Bipolar Disorder: An Informational Resource Manual for the Ministry of Community Safety and Correctional Services Adult Probation and Parole Officers

by

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Dedication

I dedicate this thesis to my parents, thank you for the unconditional support in everything I do and inspiring me every day. I am honoured to have you as my parents. Thank you for giving me the chance to explore and expand in life to improve myself each year. May this thesis make you as proud of me as I am of both of you.
Abstract

Information and resources on Bipolar Disorder for probation and parole officers is discussed in detail. Included is information on the diagnosis, etiology, symptoms, behavioural manifestations, comorbidity, and treatment of Bipolar Disorder. This information, along with additional informative resources are outlined in a manual containing helpful websites and literature, as well as community resources available to offenders serving a probation or parole order in the Kingston area. Crisis intervention is included as well for both offenders and supervising officers. The purpose of the manual is to advance the knowledge of staff at Kingston Probation and Parole of this disorder in addition to community resources available to offenders through referrals. Each community resource is outlined in detail. It is recommended that prior to making a referral, the supervising officer consult with a mental health professional to ensure the offender meets the diagnostic criteria for Bipolar Disorder. Limitations of the informational resource manual are discussed. Recommendations for future research are reviewed for the manual to aid in the continued relevance of the information for future use.
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Chapter I: Introduction

Within the last decade, mental health has significantly increased in the offender population internationally (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2000). It may be helpful for probation officers assigned to offenders living with a mental health disorder in the community to be aware of the disorder since this puts them in a position to make appropriate referrals to community resources (Manchak, Skeem, Kennealy, & Eno Louden, 2013). The Ministry of Community Safety and Correctional Services refer offenders to programming and support services through probation and parole officers working in Community Corrections with the intent of managing their mental health concerns. Programming in the community offers support for offenders who may not have the opportunity to receive the services outside of their probation order. In particular, staff at the Kingston Probation and Parole office have observed, from their perspective, an increase in the incidence of offenders diagnosed with Bipolar Disorder. Consequently, knowledge of the existence of the disorder in clients served will likely increase the chance for a referral for services to manage, if not treat, symptoms. Generally speaking, Bipolar Disorder is diagnosed in 1% of the population worldwide with high mortality and suicide rates (Mandelli, Porcelli, Fabbri, & Serretti, 2010).

Bipolar Disorder is a psychiatric disorder that affects an individual’s quality of life and can cause stress and hardship for the individual, close companions, and even those in distal relationships with the individual with the disorder (Mandelli et al., 2010). The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) states that for a Bipolar I diagnosis, a Manic episode must have occurred; however, diagnostic criteria does not necessarily include a psychotic symptom or a major depressive episode. The DSM-5’s classification of a manic episode is a distinct period of abnormally and persistently elevated, irritable or expansive mood and abnormally and persistently increased goal-directed activity or energy that, persists for at least one week and is present for most of the day, nearly every day (American Psychiatric Association, 2013). A Manic episode may occur at the time of diagnosis, but can also be historical (American Psychiatric Association, 2013). For diagnosis, the Manic episode must be accompanied by at least three symptoms from Criterion B including but not limited to a decreased need for sleep, inflated self-esteem, and distractibility (American Psychiatric Association, 2013). The symptoms that contribute to a Manic episode are severe to the extent that the individual is unable to complete their work, social obligations, and is irresponsible and unreliable in close familial relationships (American Psychiatric Association, 2013). Severe cases require hospitalization to prevent harm to the individual or others (American Psychiatric Association, 2013).

A diagnosis for Bipolar II Disorder involves meeting the criteria for a past or current Hypomanic episode, in addition to meeting the criteria for a past or current Major Depressive episode (American Psychiatric Association, 2013). A Hypomanic episode includes a distinct period of abnormally and persistently elevated, irritable or expansive mood and abnormally and persistently increased activity or energy, lasts at least four days and is present for most of the day approximately every day (American Psychiatric Association, 2013). A Hypomanic episode is accompanied by the same symptoms as a Manic episode including but not limited to a decreased need for sleep, inflated self-esteem, and distractibility (American Psychiatric Association, 2013). Diverging from mania, the DSM-5 asserts that hypomania is not severe enough to cause impairment to social or occupational functioning; however, the episode transgresses into mania if psychotic symptoms arise (American Psychiatric Association, 2013).
The DSM-5 classifies a Major Depressive episode as possessing any five symptoms from a list of nine for a period of at least two weeks. Some of these symptoms include depressed mood, diminished interest or pleasure in activities (commonly referred to as anhedonia), significant weight loss or gain, insomnia or hypersomnia, fatigue, suicidal ideation, and feelings of worthlessness (American Psychiatric Association, 2013). The DSM-5 asserts that a Major Depressive episode must be severe enough to cause impairment to social or occupational functioning (American Psychiatric Association, 2013). Taken together, the above descriptions of manic, hypomanic, and depressive episodes reflect the reality that Bipolar Disorder is a very serious disorder that can have exceptionally destructive effects on the lives of the individuals living with the disorder, their family and friends, colleagues, and even acquaintances. Accordingly, it is of paramount importance that the symptoms of this disorder are managed or treated so as to minimize the negative consequences.

By increasing a probation officer’s knowledge of Bipolar Disorder and the potential serious consequences for individuals not engaging in treatment, probation officers may be more proactive in bridging clients with this disorder to appropriate community resources. Increased knowledge of Bipolar Disorder may increase service provision and effective community referrals for offenders diagnosed with Bipolar Disorder, potentially leading to an improvement in overall quality of life. It is hoped that the development of a psychoeducational and resource manual relating to Bipolar Disorder will heighten their knowledge of the severity of this disorder, and widen understanding of available resources, which may encourage them to more thoroughly seek out available resources.

The purpose of this project is to construct a manual to be utilized as an aid for probation officers who have offenders on their caseloads who have been diagnosed with Bipolar Disorder. At the time of this project the Kingston Probation and Parole agency was lacking information and resources pertaining to this particular psychiatric disorder. Literature will be reviewed providing general information pertaining to Bipolar Disorder including etiology, prevalence, heterogeneity of symptoms, efficacious treatment interventions, and the suicide risk of for individuals with this psychiatric disorder. This will be followed by information regarding the incidence among offender populations and other comorbid problems in addition to the effectiveness of manuals in the professional setting. Moreover, a description of steps involved in the development of the manual will be laid out in the Methodology section. The final product of this project compromises the Results section. A manual design was adopted, as this was the most accessible and efficient method of conveying information about Bipolar Disorder to probation officers. The first chapter of the manual, “Bipolar Disorder: An Overview” provides the reader with a compilation of information including the definition, diagnosis, etiology, symptoms, behavioural manifestations, comorbidity, and treatment. These components are discussed in great detail in a language that is accessible to non-mental health professionals, like probation officers. The following chapter, “Informative Bipolar Disorder Resources” includes a list of supplemental websites and literature to expand knowledge on the disorder. The final chapter, “Bipolar Disorder: Community Resources” includes community agency information, program information, description of referral process, and cost of programming. Moreover, a summary of the thesis including additional strengths, limitations, and recommendations are presented in the Discussion section.
Chapter II: Literature Review

Etiology of Bipolar I and Bipolar II Disorder

Pendergast and associates (2014) assert that individuals with Bipolar Disorder often go misdiagnosed, with many waiting between 5 and 15 years before the correct diagnosis is made. According to Miller (2006), Bipolar Disorder can have a fluctuating course due to the potential for years to pass in between first and second mood episodes. According to the DSM-5, the mean age of onset of the first Manic episode is roughly 18 years old for Bipolar I Disorder (American Psychiatric Association, 2013). Bipolar II Disorder has a mean age of onset in the mid-20’s; however, it is sometimes observed during late adolescence (American Psychiatric Association, 2013). In other words, the course of Bipolar Disorder varies considerably depending on the individual, the episodes experienced, the symptoms experienced, and the age of onset.

