



# Bipolar Disorder in Youth

Scoping Review on Approaches to  
Detection and Early Intervention

February 2024

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# Executive Summary

Youth Wellness Hubs Ontario (YWHO) is an Integrated Youth Services (IYS) initiative that supports local service providers across the province to work together to provide young people aged 12-25 with access to a range of services to support their needs. In 2023, with support from the Daymark Foundation, YWHO conducted a scoping review to identify and understand early detection and intervention approaches for youth with/at risk of developing bipolar disorder (BD).<sup>\*</sup> Themes from both the research literature and stakeholder opinion (including youth, service providers, and researchers) were generally consistent regarding the importance of early detection and intervention, and related knowledge and knowledge gaps with respect to guidelines and evidence-based approaches.

## **Research and Knowledge Translation**

An important finding was the relative lack of general research focused on BD in youth, compared to other disorders and to adult populations, and the identified need for more focused attention and investment, including with respect to:

- Examination of the clinical utility/ relevance of stages of BD compared to the current 'sub-types' paradigm
- Confirmation of the optimal timing for early intervention
- Understanding service access barriers and service needs for youth with BD in general, and for youth with BD from health equity-deserving populations in particular
- Development/adaptations of psychotherapeutic interventions appropriate for youth with BD
- Identification of the most effective ways for youth-serving contexts to engage youth with BD into services and to implement evidence-based early detection/interventions for different youth populations (e.g., youth from different health equity-deserving groups, youth at different developmental stages)
- Identification of biomarkers of BD in youth

- Validation of existing adult screening tools for use with youth with BD
- Development of new screening tools for youth with BD.

### **Service Provider Capacity Building**

This review identified a number of gaps in service provider capacity to support youth with BD. With respect to early detection, it was noted that BD in youth is frequently either under- or over-diagnosed, given different circumstances – both of which can have significant negative consequences for the short- and long-term treatment of BD in youth. All stakeholders, including youth, highlighted that many health professionals struggle with identifying, screening and assessing youth for BD/risk of development BD, and to differentiate BD from other co-occurring disorders – particularly ADHD.

Although almost half have experience with Cognitive Behavioural Therapy (CBT), only a small proportion of service providers reported receiving training in Interpersonal and Social Rhythm Therapy (IPSRT), Family Focused Therapy (FFT), and traditional healing methods. Building the capacity of providers to offer a range of early intervention options is important, particularly in the context of recommendations from youth that more options should be available to them that meet their needs and preferences.

More generally, survey results suggested that service providers may need more training to support youth from health equity-deserving communities who have or are at risk of BD. There may also be important differences in capacity between different service provider roles that would be important to address. For example, front-line staff who responded to the online survey reported less confidence, relative to administrative roles, in supporting chosen families/caregivers of youth with BD and accessing appropriate resources.

### **Help-Seeking and Engagement in BD Services**

There was general consensus, across all data sources, that early intervention for BD in youth is critically important. Researchers reported that the significant “10-year gap” – cited in older research literature – between when BD is first detected (most commonly in youth) and when individuals are engaged in treatment – likely persists. The reasons for this were noted as complex and include concerns among youth regarding the perceived “life sentence” of a BD diagnosis, the stigma associated with mental health concerns in general (and BD in particular), limited service availability, and significant access barriers. All stakeholders, youth included, highlighted the importance of a strong focus on engaging youth in services and being careful to respect their wishes for treatment (e.g., preferences for psychotherapeutic interventions instead of medications) as an important way of engaging and retaining them in services. Youth also recommended that more work needs to be done to educate youth about BD (and what is available to support them) and to ensure that youth have multiple treatment options to meet their diverse needs and preferences. Service providers responding to the online survey also emphasized that more work is needed to get a better understanding of what aspects of youth experiences of BD prevent them from seeking supports.

One important area of focus across stakeholder groups was the complex and potentially significant role of social media with respect to both informing/misinforming youth about BD and, by extension, encouraging/discouraging youth to seek support. Researchers suggested that more work is needed to minimize negative impacts while also leveraging social media to better inform youth and encourage help-seeking given its potential power in reaching and influencing youth. Youth also

highlighted that they need more support to identify credible sources of information about BD from different social media platforms and to manage more general negative impacts – particularly bullying.

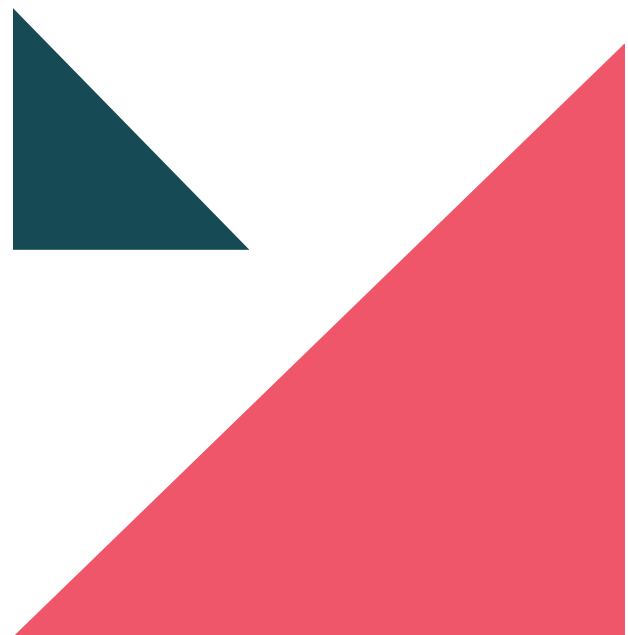
The review also sought to identify considerations for developing/ implementing early detection/intervention approaches within youth-serving contexts, as well as identifying the extent to which youth with BD from health equity-deserving populations in particular may require unique approaches to support help-seeking, engagement, and achievement of positive treatment outcomes. It was noted that there was less focus and direction in these areas in the literature reviewed and in the perspectives of researchers consulted. It is not clear whether this reflects limitations of the review process itself (e.g., limited number of researchers consulted) or whether this reflects a general lack of attention in the research community. Researchers consulted as part of this review suggested that these areas may indeed be actual (and important) research gaps. When asked how best to help prepare the service context to offer early interventions for youth with BD, service providers who responded to the online survey identified as highly important: work to better understand the experience of BD across various communities/cultures/ identities; improving access to services; and as noted above, building service provider capacity to better support youth with BD.

### **Evidence-Based Guidelines and Interventions**

A common theme, from both the research literature and expert opinion, was the general lack of guidelines regarding the operationalization of what constitutes “early” with respect to both detection and intervention, and which interventions are most appropriate for earlier/earliest

intervention among youth with BD. While there was clear consensus that pharmacotherapy, and lithium in particular, is the recommended first-line treatment for BD in youth, the need for more pharmacotherapy research was still highlighted, such as the best approach for treating depressive symptoms in youth with BD. There were also some conflicting perspectives, including among youth, regarding the use of pharmacotherapy before a BD diagnosis is made.

It was also identified that psychotherapeutic interventions should be considered an important adjunctive approach to pharmacotherapy. However, more research is needed to confirm whether existing BD therapeutic interventions are effective for youth (or whether different interventions are needed), given that most existing psychotherapeutic treatment interventions for BD have been primarily studied in adult populations. Service providers also highlighted this as an area of importance, in addition to ensuring that the development/ identification of therapeutic interventions for youth with BD are youth- and service provider-informed/co-created.



