

Working Toward Recovery In An Acute Care Setting Relapse Prevention and Wellness Strategies at MCES

The “recovery model” is becoming the basic paradigm for designing, providing, and evaluating community mental health services. Providers are recasting their missions, programs, and services to produce outcomes that facilitate recovery. This is happening in Montgomery County where the County Office of Mental Health has made a singular commitment to orienting their entire system of services to recovery.

Over the past two to three years MCES has looked at how its services can best support recovery. We approached recovery as part of an effort to reduce the incidence of relapse among consumers who we served as inpatients. Some consumers experience a crisis or even a psychiatric emergency when their symptoms return, and may need hospitalization, or in some cases, rehospitalization.

We saw relapse as more than just an element in admissions. It undermined community living and self-sufficiency and strained support systems. It temporarily derailed progress towards recovery. Worst of all, it contributed to a sense of hopelessness that heightened risk. We decided to make relapse prevention an explicit focus, and to make it part of our overall crisis intervention mission.

We developed resources to help consumers and family members see relapse as a temporary setback that can be overcome with help. We try to work with consumers to help us to leverage our short-term care to enhance their long-term recovery.

This issue looks at relapse and the development of relapse prevention and wellness promotion measures at MCES.

MCES Wellness Program and “Partners for Excellence in Psychiatry” Susan Costello, RN, MCES Nurse Educator

In March 2004, a group of MCES clinicians attended an intensive three-day training session at the University of Medicine and Dentistry of NJ-University Behavioral Health Care in Piscataway, NJ. The training centered on the interconnection of psychological and physical health in serious mental illness and how consumers and providers can collaborate to improve both behavioral and physical outcomes.

MCES was the first emergency psychiatric provider to take part in the training, which began in January 2003, and is supported by Eli Lilly and Co. We had to document what we were doing to facilitate wellness and recovery, how we used psychoeducation in our program, and our commitment to organizational change to better meet consumer needs.

This comprehensive educational program promotes healthy lifestyles for consumers with serious mental illness. One

module looks at how consumers and family members can increase their understanding of serious mental illness, symptoms, treatment, relapse, crisis management, and recovery. This information complemented the MCES Relapse Prevention Program as discussed within.

Another module focuses on nutrition, fitness, and living a healthy life style. The MCES Allied Therapy staff uses this material in inpatient groups on holistic wellness. Linking mental health and lifestyle choices empowers consumers to make important changes. MCES also offers groups on different types of relaxation. Yoga is also offered.

Our concern for wellness has also led to changes in relation to inpatient menus and the choices of snacks available to consumers. For more information about “Partners for Excellence in Psychiatry” visit www.partners4excellence.org.

Recovery and Mental Health Wellness

Pamela Santos, MSS, LSW

MCES Director of Social Services

One of the most significant changes in mental health over the past 20 years is the growing recognition that consumers with serious mental illness can achieve recovery and wellness. This means more than the reduction or remission of symptoms. It means a regaining of some of what is lost to the ongoing disease and a building of some of what we learned on the way back.

Recovery is defined in many ways. At MCES we see it as a continuing individual process by a consumer to overcome and offset the debilitating effects of a continuing serious mental illness. The recovery process is not linear, and there is no set roadmap that all consumers can simply follow.

Striving for recovery empowers consumers and enables them to be in control in seeking and accepting help. It involves the development of a “new normal” in which they and those who care for them see them as more than their disease. This new normal is a regained state of mental health wellness.

Mental health wellness involves optimal individual functioning, effective coping, self-sufficiency, and taking responsibility for, and being as involved as possible in, one’s care. Wellness is regained through the recovery process. Mental health wellness is not just the absence of psychiatric symptoms. Mental health wellness is being aware of choices and making decisions toward a more fulfilling life.