According to MacQueen, Hajek, and Alda (2005), Bipolar Disorder has a genetic basis with a heritability of approximately 80%. Contrary to MacQueen and associates’ (2005) finding, Miller (2006) offers that only 50% of individuals diagnosed with Bipolar Disorder have a family history of the illness across generations. Furthermore, the literature varies on the heredity of the disorder for individuals diagnosed with Bipolar Disorder. Miklowitz (2011) states that individuals may inherit a mild form of Bipolar Disorder; however, this illness also often develops in the presence of other predisposing conditions. Predispositional factors include undergoing a difficult or complicated birth, ingesting illicit substances, experiencing a head injury, inherited genetic predisposition from one of more biological relatives, abnormal functioning of brain circuits, and psychological agents, such as one’s belief about relationships or expectation about the ability to control things (Miklowitz, 2011). It may also be contributed to by adverse environment situations such as relationship difficulties, employment obstacles, financial difficulty, and relationship instability (Miklowitz, 2011). Environmental stress and genetic vulnerability can influence and contribute to Bipolar Disorder (Miklowitz, 2011). Stress alone cannot cause Bipolar Disorder; however, accompanied by genetics and the biological makeup of the individual, it can trigger a Manic, Hypomanic, or Major Depressive Episode (Miklowitz, 2011). Overall, the emergence of Bipolar Disorder is often the result of numerous factors, each of which varies in degree of influence across individuals. While Bipolar Disorder does not have clear causes, it does involve biological vulnerabilities that interact with various environmental stressors (Miklowitz, 2011).

Prevalence of Bipolar I and Bipolar II Disorder

With respect to Bipolar I Disorder, the 12-month prevalence rate across 11 countries ranged from 0.0% to 0.6% (American Psychiatric Association, 2013). In addition, the lifetime prevalence ratio for male-to-female individuals is roughly 1.1:1 (American Psychiatric Association, 2013). The 12-month prevalence rate for Bipolar II Disorder is estimated to be 0.3% internationally, and 0.8% in the United States (American Psychiatric Association, 2013). In a study conducted by Merikangas and colleague’s (2008), 9,282 respondents already diagnosed with Bipolar Disorder in the United States were interviewed and observed with the hypothesis that the current population estimate of 1% prevalence rate is an understatement (Merikangas et al., 2008). The study conveyed the following percentages specific to each gender related to prevalence: 0.8% for males and 1.1% for females with Bipolar I Disorder, and 0.9% for males and 1.3% for females for Bipolar II Disorder (Merikangas et al., 2008). Although the study did not provide evidence of an increased prevalence of Bipolar Disorder, the authors concluded that their findings were consistent with earlier studies. Although this study found Bipolar Disorder to be more common in females, the DSM-5 alternatively proposes there is little
to no evidence of a gender difference; however, some clinical samples suggest females are more likely to be diagnosed with the disorder than males (American Psychiatric Association, 2013). The debate about whether gender differences truly exist with respect to both the prevalence and diagnosis of Bipolar Disorder suggests that future research should be conducted in different settings to better clarify this question.

**Heterogeneity of Symptoms in Bipolar Disorder**

The DSM-5 indicates that the diagnostic threshold for Bipolar I Disorder is a Manic episode, which may be preceded or followed by Hypomanic and/or Major Depressive episodes (American Psychiatric Association, 2013). Alternatively, the diagnosis of Bipolar II Disorder requires a past or current Hypomanic episode and a past or current Major Depressive Episode, and the absence of a Manic episode (American Psychiatric Association, 2013). A Manic Episode is composed of three or more of the following symptoms: (1) an inflated self-esteem; (2) a decreased need for sleep; (3) being talkative; (4) having racing thoughts; (5) being distractible; (6) engaging in increased goal-directed activities; (7) excessive engagement in activities that have a high-risk activity (American Psychiatric Association, 2013). In addition, a Manic episode is severe to the extent that the individual is unable to complete their work, or social obligations, requires hospitalization, or psychotic traits are present (American Psychiatric Association, 2013). A Hypomanic episode has identical symptomatology with the exception that the episode is not severe enough to leave the individual incapable of performing work or social obligations, does not require hospitalization, and psychotic traits are not present (American Psychiatric Association, 2013).

A Major Depressive episode requires five or more of the following symptoms during a two-week period and produce change in functioning from an individual’s everyday functioning prior to the episode: (1) depressed mood most of the day, approximately every day; (2) reduced pleasure in all or most activities most of the day (commonly known as anhedonia), approximately every day; (3) significant weight loss or gain and/or an increase or decrease in appetite; (4) insomnia or hypersomnia; (5) an increase in activity brought on by mental strain; (6) loss of energy; (7) feelings of worthlessness; (8) difficulty concentrating or experiencing indecisiveness; and (9) suicidal ideation without a plan, or attempted suicide (American Psychiatric Association, 2013).

**Efficacious Treatment Interventions**

The efficacy of psychotherapy specialized for Bipolar Disorder is emerging (Lam, Hayward, Watkins, Wright, & Sham, 2005). In a study conducted by Lam and researchers (2005) a relapse prevention approach was used in patients with Bipolar I Disorder over an 18-month follow-up period. During the study, 52 patients were assigned to a control group and 51 patients were assigned to a cognitive therapy group (Lam et al., 2005). Treatment for the cognitive therapy group involved (1) psychoeducation about the diathesis-stress model of Bipolar Disorder that emphasized the combination of medication and psychological therapies; (2) cognitive therapy skills focused on monitoring symptoms and adapting behavior to prevent a full-blown episode; (3) underscoring the importance of a regular sleep routine; and (4) targeting appropriate attitudes and behavior (Lam et al., 2005). After controlling for medication compliance, the study concluded that the group-based cognitive therapy significantly reduced relapse rates (Lam et al., 2005). This result provides direct evidence that psychotherapy can assist with relapse prevention. The cognitive therapy group reported an improvement in coping strategies over the last 18 months of the study wherein depressive and manic symptoms had significantly improved by the 24th month (Lam et al., 2005). Since the study controlled
pharmacological treatment it is unknown whether cognitive therapy on its own would benefit individuals with Bipolar I Disorder; however, the study provides preliminary evidence for the combined treatment of psychotherapy and pharmacotherapy for the disorder. In a meta-analysis by Lynch et al. (2010) the authors concluded that, in three out of four researched trials, Cognitive-Behavioural Therapy (CBT) had no significant advantage for patients who were experiencing Manic or Hypomaniac symptoms. Consequently Lynch and colleagues (2010) concluded that CBT alone is not effective for Bipolar Disorder.