# | Introduction

## Background

Youth aged 12-24 years experience the highest incidence of mental health (MH) and substance use (SU) disorders of any age group, including bipolar disorder (BD). However, fewer than 50% of these youth receive the services they need to support them.<sup>i</sup>

To ensure that such services are meeting the needs of youth with BD, and to prevent long-term BD illness and disability in youth, a scoping review was conducted, focusing on identifying and understanding early detection and intervention<sup>ii</sup> approaches specifically targeting youth with BD.

## Project Objectives

This project was designed to meet the following objectives:

1. Identify existing knowledge and knowledge gaps regarding early detection and intervention for youth with BD
2. Identify evidence-based approaches for early detection and intervention for youth with BD.

## Methodology

### Literature Review

Research and grey literature were identified through scholarly database searches (MEDLINE, EMBASE, PsycInfo, CINAHL, Google Scholar); general internet searches (Google); manual searches of reference lists of highly relevant documents; and literature referenced in examples of identified innovations. Search terms were identified collaboratively with the project team and based on input from stakeholder consultations. Searches were inclusive of international literature but were limited to articles published in English since 2010.

An initial search produced N=1672 records. Of these, the abstracts of N=397 publications were screened, N=61 full text articles were reviewed, and N=51 identified for inclusion in the annotated bibliography. An additional N=13 articles were identified and annotated, based on the recommendations of stakeholders and a review of

*Bipolar disorder (BD) is a brain disorder that causes changes in a person's mood, energy, and ability to function. People with BD experience intense emotional states that typically occur during distinct periods of days to weeks, called mood episodes. These mood episodes are categorized as manic/hypomanic (abnormally happy or irritable mood) or depressive (sad mood). People with BD have periods of neutral mood, as well. When treated, people with BD can lead full and productive lives.<sup>iii</sup>*

*Bipolar I disorder (BD I) is diagnosed when a person experiences a manic episode. During a manic episode, people with BD I experience an extreme increase in energy and may feel on top of the world or uncomfortably irritable in mood. Some people with BD I also experience depressive or hypomanic episodes, and most people with BD I also have periods of neutral mood.<sup>iii</sup>*

references in annotated literature. In instances where a systematic review was updated, only the most recent review was included for annotation and analysis. A total of 64 articles were annotated.\*\*

## Stakeholder Consultations

### Researchers

Invitations were sent to nine researchers in the field of BD, who were identified based on the recommendations of members of the project team, the project funder, and researchers consulted. The following five Canadian and international experts accepted the invitation and participated in an interview with a member of the project team:

- **Dr. Phillip Conus**, Professor of Psychiatry at Lausanne University, Switzerland; Vice-president for Europe of the IEPA-Early Intervention in Mental Health
- **Dr. Sue Cotton**, Head, Health Services and Outcomes Research, Orygen, Australia
- **Dr. Ben Goldstein**, Clinician Scientist; Director, Centre for Youth Bipolar Disorder, Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health (CAMH), Canada
- **Dr. Mel Hasty**, Project Manager/Senior Clinical Psychologist, Orygen, Australia
- **Dr. Elizabeth A. Osuch**, Professor; Rea Chair of Affective Disorders; Founder, Medical Lead: First Episode Mood & Anxiety Program (FEMAP); Scientist, Lawson Health Research Institute, Schulich School of Medicine and Dentistry, University of Western Ontario, Canada

Consultations were conducted via videoconference and generally lasted 60 minutes. All interviews were structured according to a consultation guide, developed in collaboration with the project team, and covered the following areas:

- *Recommended approaches* for early identification/intervention of BD/risk of BD in youth, including those that incorporate the perspectives of youth and families
- *Implementation challenges and opportunities* related to supporting BD early identification/intervention for youth
- *Roles of different MH service providers* in BD early identification/intervention for youth

***Bipolar II disorder (BD II).*** A diagnosis of BD II requires someone to have at least one major depressive episode and at least one hypomanic episode. People return to their usual functioning between episodes. People with BD II often first seek treatment as a result of their first depressive episode since hypomanic episodes often feel pleasurable and can even increase performance at work or school.

*People with BD II frequently have other mental health concerns such as an anxiety disorder or substance use disorder, the latter of which can exacerbate symptoms of depression or hypomania.<sup>iii</sup>*

***Early intervention*** broadly refers to interventions from the first manic episode in BD type I. In BD type II, early interventions may target those with at least moderate to severe depressive episodes and past episodes of hypomania (Stage 2 disorder). Interventions prior to these stages may be considered to be preventive interventions or pre-onset interventions.<sup>ii</sup>

- *Research gaps* related to BD early identification/intervention, including with respect to specific population groups
- *Research currently underway* but not yet publicly available
- *Recommendations* regarding additional sources of information for this project.

### **Youth and Youth Caregivers/Supporters**

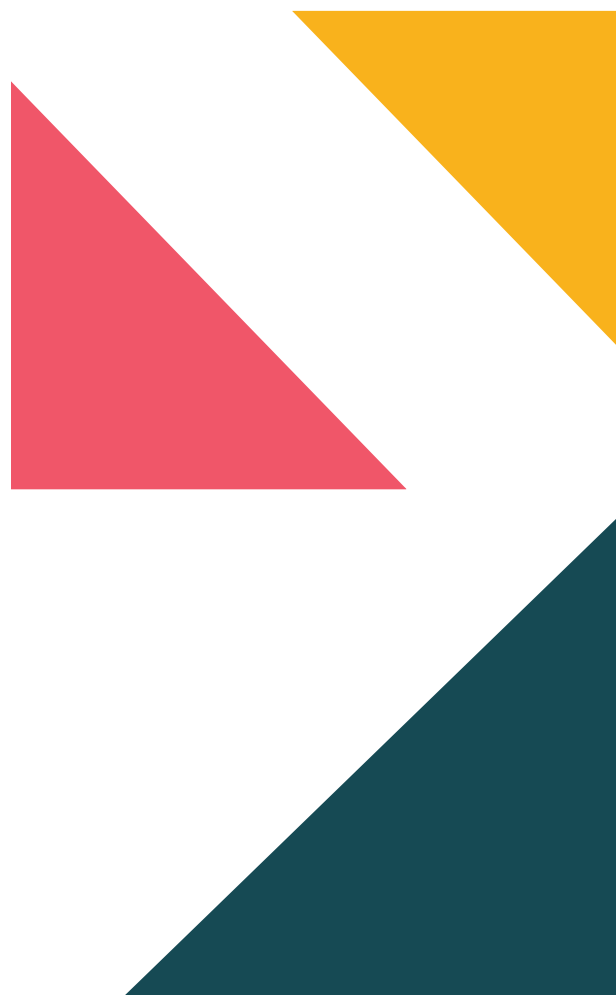
Youth between the ages of 12-35 years and youth caregivers/supporters (e.g., chosen supports, parents, siblings of youth with BD) living in Ontario were invited to participate in a two-hour virtual consultation focused on early identification and intervention for youth with BD.<sup>iv</sup> Youth and youth caregivers/supporters were recruited in April 2023 via the distribution of a poster (available in both English and French) to over 50 agencies/stakeholder groups supporting youth/young adults (e.g., IYS, other youth and family services, clinical, research, education, professional conferences, etc.). The recruitment poster emphasized interest in hearing from diverse individuals with lived/living experience of BD, including Black youth, Indigenous youth, youth of colour, 2SLGBTQ+ youth, youth with disabilities, and refugee and newcomer youth – along with those who support them. The poster also highlighted that all participants in a consultation would receive an honorarium. A structured interview guide was co-developed by members of the project team as well as evaluators and clinicians and informed by consultations with researchers and the results of the literature review.

A total of N=5 youth/caregivers/supporters participated in consultations.

