FORGET FIGHTING: DE-ESCALATION

AAPA ANNUAL CONFERENCE 2020- ON DEMAND
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DISCLOSURES

- None

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LEARNING OBJECTIVES

- Explore how to safely assess the agitated patient and what tests should be done
- Learn the 10 techniques of de-escalation as outlined by Project BETA
- Work through medication indications and treatment options
- Highlight the "can't miss" diagnosis of Excited Delirium as well as the recommended treatments

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MANAGING THE AGITATED PERSON

Can be

- In the field
- In the office
- In the ED
- In the hospital
- In your kitchen

"DR. WILLIAMS WILL BE WITH YOU SHORTLY. HE'S CONSULTING WITH A COLLEAGUE."

https://www.cartoonstock.com/cartoonview.asp?catref=dbcn218&type=download

PROJECT BETA

- Best practices in the Evaluation and Treatment of Agitation
- American Academy of Emergency Psychiatry
  - Annual conference National Updates of Behavioral Emergencies
- 6 papers
  - Verbal De-escalation
  - Psychiatric Evaluation
  - Medical Evaluation and Triage
  - The Psychopharmacology of Agitation
  - Use and Avoidance of Seclusion and Restraint
  - Best Practices for Evaluation and Treatment of Agitated Children and Adolescents
- Free from the Western Journal of Emergency Medicine http://westjem.com/

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BE SAFER

- **Stabilize** the situation by containing and lowering the stimuli.
- **Assess** and acknowledge the crisis.
- **Facilitate** the identification and activation of resources (chaplain, family, friends, or police).
- **Encourage** patient to use resources and take actions in their best interest.
- **Recovery or referral**—leave patient in care of responsible person or professional or transport* to appropriate facility.

*EMS/police version

- Initially developed for crisis intervention
- Used by EMS, police, social services
  - Expanding to "lay audience"
- Several versions exist
  - RAPID Psychological First Aid
  - ALGEE Mental Health First Aid

https://nickarnett.net/pfa_cism_confusion/
http://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/MD-Medical-Protocols-2019.pdf?ver=2019-04-18-095524-123

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GOALS OF EMERGENCY PSYCHIATRIC MANAGEMENT

- Exclude medical source
- Rapid stabilization of acute crisis
- Avoid coercion
- Treat in least restrictive setting
- Form therapeutic alliance
- Appropriate disposition and aftercare