Jones and colleagues (2014) investigated the efficacy of recovery-focused CBT, which includes a stronger emphasis on formulation to tailor therapy to each client’s needs. The study concluded that clients adapted and were successful in the recovery-focused CBT because of the flexibility the therapy allowed for each client (Jones et al., 2014). Jones and colleagues (2014) concluded that their results provide preliminary evidence in support of recovery-focused CBT for individuals diagnosed with Bipolar Disorder, especially in terms of flexibility in visiting clients homes for treatment sessions, longer session time, and tailoring personal recovery outcomes (Jones et al., 2014). According to Miklowitz (2011), individual therapy, family and couple therapy, and self-help groups are the most common forms of psychotherapeutic treatment.

The risk for relapse is life-long for individuals diagnosed with Bipolar Disorder and, to address this risk, many individuals are prescribed psychotropic medication on a long-term basis (Frecska, 2012). According to Su and colleagues (2012), many factors influence treatment decisions including: (1) previous response to specific medication; (2) family history of Bipolar Disorder; (3) age and gender; (4) personality traits; (5) psychiatric comorbidity; and (6) potential for abuse and addiction to prescribed medication. Moreover, treatment often differs between individuals diagnosed with Bipolar Disorder because there are a variety of combinations of medication which can also be combined with psychotherapy. Typically, pharmacotherapy for Bipolar Disorder includes mood-stabilizing agents, anticonvulsants, antidepressants, or antianxiolytics, alone or in some combination (Su et al., 2012). In addition, psychotherapy is an essential part of treatment and should be implemented over the whole course of the illness (Su et al., 2012). According to Miklowitz (2011), medication is used for treatment during the episode (i.e., acute-phase) and to prevent future episodes (i.e., preventative treatment). Acute-phase treatment often occurs in outpatient facilities through psychiatric appointments or through inpatient hospitalization, which may last up to three months or longer, depending on the symptoms and severity of the mental illness (Miklowitz, 2011). Preventative treatment is aimed at keeping the individual well and preventing further severe symptoms, lasts at least six months, and incorporates pharmacotherapy to stabilize mood and prevent additional episodes (Miklowitz, 2011).

**Suicide Risk in Bipolar Disorder**

It is estimated that approximately 25% of individuals with Bipolar Disorder will attempt suicide, and 15% of the attempts will succeed (Miller, 2006). Bipolar Disorder and major depression symptoms are correlated with the highest suicide rate among all psychiatric illnesses (Miller, 2006). According to the DSM-5, Bipolar Disorder may account for one-quarter of all completed suicides (American Psychiatric Association, 2013). Bipolar II Disorder has a much higher suicide risk; approximately one third of individuals diagnosed with the disorder endorse a lifetime history of suicide attempts (American Psychiatric Association, 2013). Bipolar I Disorder and Bipolar II Disorder are comparable in terms of prevalence rates of lifetime-attempted suicide (36.3% and 32.4%) (American Psychiatric Association, 2013). Dennehy et al. (2012) conducted a study investigating suicide and suicide attempts during a Systematic
Treatment Enhancement Program for Bipolar Disorder (STEP-BD). During the study, 182 participants made 270 suicide attempts; of which eight were completed (Dennehy et al., 2012). For the instances of completed suicide, each individual lived alone and did not have a history of a committed relationship; six participants were male, and five were unemployed (Dennehy et al., 2012). Most of those who completed suicide were not seriously ill, and 75% disclosed no suicidal ideation at the visit prior to the suicide (Dennehy et al., 2012). Although, it is routine practice for many clinicians to consider a suicide history in predicting future risk, this study provides unmistakable evidence that those without suicide histories and who do not endorse suicidal ideation are capable of a completed suicide. Accordingly, it is imperative that recently diagnosed individuals with Bipolar Disorder be considered and monitored for suicide risk as not all individuals attempt suicide before succeeding. In a study conducted by Simon and colleagues (2004), individuals with a comorbid Anxiety Disorder or Substance Use Disorder were more likely to have a historical attempt.

**Incidence Among Offender Populations**

It is estimated that 14.2% of correctional populations suffer from a severe mental health disorder which among others, includes Major Depressive Disorder (MDD), Schizophrenia, and Bipolar Disorder (Manchak et al., 2013). This is of particular importance since probation and parole officers supervise 69.7% of offenders with mental health struggles (Manchak et al., 2013). Lynch and colleagues (2014) conducted a study with 446 female inmates to determine the current and lifetime prevalence of mental illness (i.e., MDD, Bipolar Disorder, and Schizophrenia) in women in custody. The study utilized two assessment tools, the Composite International Diagnostic Interview (CIDI) and the Sheehan Disability Scale (Lynch et al., 2014). In this study, 43% of the full sample met lifetime criteria and 32% met current (previous 12-month) criteria for at least one of the disorders investigated (Lynch et al., 2014). Offenders in their sample had a 28% lifetime prevalence and a 22% current prevalence rate for MDD, a 15% lifetime prevalence and an 8% current prevalence rate for Bipolar Disorder, and a 4% lifetime prevalence rate for Schizophrenia (Lynch et al., 2014). Vicens and colleagues (2011) interviewed 700 inmates to ascertain prevalence of mental health disorders both lifetime prevalence and in the previous month. Lifetime prevalence of any mental health disorders in the prisons was determined to be 84.4%. In descending order of prevalence, inmates most often experienced Substance Use Disorders (76.2%), Anxiety Disorder (45.3%), a Mood Disorder (41%), or a Psychotic Disorder (10.7%) (Vicens et al., 2011). The prevalence of mental health disorder in the month preceding the interview was 41.2%; in descending order these were an Anxiety Disorder (23.3%), Substance Use Disorder (17.5%), Mood Disorder (14.9%), and a Psychotic Disorder (4.2%) (Vicens et al., 2011). Comorbidity of mental health disorders and substance abuse was very high, as reflected in the finding that only 57 of the inmates (8%) suffered from a mental health disorder without a history of co-occurring Substance Abuse Disorder (Vicens et al., 2011). In a similar study, Hodgins and Coté (1990) used the Diagnostic Interview Schedule (DIS) to explore the incidence of mental illness among 495 inmates in a Quebec correctional sample. The study concluded that the incidence of Bipolar Disorder was four times more prevalent in the correctional institution as compared to a community sample, providing direct evidence suggesting that the incidence of Bipolar Disorder is significantly higher among offender populations (Hodgins & Coté, 1990).
Comorbidity in Bipolar I and Bipolar II Disorder

The most frequent co-occurring class of mental illness with Bipolar Disorder is any Anxiety Disorder, co-existing in approximately three-fourths of individuals diagnosed with Bipolar Disorder (American Psychiatric Association, 2013). Simon et al. (2004) supervised a study of 500 patients with Bipolar I and II Disorder to assess the effects of a comorbid Anxiety Disorder. Simon and colleagues (2004) found higher rates of comorbidity with an Anxiety Disorder in patients with Bipolar I Disorder compared to those with Bipolar II. In addition, there was a high comorbidity between an Anxiety Disorder and a Substance Use Disorder for the entire sample (Simon et al., 2004). The study demonstrated decreased quality of life and functioning with a co-occurring Anxiety Disorder (Simon et al., 2004). Experiencing a comorbid Anxiety Disorder appears to be associated with greater symptom severity of Bipolar Disorder and suicide attempts and should be monitored carefully by clinicians (Simon et al., 2004).

