Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder.

BIBLIOGRAPHIC SOURCE(S)

McClellan J, Kowatch R, Findling RL, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 2007 Jan;46(1):107-25. [170 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This updates a previous version: Practice parameters for the assessment and treatment of children and adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):157S-177S.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- December 12, 2007, Carbamazepine: The U.S. Food and Drug Administration (FDA) has provided recommendations for screening that should be performed on specific patient populations before starting treatment with carbamazepine.
- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Bipolar disorder

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Pediatrics
Psychiatry

INTENDED USERS

Allied Health Personnel
Physicians

GUIDELINE OBJECTIVE(S)

To describe what is known of bipolar disorder in juveniles, where areas of controversy lie, and what constitutes acceptable practices and appropriate care

TARGET POPULATION

Children and adolescents

INTERVENTIONS AND PRACTICES CONSIDERED

Screening/Diagnosis

1. Screening for bipolar disorder
2. Diagnosis of bipolar disorder using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (May 2000 text revision) (DSM-IV-TR) criteria
3. Diagnosis of bipolar disorder Not Otherwise Specified (NOS)

4. Evaluation of other associated problems, including suicidality, comorbid disorders (including substance abuse), psychosocial stressors, and medical problems

Treatment/Management

1. Treatment of mania in well-defined DSM-IV-TR bipolar 1 disorder, with pharmacotherapy including lithium, valproate, and/or atypical antipsychotic agents, with other adjunctive medications as indicated
2. Ongoing medication therapy to prevent relapse
3. Baseline and follow-up symptom, side effect (including patient's weight), and laboratory monitoring as indicated
4. Electroconvulsive therapy (ECT) for severely impaired adolescents with manic or depressive episodes in bipolar 1 disorder, in whom medications either are not helpful or cannot be tolerated
5. Psychotherapeutic interventions
6. Treatment of bipolar disorder NOS with a combination of psychopharmacology with behavioral/psychosocial interventions

MAJOR OUTCOMES CONSIDERED

- Bipolar symptomatology and relapse rate
- Incidence and severity of medication side effects
- Level of functional impairment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature review process was performed using the National Library of Medicine database. Key words included *adolescents, children*, and *bipolar disorder*, with supplemental searches to address other relevant topics (e.g., specific medications). The Medline search was updated several times, most recently in January 2005. This process identified several hundred abstracts. Relevant papers identified through this process were reviewed in detail. Pertinent books and review articles were also used. Finally, the authors drew from their own work in this area. Experts in the field were also consulted. Their comments, including additions and clarifications of the literature review, were incorporated into the parameter.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The recommendations are based on a thorough review of the literature as well as clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply >95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but not required. There may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Practice Parameter was reviewed at the member forum in October 2004 at the annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). During August 2005, a consensus group reviewed and finalized the content of the practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts. The Practice Parameter was approved by AACAP Council on June 17, 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the categories of endorsement for the recommendations (**MS, CG, OP, NE**) are provided at the end of the "Major Recommendations" field.

Screening

Recommendation 1: Psychiatric Assessments for Children and Adolescents Should Include Screening Questions for Bipolar Disorder **[MS]**.

Screening questions include inquiries about distinct, spontaneous periods of mood changes associated with sleep disturbances and psychomotor activation. Histories of depression and family histories of mood disorders are also important to assess. Symptoms of irritability, reckless behaviors, or increased energy are important to assess, but they occur in a number of different conditions and therefore lack specificity. Because emotional and behavioral difficulties in children are often context dependent, it is important to assess symptom reports in perspective given family, school, peer, and other psychosocial factors, rather than simply using a checklist to identify psychopathology.

Assessment

Recommendation 2: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (May 2000 text revision) (DSM-IV-TR) Criteria, Including the Duration Criteria, Should Be Followed When Making a Diagnosis of Mania or Hypomania in Children and Adolescents **[MS]**.

Manic-like symptoms of irritability and emotional reactivity may be found in a number of conditions, including disruptive behavior disorders, posttraumatic stress disorder, and pervasive developmental disorders. Manic grandiosity and irritability present as marked changes in the individual's mental and emotional state, rather than reactions to situations, temperamental traits, negotiation strategies, or anger outbursts. The pattern of illness, duration of symptoms, and association with psychomotor, sleep, and cognitive changes are important diagnostic clues. The illness represents a marked departure from baseline functioning, and it should be evident and impairing in different realms of the child's life (i.e., not isolated to one setting). Acute psychosis in an adolescent may be the first presentation of mania, and it needs to be carefully assessed for other associated features, including a marked decrease in the need for sleep, affective lability, a lack of negative symptoms, and/or a positive family history.