http://primarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/

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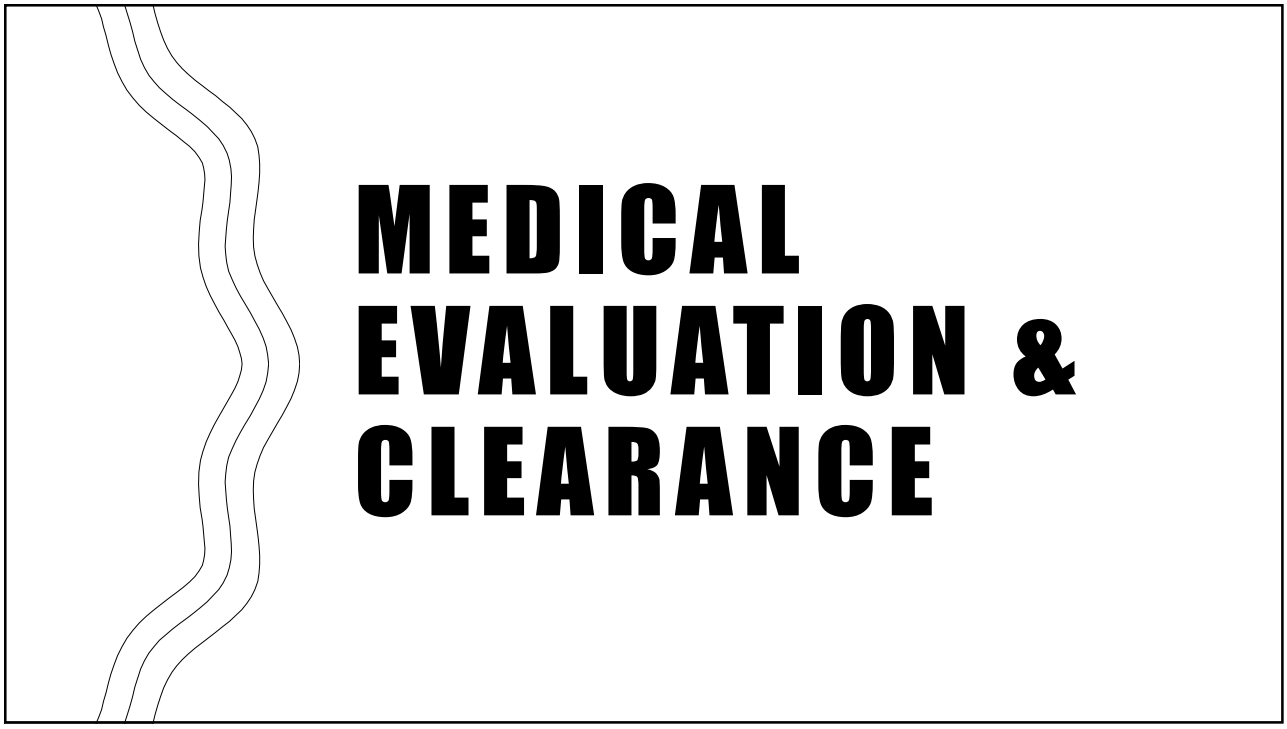

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QUESTION: PATIENTS WHO ARE AGITATED NEED MEDICAL EVALUATION AND CLEARANCE BEFORE DISCHARGE

A. True ☆

B. False

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MEDICAL EVALUATION

Project BETA recommendations

- New onset at age >45yo
- Abnormal vital signs
- Focal neurologic findings
- Evidence of head injury
- Substance intoxication
- Substance withdrawal
- Exposure to toxins/drugs
- Decreased awareness with attentional problems

https://escholarship.org/uc/item/881121hx https://fpnotebook.com/neuro/LOC/AltrdLvlOfCnscsnsCs.htm
https://www.saem.org/cdem/education/online-education/m4-curriculum/group-m4-approach-to/approach-to-altered-mental-status

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MEDICAL EVALUATION:
SOURCES OF AMS

AEIOU-TIPS

- Alcohol
- Electrolytes, Encephalopathy, Exposure, Endocrine
- Insulin
- Opiates, Oxygen
- Uremia
- Trauma, Temperature, Tumor, Toxin
- Infection
- Poison, Psychogenic, PE
- Shock, Stroke, Subarachnoid, Seizure

Other mnemonics:
I WATCH DEATH, SMASHED

https://escholarship.org/uc/item/881121hx https://fpnotebook.com/neuro/LOC/AltrdLvlOfCnscsnsCs.htm
https://www.saem.org/cdem/education/online-education/m4-curriculum/group-m4-approach-to/approach-to-altered-mental-status

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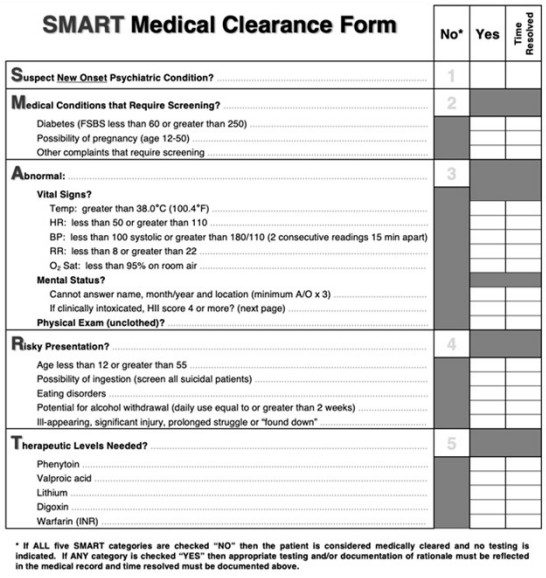
BASICS