### **Service Provider Survey**

Members of the project team distributed an online survey to service providers and other individuals supporting youth in Ontario (not necessarily youth with lived/living

experience of BD). The survey, available in both English and French and administered through SurveyMonkey, was broadly distributed via project team members and various youth-focused professional networks to clinical, primary care, research-based, and educational organizations and IYS across Ontario. It was open between June 12 – July 17, 2023. The survey asked respondents to share their perspectives regarding what is helpful with respect to early identification and intervention for youth with BD, as well as their knowledge and confidence levels in working with youth with BD. The survey was designed to take between 10-12 minutes to complete. A total of 121 service providers completed the survey.





# | Results

## Findings from the Literature<sup>v</sup>

This section presents a high-level summary of relevant themes from all referenced literature. It is important to note that confirmation of the level of evidence for these different areas was out of scope for the review. Reference to specific literature is provided in parentheses.

### Lacking sufficient research on BD in youth

An important theme identified in recent systematic reviews was the general paucity of BD research focused on youth populations relative to adult populations<sup>(20, 50, 62, 63)</sup>, though a recent systematic review noted a significant increase in research focused on clinical interventions specifically for youth<sup>(7)</sup>.

### Early detection/identification

#### Risk factors

A broad range of risk factors and signs of BD in youth were identified and discussed in the research literature – most commonly family history of BD, depression, anxiety, cyclothymia, and mania:

- Family history of BD<sup>(1, 2, 3, 7, 16, 18, 19, 21, 24, 27, 31, 34, 47, 52, 55, 58)</sup>
- Depression<sup>(1, 3, 7, 10, 11, 17, 18, 19, 21, 27, 34, 46, 52, 58)</sup>
- Anxiety<sup>(7, 11, 17, 18, 19, 21, 28, 43, 46, 58)</sup>
- Cyclothymia<sup>(10, 19, 27, 28, 34, 52, 56, 57)</sup>
- Mania<sup>(7, 10, 11, 19, 21, 34, 52, 58)</sup>
- Adverse child experiences/trauma<sup>(10, 18, 19, 21, 46)</sup>
- Attention-deficit hyperactivity disorder<sup>(18, 21, 22, 27, 43)</sup>
- Mood lability<sup>(7, 10, 18, 58)</sup>
- Substance use<sup>(10, 18, 34, 46)</sup>
- Suicidality<sup>(11, 18, 21, 46)</sup>
- Sleep problems<sup>(17, 18, 33)</sup>

#### Evidence of a long prodrome in BD

Evidence of a long prodrome<sup>vi</sup> in BD (with typical onset in youth) provides an important window for early identification and detection.<sup>(14, 19, 27, 28, 43)</sup>

#### Process to identify/diagnose BD in youth

- Fear of stigma related to the label of BD/mental illness is an important barrier to youth seeking support<sup>(10, 64)</sup>

*Cyclothymic disorder is a milder form of BD involving many “mood swings,” with hypomania and depressive symptoms that occur frequently. People with cyclothymia experience emotional ups and downs but with less severe symptoms than BD I or BD II.<sup>iii</sup>*

*The BD prodrome comprises precursor symptoms, functional impairments, and other psychiatric diagnoses present in the months or years prior to bipolar disorder onset.<sup>vi</sup>*

- Due to different circumstances, BD in youth can be either under-diagnosed or over-diagnosed, both of which present specific challenges for treatment and management <sup>(21, 64)</sup>
- There is a lack of reliable biomarkers of BD and/or risk of developing BD, in general and specific to youth <sup>(3, 16, 19, 31, 27, 58)</sup>
- Early detection of BD among help-seeking youth is feasible <sup>(6, 34)</sup>
- Diagnosis of BD in youth should be made based on the same set of symptoms as for adults <sup>(21, 64)</sup>
- Screening for co-occurring disorders is important <sup>(21, 26)</sup>
- Questionnaires can be used as screeners but do not replace a thorough diagnostic evaluation. <sup>(64)</sup>

**Biomarkers** are objective indications of a medical state or disorder that can be observed from outside the patient and measured accurately and reliably. Biomarkers differ from medical symptoms which are limited to indications of health or illness that are perceived by patients themselves.<sup>vii</sup>

**Clinical staging** describes where an individual's illness presentation can be placed on a temporal spectrum of disorder progression. Illness staging is widely used in several medical disciplines, including psychiatry, to help predict course or prognosis, and optimize treatment.<sup>viii</sup>

**Recommended areas for research**

- Confirmation of risk factors and signs/symptoms that can be applied in clinical practice; including for youth populations <sup>(19, 27, 58)</sup>
- Confirmation of BD sub-types in youth <sup>(54)</sup>
- Development/validation of diagnostic tools for youth population <sup>(46, 58, 59)</sup>
- Use of the staging<sup>viii</sup> model for diagnosis for general BD population, including youth <sup>(6, 64)</sup>

**Early intervention**

**Earlier intervention is important**

It was generally acknowledged that early intervention for youth with BD is important <sup>(4, 5, 8, 13, 16, 17, 24, 35, 43, 48, 58)</sup> and *effective* <sup>(39, 43)</sup> but is challenged by the *absence of clinical guidelines* <sup>(8, 10, 12, 13, 35, 42, 64)</sup>, including with respect to the ideal time to intervene early (e.g., when risk is first identified; within a specific period following diagnosis) and specific interventions for different populations (including youth) and at different stages of the disorder. <sup>(28, 35, 41, 42, 53)</sup>

- Primary prevention recommended/shows promise for youth, <sup>(8, 24, 31, 38)</sup> but effects are small and short-lived <sup>(31)</sup>
- Early pharmacological treatment identified as important for treatment outcomes in the general BD population. <sup>(49)</sup>

### **Evidence-based interventions**

- Pharmacological treatments are generally considered first and second-line treatments, including for youth<sup>(8, 12, 64)</sup>
- Psychoeducation and psychotherapy are also important adjunctive interventions<sup>(8, 30, 64)</sup>. A range of interventions were reviewed/discussed in the literature. There was generally more consensus regarding the strength of the evidence base for family focused therapy/psychoeducation for youth with BD, relative to other forms of treatment. The most commonly identified interventions were:
  - Family focused therapy/psychoeducation<sup>(8, 10, 21, 22, 37, 38, 39, 42, 49, 50, 53, 60, 62, 64)</sup>
  - CBT-based interventions<sup>(8, 10, 21, 43, 49, 50, 53, 56, 30, 64)</sup>
  - Youth psychoeducation<sup>(8, 10, 16, 17, 30, 43, 30, 62, 64)</sup>
  - Interpersonal and social rhythm therapy (IPSRT)<sup>(8, 10, 21, 23, 29, 42, 50, 60, 64)</sup>
  - General psychotherapy<sup>(6, 8, 10, 21, 28, 33, 64)</sup>
  - Mindfulness-based CBT<sup>(8, 9, 15, 42, 50, 64)</sup>
  - Dialectical behaviour therapy (DBT).<sup>(8, 21, 60, 64)</sup>

### **Targets for early intervention**

A range of treatment targets were identified for early BD intervention among youth including:

- Intensive family involvement/family functioning<sup>(32, 35, 60, 62)</sup>
- Co-morbid issues<sup>(32, 35, 53)</sup>
- Understanding of BD and its impacts on different life areas<sup>(32, 60)</sup>
- Coping skills/self-management<sup>(32, 60)</sup>
- Interpersonal/social skills and functioning<sup>(32, 61)</sup>
- Occupational functioning<sup>(32, 35)</sup>
- Physical health<sup>(35, 53)</sup>
- Cognitive functioning<sup>(61)</sup>