Consumers can facilitate the reclaiming of their mental health wellness by understanding their disorder, its treatment, the factors that may trigger a relapse, the early warning signs, and by developing support systems and a crisis plan. All consumers can benefit from good coping and stress management skills, maintaining overall personal health, and making sure that their health care provider helps them to monitor all aspects of their health and functioning.

The concept of recovery was introduced in the 1980s. It originated with consumers writing about coping with symptoms, getting better, and regaining an identity apart from their illness or disability. Recovery is not equivalent to cure, but it does involve some degree of healing. It is an ongoing process and a personal outlook or vision. As such it is subjective and different for each consumer.

The MCES Relapse Prevention Program

Mary Ellen O’Donnell, RN-C, MSN, MEd

Director, MCES Allied Therapy Department

In January 2002, an interdisciplinary committee was formed to look at the problem of relapse among our patients and to develop a means of reducing its incidence and the readmissions that it caused. Our mission was to identify the factors involved in this situation that we might be able to impact.

We began with an extensive review of the relapse literature and other relapse prevention efforts, including “best practices.” We found that there were many books, articles, and programs, but that few of these were pertinent to our needs. Most attention had been given to relapse among substance abusers, very little was available on mental illness relapse, and less still in regard to relapse among those with dual diagnoses.

We decided to create our own program based on concepts documented in the literature. Six such elements appeared directly applicable to our patients’ needs:

- “Stinkin’ Thinkin’” – Seeing how negativity and pessimism affected prospects for doing better.
- “Circle of Support” – Identifying and using family, friends, providers, and others as protective factors and resources.
- Problem Solving – Learning skills for effective coping and community living.
- Spirituality – Drawing on spiritual values in dealing with life’s challenges.
- Treatment Follow-Through – Understanding that treatment is a life-long proposition for many.
- Triggers – Becoming familiar with factors (e.g., stress) and behaviors (e.g., self-medication) that could lead to relapse.

We next developed material on each of these elements as it related to our patients. Our aim was to give each patient access to a state-of-the-art understanding of the nature of the relapse process and the means to devise an individualized plan for dealing with it. It was also part of our vision to increase staff familiarity with relapse and make relapse prevention part of our philosophy of care.

The end product was a narrative, case studies, examples, self-assessment checklists, “how to’s,” where-to-get-help lists, emergency phone numbers, when to contact our crisis center, and other self-help tools for patients and families. We then integrated these components into a patient

workbook entitled *My Action Plan* (MAP) (2002). Various drafts of MAP were reviewed by patients and other staff and revised according to their feedback.

While MAP was being finalized the committee turned its attention to a relapse prevention program strategy. As implemented, the MCEs Relapse Prevention Program includes:

- Offering every inpatient the opportunity to attend a daily group using the MAP workbook.
- Running psychoeducation groups on relapse prevention for inpatients.
- Educating MCEs clinical staff about relapse and the MCEs program.
- Developing relapse information for family members and the community.
- Distributing copies of the MAP workbook to other providers with permission to make additional copies for their use.
- Holding workshops on relapse prevention for other behavioral health providers.

Surveys among both patients and staff indicate that the program:

- Enhances personal dignity and builds on patient's strengths.
- Helps patients achieve and maintain self-determination.
- Fits individual and changing patient needs.
- Facilitates patient recognition that relapse is part of their disease but preventable.
- The MAP workbook is clear and easy to use.

Consumers are positive about the MAP workbook and our relapse prevention groups. We have had readmissions of consumers who participated in the program during their last stay. Most immediately join the ongoing MAP groups, and readily share their insight into what precipitated their relapse and, perhaps more importantly, their realizations about use of their personal support system and the MAP they had developed for themselves to help counter the relapse process.

The program has likewise raised staff awareness about relapse as a critical clinical issue. Our staff more clearly understand that relapse can occur even when a patient does everything right. The program's tools for identifying personal relapse triggers have been singled out as especially valuable.

