

“Psychiatry at a Glance” An Overview of Adult Mental Illness

This issue is based on a presentation of the same name that has been given for many years as part of our Community Lecture Series by Rocio Nell, MD, CPE; the CEO/Medical Director of MCES.

The Mental Wellness/Mental Illness Continuum

Mental illness is a general term for a wide variety of disorders involving the brain. Mental illness exists when there are thoughts, feelings or behaviors that cause severe psychological pain or that significantly interfere with the ability to perform in at least one important area of life.

In *Mental Health: A Report of the Surgeon General (1999)*, mental health is defined as “...the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.” The Report goes on to say, “Mental health” and “mental illness” are not polar opposites but... points on a continuum. Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other...Everyday language tends to encourage a misperception that “mental health” or “mental illness” is unrelated to “physical health” or “physical illness.” In fact, the two are inseparable.

The separation of “mental health” from “physical health” promotes the stigmatization of mental illness.

Mental illness generates frustration in those it affects, in those around them, and in those who try to improve its effects. Some disorders obstruct the individual’s personal recognition that they are ill and others interfere with the individual’s ability to effectively get help.

Recovery and Mental Wellness

Serious psychiatric disorders are not curable, but there is potential for recovery. Consumers can achieve an optimal level of functioning. Recovery empowers consumers and enables them to develop a “new normal” in which they and those who care for them see themselves as more than their disease.

Mental wellness is a new perspective. It connotes at least four elements: optimal individual functioning, effective coping, self-sufficiency, and taking responsibility for one’s care. Mental wellness is closely related to the “recovery model.” Wellness is regained through recovery.

Mental wellness is not just the absence of psychiatric symptoms. It is a process of becoming aware of choices and making decisions toward a more fulfilling life whether or not illness is present. Mental wellness (like recovery) is something that the mental health system must promote.

Consumers can facilitate wellness by understanding their disorder, its treatment, the factors that may trigger an episode or relapse, the early warning signs, and by developing support systems and a crisis plan. All can benefit from good coping and stress management skills, maintaining overall health, and making sure that their health care provider monitors all aspects of their health and functioning.

Identifying Psychiatric Disorders

Psychiatric diagnosis is based on the consumer’s description of the symptoms that he or she is experiencing, the observable clinical signs, and the clinician’s interpretation of the behavior and any functional impairment. A diagnosis is a professional judgment as to whether these sources of information meet the accepted criteria for a specific disorder. The most widely recognized psychiatric classification system is the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) (DSM-IV)* published by the American Psychiatric Association (1994).





Some important facts about mental illness and recovery

- Mental disorders fall along a continuum of severity. The most serious and disabling conditions affect 5 – 10 million adults in the US.
- Mental disorders are the leading cause of disability (lost years of productive life).
- Mental illnesses strike individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and the old are especially vulnerable.
- The best treatments for serious mental illnesses today are highly effective. Between 70% and 90% of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.
- Early identification and treatment is of vital importance. By getting people the treatment they need early, recovery is accelerated.

National Alliance for the Mentally Ill (NAMI)

The DSM-IV uses five independent criteria, called axes, for describing disorders. A complete psychiatric diagnosis consists of an evaluation on each axis:

- I. Major psychiatric illness (e.g., Adjustment, Anxiety, Cognitive, Dissociative, Mood, Psychotic, and Substance-Related Disorders)
- II. Personality disorder or mental retardation
- III. Physical illness (i.e., general medical conditions that are potentially important in understanding or managing the mental disorder)
- IV. Social/environmental problems (i.e., stressors in the environment or social setting that may affect the diagnosis and prognosis of the psychiatric disorder)
- V. Global Assessment of Functioning (GAF) (A rating given by the clinician. The score on the GAF indicates the patient's overall level of functioning. Scores range from 1 to 100, with 100 being superior functioning.)

It is possible for a consumer to have more than one diagnosis on Axis I. However, the diagnosis that is listed first is the one that represents the main area of difficulty.

Types of Psychiatric Treatment

All forms of mental illnesses are treatable. Most consumers may need medication to help control symptoms, but they can also benefit from psychotherapy, counseling, self-help groups, assistance with housing, vocational rehabilitation, income assistance and other community services.

In most settings psychiatric care is provided in the context of a multidisciplinary team. Psychiatric treatment may be broken down into psychotherapy, psychopharmacological therapy, and combinations of both.

Psychotherapy is a treatment method or modality based on verbal communication between the patient or consumer and a mental health professional. It is sometimes referred to as “talk therapy” or “active therapy.” There are many different forms of psychotherapy.

