NOTE: All treatments to be initiated by specialist only – prescribing can only transfer in line with Safe Transfer of Prescribing Guidance.

MANAGEMENT OF BIPOLAR DISORDER IN UNDER 18s

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Based on NICE CG185

People with bipolar disorder should be offered regular physical health monitoring, and a healthy eating and physical activity programme

Self-management and recovery

People with bipolar disorder can learn to manage it with the help of health professionals and family/carers.

Talking therapies and medicines help with episodes of mania and bipolar depression, and can prevent relapse and reduce symptoms. Advance statements along with care and risk management plans help with planning for the future.

Managing mania and hypomania

Step 1	Review current treatment. If applicable, consider stopping antidepressants and optimise existing lithium/valproate therapy.
Step 2	Offer an antipsychotic. Aripiprazole should be the first choice (licenced); if aripiprazole is not tolerated (at any dose) or ineffective (at max. dose), offer an alternative (see overleaf for options). After failure of two antipsychotics, add a mood stabiliser.
Step 3	If antipsychotics are ineffective at max. dose, consider adding lithium. If lithium is ineffective or unsuitable, consider valproate.
	Do not offer valproate to patients of childbearing potential*
Step 4	For severe mania that has not responded to other interventions, refer to NICE TA59 on electroconvulsive therapy.

Managing bipolar depression

Step 1	Offer at least 3 months of individual cognitive behavioural therapy or interpersonal therapy for young people with bipolar depression
Step 2	If after 4 to 6 weeks there is limited response to step 1, review and consider an alternative individual or family talking therapy, taking into consideration any other mental health problems or social/family issues.
Step 3	If the young person's bipolar depression is moderate to severe, consider a medication in addition to talking therapies. If lithium is prescribed, optimise the dose, then: a) Offer fluoxetine combined with olanzapine, or quetiapine on its own. b) Consider olanzapine on its own if preferred to option (a). c) Consider lamotrigine on its own if preferred or no response to option (a).

Managing risk

Is there a risk of suicide or self-harm?

Planning ahead	Develop a risk management plan jointly with the person and carer if possible. Include personal triggers and early warning signs of relapse. Plan coping strategies including medication adjustments. List emergency contacts and agree plans with the GP.

Longer-term care

Talking therapies	Consider a structured individual or family talking therapy for managing bipolar disorder in young people in the longer term

NICE guidelines advise the NHS on caring for people with specific conditions. This summary should not be used as a substitute the NICE guideline, available at nice.org.uk/guidance/cg185

*Note: Valproate carries a risk of polycystic ovary syndrome. It is also associated with a significant risk of birth defects and developmental disorders in children born to patients who take valproate during pregnancy.

Bipolar disorder – prescribing guidance for under 18's

Managing Mania & Hypomania

1. Aripiprazole Licensed for treating moderate to severe manic episodes in young people aged 13 years & over with bipolar I disorder for **up to 12 weeks**	Acute mania: **Aripiprazole:** Start at 2 mg daily *(using the 1 mg/ml oral solution)* for 2 days, then 5 mg daily for 2 days, then 10 mg daily *(switch to tablets as soon as appropriate)* Enhanced efficacy has not been demonstrated at doses >10 mg daily, although some patients may benefit from a higher dose, max. 30 mg daily, this may be associated with a higher incidence of significant side effects e.g. EPSEs, somnolence, fatigue & weight gain.
2. If aripiprazole is not tolerated at any dose or ineffective at max dose, try an alternative. Antipsychotics other than aripiprazole are **unlicensed** in young people Do not routinely continue antipsychotic treatment (including aripiprazole) beyond 12 weeks; if continued for prophylaxis in preference to lithium, review regularly and monitor physical health according to Trust guidelines. Record shared decision and consent in the patient record Care needed when stopping antipsychotics After failure of a trial of two second generation antipsychotics (SGA) add mood stabiliser.	Alternative antipsychotics (dose for acute mania): **Olanzapine:** 15 mg daily (5-20 mg daily); doses >15 mg daily only after reassessment. When one or more factors present that may result in slower metabolism (e.g. female gender, non-smoker), consider lower initial dose and more gradual dose increase. **Quetiapine:** Start at 25 mg twice daily on day 1, 50 mg twice daily on day 2, 100 mg twice daily on day 3, 150 mg twice daily on day 4, 200 mg twice daily on day 5 then adjust in steps of up to 100 mg daily, 400-600 mg daily in divided doses may be needed. **Risperidone:** Start at 500 micrograms once daily, adjusted in steps of 500 micrograms-1 mg daily, usual dose 2.5 mg daily in 1 or 2 divided doses) NB. Significantly greater weight gain (olanzapine, quetiapine, risperidone – in descending order of harm) & somnolence in younger people compared with adults with SGA.
3. Add Lithium	Adherence to monitoring requirements may be difficult in adolescents (Licensed product for Children aged >12 years = Liskonum)
4. If Lithium not appropriate, consider Valproate instead	DO NOT offer valproate to patients of child-bearing potential due to the risks of polycystic ovary syndrome and teratogenic risks if taken during planned or unplanned pregnancy. See MSS 13 Not recommended for children under 10, except by experts when other options have been considered.

Managing Bipolar Depression

If **Lithium** prescribed optimise dose	Adjust dose based on serum levels taken 12 hours post dose.
Then offer: • **Fluoxetine** + **Olanzapine** or • **Quetiapine** (on its own) or • **Olanzapine** (on its own) These treatments are **unlicensed** in young people Do not routinely continue antipsychotic treatment beyond 12 weeks; if continued for prophylaxis, review regularly and monitor physical health according to Trust guidelines. Record shared decision and consent in the patient record Care needed when stopping antipsychotics	Antidepressants should be used with care & only in the presence of an anti-manic agent **Fluoxetine:** 20-40 mg daily; **Olanzapine:** 5-10 mg daily **Quetiapine:** Up to 300 mg daily may be needed (initiation with immediate-release product as for mania) **Olanzapine:** 15 mg daily (5-20 mg daily); doses >15 mg daily only after reassessment. When one or more factors present that may result in slower metabolism (e.g. female gender, non-smoker), consider lower initial dose and more gradual dose increase.
Consider **Lamotrigine** if preferred or no response to previous options	Risk of rash increased in younger patients, especially if concurrent valproate or under 12 years of age. Clearance may be affected by weight; patients weighing <30 kg may require an increase of up to 50% for maintenance doses. Dose dependent on if other enzyme inducers/inhibitors co-prescribed, see BNF-C for details.

- Children & adolescents are more susceptible to metabolic side effects than adults.
- Ensure all required physical health monitoring is carried out at appropriate intervals.