- Routine testing NOT indicated
  → symptom directed testing
- New-onset agitation should be considered medical
- Abnormal vitals need addressed
- Tox screens aren't great
  - Don't forget APAP/Salicylate levels if any concern for OD



SMART Medical Clearance Form

	No*	Yes	Time Resolved
Suspect New Onset Psychiatric Condition?	1		
Medical Conditions that Require Screening?	2		
Diabetes (FSBS less than 60 or greater than 250)			
Possibility of pregnancy (age 12-50)			
Other complaints that require screening			
Abnormal:	3		
Vital Signs?			
Temp: greater than 38.0°C (100.4°F)			
HR: less than 50 or greater than 110			
BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart)			
RR: less than 8 or greater than 22			
O_2 Sat: less than 95% on room air			
Mental Status?			
Cannot answer name, month/year and location (minimum A/O x 3)			
If clinically intoxicated, HII score 4 or more? (next page)			
Physical Exam (unclothed)?			
Risky Presentation?	4		
Age less than 12 or greater than 55			
Possibility of ingestion (screen all suicidal patients)			
Eating disorders			
Potential for alcohol withdrawal (daily use equal to or greater than 2 weeks)			
Ill-appearing, significant injury, prolonged struggle or "found down"			
Therapeutic Levels Needed?	5		
Phenytoin			
Valproic acid			
Lithium			
Digoxin			
Warfarin (INR)			

* If ALL five SMART categories are checked "NO" then the patient is considered medically cleared and no testing is indicated. If ANY category is checked "YES" then appropriate testing and/or documentation of rationale must be reflected in the medical record and time resolved must be documented above.

http://smartmedicalclearance.org/presentations/

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COLLATERAL INFORMATION

- Figure out what happened before arrival
  - HIPAA: emergency situation, remember can always receive information
- Use PDMP
- Use EMS/police- call dispatch
- Use family, friends
- Use PCP or other care providers
- Assess protective vs risk factors for SI/HI/VI
  - TRAAPED SILO SAFE Mnemonic

https://emergencysuicide.wordpress.com/traaped-silo-safe-mnemonic/

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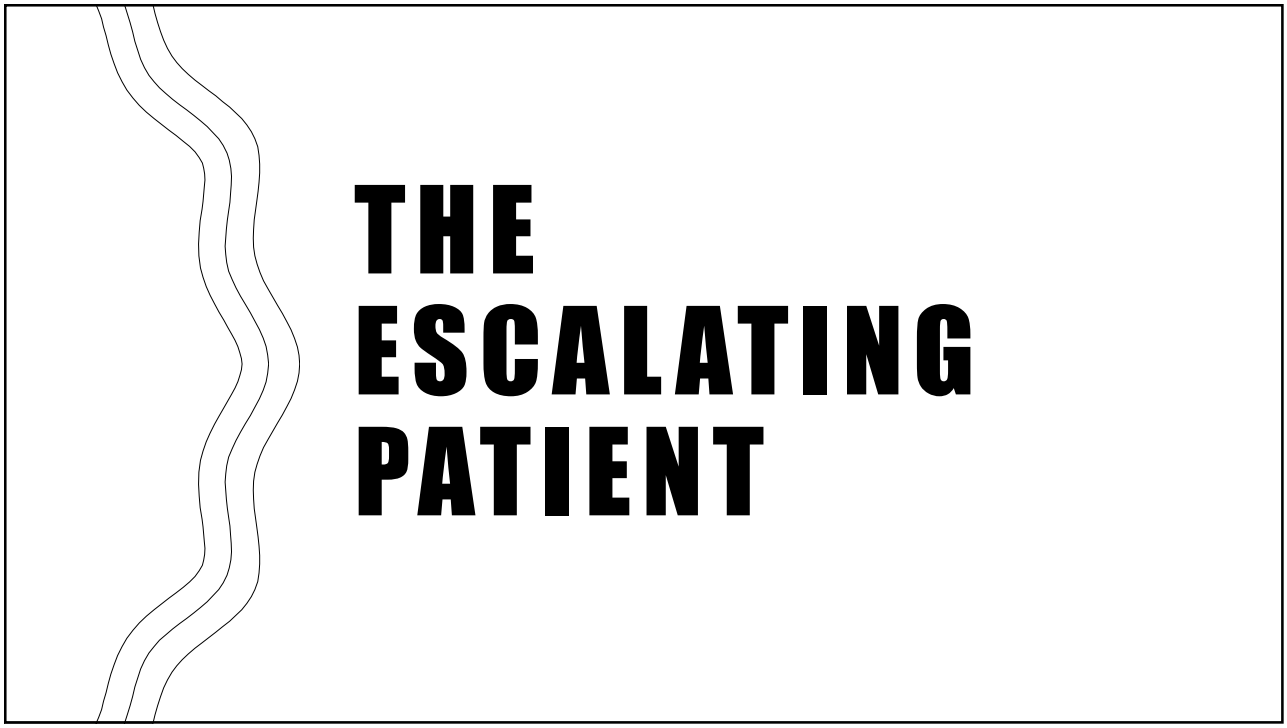