Family psychotherapy is an interpersonal approach focusing on relationships. Group psychotherapy is one of several group approaches along with group counseling and psychoeducation groups. Group methods provide a support system and are well suited to teaching interpersonal and self-help skills, and managing the side effects of medications.

Psychopharmacological therapy is the management of psychiatric illness using psychotherapeutic medication such as antidepressants and antipsychotics. It requires knowledge of the brain (neuroanatomy, neurophysiology, and neurochemistry) as well as psychology.

Care Settings

Inpatient psychiatric care is used with individuals who have acute symptoms needing intensive treatment. Inpatient stays are short and oriented to intervention, stabilization, and planning ongoing outpatient care as indicated. Inpatient care may be voluntary or involuntary. The latter is for high-risk individuals and involves a court commitment process. MCES is the sole provider of initial involuntary hospitalization for Montgomery County.

A new psychiatric care setting is the Crisis Residential Program (CRP). It offers several days of residential treatment for individuals in crisis who do not require hospitalization. The MCES CRP is known as “The Ranch House.” It serves those 18 or over who are at risk of hospitalization, who can voluntarily accept care, and who would benefit from a supportive milieu for crisis resolution and developing or strengthening a support system.

Partial hospitalization is used with consumers who are not at high risk of self-harm or harm to others. Ideally it should approximate care comparable to the day shift at an inpatient facility. It may serve to continue stabilization after a short inpatient stay or as an alternative to hospitalization.

The Acute Partial Hospitalization Program at the Central Montgomery Mental Health/Men-

tal Retardation Center. creates continuity of care for individuals discharged from an inpatient unit. The Montgomery County Office of Mental Health Services (MH) mobilized this program to reduce hospital readmissions and to serve consumers who are not linked to appropriate community resources.

Outpatient psychiatric care involves treatment sessions based on the individual’s clinical status. The Montgomery County MH Office and the Central Montgomery MH/MR Center recently developed an Intensive Outpatient Program (IOP). Its features include greater treatment session frequency and the availability of a rotating therapist on call.

Extended psychiatric hospitalization is necessary if consumers do not respond to short-term inpatient treatment and cannot live safely in a community setting. It is provided by the state hospital system where a limited number of “civil” long-term beds are available at Norristown State Hospital (NSH) for the metropolitan Philadelphia area. Stays at NSH now average two years or less.

Consumers may also live in a variety of supportive settings in the community. Examples of such services are Circle Lodge on the NSH campus and Hedwig House, which has several sites.



Thoughts on Mental Illness and Mental Wellness

Genetics and luck play a big role in where we are in the pendulum of sanity (see Fig. 1). Always remember when you think of someone who you consider mentally ill, it is not an “us” and “them.” We are all in the same continuum and life is long so we never know where we will end up.

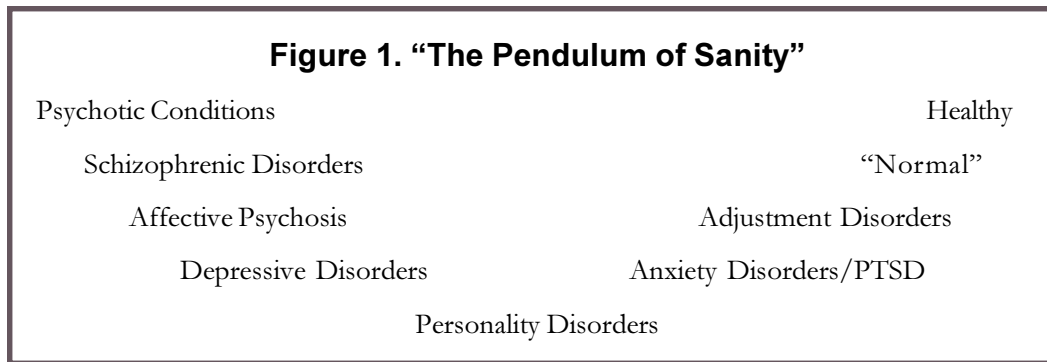
There is a parallel between mental health and physical health. In the same way that we have to exercise and be careful with what we put into our bodies to stay physically fit, we need to choose the right activities and input for our minds if we want to remain mentally healthy.

Human beings are like plants—when we are born, each one of us is like a seed that can reach its potential. Sequoia or butterfly bush all is beautiful in their own style...but many instead become bonsai.