Although this study found that Bipolar I Disorder has a higher comorbidity rate with an Anxiety Disorder than in Bipolar II, the DSM-5 estimates 75% of individuals diagnosed with Bipolar II Disorder have a co-occurring Anxiety Disorder and 37% have a Substance Use Disorder (American Psychiatric Association, 2013). This suggests a high overlap between all three classes of disorder and thereby further highlighting the complex struggles of many individuals diagnosed with Bipolar Disorder. Albert, Rosso, Maina, and Bogetto (2008) reported that a comorbid Anxiety Disorder correlated with a poor quality of life for individuals diagnosed with Bipolar Disorder. Albert and associates (2008) report individuals with Bipolar I Disorder are influenced negatively on quality of life when experiencing a comorbid Anxiety Disorder, but not for individuals with Bipolar II.

According to the DSM-5, more than half of individuals with Bipolar I Disorder have a comorbid Substance Use Disorder, and are at a greater risk for a suicide attempt (American Psychiatric Association, 2013). The most commonly abused substances by this population include alcohol, marijuana, cocaine, and other stimulants (MacQueen et al., 2005). A predisposition to use substances may arise from shared genetics, but it can also be a consequence of or a response to psychiatric symptoms (i.e., self-medication) (MacQueen et al., 2005). Furthermore, substance abuse can contribute to additional illnesses with Bipolar Disorder, most notably the development of a Substance Use Disorder, as well as physical health issues (MacQueen et al., 2005). Individuals may begin using substances to cope with symptoms of the disorder, and in turn potentially create a comorbid Substance Use Disorder (MacQueen et al., 2005). Substance Use Disorders are correlated highly with manic symptoms as substances have the potential to induce a Manic Episode (MacQueen et al., 2005).

Effectiveness of Manuals Used in the Professional Setting

Manuals have the potential to present theoretical frameworks, in depth descriptions of therapeutic techniques, and case examples (Piper & Ogrodniczuk, 1999). According to Piper and Ogrodniczuk (1999), manuals are the primary teaching aide for providing information to professionals in the workplace. Dobson and Shaw (1993) used a manual to train cognitive therapists to implement effective treatment that focused on building therapeutic relationships, case conceptualization, and cognitive techniques. The study reported high satisfaction among trainees in terms of the quality of the training received through the manual (Dobson & Shaw, 1993). Clinicians also indicated that the use of a manual was beneficial to review concepts they were unsure of, which they could then implement during therapy sessions (Dobson & Shaw, 1993). Najavits and associates (2004) reported that therapists viewed manual training as a positive experience, as suggested by a positive reaction by clinicians in the professional setting.
However, Najavits et al. (2004) indicated that 40% of clinicians reported they would not use the manual in the future without first making their own modifications to it. These findings suggest the importance and utility of manuals; however, the user of the manual may modify how the manual is used by tailoring techniques to their preferences and the needs of their clients. In addition, Najavits et al. (2004) note that clinicians were highly motivated to use manuals in the workplace because of their underlying desire to learn. Noteworthy limitations of manuals include the effectiveness being dependent on the quality of information contained in the manual, the user’s skill level, and the motivation of the user to utilize the manual (Arthur Jr., Bennett Jr., Edens, & Bell, 2003). Despite these limitations, a resource manual has the potential to clearly convey information to users, as well as provide them with important information about disorders, techniques, treatments, and resources.

**Summary**

Although it is widely believed that Bipolar Disorder is influenced by genetics, contemporary studies differ in the degree of genetic contribution (MacQueen et al., 2005; Miller, 2006) Merikangas et al. (2008) calculated gender-specific findings that were consistent with studies asserting that Bipolar Disorder affects 1% of the population worldwide. The DSM-5 asserts there is little to no evidence for gender differences in Bipolar Disorder (American Psychiatric Disorder, 2013). Two forms of therapy are predominantly used in treatment. The first, psychotherapy, may take the form of individual therapy, family, or couples therapy (Milkowitz, 2011), and is often most effective when engaged in over the whole course of unmanageable episodes (Su et al., 2012). Another common treatment modality is pharmacotherapy, which involves the prescription of any combination of mood stabilizers, anticonvulsants, antidepressants, and anti-anxiety agents with psychotherapy; however, when treating Bipolar Disorder with only one form of treatment, pharmacotherapy appears to be best (Su et al., 2012).

The DSM-5 assertion that Bipolar Disorder may be implicated in one-quarter of all completed suicides should be a concern to everyone in society. It is critical to monitor both clients with a previous history of suicide attempts and also recently diagnosed individuals, since those who do not have a history of attempting suicide may still pose some risk for suicide (Dennehy et al., 2012). Probation and parole officers supervise a large portion of offenders with mental health struggles (Manchak et al., 2013), and some evidence suggests that Bipolar Disorder is disproportionately more prevalent in offender population as compared to community samples. Anxiety and Substance Use Disorders are often comorbid and complicate the struggles and needs of individuals with Bipolar Disorder (American Psychiatric Association, 2013; Simon et al., 2004).

One way to train professionals in the workplace manuals is to use manuals (Piper & Ogrodniczuk, 1999). Some clinicians are highly motivated to use manuals, in part due to a desire to learn and acquire new techniques and resources (Najavits et al., 2004). Accordingly, a manual may be a successful way to relay information on Bipolar Disorder, as well as techniques and resources in order to aid in the successful reintegrat ion of offenders diagnosed with the disorder into the community.

At the time of this project, there was limited information on Bipolar Disorder at Kingston Probation and Parole for probation and parole officers to review when providing services to an offender with this illness. Although these areas may be addressed individually within each officer’s varying knowledge of mental health, there was no specific aid to offer information to officers who may lack prior knowledge of the disorder. Therefore, the current manual was
designed to address this absence of knowledge and resources by providing means for probation and parole officers to be more proactive in increasing the chances of making an appropriate referral and thereby aiding in integrating their clients into the community with helpful resources. Due to time constraints, it is not within the scope of the current project to test the efficacy of the manual. Instead, the manual is developed to aid probation and parole officers in future supervision and referral practices.

Word Count: 3583
Chapter III: Methodology

Description of Setting and Services

The Kingston Probation and Parole office is an agency that provides community based supervision for males and females 18 years of age or older who are serving a community sentence and/or probation order under the Ministry of Community Safety and Correctional Services. Offenders who are supervised may range from very low to very high risk and can have additional mental health issues, substance dependence, and a range of criminogenic needs. Probation and parole officers provide counselling and support services through community referrals for offenders. The role of a probation and parole officer is to enforce the conditions on the probation/parole order. The supervising officer determines frequency of reporting through assessment(s) of risk to offend, and compliance of the offender to parole or probation conditions. All support services are offered in the community, can include individual counselling or psychotherapy, group counselling, appointments related to physical health, substance abuse treatment, rehabilitative programming, employment agencies, and agencies that provide community service order hours in the community. Referrals are tailored to each offender’s needs and requirements on their probation or parole order. In addition, it is critical for probation and parole officers to use motivational interviewing strategies while engaging with client’s during reporting meetings to get them motivated to attend the support services and to speak openly about any issues they may be experiencing.

