COMMUNITY INTERVENTIONS IN BIPOLAR DISORDER—WHEN THE SYSTEM FAILS

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The objectives of this work are to disclose the critical interactions of bipolar disorder (manic-depressive illness) with the criminal justice system in the United States--especially where the intentions of law enforcement and their actions collide. In addition, the symptomatology of bipolar disorder, its prevalence, and cost-effectiveness in the medical system are described.

Tragedy has followed the lives of many celebrities afflicted with bipolar disorder—their lives are usually not storybook fairy tales. Most importantly, a person experiencing the manic phase of bipolar disorder is dangerous to all concerned. An individual in full-blown bipolar mania interacting with law enforcement may encounter a life and death situation. As a result, law enforcement officers and court officials should have special training in dealing with the mentally ill—especially with bipolar mania. Community stakeholders include those afflicted with bipolar disorder, the criminal justice system, mental health advocates, and opposing forces (e.g., those policymakers favoring cutting mental health funding). Bipolar depression ruins many productive lives and sometimes these lives end in suicide.

Keywords: Bipolar Disorder (Manic-Depressive Illness), Law Enforcement, Criminalizing the Mentally Ill, Community Mental Health, Health Belief Model

INTRODUCTION

Bipolar disorder, a form of mood or affective disorder, has a high prevalence in the United States. The prevalence of bipolar disorder (manic-depressive illness) in the United States is approximately 1% of the population, i.e., over 5.7 million people (Kessler, Chiu, Demler & Walters, 2005). For both men and women the age of onset is usually in the late

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teens or early adulthood (American Psychiatric Association, 2000). Bipolar disorder is more prevalent in lower socioeconomic classes and in minorities (National Institute of Mental Health, 2002a). In the past, bipolar disorder could not be diagnosed anatomically or physiologically in the body (i.e., with a brain scan or blood test). However, relatively recent developments in MRI technology targeting chemical changes in the brain have been employed to diagnose mental illness, including bipolar disorder (Krause, 2008).

The differential diagnosis of bipolar disorder is complicated, based on the appearance of one or more manic or hypomanic episodes (Merck Manual of Diagnosis and Therapy, 1999; 2006). Symptoms of the manic phase of bipolar disorder are an expansive or elevated mood, high-energy activity, talkativeness, increased creativity, grandiosity, decreased need for sleep, racing thoughts, and poor judgment (National Institute of Mental Health, 2001, 2002b). Symptoms of the depressive phase are an unrelenting sad mood, difficulty sleeping or sleeping too much, decreased interest in, or withdrawal from, usual activities (both from work and pleasurable activities), low energy and fatigue, feelings of guilt, feelings of low self-esteem, recurrent thoughts of suicide, and difficultly in concentrating or decision making (National Institute of Mental Health, 2002a). Bipolar disorder may manifest itself as behavior different from that of a mental illness such as substance abuse, sexual promiscuity, spending sprees, poor performance at work or school, and/or strained personal relationships. Bipolar individuals are more likely to be arrested and 'subjected' to the criminal justice system than individuals in the general population (McFarland, Faulkner, Bloom, Hallauz, & Bray, 1989).

THE PROBLEM

Why does the community fail so often in dealing with such a prevalent and treatable medical condition? The tragedy brought to the lives of bipolar individuals in our communities is often due to lack of collaboration between the criminal justice system and the mental health treatment system (McFarland et al., 1989; Teplin, 1984). Consider a recent case in Miami, Florida. A Miami-Dade County resident was gunned down by two Miami-Dade police officers (Rabin, 2003). He was killed in an encounter with police from his own community. Refusing to take his medication and in a full-blown manic episode, he broke a window at his girlfriend'shouse and threatened officers with a piece of broken glass. Instead of a medical or community intervention, he got deadly force from officers sworn "to protect and serve" him and a system untrained to distinguish between a medical condition and criminal behavior. In fact, his crime was being bipolar and falling through the cracks by not receiving the proper "community-based care" ("Reform Baker Act," 2003). Ovalle & Green (2003) have produced a list of recent police encounters with the mentally ill in their own community that resulted in the suspect being killed or wounded. According to Clark, et al. (1999, p. 641), "persons with. . .bipolar disorder are at a greater risk for arrest and incarceration than the general population.”Often the first contact of the bipolar with any form of treatment occurs with law enforcement. The bipolar, incarcerated without medicine or treatment, are often victimized in jail and have difficulty finding treatment when released (McFarland, et al., 1989). The list of bipolar individuals killed, severely in-