Rocio Nell, MD, CPE

Case studies regarding “Maria” were created by Dr. Nell.

Figure 1. “The Pendulum of Sanity”



Common Psychiatric Disorders¹

Psychiatric disorders can be seen along a continuum such as presented in Figure 1. We will use an example of a fictional individual, who we will call Maria, to show how these different factors inter-relate in regard to different states of wellness and various disorders.

Maria was happily married and had a job she greatly enjoyed. Recently her mother became terminally ill. While going to the hospital to visit her, Maria was assaulted and robbed. She lay in a hospital bed, extremely sad, feeling overwhelmed and hopeless.

Healthy Attitude: *Maria welcomed the support of her husband and friends, was very verbal about the trauma that she endured, and expressed great concern over her mother. In days she accepted what had*

happened to her and gave a detailed description to the police of her assailant, replaced her credit cards and prioritized dealing with her mother’s situation as the issue most pressing in her life.

Adjustment Disorders: An adjustment disorder usually lasts less than six months and is an incapacitating reaction to a stressor. A camel’s back that got one too many straws is one way to describe this disorder. It is a time limited response to stresses accumulated in the recent past (i.e., the last three months). Adjustment disorders are common and can affect anyone. They occur when a person can’t cope with a stressful event or situation and develops emotional or behavioral symptoms. The source can be anything. It might be one incident, or a series of problems. Symptoms

¹ Please Note: The information in this section is for educational use only. It is not intended for self-diagnosis. Questions or concerns should be directed to a qualified mental health care provider.



Psychiatric Terminology

Affect: The outward expression of one's feelings, tone, and mood.

Antipsychotic(s): A group of drugs used to treat psychosis.

Atypical antipsychotic:

A newer class of antipsychotic, developed with the aim of offering better symptom control and fewer side effects compared with older medications.

Extrapyramidal Symptoms (EPS): Movement disorders that can be a side effect of antipsychotic medications. They include acute dystonia, akathisia, Parkinsonism and tardive dyskinesia.

Negative symptoms: Symptoms relating to lack of normal behavior. A reduction or total loss of normal functions in people with psychosis. May include apathy and withdrawal.

may include hopelessness, sadness, crying, anxiety, worry, headaches, withdrawal, and inhibition, among others. A maladaptive coping method (e.g., use of alcohol) can aggravate the impact of an adjustment disorder.

Adjustment Disorder of a "Normal" Person:

Maria did all the above, but with much complaining to her husband and bitterness over the injustice of the world. She reached out to friends and frequently felt that they did not understand. Within weeks she was back to work and attending to her mother's needs, as she had originally intended, but feeling maimed by the experience.

Anxiety Disorders: Anxiety disorders (formerly known as neuroses) are the most common psychiatric illnesses and affect approximately 19 million adults in the US. They can involve extensive anxiety and fear. They are chronic and may become worse if not treated. Anxiety can be exhibited by mood disturbances, and/or disturbances of thinking, behavior and physiological activity. Subtypes include Panic Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Phobias (including Social Phobia also known as Social Anxiety Disorder), and Generalized Anxiety Disorder. Anxiety disorders have significant co-morbidity with mood disorders and substance abuse.

Panic Disorder affects over 3 million US adults. It typically begins in young adulthood, though older people and children can be affected. Women are affected twice as frequently as men. There are brief episodes of intense fear with more than one physical symptom (e.g., heart palpitations and dizziness) that occur repeatedly and unpredictably without an external threat. These are known as "panic attacks." Anxiety about such attacks and avoidance attempts can impair daily functioning.

Posttraumatic Stress Disorder (PTSD) can occur when an individual experiences, witnesses, or simply perceives a catastrophe, a natural disaster, war, a serious accident, or a violent personal assault. More than 7% of the US population may experience PTSD at some point in their lives. Women are twice as likely as men to develop PTSD. Individuals

with PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel isolated. These symptoms can significantly impair daily life. PTSD frequently co-occurs with depression and substance abuse.

Post-Traumatic Stress Disorder, Possibly Leading to a Phobia: *Maria started to have nightmares and a great fear of going out at night alone. She felt torn with her discomfort and her desire to attend to her mother. She had great anxiety that gradually subsided, but her fear of going out at night became much more limiting.*

Personality Disorders: These are long-term patterns of behavior and internal experiences that deviate from the individual's cultural norms and negatively affect functioning. There are 10 types of personality disorders. Collectively they affect 10% to 15% of the US population. The causes of these disorders are not well understood. Studies indicate that when they are co-occurring with other disorders, such as depression, they interfere with the treatment of those disorders.