The diagnostic assessment needs to incorporate both current and past history regarding symptomatic presentation, treatment response, psychosocial stressors, and family psychiatric history. It is helpful to organize the clinical information using a life chart to characterize the course of illness, patterns of episodes, severity, and treatment response. Using such a longitudinal perspective to conceptualize the disorder helps with diagnostic accuracy because the presenting symptoms during the acute phases often can be confused with other disorders. Cross-cultural issues may influence the expression or interpretation of symptoms and/or treatment response, and therefore must be assessed.

Structured diagnostic interviews and questionnaires are available that may be helpful for diagnosing bipolar disorder in youth, with the Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS) and the Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS) being the most commonly used diagnostic tools in published research. The Young Mania Rating Scale (YMRS) is commonly used in research to assess the severity of manic symptoms, and assess treatment response. However, the YMRS is not a diagnostic instrument. There are no biological tests, including imaging or genetic studies that are helpful in making the diagnosis of a bipolar disorder.

Recommendation 3: Bipolar Disorder Not Otherwise Specified (NOS) Should Be Used to Describe Youths With Manic Symptoms Lasting Hours to Less Than 4 Days or for Those With Chronic Manic-Like Symptoms Representing Their Baseline Level of Functioning **[CG]**.

Children with manic symptoms lasting hours to less than 4 days, or with chronic manic-like symptoms are significantly impaired. Until it is clear that this condition is really continuous with adult-type bipolar disorder for which the treatment literature applies, such youths should be characterized as classified as having bipolar disorder NOS, with the recognition that is a scant evidence base from which to extrapolate treatment recommendations. Youths characterized as having bipolar disorder NOS typically have high rates of comorbid disorders including attention-deficit hyperactivity disorder (ADHD), disruptive behavior disorders, posttraumatic stress disorder, anxiety disorders, and developmental disorders. Their mood states are generally volatile and reactive. It is important to examine for environmental triggers, patterns of events that reinforce the outbursts, significant pragmatic language impairment, and risk factors (e.g., history of maltreatment).

Recommendation 4: Youths With Suspected Bipolar Disorder Must Also Be Carefully Evaluated for Other Associated Problems, Including Suicidality, Comorbid Disorders (Including Substance Abuse), Psychosocial Stressors, and Medical Problems **[MS]**.

A thorough workup can rule out other confounding illnesses and identify comorbid disorders that need to be addressed as part of a comprehensive treatment plan. Adolescents with bipolar disorder are reported to have high rates of suicide attempts and are clearly at risk of completed suicides. Rates of substance abuse are high in this population. Assessments for developmental, cognitive, or speech and language disorders also may be indicated.

Recommendation 5: The Diagnostic Validity of Bipolar Disorder in Young Children Has Yet to Be Established. Caution Must Be Taken Before Applying This Diagnosis in Preschool children **[MS]**.

Preschool children who present with mood and behavioral concerns must be carefully assessed for other contributing factors, including developmental disorders, psychosocial stressors, parent-child relationship conflicts, and temperamental difficulties. The interpretation of adult diagnostic criteria in very young children is a major challenge. There are no definitive studies outlining a developmentally valid method for assessing manic symptoms in this age group, including grandiosity, flight of ideas, and attention that is too easily drawn to irrelevant stimuli. Moreover, patterns of disrupted sleep and energy must be assessed in the context of the developmental period. Highly volatile and reactive toddlers need assessment and intervention, but whether such youths have bipolar disorder, as defined by the adult literature, has not been established. The diagnosis of a bipolar spectrum disorder in very young children potentially exposes them to aggressive pharmacotherapy. There are reports describing the use of mood stabilizers and atypical antipsychotics in this age group. The short- and long-term safety of mood stabilizers and atypical antipsychotic agents for this indication in young children has not been established. It is particularly important with preschoolers that intervention strategies address environmental, developmental, temperamental, and social factors that may relate to symptom presentation.

Treatment

Somatic Treatments

Recommendation 6. For Mania in Well-Defined DSM-IV-TR Bipolar I Disorder, Pharmacotherapy Is the Primary Treatment **[MS]**.