Probation and parole officers are also often responsible for authoring many reports such as Pre-Sentencing Reports, Post-Sentencing Reports, Pre-Parole Reports, Stand-down Reports, sections in the Level of Service Inventory-Ontario Revision assessment such as the summary and yearly updates, Discharge Reports, and any letters to the Crown for sentencing purposes. It is imperative that probation and parole officers have, at minimum, adequate knowledge and resources to reference and review while writing reports about various populations within their caseloads (i.e., individuals with substance abuse concerns). The current project is interested in providing information in this regard for probation and parole officers attempting to support and manage individuals diagnosed with Bipolar disorder.

Materials

The end product of this project will be a manual entitled Bipolar Disorder: Informational Resource Manual for the Ministry of Community Safety and Correctional Services Adult Probation Officers; its intended audience will be probation and parole officers who have offenders diagnosed with this disorder on their caseload. A manual design was adopted, since this is the most accessible and efficient method of conveying information about Bipolar Disorder. In developing the manual, the author researched current information on Bipolar I and II Disorder, as well as community resources, and searched for corresponding material that may be of value and interest to probation and parole officers working with this population. The information will then be incorporated into the resource manual. The manual will consist of two sections; the first section will contain two chapters of information on “Bipolar Disorder: An Overview” and “Informative Bipolar Disorder Resources”, the second section will comprise the final chapter, “Bipolar Disorder: Community Resources” which will outline relevant agencies and services available to offenders on probation or parole in the community with this diagnosis.

Description of Methodology

The manual will be developed as a reference tool for Bipolar Disorder to be used as needed with the hope of increasing knowledge on the disorder and to assist in referring offenders in the community corrections to helpful services. The manual will be briefly presented at a staff
meeting to convey relevant information to staff regarding the purpose and contents of the project and will be located at the agency for any probation or parole officer, office personnel, or offender to view.

**Feedback**

Due to time constraints, it was decided that a feedback evaluation component of the project would not be adopted.
Chapter IV: Results

The Bipolar Disorder: An Informational Resource Manual for the Ministry of Community Safety and Correctional Services Adult Probation and Parole Officers can be found in Appendix A. The manual was created using researched information about Bipolar I and II Disorder along with researched community resources. The purpose of the manual is to advance the knowledge of staff at Kingston Probation and Parole of this disorder, in addition to referral services available to the offenders within the community. The manual is separated into two sections; the first is comprised of two chapters, which solely focus on providing the reader with information about the disorder. The first chapter includes, an overview of Bipolar Disorder containing information on the diagnosis, etiology, symptoms, behavioural manifestations, comorbidity, and treatment. Additional informative resources are provided in a second chapter containing helpful websites and literature to further aid the reader’s knowledge about the disorder. The second section includes community resources available to offenders diagnosed with Bipolar Disorder while serving a probation or parole order.
Chapter V: Discussion

Summary

The incidence of Bipolar Disorder is increasing in offenders serving a community-based sentence and in the correctional system (Brinded et al., 2000). Therefore, it is important that accurate information be relayed to probation and parole officers about Bipolar Disorder itself and the community resources that individuals living with this debilitating disorder may access. The informational resource manual contained in Appendix A aims to begin to bridge this gap. The informational resource manual was created to provide probation and parole officers with information and local resources regarding offenders diagnosed with Bipolar Disorder. In consideration that this disorder is becoming more commonly diagnosed, it is beneficial for probation and parole officers to be knowledgeable about many factors surrounding this disorder, including, etiology, symptomatology, behavioural manifestations, comorbidity, and particularly treatment to assist with resources in the community to bridge offenders with this disorder to helpful services. The information incorporated into the manual has been compiled from existing literature to comprise the overall product.

Strengths

A primary strength of this thesis is that the manual can help to inform probation and parole officers as well as agency personnel when interviewing and recommending community services. During interviews and meetings with clients, probation and parole officers will find it beneficial to know about the disorder when reading body language to examine nonverbal as well as verbal behaviour, in addition to asking questions to how the client is managing current symptoms. For the probation and parole officers, the manual may serve as an aid to complement their existing skills, and increase knowledge about Bipolar Disorder. For the offenders, the manual can serve as a useful guide offering pertinent literature that offenders may read if wanted. It also provides information to the offender that can be helpful when collaborating with the supervising officer to decide on a program that may be helpful. The manual translates mental health information into lay language with the intention of relaying mental health information that can be more readily understood by non-mental health professionals, thereby assisting probation and parole officers to interpret diagnostic jargon. The manual conveys behavioural manifestations of the disorder for probation and parole officers to be aware of as proverbial red flags, in the case that a client has difficulty managing symptoms. In addition, the manual incorporates information regarding community interventions for probation and parole officers to view and refer to in order to save them time from researching programs themselves. Crisis protocol is conveyed in the manual for the supervising officer or offender to have a variety of numbers and agencies to call should a crisis occur. A final strength is that the manual may serve as a helpful aid in providing knowledge to new staff or volunteers, who may have little, if any, experience working with individuals experiencing Bipolar Disorder. Accordingly, this manual affords others a user-friendly guide compromised of general information, additional resources, and community resources.

Limitations

Synthesizing information about a disorder from existing literature can be challenging. In creating the informational resource manual, the main challenge was identifying community resources that are available to offenders with Bipolar Disorder. While many programs are available in the community, cost effectiveness is a major concern for many offenders who are often in a financially disadvantageous position. In addition, some agencies may not be keen to service those involved with the criminal justice system. Finding resources that are cost effective
for offenders was difficult as many offenders are on an exceptionally limited budget, and many require financial assistance. In addition, many programs are not specific to Bipolar Disorder; therefore, additional inquiries were made not only to ensure Bipolar disorder fit the criteria, but also to ensure offenders were able to attend at a reasonable or no cost.

Another limitation is that the usefulness of the manual is predicated on probation and parole officers having the motivation and time to review the manual. If motivation and resultant effort is not high to review the manual, the usefulness will expectedly be reduced. Although it is more time consuming to read parts of the manual that discuss what constitutes Bipolar Disorder, probation and parole officers may choose to only view websites or call agencies to find resource information they need rather than reading the parts of the manual that describe Bipolar Disorder itself, which could hinder their understanding of the symptoms and behavioural manifestations observed in their clients in face-to-face interactions. In addition, the manual will not serve as a permanent aid for the agency due to the fact that criteria for this disorder may change with each successive revision of the Diagnostic and Statistical Manual of Mental Disorders.

Agencies may close programs depending on success and usage; therefore, the named agencies and programs may not be available in the short-and long-term. On the contrary, additional agencies or programs may begin in the community that may provide services to offenders with Bipolar Disorder; any changes in existing programs and the rise of new programs should be monitored by agency staff periodically. This manual assumes that all users do not have visual impairments and that all clients are literate. A final limitation is that probation and parole officers, prior to the result of the thesis did not formally evaluate the manual. Due to time constraints, feedback was not gathered from agency personnel and probation and parole officers. Instead the primary author was responsible for all of the research that went into summarizing available programs in the community. If the manual was evaluated at the agency, it is possible that more information could have been incorporated or esthetics of the manual could have been improved and/or customized to agency preferences.