In our November 2003 survey by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), the surveyors singled out the MCEs Relapse Prevention Program as a significant resource to help mentally ill individuals learn new self-help measures and strengthen their coping skills. The surveyors submitted the MAP booklet to JCAHO for consideration as a "best practice" for adoption by other psychiatric hospitals.

Our relapse prevention training has been well received in the provider community. The Montgomery County Office of Mental Health has promoted adoption of our program. Our program received international attention when it was presented at the American Psychiatric Nurses Association's national conference in Atlanta, GA, in October 2003.

The MAP Booklet can be downloaded from our web site (www.mces.org).

"Supportive persons/services who believe in and promote Recovery are important across all settings."

"Recovery refers not only to the process of moving forward in dealing with illness, but also dealing with the stigma and catastrophic events that often occur as a byproduct of having a mental illness."

***Key Concepts of Recovery:
A Working Document
Montgomery County Work Group,
August 2003***

Relapse and Serious Mental Illness

Cindy Gross, Allied Therapist

MCES Allied Therapy Department

What is relapse?

MCES defines relapse as a return to a past pattern of symptoms or behaviors that may lead to an inability to sustain recovery and achieve or maintain wellness. It is a process not an event and it may be involuntary or induced.

Relapse is a worsening of an existing condition for which a consumer may or may not be getting treatment. It can happen with mental illness or substance abuse or both (as well as with gambling, eating disorders, and other problems). It is a setback in how well someone is coping or responding to treatment. It is present when signs, symptoms, or behaviors that were stable or under control reoccur for more than a day or so and efforts to manage them are not effective.

If left unchecked relapse can deter recovery and threaten maintenance of or movement toward wellness. However, it is important to understand that relapse is not the opposite of recovery or necessarily “anti-recovery.” Correspondingly, relapse does not mean that the consumer is no longer well or unable to get well.

Relapse is not the same thing as recurrence. Relapse is a worsening of an ongoing episode within six months of apparent stabilization or remission. Recurrence is the occurrence of a new episode beyond six months of apparent stabilization or remission.

Relapse may be part of the disease. It can happen when treatment is being fully followed. In cases of dual diagnoses, dual disorders, or other co-morbidity, it may come about if the conditions or related behaviors interact or affect one another. Relapse is common and all consumers with serious mental illness are at high risk for relapse, but not all experience relapse.

What causes relapse?

In mental illness, relapse can happen if the illness gets worse, or it may happen if the treatment or the treatment team change. It may also be caused by not following through with treatment. In substance abuse it may also happen if treatment is stopped, or if old habits return (like going to bars or hanging out where drugs are used). Sometimes vacations, holidays, promotions, or other “celebrations” may bring it on. Untreated pain, whatever the type or source, can also precipitate relapse.

In all cases it may occur if new or old sources of stress arise that are hard to deal with. Things like relationship issues, lapsing into denial, or the breakdown of a coping strategy can cause relapse.

Relapse can even happen when treatment is being followed. Relapse may happen when an individual moves from one level of care to another (such as from a hospital or residential setting to the community). It may lead to rehospitalization.

In *Mistaken Beliefs about Relapse* (1988), Gorski and Miller defined three groups of consumers who they characterized as “relapse-prone:”

- Individuals who are unable to recognize or accept their illness (usually because of the nature of their illness).
- Individuals who do recognize that they are ill, but who do not understand their disease and the need for treatment.
- Individuals who do understand their disease and continue treatment, but who may experience a worsening of their symptoms or an increase in some source of stress or fallback on old habits or associations.

The approach to relapse prevention with consumers in each of these groups would vary, as would the prospects for success.

Behavioral health problems, like other chronic diseases, may have periods of wellness as well as periods when symptoms flare up. This is why psychoeducation is critical. Consumers need more than a statement of their diagnosis if they are to deal with the possibility of relapse.

What is the relapse process?

The relapse process is characterized by three phases. Onset is the initial stage that is triggered by intrapersonal, interpersonal, or environmental stressors. This can be a worsening of the consumer’s illness, a problem with an important relationship or a significant personal loss.

