MANAGEMENT OF

BIPOLAR DISORDER IN UNDER 18s

Based on NICE CG185

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

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

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.

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

Managing mania and hypomania

Step 1	Review current treatment; consider stopping any antidepressants; optimise existing therapy.
Step 2	Offer an antipsychotic. **Aripiprazole** is first choice (licensed); if not tolerated (at any dose) or ineffective (at max. dose), offer an alternative (see options overleaf). After failure of two antipsychotics, **move to step 3**
Step 3	If **two** antipsychotics are ineffective at max. dose, consider adding lithium.
Step 4	For severe mania that has not responded to other interventions, refer to NICE TA59 on electroconvulsive therapy.

Do not offer valproate to children unless there is no other effective or tolerated treatment*

Managing bipolar depression

Step 1	Offer at least 3 months of individual cognitive behavioural therapy or interpersonal therapy.
Step 2	After 4-6 weeks, if 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 depression is moderate to severe, consider a medication in addition to talking therapies. If **lithium** is prescribed, optimise levels; otherwise see overleaf for alternative options. If prescribed, **do not routinely continue antipsychotic treatment for longer than 12 weeks.** At 12 weeks, carry out a full multidisciplinary review of mental and physical health, and consider further management of depression and other symptoms

Managing risk

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

Is there a risk of suicide or self-harm?

Long-term care

Talking therapies

Consider a structured individual or family talking therapy for the longer term.

*Valproate should be avoided in all peri- and post-pubertal children & adolescents If no suitable alternative, follow the MHRA safety advice

Title	Management of bipolar disorder in under-18s		
Approved by	Drug & Therapeutics Committee	Date of Approval	25th September 2025
Protocol Number	PHARM-0152-v2	Date of Review	1st October 2028

Bipolar Disorder - Prescribing Guidance for under 18s

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

Managing Mania & Hypomania

1. Aripiprazole Licensed for moderate-severe episodes in 13 years & over with bipolar I disorder for **up to 12 weeks** *Available as:* • *1mg, 2.5mg, 5mg, 10mg, 15mg & 30mg tablets* • *10mg, 15mg orodispersible tabs* • *1mg/1ml oral solution*	**Acute mania:** Start at 2mg daily for 2 days, then 5mg daily for 2 days, then 10mg daily (using standard tablets wherever possible) Enhanced efficacy has not been demonstrated at doses >10mg daily, although some patients may benefit from a higher dose, max. 30mg 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. Alternative antipsychotics are **unlicensed** in young people [2,3] Care needed when stopping antipsychotics After failure of a trial of two second generation antipsychotics (SGA), add mood stabiliser.	**Olanzapine**[1]**:** 15mg daily (5-20mg daily); doses >15mg daily only after reassessment. **Quetiapine:** 25mg twice daily (day 1), 50mg twice daily (day 2), 100mg twice daily (day 3), 150mg twice daily (day 4), 200mg twice daily (day 5) then adjust in steps of up to 100mg daily; 400-600mg daily in divided doses may be needed. **Risperidone:** 500micrograms once daily, adjusted in steps of 500micrograms-1mg daily; usual dose 2.5mg daily (in 1 or 2 divided doses)
3. Add Lithium	Adherence to monitoring requirements may be a barrier in adolescents. Twice daily dosing is recommended in young people, especially if using non-MR or liquid preparations. Usual starting dose (BNF-C): 200-250mg daily in 1-2 divided doses. (Licensed preparation for aged >12 years = Liskonum 450mg MR tablets, tablets can be halved; use of alternative preparations needs approval via single application form)

Managing Bipolar Depression

If taking **Lithium,** optimise levels	Adjust dose based on serum levels taken 12 hours post-dose.
Then offer: • **Fluoxetine + Olanzapine** or • **Olanzapine** (on its own) or • **Lurasidone**[4] (on its own) or • **Quetiapine**[5] (on its own) These treatments are **unlicensed** for this indication in young people[2,3] Care needed when stopping antipsychotics.	Antidepressants should be used with care & only in the presence of an anti-manic agent. **Fluoxetine:** 20-40mg daily **Olanzapine**[1] (with fluoxetine)**:** 5-10mg daily **Olanzapine**[1] (monotherapy)**:** 15mg daily (5-20mg daily); doses >15mg daily only after reassessment. **Lurasidone:** 37mg daily, increased if necessary to 74mg daily **Quetiapine:** Up to 300mg daily may be needed (initiation with immediate-release product as for mania)
Consider **Lamotrigine** if preferred or no response to previous options	• Greater risk of rash in younger patients, especially if concurrent valproate, under 12yo, history of allergy or rash with other antiepileptic drugs. Risk increased with higher doses and faster dose escalation. • Dose titration dependent on any co-prescribed enzyme inducers/inhibitors - see BNF-C for details. • If not taken for 5 days or more restart with the initial dose titration, as rashes have been reported on re-exposure. • Risk of suicidal thoughts and behaviour, possibly within 1 week after initiation. • Be aware of potential for drug interactions between lamotrigine and contraceptives.

Title	Management of bipolar disorder in under-18s		
Approved by	Drug & Therapeutics Committee	Date of Approval	25th September 2025
Protocol Number	PHARM-0152-v2	Date of Review	1st October 2028

Notes:

1. 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.
2. Young people are more susceptible to metabolic effects, weight gain (olanzapine, quetiapine, risperidone – in descending order of risk) & somnolence compared with adults
3. Do not routinely continue antipsychotics (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. Ensure all required physical health monitoring is carried out at appropriate intervals.
4. Trust-approved for this unlicensed indication in young people aged over 13 years (no application required); approval required for young people under 13 years [this reflects the licensed status for treating schizophrenia in these age groups]
5. Maudsley Guidelines (2025) no longer recommend quetiapine for bipolar depression in young people - meta-analysis suggests it was ineffective: Systematic Review and Network Meta-analysis: Efficacy and Safety of Second-Generation Antipsychotics in Youths With Bipolar Depression - Journal of the American Academy of Child & Adolescent Psychiatry