jured, or incarcerated in the criminal justice system in the United States is a dark stain upon the fabric of our society. Surely, a civilized society does not treat its medically infirmed members like criminals.

Medical interventions, unlike the criminal justice system, are very effective in controlling both the manic and depressive states of bipolar illness. As normalcy returns to the patient's life, routines stabilize and the patient can usually return to work. However, many bipolars may have destroyed many of their work and other important relationships during the course of the disease and as a result have difficulty assuming the same position of employment that they occupied before the onset of the disease.

A Theoretical Approach

A person experiencing bipolar mania (with a persistent, elevated, and expansive mood) is often unaware that she or he is experiencing symptoms of a mental illness. Family or friends observing the abnormal behavior may confront the person and attempt to intervene. Even with a family history of mental illness, and/or previous history and treatment for depression, the person with bipolar mania often still denies experiencing any illness at all (mental or physical). This is termed "perceived susceptibility" in the Health Belief Model (Glanz, Rimer, & Lewis, 2002, p. 48). Instead, the person having a manic episode usually attributes the elevated mood and heightened self-esteem to a new vitamin or diet regimen, spiritual program, or simply being "in the zone." People with bipolar mania are unlikely to seek psychiatric care because they "feel great," believe that they are smarter than the psychiatrist or any other mental health worker. They may have no perceived benefits of seeking care. The full-blown manic episode is a dangerous and risky psychotic state--dangerous to the patient and everyone around her/him and often resulting in incarceration and/or hospitalization.

Mental Health Interventions

Mental health care professionals should routinely evaluate troubled children and adolescents for emotional or behavioral problems. Preventive measures, instituted at an early age, cut the lifetime costs of treatment and decrease the burden to society. Many children and teenagers are uninsured or inadequately covered by insurance. Mental health services for children from lower socioeconomic levels are seldom provided by Head Start or Medicaid programs (National Institute of Mental Health, 2002b). However, adults with bipolar disorder usually fare better than those at earlier stages in life in dealing with the system—especially those having the resources in the form of insurance coverage or education to use the system to access needed mental health care.

Working closely with mental health professionals, bipolar disorder can be optimally managed with medications and psychosocial treatment (i.e., psychotherapy or counseling as forms of "talk therapy"). The disrupted relationships found in bipolar disorder are often accompanied by major life changes like marital separation/divorce, job changes, financial losses, and loss of major support systems. The mental health team provides counseling and psychotherapy. Counseling is also highly recommended for the families of bipolar patients as the entire family is impacted by the disorder.

Untreated bipolar disorder can lead to serious illness and distress including hospitalization, incarceration, and injury due to risky behavior or suicide (Jain, Manning, Garlow, Skale, Jackson, Gardner, & Maletic, 2007). Eventually, a remission cycle will occur in bipolar disorder with the patient becoming asymptomatic with or without treatment (United States Public Health Service, 2000). Upon reaching remission and looking back at a recent manic or depressive episode, patients are often stunned at the horror and mayhem that they have wrought in their lives.