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BATHE FOR HISTORY

- Background: "What is going on in your life?"
- Affect: "How do you feel about it?"
- Trouble: "What troubles you most about the situation?"
- Handle: "What helps you handle the situation?"
- Empathy:
  - "This is a tough situation to be in"
  - "Anybody would feel as you do"
  - "Your reaction makes sense to me"

www.fpnotebook.com/Psych/Exam/BthTchnq.htm

http://www.dcputnamconsulting.com/wp-content/uploads/2017/03/Communication-Hints.jpg

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QUESTION: THE BEST EXAMPLE OF VERBAL DE-ESCALATION IS:

A. "Calm down"
B. "Be reasonable"
C. "Those are the rules"
D. "Do you want a pill or a shot?" ☆

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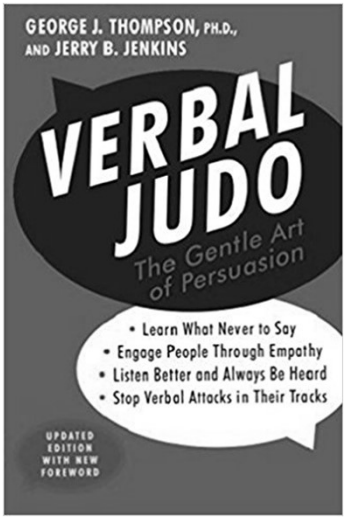
SAYINGS TO AVOID

- "Calm Down"
- "Come Here"
- "Because those are the rules"
- "You wouldn't understand"
- "None of your business"
- "What's your problem?"
- "I'm not going to say it again"
- "This is for your own good"
- "Why don't you be reasonable"



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DE-ESCALATION

1. Respect personal space
   - Safety is key
2. Do not be provocative
   - Be aware of your body language
3. Establish verbal contact
   - Only one person talks at a time, preferably only one person verbally interacts with person at all

https://escholarship.org/uc/item/55g994m6, https://ncc.expoplanner.com/files/15/SessionFilesHandouts/MLUNCH14_Zeller_1.pdf

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DE-ESCALATION

4. Be concise
   - Repetition is essential

5. Identify wants and feelings
   - "I really need to know what you expected"…."Even if I can't provide it, I would like to know so we can work on it."