The second stage is marked by what is known as “relapse mode” behavior. Examples include:

- Denial - “I don’t have a problem!”
- Self-pity - Seeing only negative – “I’m never going to get better.”
- Resentment or anger – “God must really hate me.”
- Rejecting help - “Hey, I’m really okay.”
- Impatience – “Treatment results now! – I’ve been going to therapy for a week now with no change.”
- Ego - “I’m not as bad as him!”

These attitudes are sometimes called “stinkin’ thinkin.”

The third stage is full relapse. It is denoted by the prominent presence of psychiatric symptoms, and, in many cases, a resumption of drug use and/or drinking.

What if there’s a dual diagnosis or dual disorder?

Consumers with serious mental illness often face the problem of co-morbidity, or the presence of more than one behavioral health condition. Many may have both mental illness and substance abuse problems. These consumers may experience relapse of their drug or alcohol problem and a worsening of their psychiatric disorder. Addiction relapse often leads to psychological decompensation. A decline in mental health can bring about an addiction relapse. Withdrawal may aggravate psychiatric symptoms.

Relapse prevention for those with dual diagnoses involves avoiding substance use and managing their psychiatric symptoms.

Some key points regarding relapse and dual diagnosis are:

- Symptoms may return in one or both of the consumer’s conditions.
- Addiction relapse can lead to psychological decompensation.
- Withdrawal can aggravate psychiatric symptoms.
- Mental health decline can lead to addiction relapse.
- There may be a “double relapse” involving return of both sets of symptoms.

Those with dual disorders such as serious mental illness and an organic disorder or a developmental disability also confront high risk of relapse. Depending upon individual circumstances and need the support system may have to play a very active role in relapse management.

Avoiding Relapse: What Can Be Done

Mark Sigmund, Allied Therapist
MCEs Allied Therapy Department

What are the warning signs of relapse?

Relapse usually comes about over time, but it can happen suddenly if the change or stress is overwhelming. Feeling more stress or having a harder time handling stress are signs. So is defensiveness and increased emotionality, impaired thinking, and difficulties with eating, sleeping, or other routines.

Those in relapse may isolate themselves or seem out of control. There may be a deepening depression and declining sense of self-image or self-worth. Often the problem is denied and help is rejected. However, without help relapse may lead to a crisis and may increase the risk of self-harm, or in some cases, harm to others.

Some of the key signs of relapse are:

- Feeling more stress.
- Harder time handling stress.
- Problems with routines.
- Emotionality and defensiveness.
- Impaired thinking.
- Self-image/self-esteem declines.
- Depression increases.

Can relapse be prevented?

In most cases, it can be prevented, but it takes planning and the help of the family or support system. There are four fundamental steps to relapse prevention:

Step one is the understanding that it can happen, that it is generally preventable, and that it can be stemmed early on. This is done through education about the psychological and environmental factors that may lead to relapse, and learning about the illness and its treatment.

Step two is to try to keep things structured, developing a daily schedule, and to avoid “downtime” (i.e., having “nothing to do”). It also involves anticipating potential problems (e.g., celebrations, vacations, etc.).

Step three is to identify potential warning signs and to take them seriously (i.e., not ignoring any warning sign). Some practical actions are reviewing signs and triggers daily and keeping a journal.

Step four is learning how to ask for help and knowing where to get help. A personal emergency plan listing sources of help should be developed. This step also includes involving the family, significant others, and support network members. This prepares support system members, assures early recognition of warning signs, and enables them to give help.

If relapse does happen the consumer should shift into “damage control” mode as soon as possible — with an emphasis on the word control. Relapse must not be seen as meaning that the illness can’t be managed. Also a relapse shouldn’t be seen as an automatic “I blew it” or indicating failure. Guilt and shame may not only be unwarranted, but they make it harder to get back on track.