- Developmental processes<sup>(53)</sup>
- Medication adherence<sup>(32)</sup>
- Relapse prevention.<sup>(32)</sup>

### **Evidence of a significant time gap between emergence of BD and treatment**

Evidence of a significant time gap between emergence of BD, which typically presents in youth, and treatment<sup>(10, 13, 21, 44, 56, 64)</sup> was also commonly identified:

- Earlier age of onset tends to have longer delay to treatment<sup>(41, 61)</sup> and worse outcomes<sup>(2, 44, 64)</sup>
- Reasons: diagnostic difficulties<sup>(10, 21, 64)</sup>; lack of help-seeking<sup>(10, 21, 64)</sup> including among youth with cyclothymia<sup>(56)</sup>; fear of stigma related to the label of BD/mental illness.<sup>(10, 48, 64)</sup>

### **Recommended areas for research**

- Efficacy of prevention/early interventions for youth, including for youth of different ages and at different stages of illness<sup>(8, 19, 20, 22, 42, 58, 64)</sup>
- Developmentally appropriate modifications to existing adult interventions<sup>(19)</sup>
- Mechanisms of change/essential components of interventions in the general adult and youth BD populations<sup>(19)</sup>
- Optimal combination of pharmacotherapy and psychotherapy in the general adult and youth BD populations<sup>(19)</sup>
- Pharmacological treatment of cyclothymia for youth<sup>(54)</sup>
- Utility of clinical staging in providing guidance for early intervention.<sup>(6, 16, 64)</sup>

### **Health Human Resources**

A small number of research articles included recommendations pertaining to the workforce supporting youth with BD. The following considerations were noted in relation to the general BD population:

- Need for more training/uptake of evidence-based assessments and interventions among clinicians <sup>(19, 56)</sup>
- Multidisciplinary approach recommended to address BD <sup>(64)</sup>
- General practitioner or other front-line MH professional recommended to offer primary prevention interventions for youth; early secondary interventions should be offered by a general psychiatric or general medicine service. <sup>(10)</sup>

## Findings from Researcher Consultations

### Early detection/identification

#### *Challenges detecting/identifying BD and/or risk of BD in youth*

Researchers confirmed that BD is often undetected in youth due to a number of factors that make early detection/identification challenging:

- The field is lacking tools/measures developed and validated for youth population. There are some self-report and parent screeners that are effective in identifying risk of BD, but none are sufficient for making a diagnosis
- Clinical presentation in youth is different relative to adults (symptoms of mania); and also changes over time
- It is difficult to differentiate BD from typical developmental stages and from other co-occurring issues (e.g., ADHD, personality disorder, substance use)
- MH professionals are generally lacking experience/training (e.g., insufficient training in clinical psychology programs), making it important to increase their capacity in this area. There are challenges with both under- and over- diagnosing BD

**“It takes a lot of work to stay in the middle ground”**

- There is a reluctance among qualified mental health professionals to make a BD diagnosis among youth. BD is seen as a “life sentence” and a “heavy burden,” particularly among youth

**“People dismiss the possibility of BD in young people”**

- There is a lack of help-seeking among youth (e.g., due to stigma, not wanting to become dependent on the medical system; feelings of invincibility; influence of misinformation on social media)

**“Mental health terms are being defined by millions of people on TikTok... I see that it’s actually a huge risk; that the voices of the professionals are going to be drowned out completely by social media”**

#### *Evidence-based risk factors*

- There was general consensus that the presence of family history of BD, depressive symptoms, and adverse childhood experiences are generally the most commonly identified risk factors for youth BD. Researchers shared the following cautions, however, with respect to the clinical utility of some of these risk factors in identifying BD/risk of BD in youth:
  - Adverse childhood experiences are a risk factor for many mental health disorders, making them less helpful in identifying risk for a specific disorder

- There is emerging research that some subtypes of depression are more indicative of BD risk than others. More education and awareness are likely needed of the specific atypical depressive features that often signal risk of BD.
- Substance use was also identified as an important sign of risk of BD in youth (e.g., use of stimulants to “keep up” with racing thoughts).

### **Recommended areas for research**

Researchers confirmed that few tools/measures aimed at identifying BD/risk of BD have been validated for youth populations. Most identified the importance of more research focused on the biological and epigenetic markers of BD (“we don’t even know what this is”). The need for more work focused on identifying the risks and signs of BD in the prodromal phase was also identified.

### **Early intervention**

#### **Timing**

Researchers noted that there are currently no clear guidelines regarding the best time to intervene for youth with BD/risk of BD (nor are there lower age limitations for making a BD diagnosis). One stakeholder noted that operationalized criteria for early intervention have not been adequately defined for BD (particularly in comparison to schizophrenia and psychosis) but suggested that the ‘staging model’ may be a useful paradigm to guide decisions about when to offer interventions. One stakeholder suggested that BD primary prevention is generally not cost effective, but that secondary prevention should be widely implemented.

Researchers generally agreed that there continues to be a significant gap between when BD emerges and when youth are engaged and supported in treatment. This was noted to be particularly concerning given the significant negative outcomes for youth with untreated BD (e.g., increase risk for problematic substance use; risk of injury during manic episodes).

### **Interventions**

Researchers were asked to identify which interventions have the strongest evidence base for youth.

- Researchers agreed that **pharmacotherapy is the first-line treatment for BD**, with the best research evidence available for the pharmacological treatment of mania. It was noted that there is less evidence available for medications aimed at treating depressive episodes of BD, a particularly concerning gap given that significantly more time is spent managing symptoms of depression among youth with BD. One stakeholder noted that the pharmacological research evidence is generally sparser for younger children (relative to adolescents).
- Most researchers highlighted that **medications should ideally be combined with psychotherapeutic interventions** and there was general consensus that family focused therapy has the best evidence base. Other interventions, including DBT, CBT, IPSRT, and psychoeducation were also commonly identified as having some, but limited, evidence. One stakeholder cautioned that while psychological interventions can often be helpful, they are usually not sufficient without pharmacotherapy.
- Researchers also emphasized the importance of focusing on **engagement and psychoeducational support** when working with youth – for example,

careful communication regarding risk or diagnosis of BD (e.g., avoiding perception that BD is a “*life sentence*”)

- Respecting youth ambivalence/ concerns about pharmacotherapy (one stakeholder noted that it may not even be clinically useful to recommend medications to youth who have yet to express the full disorder)
- Ensuring that interventions are developmentally appropriate, and that sufficient attention is given to supporting the family (see “*Spotlight on Promising Practice*” of intervention developed by researchers at Orygen in Australia for an example).

Researchers discussed the importance of **addressing co-occurring conditions** as part of early intervention. Unfortunately, it was noted that most BD intervention trials exclude youth with co-morbidities, which was identified as an important research gap. Similarly, one stakeholder noted that MH services tend not to integrate a focus on physical health, which represents a significant “*lost opportunity*,” particularly given the increased risk of cardiovascular problems and other physical health issues among individuals with BD.

Finally, challenges regarding the limited availability of evidence-based BD services and barriers to accessing services (e.g., long wait times; difficulty navigating services) were also noted as significantly impacting effective early intervention.