Pharmacological Interventions

Effective medical interventions in bipolar disorder usually include combinations of treatments, for example, psychopharmacology, psychosocial therapy (counseling and 'talk therapy'), and sometimes electroconvulsive therapy (ECT). The most widely prescribed drug regimen for bipolar disorder is lithium carbonate--acting to prevent both the manic and depressive episodes of the disorder (Merck Manual of Diagnosis and Therapy, 1999; 2006). According to the Psychiatry24X7 Website (2002) and the Physicians' Desk Reference (2008), other medications commonly used in bipolar patients are the mood-stabilizing anticonvulsants carbamazepine (brand name: Tegretol) and valproate (brand name: Depakote). Lithium maintenance therapy (including regular blood-level monitoring) is the most successful medication regimen, i.e., the "gold standard" of the pharmacologic treatment of the disorder (Hirschowitz, Kolevzon, & Garakani, 2010). However, according to the National Institute of Mental Health (2002b), Lithium treatment is fraught with numerous and dehabilitating side effects. Unfortunately, so is therapy with Tegretol and/or Depakote but they are generally less effective. The most common short-term side effects of Lithium therapy are severe dry mouth, diarrhea, and tremor. The chronic effects of Lithium therapy are compromised thyroid function and the metabolic changes of nephrogenic diabetes insipidus (Merck Manual of Diagnosis and Therapy, 1999, 2006). Unwanted or side effects of Lithium maintenance therapy can be controlled by regular measurement of blood levels--subsequently adjusting dosages, switching medications, or relying on the body's own development of tolerance to these effects.

Psychosocial Interventions

"The development of psychosocial interventions for the major psychiatric disorders has lagged behind comparable research on pharmacological interventions" (Simoneau, Miklowitz,Richards, Saleem, & George, 1999, p. 588). Psychosocial treatment of bipolar disorders includes behavioral therapy, education, and family therapy (National Institute of Mental Health, 2001, 2002b). Psychosocial interventions for bipolar disorder, including group or individual psychotherapy ("talk therapy"), involve working closely with psychologists, psychiatric social workers, or mental health counselors.

Many psychiatrists focus on medication management of the patient and leave the lion's share of the psychotherapy to psychologists and social workers. Optimally, the psychotherapist works closely with the patient's psychiatrist to assure coordinated treatment and to monitor the progress of therapy. These treatment interventions provide emotional support--the patient is able to discuss her/his problems and receive feedback from the therapist (usually improving treatment effectiveness).

The medical threat to the patient of untreated bipolar disorder looms as the perceived reoccurrence of severe manic or depressive episodes. Since bipolar disorder is a recurrent and treatable illness, preventing recurrence is the key to successful treatment. The success of prevention for the bipolar patient is aided by continuity of therapy, i.e., the patient builds a stable ongoing relationship with the individual(s) providing therapy—looking to them for continuing medical treatment and counseling.

Adherence to a treatment regimen of medication and psychotherapy is often particularly difficult in bipolar disorders. During a manic episode, the patient feels good, even very good, and feels no need to continue needed medication or psychotherapy. The full-blown manic patient may be arrested by the police or admitted to a mental hospital (either voluntarily or involuntarily) before undergoing remission under continuing medical monitoring, medication, and psychotherapy or sometimes spontaneously.

The bipolar patient in remission should take the opportunity to "mend fences" with family, friends, and rebuild her/his support network. The resultant increased level of socialization has a strong positive influence on the patient's overall physical and mental well-being. Education for family members, coworkers, and trusted friends/colleagues about treatment modes, behavioral symptoms, and signs of relapse creates a social network for the patient and may prevent recurrence of episodes of mania or depression (National Institute of Mental Health, 2002b).

Group therapy has also been found to be an effective tool in bipolar disorder. Group therapy, though, is not for everyone as many individuals fear being stigmatized as “mentally ill” and are uncomfortable with participating in such meetings. These individuals should seek care privately or in an outpatient medical school/teaching hospital setting. With ongoing social support, treatment for bipolar disorder will be successful and return the individual to a useful and productive life.

DISCUSSION

The 911-emergency system is often invoked during the manic episode of a patient with bipolar disorder. Over any given period of time, this system is not usually coordinated to recognize repeated calls for help that are the result of mental illness (i.e., from the same address or neighborhood). The police officers responding to the 911-call are often not aware that the call is mental health related and come prepared to deal with criminal behavior rather than a medical problem. Mishandling of an emergency call often results in tragedy in the form of the use of unnecessary and even deadly force by the police (Ovalle & Green, 2003; Rabin, 2003; “Reform Baker Act,” 2003). The costs of coordinating already computerized 911 databases to recognize a mental health-related call are negligible when considering the benefits to mentally ill individuals and to society.