Standard therapy, based on the adult literature, typically includes lithium, valproate, and/or atypical antipsychotic agents, with other adjunctive medications used as indicated. The choice of medication(s) should be made based on (1) evidence of efficacy, (2) the phase of illness, (3) the presence of confounding presentations (e.g., rapid cycling mood swings, psychotic symptoms), (4) the agent's side effect spectrum and safety, (5) the patient's history of medication response, and (6) the preferences of the patient and his or her family. A history of treatment response in parents may predict response in offspring. Pharmacokinetic parameters of psychotropic agents may vary in different ethnic groups, with a

potential impact on side effects, blood levels, efficacy, and cultural expectations. Although multiple agents are often required, care should be taken to avoid unnecessary polypharmacy.

Treatment should begin with an agent that is approved by the United States Food and Drug Administration (FDA) for bipolar disorder in adults, recognizing that the evidence of the efficacy for these agents in children and adolescents is sparse at best, including the following:

- Lithium is approved down to age 12 years for acute mania and maintenance therapy.
- Aripiprazole, valproate, olanzapine, risperidone, quetiapine, and ziprasidone are approved for acute mania in adults. Chlorpromazine is also approved for acute mania in adults, but it is generally not used as a first-line agent.
- Both lamotrigine and olanzapine are approved for maintenance therapy in adults.
- The combination of olanzapine and fluoxetine is approved for bipolar depression in adults.

Antidepressants (selective serotonin reuptake inhibitors [SSRIs] or nontricyclics) may be useful adjuncts for depression as long as the patient is also taking at least one mood stabilizer. Caution must be taken, however, because antidepressants may destabilize the patient's mood or incite a manic episode. It is important to note that a manic episode precipitated by an antidepressant is characterized as substance induced per DSM-IV-TR. Manic symptoms associated with an SSRI may represent the unmasking of the disorder or disinhibition secondary to the agent. Clinicians should also be aware of the concerns regarding the efficacy and safety (included suicidality) of antidepressants in youths.

Recommendation 7: Most Youths With Bipolar I Disorder Will Require Ongoing Medication Therapy to Prevent Relapse; Some Individuals Will Need Lifelong Treatment **[CG]**.

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, 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 after discussing the risks and benefits of continued treatment.

Until more definitive information is available about the long-term effects of mood stabilizers and antipsychotics, the clinician must balance the potential deleterious impact of symptom reoccurrence versus that of the side effects of the medications. Any attempts to discontinue prophylactic therapy should be done gradually, while closely monitoring the patient for relapse. Furthermore, patients and families must be thoroughly educated as to the early signs and symptoms of mood episodes so that, if necessary, resumption of treatment occurs as soon as possible. Diagnostic status should also be reviewed over time to ensure that the course of medication therapy is justified.

Recommendation 8: Psychopharmacological Interventions Require Baseline and Follow-up Symptom, Side Effect (Including Patient's Weight), and Laboratory Monitoring as Indicated **[MS]**.

Medication trials should be as systematic as possible, with the duration of trials sufficient to determine the agent's effectiveness. In general, a 6- to 8-week trial of a mood-stabilizing agent is recommended, using adequate doses, before adding or substituting other mood stabilizers. Phase of illness is an important consideration when choosing a medication. Care should be taken to avoid unnecessary polypharmacy, in part by discontinuing agents that have not demonstrated significant benefit.

Before the initiation of lithium therapy, baseline laboratory assessment should include complete blood cell counts; thyroid function tests; urinalysis; blood urea nitrogen, creatinine, and serum calcium levels; and a pregnancy test in female adolescents. Once a stable lithium dose is obtained, lithium levels, renal and thyroid function, and urinalyses should be monitored regularly (every 3-6 months). For valproate, baseline liver function tests, complete blood cell counts, and pregnancy tests are recommended. Serum drug levels, plus hepatic and hematological indices, should be monitored periodically (every 3-6 months). However, it is also important to advise patients and families about presenting symptoms of potential adverse effects because periodic monitoring does not ensure that abnormalities will be readily identified. Finally, clinicians should be aware of the concerns raised regarding valproate and the development of polycystic ovary disease in females.

The atypical antipsychotics as a class are associated with significant weight gain and other metabolic problems (e.g., type 2 diabetes, hyperlipidemia). Thus, the American Dietetic Association's recommendations for managing weight gain for patients taking antipsychotics should be followed. This includes baseline body mass index, waist circumference, blood pressure, fasting glucose, and a fasting lipid panel. The body mass index should be followed monthly for 3 months and then quarterly. Blood pressure, fasting glucose, and lipids should be followed up after 3 months and then yearly. Some agents have additional monitoring requirements (e.g., white blood cell counts with clozapine). Extrapyramidal side effects, including tardive dyskinesia, may occur with atypical agents and need to be monitored.

