social study, family therapy etch)

6.5.1. Keep in touch with the medical team and attend the medical rounds for exchange of feedbacks and opinions concerning social issues relevant to the holistic patient care

6.5.2. Coordinate with Discharge planner relating to discharge plans concerning patient's social issues that may affect the treatment plans or patient's condition and recovery.

7. Document History and Version Control Table

Document History and Version Control			
Version	**Description of Amendment**	**Author/s**	**Review Date**
1.	Initial Release	Dr. Muna Al Salmi Dr. Furqan Al Lawati Dr. Shaimaa Mohamed Abady Maria Claudia Fajardo-Bala	January 2026
2	Update		

Written by	**Reviewed by**	**Approved by**
Dr. Muna Al Salmi Dr. Furqan Al Lawati Dr. Shaimaa Mohamed Abady Maria Claudia Fajardo-Bala	Dr. Said Al Kaabi	Dr. Bader Al Habsi

8. Related Documents

Appendix 1.Audit Tool

Appendix 2.Document Request Form

Appendix 3.Validation Checklist

9. References

Title of book/journals/articles/Website	Author	Year of publication	Page
https://psychiatry-psychopharmacology.com/en/maintenance-treatment-in-bipolar-disorder-what-do-guidelines-recommend			
https://www.ncbi.nlm.nih.gov/pmc/artciles/PMC5310104			
https://www.ncbi.nlm.nih.gov/books/NBK558998			
Dore G, Romans SE. Impact of bipolar affective disorder on family and partners. J Affect Disord. 2001 Dec;67(1-3):147-58. doi: 10.1016/s0165-0327(01)00450-5. PMID: 11869762.	Dore G, Romans SE	2001	
Grover S, Nehra R, Thakur A. Bipolar affective disorder and its impact on various aspects of marital relationship. Ind Psychiatry J. 2017 Jul-Dec;26(2):114-120. doi: 10.4103/ipj.ipj_15_16. PMID: 30089956; PMCID: PMC6058431.	Grover S, Nehra R, Thakur A.	2017	
Chakrabarti S. Mood disorders in the International Classification of Diseases-11: Similarities and differences with the Diagnostic and Statistical Manual of Mental Disorders 5 and the International Classification	Chakrabarti S	2018	

of Diseases-10. Indian J Soc Psychiatry 2018;34:S17-22.			
Behrouz Nabavi, Alex J. Mitchell, David Nutt, A Lifetime Prevalence of Comorbidity Between Bipolar Affective Disorder and Anxiety Disorders: A Meta-analysis of 52 Interview-based Studies of Psychiatric Population, EBioMedicine, Volume 2, Issue 10, 2015, Pages 1405-1419,ISSN 2352-3964, https://doi.org/10.1016/j.ebiom.2015.09.006. (https://www.sciencedirect.com/science/article/pii/S2352396415301304)	Behrouz Nabavi, Alex J. Mitchell, David Nutt	2015	
World Health Organization. (2018). THE ICD-11 Classification of Mental and behavioral Disorders Diagnostic criteria for research. *ICD 11 MMS- 2018*, 23-31.		2018	

Appendices

Appendix 1.Audit Tool

Clinical and Treatment Guidelines for Bipolar Affective Disorder							
Department:						**Date:**	
No.	**Audit Process**	**Criteria**	**Yes**	**Partial**	**No**	**N/A**	**Comment**
1	Interview	Are all the staff/ doctor aware of the guideline for assessment and management for bipolar affective disorder?					
2	Checking document	Are the doctors and/or staff documenting properly the proper assessment of symptoms for manic/ depressive/ mixed/ and psychosis?					
3	Interview	Are the psychiatrists following recommended guidelines in the pharmacologic management of bipolar affective disorder?					
4	Checking document	Maintain the records of proper risk assessment such as Suicide Risk Assessment Tool or Brocet Violence Checklist					

Appendix 2.Document Request Form

Document Request Form			
Section A: Completed by Document Requester			
1. Requester Details			
Name	Dr. Furqan Al Lawati Maria Claudia Fajardo-Bala	Date of Request	January 2023
Institute	Al Masarra Hospital	Mobile	
Department	Psychiatry	Email	claudia_hao@yahoo.com
The Purpose of Request			
☐ Develop New Document	• Modification of Document	• Cancelling of Document	
1. Document Information			
Document Title	**Clinical and Treatment Guidelines for Bipolar Affective Disorder**		
Document Code	AMRH/PSY/GUD/03/Vers.01		
Section B: Completed by Document Controller			
✓ Approved	• Cancelled	• Forward To:……..	
Comment and Recommendation:	to proceed with document		
Name	Kunooz Al Balushi	Date	January 2023
Signature	for Kunooz	Stamp	

Appendix 3. **Document Validation Checklist**

Document Validation Checklist					
Document Title: Clinical and Treatment Guidelines for Bipolar Affective Disorder		**Document Code:** AMRH/PSY/GUD/03/Vers.01			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**	✓			
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed			✓	
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)			✓	
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner			✓	
3.2	Procedure define personnel to carry out step			✓	
3.3	Procedures define the use of relevant forms			✓	
3.4	Procedures to define flowchart			✓	
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed			✓	
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed	✓			
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			
Recommendations ..... For implementation ✓..... More revision ..... To be cancelled					
Reviewed by: Kunooz Al Barushi for Kunooz **Reviewed by:** Maria Claudia Fajardo Bala