Fear of relapse can also be an obstacle to trying to do something about it. A consumer who worries constantly about relapse will never be able to do anything about it. Preoccupation with relapse may lead to anxiety or even panic. Worst of all, it may lead to a sense of fatalism about one’s chances of recovery.

At the same time it must be remembered that relapse is part of the illness, and that even a good relapse prevention plan is not a guarantee that relapse won’t happen. Having a realistic view of the reality of relapse is also healthy. Even when relapse occurs it is still possible to lessen its impact by reducing the time span between the onset of symptoms and treatment. There is an important benefit of having a relapse prevention plan.

Providers can help prevent relapse by increasing staff awareness and sensitivity to the problem. They can also educate consumers on relapse and inform family members about relapse. Providers can make tools for relapse prevention planning (e.g., MCES’s MAP booklet) available to those they serve. If they offer support groups they can consider including relapse prevention.



Mark Sigmund,
Allied Therapist
facilitating an MCES
therapy group.

Families too can help with relapse prevention and recovery. They can be supportive of the consumer and ongoing treatment. With the consumer’s permission, they can try to get as involved as possible in the treatment. They should ask providers for information and updates. They can turn to the resources offered by the National Alliance for the Mentally Ill (NAMI) and the Mental Health Association. If relapse occurs they can assist the consumer to get help as soon as possible. They should avoid being critical or judgmental.

Remember that recovery doesn’t have any specific starting point and consumers (and providers) can begin working on it just about anywhere as long as the necessary personal concentration and motivation are there. Accordingly, doing whatever can be done to avoid relapse would seem like a very good place to get moving toward recovery.

The MCES Inpatient Philosophy of Care

Lina Atkinson, RN, MSN
MCES Nurse Executive

Every spring MCES holds an evening retreat involving the Board of Directors and a large number of staff representing all departments and programs. The retreats focus on both current and long range service policy or program issues as well as unmet community needs and employee relations concerns. Many major changes in our organization had their genesis at the annual board/staff retreat.

In 2003, the board/staff retreat centered on our largest service, our inpatient program that provides intensive short-term psychiatric hospitalization on both a voluntary and involuntary basis. Each department and program gave a brief presentation on how its services impacted consumers from intake to discharge. In addition, we tried to identify any factors that might affect the effectiveness of our services.

Board and staff members broke out into separate work groups to discuss some of the key concerns that came up in the service discussion. Then we reconvened to report on some possible strategies that could be put in place over the coming year through our Continuous Quality Improvement (CQI) process.

There was a consensus that, though MCES had a strong and long-standing organizational philosophy and values, we should develop an explicit statement of philosophy for our inpatient program. A task force was formed to draft

an inpatient philosophy of care statement. Over the next several months the group benchmarked care philosophies of other psychiatric hospitals, both local and elsewhere. We also carefully reviewed our existing value statements and external sources such as the recovery model and the Community Support Principles.

After circulating many drafts and gathering input from our stakeholders the following statement of our inpatient care philosophy was adopted in May 2004 at our annual board/staff retreat:

The purpose of our inpatient service is to:

- *Help with psychiatric emergencies and episodes of serious mental illness.*
- *Promote relapse prevention, self-help and support.*
- *Enhance the recovery process.*

Our services are based on the Recovery Model. We believe that:

- *Recovery is an active, ongoing individual process.*
- *Recovery is achievable despite reoccurrence of symptoms or crisis.*
- *Recovery is about the consumer and not about her or his illness.*
- *Recovery is facilitated by self-management.*
- *Recovery is helped by peer support and community living.*
- *Recovery is built on wellness and self-awareness.*

Our services are consistent with consumer dignity, privacy, autonomy and self-sufficiency, strengths, consistent with the highest accepted practices and standards, and the safety of all parties. Our practices are evidenced-based and incorporate the best practices of other providers in comparable settings.