**Recommended areas for research**

Researchers noted the general lack of “*international consolidation and integration of BD research*” (though recent work by Orygen in Australia to develop an international centre of excellence for BD research may help

fill that gap). It was noted that “*there’s a lot we don’t know*” and that this disparity needs to be addressed “*in order to make meaningful change.*” BD was described as the “orphan illness” that “*gets lost in the shuffle*” relative to other disorders, particularly depression (the most common mental disorder) and schizophrenia (the most burdensome). This was attributed, in part, to the challenges of obtaining funds for research focused on a population with a particularly complex profile, including multiple co-morbidities (“*people have just kind of avoided it*”). It was also noted that existing BD research fails to “*reflect real-life circumstances*,” including the high prevalence of co-occurring disorders found in the BD population. Additional gaps identified include:

- Pharmacotherapy:
  - Maintenance therapy (i.e., benefits of long-term use of medication for youth who are doing well symptomatically)
  - Alternatives to lithium, the most commonly prescribed medication for mania in BD, should be examined for the general BD population (e.g., nutritional supplements and other non-medication substances)
- Most effective forms of psychotherapy
- Lack of involvement of youth in the development/evaluation of interventions
- Longitudinal data on BD interventions
- Exploration of longitudinal model of BD itself (including youth BD, as opposed to the current paradigm of siloed subgroups; e.g., BDI, BDII, BD NOS).

## Implementation Considerations

### Health Human Resources

- **Early detection/identification:** Researchers acknowledged that it is possible to train non-physicians/psychologists to conduct semi-structured interviews for the purpose of diagnosing BD (though researchers also highlighted the significant challenges associated with early detection/identification and the importance of clinical experience and training)
- **Early intervention:** There were varying opinions regarding the level of expertise/training required for delivery of early interventions. One researcher noted that “any person with interpersonal, human skills” could provide basic supports, including psychoeducation. Another researcher cautioned that more structured psychological interventions are best delivered by individuals who have received rigorous training and have professional affiliations (e.g., occupational therapists, nurses, social workers). This same researcher also highlighted the importance of ongoing supervision and mentoring (“if you don’t continually train and assess people’s adherence, you’re going to get drift and the efficacy of the treatment is going to drift”).

### Infrastructure

- One researcher identified the need to incentivize “sub-specialized, high frequency, high volume clinics” serving individuals – including youth – with BD, that are available across a province (e.g., similar to clinics with cardiac surgery capacity). These should be supported by a “network of centres of excellence” that can “plug into more general resources.”

### Spotlight on Promising Practice

#### *REsearch into COgnitive and behavioural VERsatility (RECOVER) – Orygen (Australia)*<sup>ix</sup>

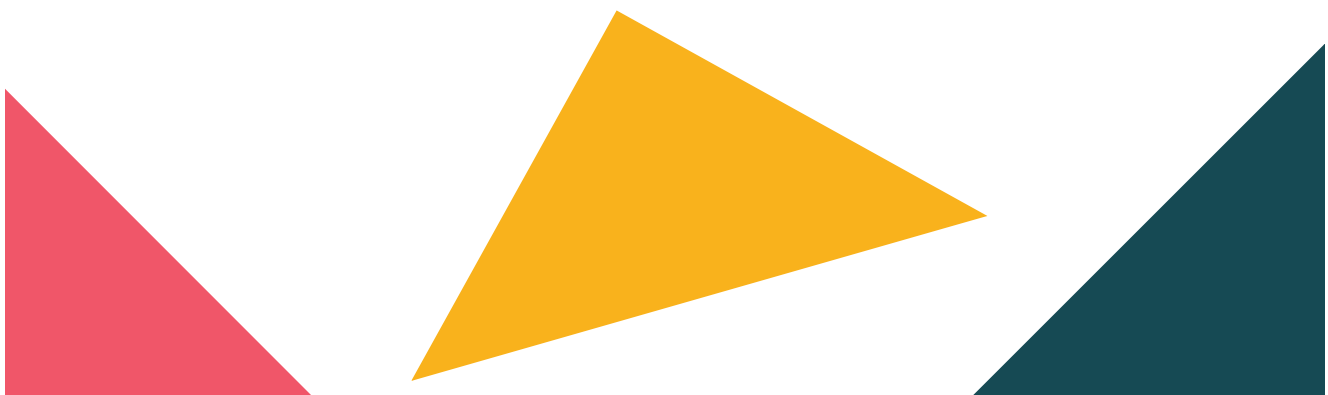
RECOVER was developed by a multidisciplinary team in close collaboration with youth. It is offered to youth with BD, including youth with other co-occurring disorders (e.g., personality disorders, SU, anxiety). RECOVER targets symptoms and has a particular focus on obtaining improved functional outcomes and on identifying and modifying maladaptive schemas that can contribute to the disorder. It is **developmentally appropriate** and **phase-specific** and differs from existing psychological interventions for BD in key ways. Specifically, it has a **strong focus on developmental and clinical staging issues** that are critical when working with this population. The intervention includes phase-specific **cognitive behavioural strategies** should a young person experience a mood episode during the course of therapy. **Engagement is also targeted**, an issue that is not commonly addressed in existing treatments, where there can be an assumption of active help-seeking and insight, which often only occurs after multiple episodes.

RECOVER is delivered over a 6-month period by psychologists who have received formal training, and treatment integrity is supported by regular supervision and a treatment fidelity checklist.

The therapy is divided into four phases:

1. **Core modules:** (a) assessment and engagement; and (b) cognitive behavioural formulation. These provide the basis for collaborative goal setting and development of a treatment plan.
2. **Core modules:** (a) making sense of what has happened (psychoeducation); (b) specific CBT interventions; (c) social rhythm regulation; and (d) wellness planning.
3. **Additional modules** (up to eight sessions) are selected based on the young person's formulation and treatment goals and can include further focus on core modules and/or focus on any of the targeted modules
4. **Therapy concludes** with a termination session including discussion of a "goodbye letter."

**A pilot of a longer version** of RECOVER (offered over a period of 18 months to 2 years) found reductions in depressive symptoms and improvements in functioning. Based on these promising results, the intervention was modified and a randomized controlled trial is currently underway. Early results show a high rate of retention (77%).





## Findings from Youth/Caregiver/Supporter Consultations

This section presents the perspectives of five youth/caregivers/supporters who were consulted as part of this project.<sup>x</sup>

### Lack of BD education/awareness

Youth/caregivers/supporters highlighted a lack of education and awareness of BD, and related challenges, among different groups in general, and with respect to specific providers.

#### *General challenges detecting/recognizing BD/BD risk:*

- Misinformation and confusion regarding the nature of BD (including the difference between BD-I and BD-II) and the signs and symptoms that would flag the potential for having/developing BD
- Signs of BD/BD risk (and particularly signs of mania/hypomania) are often more difficult to recognize in youth because some behavioural signs are attributed to normal developmental stages and/or to problematic substance use
- BD/risk of BD may not be identified and/or are dismissed because youth appear to be “high functioning”
- Signs of BD can look different at different developmental/life stages
- Youth are often in “denial” that they have BD/are at risk of developing BD.

#### *Knowledge/experience of health and social service provider groups:*

- **Primary care providers:** Insufficient knowledge of/experience with BD (and particularly hypomania) among primary care physicians and other providers in “walk-in” primary care health clinics can result in the following challenges:
  - Youth being misdiagnosed and treated for depression instead of BD (which often can result in worsening BD symptoms)

- Concerns regarding potential “overmedicalization”
- **Police:** Police officers require more education regarding BD in youth, including how best to manage and support youth experiencing BD symptoms, and attend to legal considerations when called to address behavioural concerns in specific contexts (e.g., manic behaviours in the workplace)
- **Educators:** Elementary and high school teachers would benefit from more education about BD in youth so that they can: (1) educate students and parents about BD; and (2) identify signs of potential risk of BD in their students, and support students and parents to connect to appropriate services and supports as appropriate.

