Factors influencing delays in the diagnosis and treatment of bipolar disorder in adolescents and young adults: A systematic scoping review.

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**Background**

Bipolar Spectrum Disorders (BSD) include complex psychiatric conditions that typically manifest during late adolescence and early adulthood. Delays in diagnosis and appropriate treatment lead to negative clinical and functional outcomes. International studies have reported that Bipolar Disorder (BD) often goes unrecognized and untreated for 5-10 years; many experience even greater delays, including youth. However, the factors that delay recognition, diagnosis, and treatment of BSD in adolescents and young adults have not been systematically explored.

**Aims**

Determine the known factors that contribute to the delay in the treatment of BD in adolescents and young adults and identify current knowledge gaps.

**Methods**

A conceptual framework based on the Model of Pathways to Treatment by Scott and colleagues was used as a foundation for our search and extraction strategy to ensure a systematic review of potential contributing factors. Following PRISMA guidelines, Embase, PsycINFO, MEDLINE, and CINAHL databases were queried with the search parameters detailed below: Two reviewers independently screened abstracts and subsequently full texts for inclusion, using Covidence, a systematic review management tool.

**Population**

Age 13 - 24 years

**Diagnosis of bipolar spectrum disorder**

**Concept**

Patient, disease and healthcare system-provider factors related to the components of delay in the diagnosis and treatment of bipolar spectrum disorder.

**Context**

All clinical settings (inpatient, outpatient).

**Geography**

No limits

**Publication type**

Primary qualitative and quantitative

**Language**

English

**Publication date**

2000 - 2023

**Identified Factors**

**Interval:** Appraisal Onset of mood symptoms Help-Seeking Seeking clinic/assessment Diagnostic Encounter with clinician Pre-Treatment Initiation of indicated treatment

**Factors:**

- **Patient Individual**
  - Delay with younger age and male gender
  - Sought traditional healers with \\_ education & JGAF. age, gender, religion, and family history was not associated with this
  - Indigenous status was not associated with delays (New Zealand)
  - Stability of new diagnosis was not affected by age, gender, or geographical region (US)
  - Lack of family history of BSD increased chances of a missed diagnosis.
  - Indigenous status was associated with high rates of a diagnosis of schizophrenia following episodes of affective psychosis (New Zealand)

- **Family Socioeconomic**
  - ↑ Delay with y
  - ↑ Delay with absence of subjective disability
  - ↑ Stability of diagnosis with greater clinical
  - ↑ Stability of diagnosis with greater clinical

- **Systemic**
  - Delay with initial depressive polarity and absence of greyness & psychosis
  - Acute vs insidious onset and bipolar type were not associated with delays in diagnosis
  - Stability of diagnosis with greater clinical resources needed, fewer psychiatric comorbidities prior to BSD diagnosis, yet greater psychiatric comorbidities after BSD diagnosis.

- **Crisis Mental Health System**
  - ↑↑ Delay due to wait-times to see a psychiatrist.
  - ↑ Stability of diagnosis with managed care and diagnosis by a mental health professional.

**Systematic Review**

- Publication of 25 studies
  - Of those who sought traditional healers, 22/3 did so before contacting psychiatric services.

- Diagnostic agreement between referring providers and psychiatrists is poor

- Lack of systematic screening for BSD in patients referred for MDD contributes to misdiagnosis.

- Diagnostic agreement between referring providers and psychiatrists is poor

- Delay due to wait-times to see a psychiatrist

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**Publications**

- ↑↑ Delay due to wait-times to see a psychiatrist.

- Stability of diagnosis with managed care and diagnosis by a mental health professional

**Conclusions**

- ↑↑ Initial adherence with
  - ↑↑ # of non-medication related mental health contacts

- ↑↑ Likelihood of adjunct psychotherapy with prior outpatient mental health care and with delayed but continuous use of a mood stabilizer

- ↑↑ # of non-medication related mental health contacts

- ↑↑ Likelihood of adjacent psychotherapy with prior outpatient mental health care and with delayed but continuous use of a mood stabilizer

- ↑↑ Initial adherence with
  - ↑↑ Likelihood of standard monitoring of serum drug levels and side effects was greater in those treated by a primary care provider, but not a prior history of inpatient care nor outpatient care.

- ↑↑ Continuity of treatment with continuity of diagnosis

- ↑↑ Mixed evidence on role of age, sex, race, and gender for treatment initiation and initial adherence; treatment initiation not associated with gender

- ↑↑ Black Americans had ↓↓ initial adherence and were more likely to be prescribed antipsychotics, but had no difference in dose & duration of antipsychotics nor in prescription of mood stabilizers.

- ↑↑ Initial adherence with subjective rating of treatment helpfulness and ↑↑ socioeconomic status.

- ↑↑ Adjust psychotherapy for rural residents, though this had no association with pharmacotherapy.

- ↑↑ Though first episode and treatment occurred earlier in BD1,27 Bipolar type was not associated with delay to first treatment.27

- ↑↑ Delay with absence of subjective disability or a history of suicide attempt; presence of psychosis had mixed evidence.10,12

- ↑↑ Acute vs insidious onset was not associated with delays in diagnosis.

- ↑↑ Delay with prior or comorbid history of ADHD, alcohol use disorder, or other substance use disorder.

- ↑↑ Initial adherence with comorbid ADHD and alcohol use disorder.

- ↑↑ Stability of diagnosis with greater clinical resources needed, fewer psychiatric comorbidities prior to BSD diagnosis, yet greater psychiatric comorbidities after BSD diagnosis.

- ↑↑ Delay in the US than Europe, regardless of polarity or age at onset.

- ↑↑ Likelihood of recommended pharmacotherapy for those who had received care from a psychiatrist, prior inpatient & outpatient mental health care, but not prior psychotherapy.

- ↑↑ Stability of diagnosis with managed care and diagnosis by a mental health professional.

- ↑↑ Lack of systematic screening for BSD in patients referred for MDD contributes to misdiagnosis.

- ↑↑ Diagnostic agreement between referring providers and psychiatrists is poor

- ↑↑ Stability of diagnosis with managed care and diagnosis by a mental health professional.

- ↑↑ Continuity of treatment with continuity of diagnosis; delayed treatment start did not predict later continuity of treatment.

**Key Results & Conclusions**

- The Model of Pathways to Treatment framework systematically identifies the barriers and facilitators of timely recognition, diagnosis, and effective treatment of BSD.

- This framework would likely be of value to studying other psychiatric conditions as well.

- A wide variety of patient, illness, and systemic factors are associated with delays across the trajectory to effective treatment; non-modifiable factors were common.

- This systematic approach identified a relative paucity of research around the appraisal and help-seeking intervals in adolescents and young adults.

- Future studies should be designed to evaluate these intervals; we hypothesize that key modifiable factors may exist in these intervals.

- The most common reason that studies were excluded from our review was a lack of reported chronological data regarding illness onset, help-seeking, diagnosis, and treatment initiation.

- Where possible, collecting this data should be encouraged in future studies.

- Publication of included studies peaked in the late 2000s, suggesting a concerning trend.

- Limitation: Present study is not generalizable to those with onset before age 13 or after 24.