6. Listen closely to what the patient is saying
   - Summarize "So what I'm hearing you say is…" "Tell me if I've got this right…"
   - Use Miller's law which states, "To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of".

https://escholarship.org/uc/item/55g994m6, https://ncc.expoplanner.com/files/15/SessionFilesHandouts/MLUNCH14_Zeller_1.pdf

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DE-ESCALATION

7. Agree or agree to disagree in 3 ways
   - 1 - agree with the truth. If the patient is agitated after 3 attempts to draw his blood, one might say, "Yes, she has stuck you 3 times. Do you mind if I try?"
   - 2 - agree in principle. For the agitated patient who is complaining that he has been disrespected by the police, you don't have to agree that he is correct but you can agree with him in principle by saying, 'I believe everyone should be treated respectfully.'
   - 3 - agree with the odds. If the patient is agitated because of the wait to see the doctor and states that anyone would be upset, an appropriate response would be, 'There probably are other patients who would be upset also."
   - **Goal: Agree as much as possible**

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DE-ESCALATION

8. Lay down the law and set clear limits
   - Limit setting must be reasonable and done in respectful manner; Feel free to say behavior is inappropriate and WHY
   - "I really want you to sit down; when you pace, I feel frightened, and I can't pay full attention to what you are saying. I bet you could help me understand if you were to calmly tell me your concerns."
9. Offer choices and optimism
   - Choices must be realistic. Ask what patient needs. Point out "your pacing and loud voice make it seem like you're angry. What can we do to help you be less angry?" – Can offer medicine to help calm/relax.
   - If situation worsens, can still partner by saying "It looks like we're going to have to give some emergency medicine to keep us all safe. Would you like a pill or a shot?" Even offering where they would like the shot (arm/leg/buttock)

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DE-ESCALATION

10. Debrief the patient and staff
    - Explain to the patient why things went the way they did- "you tried to punch someone and we don't allow that. What can we do in the future to help you get yourself calm before it escalates?"
    - Debrief with staff- how could we have avoided ended up with restraints/involuntary medicine?

JCAHO Weighs In:
https://www.jointcommission.org/resources/news-and-multimedia/blogs/dateline-tjc/2019/03/deescalate-aggression-and-potential-violence/

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TRICKS AND TIPS

- BE GENUINE
- Matched pacing/mirroring to relax
- Voice dropping
- Offering choices

- Noncomplimentarity: not matching the tone/message of the other person
  - https://community.macmillan.com/community/the-psychology-community/blog/2016/08/03/noncomplementarity-video-and-activity

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QUESTION: THE FIRST LINE TREATMENT FOR THE AGITATED PATIENT IS:

A. Midazolam

B. Haloperidol

C. Olanzapine ☆

D. Diphenhydramine

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PROJECT BETA MEDICATION SUMMARY

1. Treat the cause of the agitation-if medical, fix that before restraint/sedation
2. PO should be offered over IM/IV
3. Antipsychotics are first line if psychiatric origin
4. SGAs (such as olanzapine [Zyprexa], risperidone [Risperdal], or ziprasodone [Geodon]) are preferred over haloperidol.
   - If agitated due to alcohol, haloperidol has more data to support it's use
5. If using haloperidol, give with BZD to lower side effect risk

https://escholarship.org/uc/item/5fz8c8gs

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MEDICATIONS

ANTIPSYCHOTICS

- First line: oral SGA
  - Risperidone 2mg
  - Olanzapine 5-10mg
- Second line: oral FGA
  - Haloperidol 5mg
- Third line: injected SGA
  - Ziprasidone 10-20mg
  - Olanzapine 10mg
- Fourth line: injected FGA
  - Haloperidol 5mg

OTHERS

- Lorazepam 1-2mg
- Diazepam 5-10mg

Note: Project BETA did not make recommendation re: Ketamine for agitation and does not recommend routine use of antihistamines in adults

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PROLONGED QT AND ANTIPSYCHOTICS

- Risk is there, but minimal
- Increases with other QT prolonging meds, electrolyte imbalances (K, Mag), thyroid disease
- Droperidol in particular has black box warning
  - Review of data that led to FDA warning had lot of inconsistencies
- Another reason to focus on verbal de-escalation first