Character Pathology/Personality Disorder is a rigid way of going through life, which is not consistent with cultural style. Predominance is given to one of the issues of dependency, control or self-esteem to the sacrifice of others. Like a painting rendered only in one hue, all issues are perceived in one way even when that is not what is expected by others in the situation.

Character pathology is a maladaptive character style. It becomes evident when the person is in an environment that is not tolerant of her or his style. For example, a dependent person may not be able to perform in a job where he/she is expected to make decisions and take initiative, but will do very well in a routine job with a supportive, caring supervisor.

Borderline Personality Disorder is a very serious illness characterized by pervasive instability in mood, interpersonal relationships, behavior, self-image, and self-efficacy. It affects approximately 2% of all US adults, and

is most common in young women. Sufferers manifest a high incidence of non-suicidal self-injury (e.g., cutting), suicide attempts, and suicide completions.

Depressive Reaction in a Person with Underlying Character Disorder: *Maria became very resentful that all the pressure was on her to attend to her mother and that she had to go to the hospital when other siblings could have done it. She was full of complaints feeling that no one really loved her, cared for her, or took her seriously. Her arm took a long time to heal with many complications and she felt she was limited in her ability to be fully independent. Hence she harbored secret feelings of anger toward her mother, husband and all caregivers, although she not dared talk to anyone about it and instead complained of the pain and her limitations.*

Mood or Affective Disorders: These include Major Depressive Disorder; Bipolar Disorder, and Dysthymic Disorder. Mood disorders are very common in the US and are estimated to affect almost 20 million people or nearly 10% of those over age 18. About twice as many women as men are affected by these conditions. They often co-occur with other disorders (e.g., schizophrenia, anxiety and personality disorders), substance abuse, and other illnesses (e.g., cardiac disease).

Depressive Disorders: Several conditions fall in this grouping. It can be caused by illness that manifests itself with the symptoms of depression, as part of Major Depression, Single Episode, Recurrent, or of a Bipolar Disorder. Depression can be a manifestation of unhappiness with life or a reaction to personal loss.

Some symptoms can be a reaction to an incident and resolve in three months like in an Adjustment Disorder or become more prolonged and become a Depressive Disorder. If condition reaches two years or longer, it would be considered a Dysthymic Disorder, a chronic, low level depression that continues for years. In these long-term situations, the issue of character pathology has to be considered and the possible underlying causes for the chronicity of symptoms.

Major Depression (also known as Major Depressive Disorder, Clinical Depression, or Unipolar Depression) is manifested by a combination of symptoms that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. Such a disabling episode of depression may occur only once or several times in a lifetime. This is the most severe category of depression. In Major Depression, more symptoms are present, and they are usually more intense. Major Depression is marked by a combination of symptoms that occur together and last for at least two weeks without significant improvement.

Major Depression affects twice as many women as men. It is most common between 25-44 years of age, and least common over age 65. Major depression affects 10-25% of women and 5-12% of men. At any one point in time, 5-9% of women and 2-3% of men are likely to be clinically depressed. The average age for onset seems to be the mid-20's. Up to 15% of those affected complete suicide.

Major Depression Superimposed to a Dystonic Disorder: *Maria felt as though life was hopeless. For some time she had gone to work without really enjoying it and she felt her marriage, in a way, was a farce. Still out of the fear of change, she had continued attending to all her duties. After this event happened she felt she could no longer take the pressure and succumbed to feelings of sadness. She felt that the condition of her mother was too much to deal with and her siblings had to attend to her. Maria just felt she was sinking into a dark place from where she could not move.*

Bipolar Disorder (formerly called manic depressive disorder) affects approximately 1.2% of US residents over age 18. It is estimated that the disorder is present in about 10% of all mental health outpatients and in approximately 20% of psychiatric inpatients. It involves manic and depressive episodes and requires medication for treatment intervention. Psychotic symptoms can occur in bipolar disorder. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior are not uncommon. Frantic efforts to avoid real or imagined abandonment are often present.



Psychiatric Terminology

Positive symptoms: A distortion of normal functions in people with psychosis, e.g., delusions, hallucinations, disorganized speech and cognitive dysfunction.

Neuroleptics: A group of medications used to treat psychotic illnesses.

Psychosis: A major impairment of an individual's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately.

Psychoactive Medications: Medications that affect people psychologically and relieve symptoms of psychiatric disorders.