Recommendation 9. For Severely Impaired Adolescents With Manic or Depressive Episodes in Bipolar I Disorder, Electroconvulsive Therapy (ECT) May Be Used If Medications Either Are Not Helpful or Cannot Be Tolerated **[OP]**.

In adults, ECT is an effective treatment for mania, but it is generally offered only for patients who have not responded to standard medication treatment. ECT is safe as long as modern methods are used (i.e., appropriate anesthesia, alterations in the delivery of the electrical stimulus, the selected use of unilateral treatment, and cardiopulmonary monitoring). ECT is generally considered the treatment of choice for bipolar disorder in the following clinical situations: (1) pregnancy, (2) catatonia, (3) neuroleptic malignant syndrome, and (4) any other medical condition in which more standard medication regimens are contraindicated.

Case reports indicate that ECT may be beneficial for youths with bipolar disorder (including mania, rapid cycling, and depressed phases), although the literature at this time is extremely limited. ECT should only be considered for adolescents with well-characterized bipolar I disorder who have severe episodes of mania or depression and are nonresponsive (or unable to take) standard medication therapies. ECT should not be considered an option for cases best described as bipolar disorder NOS or the atypical presentations of juvenile mania. Potential side effects include short-term cognitive impairment, anxiety reactions, disinhibition, and altered seizure threshold.

Psychotherapeutic Interventions

Recommendation 10. Psychotherapeutic Interventions Are an Important Component of a Comprehensive Treatment Plan for Early-Onset Bipolar Disorder [**MS]**.

The development of bipolar disorder during childhood or adolescence disrupts ongoing developmental processes, including academic, social, and family functioning. Therefore, a comprehensive, multimodal treatment approach that combines psychopharmacology with adjunctive psychosocial therapies is almost always indicated for early onset bipolar disorder. Although medications help with the core symptoms of the illness, they do not necessarily address the associated functional and developmental impairments and the frequent need for support and skills building. Preexisting behavior disorders, substance abuse disorders, learning problems, and confounding psychosocial issues may require additional and specific treatments related to those problems once the affective episode is stabilized. Psychotherapeutic interventions are needed to promote medication compliance and avoid relapse. Finally, interventions are needed to help youths and families cope with the developmental impact on peer relationships, academic performance, and psychological health.

Extrapolation from the adult literature plus preliminary studies suggests several areas in which psychotherapeutic interventions should be directed:

1. *Psychoeducational therapy*. Information should be provided to both the patient and family regarding the symptoms and course of the disorder, treatment options, the potential impact of the illness on psychosocial and family functioning, and the heritability of the disorder.
2. *Relapse prevention*. Education should be provided to the patient and family regarding the impact of noncompliance with medications, the recognition of emergent relapse symptoms, and other factors that may precipitate relapse (e.g., sleep deprivation, substance abuse). Stress reduction and the promotion of stable social and sleep habits may be particularly helpful areas to target, especially for adolescents. Medication noncompliance is a major contributor to relapse. Therefore, efforts must be made to educate both the patient and family about the importance of ongoing treatment as well as dealing with psychological resistance to taking medication. Establishing a strong therapeutic relationship and providing regular follow-up assessments are important in maintaining compliance.
3. *Individual psychotherapy*. Based on studies of cognitive-behavioral therapy and interpersonal therapy in adults as well as clinical consensus of therapy

with bipolar youths, individual psychotherapies support psychological development, skill building, and close monitoring of symptoms and progress.

4. *Social and family functioning*. Bipolar disorder significantly affects social, family, academic, and developmental functioning. Therefore, in addition to efforts directed at reducing further episodes, psychosocial interventions are needed to address the myriad of disruptions that emerge in the wake of the disorder. Efforts to enhance family and social relationships, including therapies directed at communication and problem-solving skills, are likely to be helpful. Cultural issues must be taken into account when devising psychotherapeutic strategies.
5. *Academic and occupational functioning*. The educational needs of youths with bipolar disorder must be adequately addressed to help promote long-term academic growth, especially given the high rates of comorbid disruptive behavior disorders. School consultation and an individual educational plan are often necessary to help develop an appropriate educational environment. Some youths will need specialized educational programs, including day treatment or partial hospitalization programs. For older teenagers, vocational training and occupational support may also be important needs to address.
6. *Community consultation*. Consultation may be needed with other involved community, juvenile justice, and/or social welfare programs. Some youths, because of either the severity of their symptoms or confounding environmental stressors, will need referral for intensive community-based services to maintain them at home. Alternatively, some patients may need foster care or residential services. Finally, patients and families often receive benefit by participating in community support and advocacy programs.