- Note: Antipsychotics are preferred for agitation from alcohol *intoxication* but BZDs are preferred for agitation from alcohol *withdrawal*

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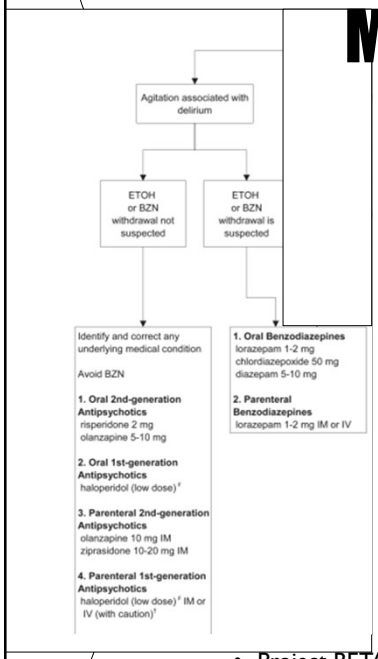
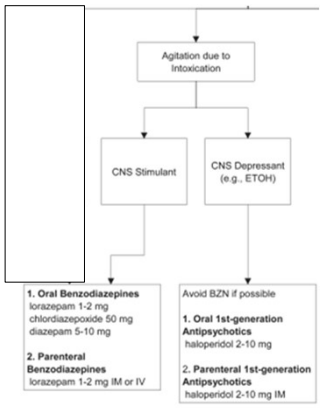
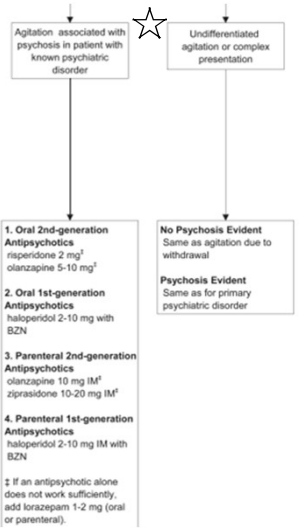
MEDS FOR AGITATION







- Project BETA recommendations https://escholarship.org/uc/item/5fz8c8gs

☆ Prefer antipsychotics as it also treats underlying issue vs just sedation

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KETAMINE

- Increasing push for use of Ketamine in variety of settings
  - ALTO for pain
  - Weekly infusion or intranasal spray for depression
- High dose for anesthesia, agitation
  - Protocols for 400-500mg IM once or 4-5mg/kg for initial dose
    - May also be role for reduced dose (2mg/kg) as second line agent
  - Quicker onset than FGA/SGA but also faster clearing

https://rebelem.com/the-evolution-of-ketamine-for-severe-agitation/ https://emupdates.com/jon-cole-on-ketamine-for-agitation/
https://www.tandfonline.com/doi/abs/10.1080/15563650.2019.1643468
http://www.jems.com/articles/print/volume-42/issue-2/features/ketamine-s-versatility-makes-it-a-powerful-tool-for-ems.html

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KETAMINE

- Caution for use when acutely psychotic due to MH
- Evolving state EMS protocols re: use of Ketamine pre-hospital
  - Fear of increased need for intubation likely not realistic
  - Consider how often Ketamine used for procedural sedation w/o intubation

https://rebelem.com/the-evolution-of-ketamine-for-severe-agitation/ https://emupdates.com/jon-cole-on-ketamine-for-agitation/
https://www.tandfonline.com/doi/abs/10.1080/15563650.2019.1643468
http://www.jems.com/articles/print/volume-42/issue-2/features/ketamine-s-versatility-makes-it-a-powerful-tool-for-ems.html