As appropriate and as possible, with the patient's consent, we will involve and educate the family and assure their participation in care planning and treatment.

Our programs are consumer-centered, address the immediate needs of those we serve, and the need to avoid future emergencies, crises, relapse and other episodes. We value collaboration and involvement of other providers in care planning and delivery.

Our services are based upon a comprehensive and holistic evaluation and ongoing reassessment. We endeavor to maintain a uniform and consistent level of care at all times. We strive to

reasonably accommodate consumer needs in relation to culture, spirituality, diet, and other pertinent factors.

We offer consumers opportunities to:

- *Learn about their illness and treatment.*
- *Take responsibility for the treatment of their illness as appropriate.*
- *Strengthen coping and self-help skills.*
- *Assure continuity of care and community support resources.*

Interdisciplinary teams using an integrated treatment model give our care. We rely on multiple treatment modalities. We offer an integrated approach in serving consumers with Dual Diagnoses. Our services facilitate short-term stays in the least restrictive setting suitable to needs and safety.

This statement codifies many goals, principles, and beliefs that are well established at MCEs, but it also incorporates new concepts that will strengthen and change our service delivery. In regard to provider change, ***Mental Health: A Report of the Surgeon General*** (1999) offered this:

Champions of recovery assert that its greatest impact will be on mental health providers and the future design of the service system. They envision services being structured to be recovery-oriented to ensure that recovery takes place. They envision mental health professionals believing in and supporting consumers in their quest to recover.

Here at MCEs we see our new inpatient philosophy of care as empowering us to better help and, whenever possible, partner, with those we serve in moving toward recovery.

Self-Destructive Behavior and Recovery

Tony Salvatore, MCEs Director of Development

As noted above, MCEs accepts the premise that recovery must be the central organizing concept of the behavioral health system. However, we have found little practical guidance on applying that premise in nurturing recovery in an emergency psychiatric setting. As a crisis facility, we have a medical model, a high level of patient acuity, 50%-60% involuntary admissions, and relatively short stays.

Nonetheless, we are striving for a recovery-oriented organizational culture. Part of our strategy is exemplified by our relapse prevention program, which offers an opportu-

nity for consumers to learn recovery-related skills during their inpatient stay.

Self-harm may be associated with a number of psychiatric disorders and illnesses. Cutting and other self-injury as well as various levels of suicidal behavior are among the most common and the most serious. These behaviors present treatment challenges, impede recovery, and often increase the consumer's risk of accidental death or suicide.

The high potential for suicidality inherent to these behaviors put them on the agenda of the MCES Suicide Prevention Team. After reviewing the problem the group looked at how MCES might broaden its service resources for consumers who engage in self-harm and suicidal behavior. We are currently completing work on a new inpatient psychoeducational program and self-help workbook on self-destructive behavior.

Here is an excerpt from the workbook chapter entitled "Suicidal Behavior and Suicidal Acts."

A suicidal act occurs when someone harms himself or herself in such a way as to bring sympathy or concern but not death. It is an attempt by an individual to control her or his environment or those around them by self-harm or doing something that may not involve injury but could lead to serious harm or death. Suicidal acts are destructive behaviors because you can go too far and end up dying.

Suicidal acts often take the form of plans and actions that seem unlikely to result in death. They are sometimes seen as communicative, and some professionals use the term "parasuicide" or "suicide communication" to describe such behavior.

They should not be taken lightly. They require a thorough evaluation and treatment aimed at relieving the underlying pain that may be causing you to engage in such acts. Suicide acts can result in death if left unattended. Suicidal acts are a kind of suicidal behavior.

Both suicidal acts and self-injury are self-harming and self-destructive in nature. In addition, both are a very bad form of coping.

Repeated suicidal acts may cause those around you to stop taking you seriously. They may let their guard down and not respond to what they think is just another "false alarm." They may withdraw their support and caring. In turn, you may try even more serious suicidal behavior to get their atten-

tion. Staying involved with suicidal acts can literally lead to self-destruction.