Recommendation 11. The Treatment of Bipolar Disorders NOS Generally Involves the Combination of Psychopharmacology With Behavioral/Psychosocial Interventions **[CG]**.

Strategies for treating bipolar disorder NOS are not well defined because it is not clear how well the adult bipolar treatment literature extrapolates to this population. Intervention strategies should be based on the specific symptom presentations of the child, comorbid conditions, and family needs rather than initiating standard protocols for bipolar I disorder. Evidence-based therapies for behavioral difficulties should be used. Dialectical behavioral therapy may be helpful for youths with mood and behavioral dysregulation.

Mood stabilizers and atypical antipsychotics are often used to help control severe mood lability and explosive outbursts. In general, although open trials have supported efficacy for juvenile mania, the impact of medication treatment on outcome remains in question. The specificity of the treatment response is unclear because these agents also help in the treatment of aggression, with risperidone being the agent best studied to date.

Other medications, including stimulants and antidepressants, may be used to treat comorbid ADHD or associated depression. Perhaps the most common dilemma is whether and when to use stimulants in children when there is a question of whether one is dealing with mania/hypomania or ADHD with mood lability and low frustration tolerance.

Definitions:

Categories of Endorsement for the Recommendations

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[NE] Not endorsed refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate care with use of acceptable practices for children and adolescents with bipolar disorder

POTENTIAL HARMS

- Side effects of pharmacological agents. For example, atypical antipsychotics as a class are associated with significant weight gain and other metabolic problems (e.g. type 2 diabetes, hyperlipidemia); extrapyramidal side effects, including tardive dyskinesia, may occur with atypical agents.

- Side effects of electroconvulsive therapy (ECT), including short-term cognitive impairment, anxiety reactions, disinhibition, and altered seizure threshold.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The interpretation of adult diagnostic criteria in very young children is a major challenge. There are no definitive studies outlining a developmentally valid method for assessing manic symptoms in this age group, including grandiosity, flight of ideas, and attention that is too easily drawn to irrelevant stimuli. Moreover, patterns of disrupted sleep and energy must be assessed in the context of the developmental period.
- Because there are limited studies in youths, most of the treatment recommendations for early-onset bipolar disorder are derived from the adult literature for acute mania.
- Although the medications used in adults may be helpful, youths may be more difficult to treat and likely also need additional interventions in conjunction with pharmacotherapy.
- Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision making. American Academy of Child and Adolescent Psychiatry practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 2007 Jan)

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by: Jon McClellan, M.D.; Robert Kowatch, M.D.; Robert L. Findling, M.D.

Work Group on Quality Issues Members: William Bernet, M.D. (Co-Chair); Oscar Bukstein, M.D. (Co-Chair); Joseph Beitchman, M.D.; R. Scott Benson, M.D.; Joan Kinlan, M.D.; Ulrich Schoettle, M.D.; Jon Shaw, M.D.; Saundra Stock, M.D.; Heather Walter, M.D.

AACAP Staff: Kristin Kroeger Ptakowski

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Members of the consensus group were asked to identify any conflicts of interest they may have with respect to their role in reviewing and finalizing the content of the Practice Parameter.

- Dr. McClellan has received a research grant from Pfizer.

- Dr. Findling receives or has received research support, acted as a consultant, and/or served on the speakers' bureau of Abbott, AstraZeneca, Bristol-Myers Squibb, Celltech-Medeva, Forest, Glaxo SmithKline, Johnson & Johnson, Lilly, New River, Novartis, Otsuka, Pfizer, Sanofi-Aventis, Shire, Solvay, and Wyeth.
- Dr. Kowatch has no financial relationships to disclose.

GUIDELINE STATUS

This is the current release of the guideline.

This updates a previous version: Practice parameters for the assessment and treatment of children and adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):157S-177S.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

A CD-ROM containing all parameters is available for a fee. See the AACAP Publication Store for more information.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This NGC summary was updated by ECRI on March 5, 2007. The updated information was verified by the guideline developer on April 3, 2007. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This summary was updated by ECRI Institute on January 10, 2008, following the U.S. Food and Drug Administration advisory on Carbamazepine.

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