

## Preferred Practice Guidelines Bipolar Disorder in Children and Adolescents

These Guidelines are based in part on the following:

American Academy of Child and Adolescent Psychiatry's "Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder," January, 2007.

<http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709619687.pdf>

*The practice guidelines included in this document are not intended to be required treatment protocols. Physicians and other health professionals must rely on their own expertise in evaluating and treating patients. Practice guidelines are not a substitute for the best professional judgment of physicians and other health professionals. Behavioral health guidelines may include commentary developed by the Company's behavioral health committees. Further, while authoritative sources are consulted in the development of these guidelines, the practice guideline may differ in some respects from the sources cited. With respect to the issue of coverage, each patient should review his/her Policy or Certificate and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The practice guidelines do not supersede the Policy or Certificate and Schedule of Benefits.*

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Adoption Date:  
Revision Dates: September 2013  
Review Dates: October 18, 2013

**Summary:**

Although the company maintains a Clinical Practice Guideline for treatment of Bipolar Disorder in adults, the number of adolescents receiving a diagnosis of bipolar disorder has increased markedly in the past ten years and research suggests that there are differences in the identification and treatment of the disorder in adolescents and children.

**Rationale:**

A diagnosis of bipolar disorder is made when the required Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) target symptoms for mania and mixed state are present, either currently or by history, and other disorders, such as schizophrenia or organic affective disturbances, have been adequately ruled out. Once the diagnosis has been established, it should be reassessed longitudinally to ensure accuracy.

**Assessment Should Include a Review of:**

- Premorbid history
- History of present illness
- Family history and dynamics
- School information
- Consultation and collaboration with other mental health and/or social service providers as necessary
- Past medical history
- Suicide risk
- Safety issues
- Ruling out other disorders and determining if it is necessary to hospitalize
- Ruling out and including an assessment of adjustment to trauma and PTSD
- Neuropsychological functioning
- Substance-induced mood or symptoms
- Physical evaluation of the child to rule out organic conditions
- Identifying other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties and comorbid disorders)

**When ascertaining the presence or absence of manic symptoms, the frequency, intensity, number, and duration guidelines are:**

- Frequency: symptoms occurred most days in a week
- Intensity: symptoms are severe enough to cause extreme disturbance in one domain or moderate disturbance in two or more domains
- Number: symptoms occur three or four times a day
- Duration: symptoms occur a total of four or more hours a day, not necessarily contiguous

**Lab Values to Obtain:**

Laboratory and other diagnostic studies should be guided by the psychiatrist's evaluation of the individual's condition and by the choice of pharmacologic treatment.

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Thyroid function should be assessed in mood disordered patients.

### **Bipolar I Disorder:**

When diagnosing bipolar I disorder in adolescents and children, the same criteria should be used for adults except that:

- Mania must be present
- Euphoria must be present most days, most of the time (for at least seven days)
- Irritability can be helpful in making a diagnosis if it is episodic or severe, results in impaired function, and is out of keeping or not in character; however, it should not be a core diagnostic criterion

Bipolar I disorder should not be diagnosed solely on the basis of a major depressive episode in an adolescent or child with a family history of bipolar disorder; however, adolescents and children with a history of depression and a family history of bipolar disorder should be carefully monitored for emergence of mania or hypomania.

### **Bipolar II Disorder:**

In adolescents and children, the criteria for diagnosing bipolar II disorder should normally not be used because the diagnostic criteria are not well-enough established for routine use. In older adolescents, the criteria for diagnosing bipolar II disorder in adults should be used.

### **Treatment:**

#### Treatment Goals:

- Achieve control of acute manic and depressive symptoms
- Reduce the number of times that mood cycling and mood instability occur
- Help people with bipolar disorder function at the highest level possible
- Minimize lesser bipolar symptoms that still could have an impact
- Minimize side effects of treatment
- Help people with bipolar disorder adhere to their management plan
- Increase skills in regulation of emotion goals of psychiatric management:
- Establish and maintain a therapeutic alliance
- Monitor the individual's psychiatric status
- Provide patient and family education regarding bipolar disorder
- Promote understanding of and adaptation to the psychosocial effects of bipolar disorder
- Enhance treatment compliance
- Promote regular patterns of activity and wakefulness
- Reduce the morbidity and sequelae of the disorder

### **Psychotherapeutic treatments:**

- Psychosocial therapy
- Psychoeducational therapy
- Psychotherapy (individual, group, family)

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- Cognitive-behavioral therapy
- Treatment of associated disorders or symptoms, such as substance abuse disorder, depression or suicidality
- Inpatient admission for acute phase of illness

- Partial hospitalization or day treatment programs
- Residential treatment
- Psychosocial rehabilitation

**Pharmacotherapy:**

For mania, mood stabilizers have been the traditional primary mode of preferred treatment, but second generation antipsychotics have increasing support as an initial treatment in seriously ill bipolar adolescents.