Many suicidal acts turn out to be unintentionally deadly. Someone may take an overdose of an over-the-counter medication and not know that it could be fatal. For this reason and others, suicidal acts are extremely dangerous and they increase in risk over time.

Suicidal acts are not a "fix." The underlying problems are still there and usually get worse unless some effort is made to solve them. Suicidal acts are a signal that something is very wrong and a warning that more bad things may be on the way.

Progress toward recovery cannot begin in the presence of suicidal acts or suicidal behavior. If someone who has made progress towards recovery falls back on suicidal acts all that he or she has accomplished may be quickly lost.

Consider the following:

Requirements for Recovery	Effects of Suicidal Acts
Hope, adaptability, positive-ness, and the capacity to change	<ul style="list-style-type: none"> - More hopelessness - Maladaptive and negative - Resistance to change
Self-management as well as self-respect	<ul style="list-style-type: none"> - Decreased self-control - Decreased self-respect - Decreased self-esteem/self-worth
Wellness and self-awareness	<ul style="list-style-type: none"> - Increased illness and symptoms - Less self-awareness/greater denial
Peer support and community living	<ul style="list-style-type: none"> - Loss of peer support/other supports - Increased risk of hospitalization

Recovery is really the only way to get out of the worsening cycle of self-destructive acts and suicidal behavior. When the requirements necessary for recovery are in place they will serve as protective factors against these potentially life-threatening behaviors.

Recovery in Montgomery County

William Leopold, MBA
MCES COO/Administrator

Nancy Wieman, Deputy Administrator of the Montgomery County Office of Mental Health/Mental Retardation Drug & Alcohol Services, officially put recovery on the agenda of all mental health providers in the county at the Annual Mental Health Luncheon in May 2003. Ms. Wieman announced the County Office's plan to focus on supporting the recovery of mental health consumers. She called on consumers, family members, and providers to join the County Office in this system change effort.

During the MCES 30th Anniversary Dinner, recognition was given to the County Office for their steadfast support of MCES.



Photographs by Scott Weiner

Left to Right: R. Thomas Marrone, MCES Board President, Nancy Wieman, Deputy Administrator & Eric Goldstein, Administrator of Montgomery County Office of Mental Health/Mental Retardation Drug & Alcohol Services.

One year later a broad array of county initiated and supported activities are underway. Several countywide task forces are working on making the community mental health system more recovery-oriented. New or upgraded services are in place or are coming on line. Most notable among these are the Acute Partial Hospitalization Program and the Intensive Outpatient Program at Central Mental Health/Mental Retardation Center. Community Treatment Teams (CTT) are starting in other areas.

Another component of the County Office's plan is the funding of provider-based Consumer Peer Support

Specialist positions. These new staff members will serve as models of recovery for both other consumers and other provider staff. They will serve in a variety of outreach and direct service roles. Start-up financing for the positions is coming from the Reinvestment Fund generated by the Behavioral Health Choices Program. MCES recently added a Relapse Prevention/Recovery Support Specialist to its Allied Therapy Department through this program and other consumer hires are planned.

At MCES's 30th Anniversary Dinner on April 28, 2004, Keynote Speaker, Estelle Richman, Secretary of the Pennsylvania Department of Public Welfare, commended the County Office for its leadership in promoting recovery and she cited Montgomery County as an example for other counties to emulate. Secretary Richman also outlined the Department of Public Welfare's plans for recovery, which will complement those already being implemented in the county.

"To promote wellness and recovery by creating an environment where all people are empowered to have freedom to make choices about their lives, to pursue their personal goals, and to do so with dignity, and the respect of others."

Montgomery County Recovery Vision Statement



Photographs by Scott Weiner

Estelle Richman, Secretary of the Pennsylvania Department of Public Welfare addressing the audience at the MCES 30th Anniversary Dinner.