“If I had teachers trained in what was happening, it would have been helpful – I would’ve understood my symptoms weren’t ‘normal adolescence’”

#### *Awareness and education in general public (including youth)*

Public information is generally not broadly available/promoted about BD (relative to depression, for example), and particularly the signs of mania; the differences between BD-I and BD-II and between BD and ADHD; and what should be done if somebody is showing signs of BD.

#### *Cultural considerations*

Youth/caregivers/supporters highlighted the impacts related to varying perceptions and understandings of BD across different cultural groups:

- A general taboo associated with mental illness in some cultures can result in

people “masking” a diagnosis and/or not seeking help

**“When I was diagnosed with BD, my mother said she always suspected I had BD but never said anything because [it was] frowned upon in [our] community and there was no access to any resources”**

- There can be a tendency in some cultures to encourage religious practices (e.g., praying) to address mental health concerns and/or to seek help exclusively from religious leaders instead of seeking supports from mental health professionals

**“if you’re diagnosed with BD, it should be complete care – not just medication!”**

- Work with community organizations that have cultural relevance to create resources
- Ensure more representation from diverse communities in BD research and service provision
- Be culturally sensitive: approach conversations about mental health and BD *“with a scalpel, not a sledgehammer”* so that entire communities are not alienated about a topic that has not previously been given much significance.

***Lack of BD resources and services and service access barriers***

- Need for more BD services:
  - Diverse options (beyond primary care and psychiatry) so that youth can make informed choices that meet their needs and preferences
  - Trauma-informed
  - Youth-oriented and specific, including practical coping skills relevant to youth

**“you can’t just map adult BD stuff onto youth”**

- For youth with complex needs
- Pharmacotherapy
- Dialectical behaviour therapy (one-on-one)
- For families
- Free/affordable services
- Comprehensive, integrated, and long-term services

**“3-4 sessions isn’t sufficient – that’s enough to build rapport and then you have to repeat your story another time with someone else”**

- In diverse settings that are accessible to youth:
  - Schools (e.g., delivered by nurses, guidance counsellors)
  - Community-based services delivered in non-clinical settings, including schools

“If you leave it to the student to go and find the support, it may not happen”

“Being in hospitals can be uncomfortable for many people, they can feel like a ‘lab rat’”

- Youth/caregivers/supporters highlighted significant barriers to accessing BD supports and services including:
  - Lack of access to primary care providers (who can help identify BD, provide support, and connect youth to specialized services like psychiatric consultation)
  - Significant wait times to access services and related follow-up services. Waiting without support “*can be dangerous*” and can result in a worse health trajectory
  - Lack of information/promotion of what BD services and supports are available for youth and how they can be accessed
  - Past negative experiences of mental health services may discourage youth from seeking support for BD. It is important that youth are connected to services that are youth-friendly and engaging

“people do not even have family doctors!”

“Youth are left to figure it out on their own, situation continues until it is serious and youth are in ER – only then do youth get treatment”

- Youth/caregivers/supporters recommended the following to make BD resources more available:
  - “*Amplify*” existing information and resources about youth BD
  - Develop and disseminate new/additional standardized, accurate, detailed and accessible educational resources about BD for youth/students:
    - What BD is and isn’t
    - How to recognize and understand the signs and symptoms of BD and how they may impact different areas of life and behaviours (including, for example, substance use, so that youth do not “*self-medicate*”)
    - Self-guided resources for youth with BD (including resources to help address any distress of “*living with BD*”).

“you can’t ask for something if you don’t know it exists”

### Stigma and Fear

Youth/caregivers/supporters emphasized that the stigma associated with BD and fear of a BD diagnosis significantly impact their recognition of BD, help-seeking, and long-term engagement in treatment and supports. In addition to more overt experiences and stereotypes of stigma (“people call me crazy or a freak”), misinformation/negative perceptions about BD (e.g., that it is not common among youth; that, unlike depression and anxiety, BD is always a difficult-to-treat, lifelong, all-consuming issue (“there’s no solid identity outside of a BD diagnosis”)) can result in youth internalizing shame about BD and make it hard for them to “open a conversation around BD.”

Youth/caregivers/supporters offered a number of solutions to address this issue:

- Share accurate, balanced information about BD in youth
- Avoid stigmatizing/negative language in service provision. Build provider capacity to appropriately communicate the details of a BD diagnosis/risk of diagnosis with youth (e.g., “*Diagnosis needs to be delivered with tact*”)
  - Encourage help-seeking
  - Convey hope (“diagnosis is not the end”)
  - Offer practical advice and immediate supports (e.g., coping techniques)
  - Use youth-friendly language
- Encourage connection with supportive peers/friends.

**“people with BD can be stable and live normal lives!”**

**“I was a child but hearing information about a BD diagnosis like an adult, and I was not cognitively at that level – I wanted to be treated like the youth I was”**

**“It is important to communicate in a way that youth understand, staying with them as they work through a BD diagnosis”**

**“there may be other friends who are struggling and that will encourage them to seek help”**

**“don’t overfocus on the illness or make youth feel incapable of things”**

### Involvement of youth's families/chosen supports

Youth/caregivers/supporters emphasized the importance of involving family members/chosen supports of youth in their treatment and support services.

The following suggestions were offered to support this goal:

- Encourage youth to connect to a “*strong circle of support*”
- Involve the support of a trusted adult or caregiver (i.e., in addition to supports from peers/friends) but be sensitive to:
  - Family relationships, dynamics, and history, and the understanding and perceptions of BD among family members
  - The preferences of youth (e.g., some youth may not be comfortable having a family member be a part of therapeutic sessions)
- Allow youth to identify their supports (including, for example, friends) and work with youth to involve their chosen supports into their treatment as desired
  - Be sensitive to family dynamics and history and recognize that not all family members/supporters may have a positive impact on a youth's mental wellness
- Provide BD education to families (so that the responsibility to educate does not fall on youth)
- Encourage supports from individuals who can help youth navigate the service system.

“Substitute decision makers can have long-term roles and ramifications”

“[You] cannot expect youth to get better on their own in therapy”

### Technology

A number of different examples were offered of how technology could be leveraged to support the early identification/intervention of BD in youth:

- Digital delivery of clinical/support services (e.g., online/web-based screening/assessment; virtual therapy sessions)
- Online navigation services
- Online BD support groups (in conjunction with other forms of services and supports)
- Online information platforms for youth to learn about BD from a diversity of perspectives
- Smartphone apps to remind youth to take medications
- Social media was identified as a youth-friendly, accessible option to inform, educate, and support youth; the types of social media and the ways that they are leveraged needs to be done cautiously:
  - Connect youth to reputable/supportive/youth-friendly platforms
    - Be aware of, inform, and steer youth away from less reputable platforms targeting youth that are sharing inaccurate/stigmatizing information
    - Advise against platforms that are known to perpetuate misinformation (e.g., TikTok)
  - Note the degree of monitoring of platform and risk of bullying
  - Consider opportunities for youth-service organizations to “push” targeted information to youth through social media.

“There is a disparity between ways youth communicate and how services are being offered”

“Youth aren’t calling/phoning services anymore – even email isn’t good”

“People expect things to be digital these days”

“I think this engages more youth and it’s easier to keep youth in treatment”

### Considerations for early intervention

In addition to the above considerations, youth/caregivers/supporters identified the following recommendations aimed at engaging, supporting, and retaining youth in early intervention services and supports:

- Develop, adapt, and evaluate interventions in collaboration with youth (and offer appropriate remuneration for their work)
- Work with youth to identify all life domains that may be impacted by BD (e.g., school, relationships, lifestyle, physical health) and work with them to prioritize and develop a plan that resonates with them
  - Build provider capacity to address sexuality and substance use as they relate to BD – two areas that can be difficult to address with youth

- Offer choices and work with youth to identify their needs and preferences (but be sensitive to not overwhelm youth with too many options):
  - Delivery: individual, group based, online
  - Modality: be open to integrating complementary treatments (e.g., mindfulness practice, exercise, diet, land-based) into conventional BD interventions
- Be transparent about the risks and benefits of pharmacotherapy
- Ensure that treatment and support environments are youth-friendly and engaging
  - Make “*contained forms of stimulation*” (e.g., art supplies) available during therapy sessions
- Offer team-based and integrated services and supports.