**Anticipated Challenges and Limitations for Practical Application**

Not all community resources mentioned in the manual may be suitable for offenders. Depending on conditions of the probation order, the location of the group, other group members, or treatment approach, certain programs may not be a viable option for a particular offender. For example, if the offender knowingly has not succeeded in a particular treatment approach a program is offering, it would not be wise to refer him or her there. Since probation orders can be very specific, offenders may be limited in programming they are allowed to attend in the community if certain peers may be around that they have a strict order to avoid. For example, an offender may have a no contact order with another offender; therefore, programs need to be individually chosen in accordance to the probation order.

**Contribution to the Behavioural Psychology Field**

The field of Behavioural Psychology aims to promote adaptive behaviour change to improve an individual’s daily functioning and overall quality of life. This thesis contributes to this field as it provides information regarding Bipolar Disorder as well as community resources to the probation and parole officer, which can then be passed on to clients living with this disorder. Accordingly, this manual, when used properly, can have direct consequences on the quality of life for offenders in the Kingston area who have been diagnosed with Bipolar Disorder. As laid out in the manual, behavioural manifestations are heavily connected to symptoms; therefore, it is necessary for professionals working in this area without a behavioural psychology background to be aware of the best treatment and services in the community to assist
with maintenance and improvement. Within the manual, behaviours are explained as a relation to Bipolar Disorder, although the behaviours may be reflective of other issues the offender is experiencing. The manual has the potential to increase the chances that offenders receive the services they need to promote success in maintenance or reduction of Bipolar Disorder symptoms, as well as success in the community. Lastly, the treatment section of the manual combines several approaches that are used among different client populations within behavioural psychology, adding to the growth of literature throughout this field.

**Recommendations for Future Research**

It is recommended that agency personnel, in addition to probation and parole officers, evaluate the manual to test the usefulness according to agency preference through feedback. Following a formal evaluation, it is suggested that revisions be made to the manual based on the results obtained, in an effort to improve the overall content and usability of the informational resource manual. Finally, it is suggested that the manual be updated as each diagnostic manual is updated to ensure all literature and diagnostic criteria is accurate. In addition, updating the community resources would be beneficial as agencies have the potential to discontinue programs, make changes, or close entirely. In the case that updates are made, amendments should be identified to prevent potential inaccurate information as being attributed to the author. Moreover, it is suggested that new agencies and program services be added to the manual to help aid probation and parole officers bridging offenders to appropriate programming to increase overall quality of life as well as helping them to abide by probation order conditions as necessary.
References


Bipolar Disorder: An Informational Resource Manual for the Ministry of Community Safety and Correctional Services Adult Probation and Parole Officers

Created and Written: Vanessa Barbosa

In consultation with the Kingston Probation and Parole Services Office
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Introduction

The Bipolar Disorder: Informational Resource Manual for the Ministry of Community Safety and Correctional Services Adult Probation Officers is designed to assist in furthering knowledge about Bipolar Disorder for probation and parole officers with offenders diagnosed with this disorder on their caseload. It possesses an array of information on the diagnosis, symptoms, etiology, behavioural manifestations, comorbidity, and treatment of Bipolar Disorder. Also included are additional informational resources including websites and literature as well as community resources to aid in referral services for the offenders diagnosed with the disorder. Probation and parole officers, office personnel, and offenders may utilize this manual as needed.
Chapter 1:

Bipolar Disorder: An Overview
Diagnosis/Symptoms

Bipolar I Disorder:

A Manic Episode must have occurred for a diagnosis of Bipolar I; however, a Manic Episode can be preceded or followed by Hypomanic or Major Depressive Episodes. A Manic Episode is a clearly identifiable period of irregular and constantly inflated, irritable or wide-ranging mood changes much like a roller coaster that occurs most of the day for at least one week. The individual will have frequent changes in activity and drive, a shift in thinking and perception, and impulsive or self-destructive behaviours. Also included is an increase in energy, as well as taking on new projects (for example, painting a room at 1:00 a.m. or frenzied cleaning of entire living space), that continues most of the day, everyday for at least one week.

The symptoms of a Manic Episode are severe enough to cause noticeable deterioration in the individual’s work or family life. For example, large scale family arguments, or loss of job. It may also have the presence of psychotic features, which include delusions, or hallucinations that impair the individual’s contact with reality. Delusions are a belief system that is unchanging even in the wake of incontrovertible evidence to the contrary. Hallucinations may occur in any sensory domain (taste, touch, audio, visual, olfactory) including seeing and hearing things that are not actually present. It is important to know that the delusions and hallucinations are related to the feelings the individual is having, for example, an offender may hear voices telling them that they no longer deserve to live. Sometimes it requires hospitalization due to excessive risk taking behaviours, a high likelihood for self-injurious behaviour, or the psychotic features mentioned above. In order to experience a Manic Episode an individual must have three or more of the following symptoms during which the individual suffered from a deterioration from everyday functioning:

- An inflated self-esteem;
- A decreased need for sleep;
- Being more talkative than usual;
- Having racing thoughts;
- Being distractible;
- Engaging in increased goal-directed activities (taking on new projects such as organizing a closet the second the idea is thought of by an individual)
- Engaging in in activities that have a high chance of painful consequences.

Bipolar II Disorder:

A diagnosis of Bipolar II requires a past or current Hypomanic Episode and a past or current Major Depressive Episode. In regards to a Hypomanic Episode, the symptoms are identical to those of a Manic Episode with the exception that the episode is not severe enough to cause noticeable deterioration in the individual’s work or family life, does not require hospitalization, and does not involve psychotic symptoms. Also, a Hypomanic Episode has to last at least four consecutive days in order to meet the diagnostic criteria. A Major Depressive Episode requires five or more of the following symptoms during a two-week period and is a big change from the individual’s every day functioning prior to the episode:
• Depressed mood most of the day (i.e., feeling sad or empty), approximately every day;
  o Examples: The offender may sound weepy, disinterested, and make statements evidencing hopelessness or worthlessness.
• Reduced pleasure in all or most activities that were previously enjoyed;
  (commonly known as anhedonia), approximately every day
  o Examples: A mother no longer gaining joy from playing with her child, an offender unmoved by gaining their dream employment, or an offender who plays sports and no longer wishes to play.
• Significant weight loss or gain with a shift of 5% or more, and/or an increase or decrease in appetite;
• Sleeping not enough or sleeping many more hours than necessary for a restful night’s sleep;
• Delayed or agitated mental and physical processes;
  o Examples: pacing, toe-tapping, difficulty performing a task such as getting out of bed, or difficulty making a shopping list.
• Loss of energy;
• Feelings of worthlessness;
• Difficulty concentrating or being indecisive;
• Suicidal ideation (i.e., thoughts about how to kill oneself, ranging from detailed plans to momentary considerations; however, does not include the act of killing oneself) or attempted suicide.