"Understanding the Warning Signs of Suicide"

2nd Annual Montgomery County Suicide Prevention Awareness Fun Run, Walk, and Wheelchair Wheel

Benefiting the Montgomery County Suicide Prevention Task Force

Sponsored by:

Montgomery County Health Department & Montgomery County Emergency Service, Inc.

Saturday, October 16, 2004 (Rain or Shine) ♦ 10:00AM - 12:30 PM
Montgomery County Farm Park ♦ Germantown Pike & North Wales Road ♦ East Norriton, PA

\$5.00 for adults and students (Children Under 12 Free). Custom T-shirt, Refreshments, Giveaways, Mental Health Information, LifeKeeper Memory Quilts on Display; Remembrance Board (post memories of those lost to suicide). The course is 3.2 Kilometers or 2.3 Miles. Volunteers needed. Team walkers/runners welcomed.

For More Information: 610-279-6100, ext. 227 ♦ tsalvatore@mc.es.org ♦ www.mc.es.org

Montgomery County Emergency Service, Inc.

Cookbook

In celebration of our 30th Anniversary, MCES has created a cookbook, *Committed to Good Taste*. As most of you are familiar with MCES, be assured the recipes are as extraordinarily diverse as our staff.

The books are being professionally printed and cost \$10 each. They will be ready for pick-up in September or October—just in time for the holidays!

Advance orders have been brisk, so don't miss your chance to obtain one of these fun books. To order your copy, or copies, please fill out the form below. (Don't forget family and friends on your holiday gift list!) Payment is due at time of order. Thanks for your continued support of MCES!

Name: _____

Company: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

of cookbooks I am ordering: _____

- Check enclosed and payable to: MCES.
- Please accept my credit card # for payment in the amount of \$ _____
 - Visa • Mastercard Exp. Date _____

Card #: _____

Signature: _____

MCES 2004 Community Lecture Series

Lectures are held in the MCES Board Room from 9 am to 12 pm. Cost is \$20 each. Please use this registration form and mail to MCES Lecture Series, 50 Beech Drive, Norristown, PA 19403-5421.

- 9/16 Recognizing Character Pathology and the Impact on Major Psychiatric Conditions
Presenter: Rocio Nell, MD, CPE
- 9/23 Understanding Mental Health Law ♦ Presenter: Donald Kline, Ph.D.& Paul DeMarco, BS, RN
- 9/30 Handling Crisis Calls: Learning to Listen ♦ Presenters: Michelle Monzo, BS & Paul DeMarco, BS, RN
- 10/7 Understanding & Managing Borderline Personality Disorder ♦ Presenter: Steven Shapiro, Ph.D.
- 10/14 Understanding Deliberate Self-Injury in Adolescents & Young Adults ♦ Presenter: Steven Shapiro, Ph.D.
- 10/21 Psychotropic Medications ♦ Presenter: Rocio Nell, MD, CPE
- 10/28 Hands On Crisis Intervention (class limit 30) ♦ Presenter: Michelle Monzo, BS
- 11/4 Assessment & Treatment of Suicidal Behavior ♦ Presenter: Steven Shapiro, Ph.D.
- 11/11 Relapse Prevention in Behavioral Health
Presenters: Mary Ellen O'Donnell, RN, MSN, MEd & Mark Sigmund, BA
- 11/18 Basic Psychiatry as Applied to the Developmentally Disabled ♦ Presenter: Rocio Nell, MD, CPE
**(This lecture, 11/18, will be held at Bldg. 33 on the Norristown State Hospital Grounds)*

Please sign me/us up for the following lectures:

	9/16	9/23	9/30	10/7	10/14	10/21	10/28	11/4	11/11	11/18*
# Coming										

Name: _____

Company: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

- Check enclosed and payable to: MCES.
- Please accept my credit card # for payment in the amount of \$ _____
 - Visa • Mastercard Exp. Date _____

Card #: _____

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