Relapse: A return to a pattern of symptoms or behaviors that lead to an inability to sustain recovery



Signs of Major Depression Include:

- Persistent sad, anxious, or “empty” mood.
- Feelings of hopelessness, pessimism, futility.
- Feelings of guilt, worthlessness, helplessness.
- Loss of interest or pleasure in activities that were once enjoyed.
- Decreased energy, fatigue, “slowing down.”
- Difficulty concentrating, remembering, making decisions.
- Insomnia, early-morning awakening, or oversleeping.
- Appetite and/or weight loss or overeating and weight gain.
- Thoughts of death, suicidal ideation, suicide attempts.
- Restlessness, irritability.
- Persistent headaches, digestive disorders, and chronic pain that do not respond to treatment.

Manic episodes include periods of abnormally and persistently elevated, expansive, or irritable mood, inflated self-esteem, hyperactivity, impulsivity, and high risk-taking. There may be a lessened need for sleep, greater talkativeness, high distractibility, and increased pleasure seeking. Depressive episodes include long periods of sad, apathetic mood, and altered thinking, activity, and bodily function.

In Bipolar Disorder mood becomes elevated or decreased to the point of the person becoming non-functional and at times losing control of contact with reality, thus becoming psychotic. Frequently a person remains aware of reality but with changes in mood. They may be in such a state that they can not control their behavior and their judgment becomes impaired leading to impulsive acting out even if there may be an awareness that what they are doing is not correct.

Bipolar I Disorder involves one or more manic episodes or mixed episodes (symptoms of both a mania and depression) and one or more major depressive episodes. This the most severe form of the illness. Bipolar II Disorder involves one or more depressive episodes and at least one hypomanic episode, which are less severe than manic episodes. Cyclothymic Disorder involves chronic fluctuating periods of hypomania and depression. There is also Bipolar Disorder Not Otherwise Specified (NOS).

Bipolar Disorder, Manic: *Maria was very unhappy in the hospital with her broken arm. There was a contradiction between her statement and police report that indicated that in her rush to get to her mother she had run in traffic where she had been hit by a car. She was extremely hyperactive, restless and upset since she believed she could not be harmed. She presented as very entitled and no one could please her.*

Schizophrenia: “Schizophrenia” literally means, “split mind.” It is a very serious mental illness where there is a problem of perception or loss of contact with reality. Schizophrenia is a chronic relapsing psychotic disorder that primarily affects thought and behavior. It often has a devastating impact on all facets of life and carries a high risk of

suicide. Compensatory symptoms develop to create a personal reality that just reinforces the psychosis. These are usually hallucinations and delusions. The core problem in schizophrenia is the inability to think and perceive correctly.

Approximately 2.2 million adults in the US, or about 1.1% of those 18 and older, have schizophrenia in a given year. In terms of onset, 75% of individuals with schizophrenia show initial signs of the disease between 16-25. Few cases appear over age 30, and cases in which those over age 40 are affected are very rare. In the 16-25 age range, more men than women manifest schizophrenia; in the 25-30 population more women than men show the disease.

Consumers with schizophrenia suffer chronically or episodically throughout their lives. They may experience frequent crises, have encounters with the police, and have many hospitalizations. At MCES those with a primary diagnosis of schizophrenia make up less than 10% of first-time admissions but almost 40% of readmissions. 81% of the patients at Norristown State Hospital have a form of schizophrenia.

Schizophrenia is characterized by positive and negative symptoms. Positive symptoms are abnormal behaviors that include disordered thought, delusions, and hallucinations. Negative symptoms represent the “absence of normal behavior” such as apathy, blunted or flat affect, low motivation, withdrawal, and anhedonia (the inability to experience enjoyment or pleasure).

Other symptoms of schizophrenia include marked social isolation, peculiar behavior (e.g., hoarding food, gathering trash or garbage), beliefs in magical thinking and clairvoyance, disturbed sleep patterns, psychomotor activity (e.g., pacing, rocking), lack of insight and judgment, and preoccupation.

There are different subtypes of schizophrenia. The disorganized type, which tends to be the most severe, features bizarre delusions and hallucinations, inappropriate speech and

affect, loose associations, and overall poor activities of daily living. The paranoid type is indicated by persecutory and grandiose delusions, superior or patronizing manner, prominent delusions and auditory hallucinations, and may include anger, anxiety, aloofness, and argumentativeness. Immobility, mutism, and psychomotor disturbances mark the catatonic type. The undifferentiated type has the features of the other types but defies classification.