### Providers

- Importance of multi-disciplinary, team based approach:
  - Can potentially improve access to services (e.g., nurse practitioner may be able to review medications if psychiatrist is not available)
  - Better able to offer comprehensive, wholistic, and diverse services and supports
- Range of service providers is important:
  - **Physicians/psychiatrists** are often the first point of contact and in a good position to offer early interventions and support
  - **Nurse practitioners** can offer clinical support and may have a bridging role between social worker and physician
  - **Peer support** particularly in conjunction with services and while waiting for services
  - **School guidance counsellors and nurses** can help identify risk of BD and offer early interventions and supports (to youth and families).

**“Peer support helps to see yourself in a service provider”**

### **Conflicting youth perspectives regarding BD interventions**

There were conflicting perspectives from youth regarding whether BD interventions – both pharmacological and therapeutic – should be provided to youth before an official diagnosis is made. For example, it was suggested that there is value in offering psychotherapeutic interventions to youth prior to BD diagnosis, but that pharmacotherapy may be best reserved for after a diagnosis is made. Another youth felt that it was inappropriate *“to treat folks that haven’t been diagnosed with BD, for BD. Until a diagnosis is made, take a broader brush around mental health and well-being assistance.”*

### **Findings from Service Provider Survey**

A total of 121 service providers (59% front-line staff, 21% administrators, 21% other) submitted responses to the online survey (90% completed the survey in English, 10% in French). Given that the survey was broadly distributed via different professional networks, it is not possible to determine the precise response rate.<sup>xi</sup>

### **Respondent knowledge, confidence and experience supporting youth with BD**

This section provides a summary of survey respondents’ reported knowledge, confidence, and experience supporting youth with BD. Analysis by provider role was limited by the small sample size overall, and for the care coordinator and peer support roles, in particular. As applicable, noteworthy differences in reported knowledge, confidence and experience between front-line staff and administrator roles are included.

Survey respondents were asked to rate their *level of knowledge* in different areas of supporting youth with BD, which included:

- Providing therapeutic interventions for youth with BD
- Working with youth with BD from health equity-deserving communities
- Screening/assessing for BD in youth and identifying risk factors and co-occurring challenges
- Supporting chosen families/caregivers of youth with BD and accessing appropriate resources
- Differentiating youth BD from other related disorders
- Recognition of youth BD including types and symptoms.

Most respondents reported at least ‘some’ knowledge in all areas. Respondents reported higher levels of knowledge in the area of recognizing youth BD, followed by differentiating youth BD from other related disorders. Respondents reported having the least amount of knowledge in the area of screening/assessing for BD, including identifying risk factors and co-occurring challenges, and working with youth from health equity-deserving communities who have BD.

In general, reported levels of knowledge were similar for the front-line staff and administrator roles. The one exception was with respect to knowledge regarding how to support chosen families/caregivers of youth with BD and accessing appropriate resources – respondents in administrative roles tended to report higher levels of knowledge in this area.

Levels of reported confidence followed similar patterns as those reported for levels of knowledge.

Respondents were also asked about their experience providing and/or having training.

Figure 1. Percentage of Service Providers Surveyed Who Have Experience Providing or Having Training in Various Therapies

Psychoeducation	49%
Cognitive Behavioural Therapy (CBT)	49%
Dialectical Behavioural Therapy (DBT)	37%
Peer Support	24%
Mindfulness-Based Cognitive Therapy (MBCT)	21%
Family Focused Therapy (FFT)	17%
Traditional Healing Methods	8%
Interpersonal and Social Rhythm Therapy (IPSRT)	4%
Other	1%

Across all respondents, almost half (49%) reported experience providing and/or having training to deliver cognitive behavioural therapy (CBT) and psychoeducation interventions to support youth with BD. In contrast, relatively few respondents reported receiving training in traditional healing practices (8%) and Interpersonal and Social Rhythm Therapy (4%; IPSRT).

**Respondent perspectives regarding approaches to supporting youth with BD**

**Ways to enhance provider effectiveness**

Survey respondents were asked to rank, from most to least important, different approaches that would help service providers feel better equipped to identify and offer early intervention to youth with BD. Options included:

- Education and time at work to learn about BD in youth, and related assessment, identification and early interventions

- Hands-on training of early BD interventions and opportunities to work directly with youth with BD
- Having a team/interdisciplinary approach and effective supervision/clinical consultation
- Understanding how to communicate with/educate youth about BD across various communities/identities in culturally safe and competent ways
- Understanding how to effectively support the integration of medication and/or traditional medicines with therapeutic supports.

Almost half (47%) of all respondents identified education and time at work to learn about BD in youth (and related assessment, identification, and early intervention) as the most important opportunity for capacity building.

In general, the perceived importance of different approaches for building capacity to better support youth with BD were similar for the front-line staff and administrator roles. The one exception was with respect to the importance of understanding how to effectively support the integration of medication and/or traditional medicines with therapeutic supports – which more front-line staff identified as important, relative to staff in administrator roles.

**Priorities regarding therapeutic intervention considerations**

Survey respondents were also asked to rank, from most to least important, considerations in the development and implementation of early therapeutic interventions for youth with BD. Options included:

- Therapeutic interventions are evidence-based and consider concurrent disorders
- Therapeutic interventions are youth and/or service provider informed/co-created



- Therapeutic interventions are youth-friendly/focused, and applicable to youth from a range of communities and identities (opportunity for adaptability/modifications)
- Therapeutic interventions outline whether a youth BD diagnosis is a prerequisite, family/caregiver involvement is required, and who can provide the intervention
- Therapeutic interventions have a fixed number of sessions.

Almost half (47%) rated as most important interventions that are evidence-based and consider concurrent disorders. There was striking agreement, by most respondents, that having therapeutic interventions with a fixed number of sessions was least important, relative to the other options provided.

#### ***Priorities for preparing service context to offer early interventions***

In terms of priorities, survey respondents were asked to rank, from most important to least, activities aimed at helping prepare a service context to offer early interventions for youth with BD. Options included:

- Having a better understanding of what aspects of youth experiences of BD prevent them from seeking supports
- Having a better understanding of the experience of BD across various communities/cultures/identities
- Addressing stigma that youth with BD may experience (e.g., BD diagnosis, seeking help, taking medication)
- Leveraging technology/social media to engage youth at risk of BD into services and as part of therapeutic interventions
- Leveraging technology/social media to educate/inform youth about BD (e.g., online apps, forms, social media pages).

Ranked importance across the different options were largely consistent across

survey respondents, with half (50%) identifying as most important processes to better understand what aspects of youth experiences of BD prevent them from seeking support. Almost half (49%) rated as least important leveraging technology/social media to educate/inform youth about BD (e.g., BD diagnosis, seeking help, taking medication).

#### ***Perceived factors that play a role in the diagnosis/treatment gap***

Survey respondents were also asked to identify, from a service provider perspective, 5 factors out of a list of 12 that they felt play a role in the long period of time between when BD is identified and when youth are engaged in therapeutic treatment. The most commonly identified factor, identified by 13% of respondents, was youth feeling stigmatized by a BD label or diagnosis. No respondents identified a lack of capacity among service providers to diagnosis BD as a factor in the gap between diagnosis and treatment initiation.