The symptoms for Bipolar I and II Disorder are present on their own without the effects of a medication or drugs, which can mimic these symptoms. If drug or medications are discontinued and the symptoms remit, then this is not Bipolar Disorder. The symptoms are a large change from an individual’s baseline mood.
**Etiology**

- Individuals with Bipolar Disorder may wait between 5 and 15 years before the correct diagnosis is made.
- Bipolar Disorder can have an unpredictable course due to the potential of years to pass between first and second mood episodes. Observed symptoms may be sporadic as a result.
- The average age that symptoms of Bipolar I Disorder emerge is 18.
- The average age that symptoms of Bipolar II Disorder emerge is in the mid-20's.
- Individuals with Bipolar Disorder tend to have a close family member with this illness. Estimates range that this is the case for 50-80% of individuals.
- Although heritability differs for each person; this disorder often develops in the presence of other active conditions such as complicated births, ingesting illicit substances, head injuries, and overcoming adverse environment situations (e.g., relationship difficulties).
- Stress has the potential to trigger a Manic, Hypomanic, or Major Depressive Episode in interaction with the genetics and the biological makeup of the individual.
- Bipolar Disorder does NOT have a clear cause, but does involve biological vulnerabilities that interact with various environmental stressors. This means that the emergence of Bipolar Disorder symptoms is the product of both the person and the environment together.
- One percent of the population worldwide has Bipolar Disorder, but this illness is higher among incarcerated populations. However, the impact of this illness is much wider since this disorder affects a much higher percentage in terms of family, friends, and colleagues of these individuals.
Behavioural Manifestations

The symptoms of Bipolar Disorder result in unpredictable shifts in an individual’s mood, energy, decision-making, and ability to function. The individual often experiences serious alternating periods of deep lows and excessive highs. During a Major Depressive Episode, observed behaviour may include some or several of the following:

- Excessive or inappropriate intense feelings of sadness, hopelessness, worthless, and/or guilt;
- Socially withdrawn from family and peers such as an overwhelming urge to be alone;
- Loss of interest in usual activities;
- Loss of confidence;
- Trouble with concentration;
- Restlessness, difficulty making decisions;
- Increased alcohol and/or drug abuse;
- Frequent suicidal ideation or attempts;
- Significant weight loss or gain with a shift of 5% or more;
- Sleep difficulty or fatigue.

During Manic or Hypomanic Episodes, present behaviour may include:

- Increased energy;
- Restless, decreased need for sleep;
- Rapid speech;
- Feeling invincible or “on top of the world”;
- Increased self-esteem;
- Irritability, hypersensitivity, rapid mood changes;
- Racing thoughts;
- Poor judgment;
  - Examples: Knowing one is financially unstable yet the individual spends money on a brand new car, or dressing in shorts and a T-shirt in the winter.
- Increased use of alcohol and/or drug abuse;
- Increased sexual drive.
Comorbidity

The term comorbidity is meant to refer to other mental illnesses that often occur simultaneously. The following discussion is meant as a brief overview of mental illnesses that often co-occur with Bipolar Disorder.

Anxiety Disorders

For the purpose of the manual, the most frequently occurring, two comorbid disorders will be discussed. Comorbidity is quite common in individuals with Bipolar Disorder. Three fourths of individuals diagnosed with Bipolar Disorder have a co-occurring Anxiety Disorder. A comorbid Anxiety Disorder appears to be related to higher symptom severity as well as a heightened risk for a suicide attempt. It is estimated that 75% of individuals diagnosed with Bipolar II Disorder have a co-occurring Anxiety Disorder and 37% have a Substance Use Disorder.

Substance Use Disorders

More than half of the individuals with Bipolar I Disorder have a comorbid Substance Use Disorder, putting these individuals at greater risk for a suicide attempt. Ingestion of illicit substances can contribute to suicide in many ways. It can lead to accidental overdoses, or worsen depressive symptoms. Additionally, it can impair decision-making and contribute to a decision to attempt suicide. This is because substances can act as stimulants, having the opposite effect of depressants. The most commonly abused substances used by these individuals include alcohol, marijuana, cocaine, and other stimulants. Individuals may begin using substances to cope with various symptoms of this disorder, in turn potentially creating a comorbid disorder of Substance Use. Substance Use Disorders is reasonably correlated with manic symptoms as substances have the potential to induce a Manic Episode.

Suicide Risk

A heightened potential of suicide risk is associated with comorbidity. Approximately 25% of individuals diagnosed with Bipolar Disorder will attempt suicide, and 15% of the attempts will be successful. Bipolar Disorder may account for one quarter of all completed suicides.
Psychotherapy

Psychotherapy can be used in conjunction with medication. Speaking with a therapist about stressors, impact on the individual’s quality of life, or to address personal problems that may arise whether mood is stable or not can be very beneficial. Psychotherapy can also help manage symptoms of this disorder and help to prevent relapse once an individual’s symptoms return to baseline. An individual can benefit greatly with the help of psychotherapy over the entire course of the disorder. There are eight objectives of psychotherapy for individuals diagnosed with Bipolar Disorder:

- To help make sense of current or past episodes.
- To discuss long-term planning and relapse prevention in relation to future episodes.
- To help interested individual accept and adapt to a medication regimen.
- To identify and develop strategies to cope with stress and mood.
- To improve overall functioning at school or workplace.
- To deal with social and self stigma of Bipolar Disorder.
- To deal with comorbid disorders.
- To improve family or romantic relationships.
- To reduce or manage risk for suicide when applicable.

Medication

The risk for relapse in to a Depressive, Manic, or Hypomanic Episode is lifelong for individuals diagnosed with Bipolar Disorder; therefore, many individuals are prescribed long-term medication to prevent relapse. Treatment differs for every individual, as there are a variety of combinations of medication in addition to combining medication with psychotherapy. Typically medication for Bipolar Disorder will include some combination of mood-stabilizing agents, antidepressants, atypical antipsychotics, or anti-anxiety agents. However, it should be noted that some individuals are able to manage without medication entirely for periods of time. Common mood-stabilizing medications include Lithium, Depakote, Lamictall, and Tegretol. Common atypical antipsychotic medications include Thorazine, Haldol, Zyprexa, Seroquel, Risperdal, and Abilify. Medication may be used as treatment during an episode (acute-phase), or treatment to prevent future episodes. During the acute phase, treatment may occur in outpatient facilities such as psychiatry offices or hospitals. Preventative treatment is aimed at keeping the individual well and to prevent further severe symptoms.
Chapter 2:

Informative Bipolar Disorder Resources
Websites
The following are Internet resources that can be used at any time to research more information or join forums to discuss Bipolar Disorder.

American Psychological Association (www.apa.org) provides an in depth overview of Bipolar Disorder in addition various psychological and mood disorders.

Bipolar World (www.bipolarworld.net) presents information on diagnosis, treatments, and suicide. In addition, forums and chat rooms are available.

Medline Plus Health Information (http://www.nlm.nih.gov/medlineplus/bipolardisorder.html) provides an overview of the disorder in addition to academic research articles and external links to government and non-government websites for latest news on the disorder.

The International Society for Bipolar Disorders (http://www.isbd.org) provides information on conferences, educational opportunities, memberships, and resources in the form of website links for patients.
Literature

The following are informational books, articles, and self-help guides on Bipolar Disorder. The book that is bolded may be of particular help as it can be used with offenders during meetings and is written in layman’s terms.