Channeling the mentally ill towards work with the use of their human potential (medical/social treatment versus incarceration) are key features of a “medical model” of mental illness (Wampold, Ahn, Ahn, & Hardin, 2001). The cost of reforming how society

treats the mentally ill is low in comparison to the potential waste of human resources by not acting and maintaining the status quo (Glanz et al., 2002). Fewer violent outcomes in dealing with the bipolar in manic episodes will result in more productive law enforcement and lower medical costs as cost/benefit relationships equalize (Glanz et al., 2002). From the viewpoint of the "medical model" of mental illness, identifying and treating bipolar disorders results in augmented societal resources by the promotion of human worth and dignity (Wampold et al., 2001). The primary 'perceived barrier' to change is the re-education of all personnel in emergency response teams. Officers need to better understand the potential threats of interacting with the manic patient in order to properly respond to an emergency call. Change should be made in the form of requiring increased training and continuing education on mental illness and abnormal psychology for police officers and 911-operators. In addition, certified officers with specialized training in dealing with mental crises can be called to emergency scenes to direct the situation in the best interests of the patient, medical, and law enforcement personnel.

The bipolar individual experiencing a manic episode characteristically destroys relationships making up her/his social network--including colleagues from the workplace, friends, and family. When the mania subsides (usually after a hospitalization), the person is often left isolated and alone. Many of the bipolars that cannot repair their support mechanisms end up as homeless, facing life on the street and an uncertain future.

Limited social support is available in the form of community organizations that provide shelter, food, information, and counseling for mentally ill individuals. On state and national levels, many organizations promote the causes of the mentally ill. The National Alliance for the Mental Ill (NAMI) is available as a support mechanism for families and friends of the bipolar, providing seminars, newsletters, and other informative activities. Other support groups for bipolar individuals include the National Depressive and Manic Depressive Association (NDMDA) and the National Mental Health Association (NMHA). One of the major functions of these organizations is to represent the mentally ill and their families in lobbying efforts for mental health related legislation in Congress.

Sociometric Research

Pharmacological research has been very productive in recent years for the treatment of mood disorders (especially for unipolar depression) and moreover, psychosocial interventions have matured (Hyman, 2000). Large-scale clinical trials (i.e., randomized controlled trials) are necessary to determine the most effective protocols for the treatment of patients with bipolar disorder. According to the National Institute of Mental Health (2002a), the success of clinical trials is dependent upon the education and re-education of those "community players" most impacting the public health, i.e., practitioners, policymakers, law enforcement, insurance companies, and the local government. Priorities and funding of research in mood disorders have not yet balanced the generation of new knowledge and the creation of new treatment modes (National Institute of Mental Health, 2002a). However, research in mood disorders may not be getting "the best bang for the buck" when translated into improvements in patient care and rehabilitation.

CONCLUSIONS

The bipolar individual having a full-blown manic episode usually clashes first with members of law enforcement. Incarceration and/or hospitalization are usually the results of this interaction but deaths have occurred. At the scene of the initial confrontation of the police or other first responders there may be physical, even violent, conflict with the bipolar individual. However, sometimes this is the bipolar individual's first contact with treatment. In the best case scenario, the emergency room at a hospital or mental facility should continue the "chain of treatment" of the patient with inpatient treatment and outpatient referral. On the other hand, "treatment by incarceration" is a poor outcome in any civil, democratic society and must be avoided.

Bipolar disorder is a medical condition requiring medical and psychosocial treatment. Fraught with several acute and chronic side effects, Lithium remains the "gold standard" of pharmacological treatments in bipolar disorder. Drug regimens are usually given in conjunction with ongoing psychosocial therapy in the form of psychotherapy and counseling. Priorities in mood disorder research need to emphasize cost-effective treatments that can be applied across populations, cultures, and communities.

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