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AGITATED KIDS

- 5% of all pediatric ED visits are related to MH
  - 6-10% of peds psych visits to EDs require restraint
- Can start with extra half dose or full dose of home meds
- More often have paradoxical rxn to meds
- Often diphenhydramine [Benadryl] alone is best
- Consider antipsychotic
  - Olanzapine, Risperdal, Quetiapine, Haloperidol, Chlorpromazine
  - Avoid Olanzapine with BZDs → some evidence of increased respiratory depression
- Guanfacine or Clonidine may be useful, especially if hx of ADHD/anxiety but watch BP

https://www.jem-journal.com/article/S0736-4679(17)31215-5/fulltext https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1802106/
https://www.psych.theclinics.com/article/S0193-953X(17)30047-3/fulltext https://www.ncbi.nlm.nih.gov/pubmed/28697164/

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"BABY BETA": TREATMENT OF AGITATION IN PEDIATRICS

PO only

- Clonidine
- Olanzapine
- Risperidone
- Quetiapine

PO/IM

- Diphenhydramine
- Lorazepam
- Chlorpromazine
- Haloperidol

REALLY want to avoid IM meds in pediatric patients- very traumatizing for all involved!

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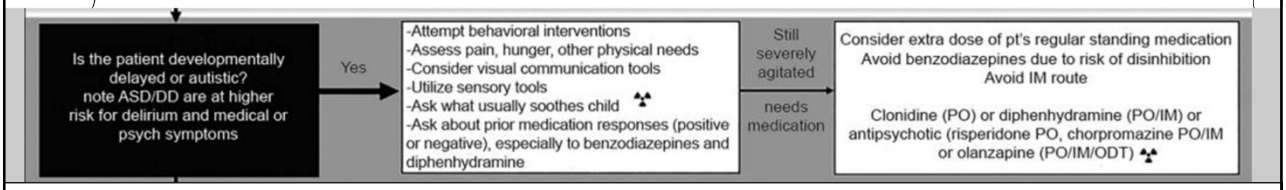
"BABY BETA": TREATMENT OF AGITATION IN PEDIATRICS



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6404720/

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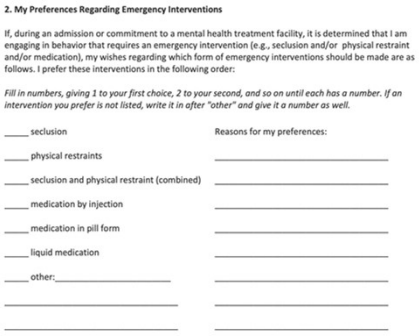
SPECIAL NOTE

- Children and adults with developmental and/or sensory processing issues are high risk for adverse /paradoxical reactions
- Those with SPMI often have had multiple bad interactions with health care system
- Use caregivers/collateral information for what helps
- Consider Psychiatric Advanced Directives for individuals in your system
  - E.g. allow use of weighted blanket, preferred med route (e.g. liquid vs pill crushed in applesauce)

https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-(PAD) https://www.nrc-pad.org/