Books
Chapter 3:

Bipolar Disorder: Community Resources
Community Resources

Canadian Mental Health Association

Program: Mental Health Awareness
Description: The Mental Health Awareness Program is a public education program available to all individuals to help increase understanding and acceptance of mental illness, increase awareness of family violence, and promote development and maintenance of mental health. During the program, resources are given to clients at no cost to assist with the learning process.

Referral Process: Contact the information and referral program at the number below.

Cost: 0$

Contact Information:
Phone: 613-549-7027
Fax: 613-549-7098
Email: cmhastaff@kingston.net
Website: www.cmhakingston.blogspot.ca
Address: 400 Eliott Avenue, Unit 3
            Kingston, ON K7M 6M9
**Program:** The Assertive Community Treatment Team (ACTT)

**Description:** A multi-disciplinary professional team composed of occupational, behavioural, recreational and vocational therapists; addictions specialists; nursing, social work and psychiatry supports. A high level of support is provided to clients to ensure success in the community and who may have not benefited from previous mental health supports in the community.

**Referral Process:** A referral form can be found at http://www.fcmhas.ca/index.cfm/services1/assertive-community-treatment-teams1/. Please follow the instructions on the form for return. When working with a client diagnosed with Bipolar Disorder. It is best to call the number below and speak to a member of the referral team about the client to determine the best program for them as treatment can be individually tailored.

**Cost:** 0$

**Contact Information:**
Phone: Access Team – 613-544-1356 ext. 2356
Website: http://www.fcmhas.ca/index.cfm/services1/assertive-community-treatment-teams1/.
Address: Three locations - 552 Princess Street
  Kingston, ON K7L 1C7
  385 Princess Street
  Kingston, ON K7L 1B9
  105 Wellington Street
  Kingston, ON K7L 3C6

Crisis Line: 613-544-4229 for a telephone response 24 hours every day.
Providence Continuing Care Centre

**Program:** Mood Disorders Outreach Team  
**Description:** The Mood Disorders Outreach Team provides specialized care to clients with Bipolar Disorders and other mood disorders. Services provided include psychiatry, occupational therapy, social work, cognitive behavioural therapy groups, and Changeway groups (an introduction to cognitive therapy). The team is located at the Providence Care Mental Health Services and each client’s care plan is individualized through the clinic. Psychotherapy and psychoeducational groups are included such as cognitive behavioural therapy, Changeways, interpersonal psychotherapy, expressive psychiatric therapy groups, and relaxation and calming techniques.  
**Referral Process:** A one-time clinical consultation may be available to the client and involves assessment by a clinician from the clinic. The probation and parole officer will need to be in contact with the client’s family doctor in order for the referral to be endorsed.  
**Cost:** 0$  
**Contact Information:**  
Intake Coordinator: Ann Shea  
Phone: 613-548-5567 ext. 1275  
Fax: 613-540-6114  
Email: sheaa@providencecare.ca  
Address: 752 King St. West  
Kingston, ON K7L 4X3

**Program:** Outpatients Forensics Mental Health  
**Description:** A team of professionals offers clinical support to clients with mental health illness who have come into conflict with the law and who have community access (for example, probationers and parolees). This program is based solely around offenders in the community.  
**Referral Process:** Contact Chantal Thompson (see below).  
**Cost:** 0$  
**Contact Information:**  
Chantal Thompson  
Phone: 613-548-5567 ext. 5914  
Email: thompsc3@providencecare.ca  
Website: http://www.providencecare.ca/CareServices/outpatient-mental-health/Pages/default.aspx
Queen's University Department of Psychiatry

**Program:** Choices Group  
**Description:** Ten-week group that takes place for two and a half hours. Psychotherapy and Dialectical Behaviour Therapy are used for skills training. Dysfunctional patterns of thinking and behaviour are reviewed through weekly homework assignments and distress tolerance tools. The group is applicable for individuals struggling with low self-esteem, emotional instability, self-damaging behaviour, unstable relationships, and suicidal thoughts and/or behaviour.  
**Referral Process:** To participate a referral is mandatory and can be made by contacting the professional below in addition to a screening process. Referrals are accepted by family physicians, psychiatrists, and community mental health workers (family physician should endorse the referral when possible).  
**Cost:** 0$  
**Contact Information:**  
Intake Coordinator: Paula Van Strien  
Phone: 613-542-8344 ext. 301  
Fax: 613-542-1400

**Program:** Managing Powerful Emotions Group  
**Description:** Fifteen-week psychoeducational group for client’s who suffer from emotional dysregulation. Clients learn skills and strategies to assist with tolerating emotional crises and intense emotions. This is an educational group that teaches clients tools to understand feelings and control outbursts.  
**Referral Process:** Clients may self-refer to the professional below.  
**Cost:** 0$  
**Contact Information:**  
Intake Coordinator: Paula Van Strien  
Phone: 613-542-8344 ext. 301  
Fax: 613-542-1400

**Program:** Keep It Simple Skills Group  
**Description:** Short-term skill building group for individuals in the community to participate in six sessions of Dialectical Behaviour Therapy. The core modules incorporated into the group are Mindfulness, Emotion Regulation, Interpersonal Effectiveness, and Distress Tolerance. Individuals struggling with impulsivity, self-harm, unstable moods, and relationship difficulties can benefit from this group.  
**Referral Process:** Self-referrals are accepted. Contact the professional below.  
**Cost:** 0$  
**Contact Information:**  
Intake Coordinator: Paula Van Strien  
Phone: 613-542-8344 ext. 301  
Fax: 613-542-1400
Emergency Resources for Suicide

In any event where there are concerns for an offender’s safety or security (suicidal ideation or attempts) immediate referral to Kingston Police, FCMHAS, Kingston General Hospital, or Hotel Dieu Hospital must be made.

**Kingston Police:** 613-549-4660  
Address: 705 Division St.  
Kingston, ON K7K 4C2

The police can assist an offender to the nearest hospital for a psychiatric evaluation if the offender agrees to go voluntarily. In the case that an offender does not voluntarily go with the police, an arrest can be made under the Mental Health Act (MHA) and the offender will be transferred to the nearest hospital for evaluation by a physician who will make a determination about the person’s safety to themselves and others.

**Hotel Dieu Hospital, Urgent Care Centre:** 613-546-1240 Open 8:00am – 10:00pm daily.  
Address: 166 Brock St.  
Kingston, ON K7L 5G2

**Kingston General Hospital:** 613-549-6666 Open 24/hours a day.  
Address: 76 Stuart St.  
Kingston, ON K7L 2V7

**Frontenac Community Mental Health Addictions Services Crisis Services**  
Phone Number: 613-544-4229 Open 24 hours a day, 7 days a week.  
Toll Free Number: 1-866-616-6005 Open 24 hours a day, 7 days a week.  
Address: 385 Princess St.  
Kingston, ON K7L 1B9

Walk-in services (crisis counseling/referrals) available Monday to Friday from 8:30am – 4:30pm. Mobile Crisis team is available Monday to Friday from 8:30am – 12:00am and Saturday to Sunday from 12:00pm – 12:00am.  
Depending on the situation, the crisis line is available for emergency response or as a listening service.

**Telephone Aid Line Kingston:** 613-544-1771  
This helpline is confidential and anonymous and is open everyday from 7:00pm – 3:00am. The aid line offers emergency telephone counseling and both crisis and non-crisis calls are accepted for individuals whom are contemplating suicide.