*Figure 2. Perceived Factors that Play a Role in the Diagnosis/Treatment Gap, by Percentage of Service Providers*

Youth may feel stigmatized by BD label or diagnosis	13%
Challenging and timely process to distinguish BD from other MH concerns in youth	12%
Lack of health human resources to provide BD treatment	11%
Service providers may not feel sufficiently confident to diagnose or treat BD in youth	11%
Youth may not be engaged/interested in BD intervention	9%
Lack of public awareness and visibility of BD	9%

Cultural, gender, age, other related considerations, barriers for youth	9%
Lack of early interventions at agency for youth with BD	8%
Only certain professions are permitted to diagnose BD in youth	7%
Effects of medication are waiting to be seen first	5%
Lack of clarity on when to provide intervention support for BD	5%
Other	1%
Service providers may not be able to clinically diagnose BD	0%

Finally, survey respondents were asked whether there was anything else that came to mind that could assist service providers in supporting young people with BD. A total of 28 respondents shared suggestions.

Categories of responses and, as applicable, direct quotations providing important context, are provided:

- Improve youth access to services, including low/no cost options and clear pathways (N=5)
- Clinician capacity building and support, including supervision, access to consultation teams, and peer support between providers (N=5)
- Increase awareness and training for public and in educational system (N=4)
- More funding invested in the area of youth BD (N=3)
- Better/more education to families and youth regarding BD (N=3)
- More focus on early intervention/diagnosis, including aftercare supports following diagnosis to support emotional responses from receiving a diagnosis (N=3)
- Need for a better understanding of the needs of families (N=1)

- More work to better distinguish borderline personality disorder from BD (N=1)
- Group life skill building like communication, work ethic (N=1)
- Transdiagnostic interventions (N=1)
- Connect and support youth through youth-oriented settings/mechanisms (N=1) such as social media, online platforms, community hubs, schools
- “Embrace the voice of lived experience” (N=1)
- Encourage help-seeking (N=1)
- Development of focused BD interventions for youth (N=1)
- Evidence-informed tools/techniques to work with clients before a diagnosis (N=1)
- Address the potential negative impacts of self-diagnosis (N=1).

**“Getting a young adult to see a psychiatrist is near impossible”**

**“Youth feel discouraged when they are diverted away from psychiatrists, or are left waiting for months to years to see one. Emergency department psychiatrists are overburdened with offering assessment and treatment during crises, when earlier intervention could prevent decompensation”**

**“I feel we wait too long to identify at-risk youth”**

# | Conclusion

This review aimed to identify existing knowledge and knowledge gaps regarding early detection and intervention for youth with BD, including with respect to evidence-based approaches for early detection and intervention. Critical knowledge gaps and challenges were identified, including a general shortage of research focused on youth BD; limited service provider capacity to detect and support youth with BD; poor availability of services and access barriers; lack of knowledge of BD among youth and fear of seeking help due to stigma; and the need for clinical guidelines and a range of evidence-based interventions to offer to youth.

Another important objective of this project was to identify considerations related to developing and implementing early detection/intervention approaches within youth-serving contexts, including to specifically engage and support youth from health equity-deserving populations. There was a noticeable lack of attention on these topics in the research literature and by stakeholders, including youth who were consulted as part of this project, emphasizing the need for more focused work in these areas.



“There remains a tremendous lack of acceptance in our education system of what support a youth may need when faced with this dx [diagnosis] as well as how it will impact them in the education sector”

“Youth in a drop-in setting often (sometimes?) would rather work on presenting issues than follow protocols for a diagnosis or suspected diagnosis/MH problem. Using transdiagnostic methods could be helpful and less diagnosis driven by design”

“Families accept a lot of behaviours that are concerning before reaching out for help, and given that mental health is a continuum, we need to encourage reaching out earlier before the problem becomes more entrenched in the individual”

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- ### Additional Notes and References
- \* Youth Wellness Hubs Ontario (YWHO) is an initiative that brings service providers together to deliver Integrated Youth Services (IYS) for youth ages 12-25 and their families at the right time and in the right place. YWHO works in partnership with young people to help improve Ontario's mental health and substance use supports for youth and young adults by providing rapid access to easily identifiable mental health and substance use services with walk-in, low-barrier services, and clear service pathways. This project was conducted with assistance from April Furling Consulting Inc.
- \*\* Annotated Bibliography available upon request.
- i. Goldstein, B. I., & Birmaher, B. (2012). Prevalence, clinical presentation, and differential diagnosis of pediatric bipolar disorder. *The Israel Journal of Psychiatry and Related Sciences*, 49(1), 3.
- ii. Early intervention broadly refers to interventions from the first manic episode in BD type I. In BD type II, early interventions may target those with at least moderate to severe depressive episodes and past episodes of hypomania (Stage 2 disorder). Interventions prior to these stages may be considered to be preventive interventions or pre-onset interventions (Gama, C. S., Kunz, M., Magalhães, P. V., & Kapczinski, F. (2013). Staging and neuroprogression in bipolar disorder: a systematic review of the literature. *Revista brasileira de psiquiatria*, 35(1), 70–74).
- iii. Description from American Psychiatric Association (<https://www.psychiatry.org/patients-families/bipolar-disorders/what-are-bipolar-disorders>)
- iv. Initially, the target population was limited to youth between the ages of 12 and 25 years and to youth caregivers/supporters between 12 and 30 years. Age limits were broadened for these two groups due to low rates of response to participate in a consultation.
- v. It is important to note that confirmation of the level of evidence for these different areas was out of scope for the review.
- vi. The BD prodrome comprises precursor symptoms, functional impairments, and other psychiatric diagnoses present in the months or years prior to bipolar disorder onset. (Conroy, S. K., Francis, M. M., & Hulvershorn, L. A. (2018). Identifying and treating the prodromal phases of bipolar disorder and schizophrenia. *Current Treatment Options in Psychiatry*, 5, 113-128).
- vii. Strimbu, K., & Tavel, J. A. (2010). What are biomarkers? *Current Opinion in HIV and AIDS*, 5(6), 463.
- viii. Clinical staging describes where an individual's illness presentation can be placed on a temporal spectrum of disorder progression. Illness staging is widely used in several medical disciplines, including psychiatry, to help predict course or prognosis, and optimize treatment. (Berk, M., Post, R., Ratheesh, A., Gliddon, E., Singh, A., Vieta, E., & Dodd, S. (2017). Staging in bipolar disorder: from theoretical framework to clinical utility. *World Psychiatry*, 16(3), 236-244.)
- ix. This description is based on details provided by stakeholders and information included in Cotton, S. M., Berk, M., Jackson, H., Murray, G., Filia, K., Hasty, M., Chanen, A., Davey, C., Nelson, B., Ratheesh, A & MacNeil, C. (2019). Improving functional outcomes in early- stage bipolar disorder: The protocol for the REsearch into COgnitive and behavioural VERsatility trial. *Early Intervention in Psychiatry*, 13(6), 1470-1479.
- x. Given the small size of this sample, these findings should not be generalized to all youth/caregivers/supporters in Ontario.
- xi. Given the relatively small sample size, the findings should not be generalized to all providers who support youth in Ontario.





**Daymark Foundation**

95 St. Clair Avenue West, Suite 200  
Toronto, Ontario, Canada M4V 1N6

**LinkedIn:** [linkedin.com/company/daymarkfdn](https://www.linkedin.com/company/daymarkfdn)

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