**Treatment of Episodes:**

Manic

Mood stabilizers and/or SGA's are indicated for manic episodes in children or adolescents. In addition, at initial presentation:

Height and weight should be checked (and monitored regularly afterwards — for example, monthly for six months then every six months).

When considering an antipsychotic, the risk of metabolic side effects such as weight gain and increased prolactin levels should be considered.

When there is an inadequate response to an antipsychotic, adding Lithium or Valproate should be considered.

In young women, use of Valproate should be carefully considered because of risk during pregnancy and the possible association with polycystic ovary syndrome.

Treatment planning for the manic phase of the disorder appears to benefit from consideration of medication differential effectiveness that does not seem to apply to adults.

**Depressive:**

Adolescents and children with bipolar disorder experiencing mild depressive symptoms assessed as not requiring immediate treatment should be monitored weekly and offered additional support (e.g., at home and in school).

Adolescents and children with depressive symptoms needing treatment should normally be treated by specialized adolescent/child mental health services for severe, complex or persistent disorders. Staff should include child and adolescent psychiatrists, clinical psychologists, nurses and adolescent psychotherapists. Treatment should be the same as for adults with bipolar disorder except that a structured psychological therapy aimed at treating depression should be considered in addition to prophylactic medication.

Antidepressants should only be used in conjunction with adequate mood stabilization.

**Mixed or Rapid Cycling:**

Based on the adult literature, the treatment of mixed episodes in adolescents and children is basically the Adoption Date.

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same as that for mania, although lithium may be less often effective. Antidepressants are best avoided. The anticonvulsants may be particularly effective for mixed episodes, but further research is needed.

Similar to patients with mixed episodes, those with rapid cycling may be less responsive to lithium. Clinical experience suggests that antidepressants be avoided and that a combination of antimanic agents is often necessary to relieve symptoms. It is also important that patients with rapid cycling mania undergo a thorough medical evaluation to rule out potential medical conditions (e.g., thyroid disorder, substance abuse) that may be exacerbating the affective instability.

**Other treatment considerations:**

**Maintenance Phase:**

The basic goals of maintenance treatment include prevention of relapse and recurrence; reduction of sub threshold symptoms, suicide risks, affective cycling, and mood instability; reduction of vocational and social morbidity; and promotion of wellness.

Although more definitive studies are needed, current evidence suggests that the regimen needed to stabilize acute mania should be maintained for 12 to 24 months. Maintenance therapy is often needed for youths with bipolar disorder and with some individuals needing lifelong therapy when the benefits of continued treatment outweigh the risks. This should be decided on a case-by-case basis.

Any attempt to discontinue prophylactic therapy should be done gradually while closely monitoring the patient for relapse.

Patients and families must be thoroughly educated as to the signs and symptoms of recurrence of mood episodes.

For those patients in remission but who have not achieved optimum functioning, consider comorbid conditions such as Attention Deficit Hyperactivity Disorder (ADHD) or other conditions which might contribute to the functional impairment.

Patients and families must be informed about the potential metabolic side effects of the atypical antipsychotics (particularly clozapine, olanzapine and quetiapine) such as weight gain, hyperglycemia, dyslipidemia and increased risk of diabetes mellitus.

An outpatient visit with a behavioral health practitioner should take place within seven calendar days of discharge from acute care for both children and adults\*.

**Specialist referral criteria:**

**Referrals may be considered for:**

- Case management
- In-home services
- Family support
- School-based services
- Community treatment programs

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**Patient Education:**

Ideally, education is provided to the patient and family on the impact of noncompliance with medications, the recognition of emergent relapse symptoms and other factors that may promote relapse (e.g., sleep deprivation, substance abuse).

Medication noncompliance is a major contributor to relapse. Providers are encouraged to educate both the patient and family of the importance of ongoing treatment.

Establishing a strong therapeutic relationship and providing regular follow-up assessments are important in maintaining compliance.

The following themes ideally will be communicated:

- Bipolar disorder is a no-fault illness
- Bipolar disorder is responsive to medication
- It may take time for the medication to become effective
- Continue medications even when you are feeling better
- Talk to your doctor about any side effects
- Talk to your doctor before stopping medications or if you have any questions

**References:**

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