There is presently no cure for schizophrenia. Treatment can lessen the morbidity associated with the disorder. Basic treatment aims are to reduce the occurrence, severity, and psychosocial consequences of psychotic episodes and optimize the individual's functioning between episodes.

Schizophrenia has three phases. In the acute phase, the individual has a psychotic episode that requires intervention and treatment. In the stabilization phase, the initial psychotic symptoms are being managed but there is risk of relapse if treatment is interrupted or the disease worsens. In the maintenance phase, the individual can remain relatively stable with antipsychotic medications, but relapse is still possible and full functioning remains compromised in most cases.

Some individuals experience schizophrenia that is treatment-resistant or treatment-refractory. This involves enduring positive and negative symptoms despite treatment with antipsychotic medications.

Schizophrenia: *Maria was seen by a psychiatrist in the emergency room. Apparently her report of having a happy marriage and a stable employment was not correct. She had been staying with her parents since she was 20 years old. At that time she was a college student and gradually started to fail, being unable to attend to classes and eventually had secluded herself. She now believed her mother was ill and was going to die soon and afterward resurrect and be her savior. On the day of the incident she had gone to the hospital believing her mother had finally been admitted there and got into a physical altercation with a stranger whom she believed had harmed her mother. In their altercation she suffered a broken arm, but she firmly believed that this person was evil and had harmed her mother.*

Schizoaffective Disorder: This disorder is similar to schizophrenia. It has symptoms of both schizophrenia and affective disorders (either bipolar disorder or depression). There is a major depressive component, manic or mixed episode with the symptoms of schizophrenia. Misdiagnosis is common. Many cases are initially diagnosed as bipolar. Those with this disorder may experience hallucinations and delusions, depression, low motivation, an inability to experience pleasure, and poor attention. They may have difficulty distinguishing reality and fantasy. Work, social relationships, and self-care skills may be affected. About one in every 200 people develops Schizoaffective Disorder during his or her life. The illness usually begins in early adulthood and is more common in women.

Related Behavioral Health Disorders

Organic Disorders: These are transient or permanent dysfunctions of the brain caused by a disturbance at any level of organization (i.e., structural, hormonal, biochemical, electrical, etc.). This may be caused by aging, drugs or toxic substances, or a variety of physical conditions.

Organicity: *Besides a broken arm, Maria suffered a head injury. After she recuperated, her thinking was not as clear and her memory was impaired. She had no recollection of what happened to her that day, but the problem was that now she was disconnected from what was happening in her life. People would try to force her and she would become irritable and just very frustrated.*

Psychiatric conditions often occur with substance use disorders. This is termed “dual diagnosis.” Co-morbid patients present dilemmas on how to provide the best treatment to address both conditions. At MCEs about 80% of all inpatient admissions involve a primary diagnosis of mental illness and a secondary diagnosis of substance abuse. MCEs has developed an inpatient Dual Diagnosis Program to provide integrated care to these consumers. It uses a psychoeducational model that includes an assessment of the consumer's ability to deal with her or his issues and participation in 12-step programs.



Early Warning Signs of Schizophrenia

- Thought patterns become illogical.
- Auditory hallucinations are experienced.
- Emotions become grossly inappropriate or flat.
- Feelings that thought processes are being externally controlled arise.
- The sense of body boundaries weakens.

About Psychotherapeutic Medications

- Medications make other treatment more effective.
- Medications control symptoms.
- Medications do not cure mental illness, but in many cases, they can help a person function.
- How long someone must take a medication depends on the individual and the disorder.
- Medications do not produce the same effect in everyone.

Medications, National Institute of Mental Health (2002)

Coming Up:

The 30th Anniversary of MCES – Wednesday April 28, 2004

Silent Auction and Recognition Dinner at the Westover Country Club, Jeffersonville, PA, featuring Estelle Richman, Secretary of the PA Department of Public Welfare, Keynote Speaker.

More information at www.mces.org or 610-279-6100, Ext. 227.

MCES Spring Community Lecture Series – May/June 2004

Full morning education sessions on basic psychiatry and mental health wellness, crisis intervention, crisis communication, traumatic stress basics and other topics presented by MCES clinical and program staff.

“Relapse Prevention in Behavioral Health - What MCES is Doing”

Relapse is a challenge to the wellbeing, recovery, and, in some cases, the lives of consumers with serious mental illness. Our next issue looks at the nature of relapse and the development of relapse prevention and wellness promotion measures at MCES. This includes the MAP (My Action Plan) program submitted as a “best practice” to JCAHO in 2003.

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