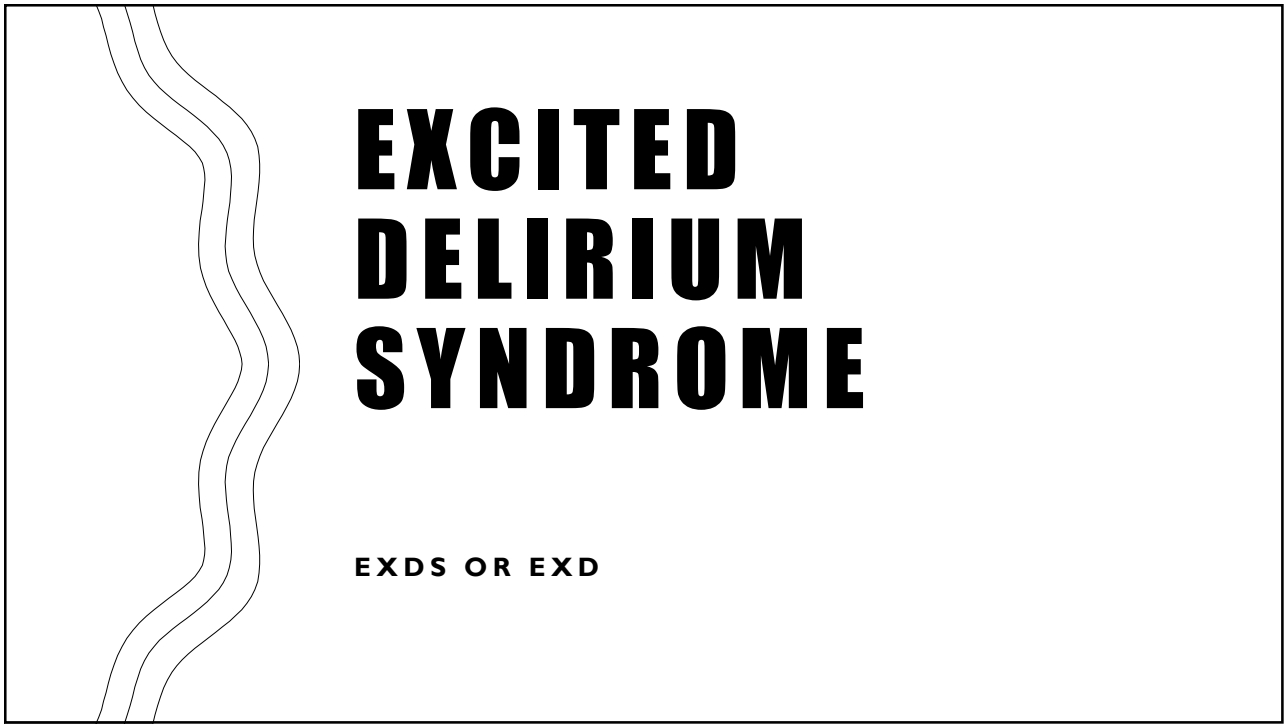
2. My Preferences Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made are as follows. I prefer these interventions in the following order:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.

	Reasons for my preferences:
____ seclusion	_____
____ physical restraints	_____
____ seclusion and physical restraint (combined)	_____
____ medication by injection	_____
____ medication in pill form	_____
____ liquid medication	_____
____ other:_____	_____
_____	_____
_____	_____

http://www.bazelon.org/our-work/mental-health-systems/advance-directives/



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QUESTION: THE FIRST LINE TREATMENT FOR A PATIENT WITH EXCITED DELIRIUM IS

A. Midazolam ☆

B. Haloperidol

C. Olanzapine

D. Diphenhydramine

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Delirium vs. Dementia vs. Depression

Features	Delirium	Dementia	Depression
Onset	Acute (hours to days)	Insidious (months to years)	Acute or Insidious (wks to months)
Course	Fluctuating	Progressive	May be chronic
Duration	Hours to weeks	Months to years	Months to years
Consciousness	Altered	Usually clear	Clear
Attention	Impaired	Normal except in severe dementia	May be decreased
Psychomotor changes	Increased or decreased	Often normal	May be slowed in severe cases
Reversibility	Usually	Irreversible	Usually

https://emergencymedicinecases.com/wp-content/uploads/2016/08/delirium-in-palliative-care-and-hospice-10-638.jpg

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WHAT IS EXDS

- Psychosis with physical distress
  - HIGH FATALITY RATES, 2/3 never make it to hospital
- Can happen due to intoxication, withdrawal, starting/stopping meds (esp. psych), recent TASER injury
- May look like hypoglycemia, hypoxia, seizures, head injury
- Tx:
  - IVF (LR preferred), check sugar, ice packs to lower temp
  - BZDs or Ketamine
  - NO Antipsychotics or Antihistamines

https://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/MD-Medical-Protocols-2019.pdf
https://www.aliem.com/2015/05/ketamine-for-excited-delirium-syndrome/ https://www.emra.org/emresident/article/excited-delirium/

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WORKPLACE VIOLENCE

- Multifactorial
  - Because of what we do, where/when we do it, who we serve
  - Not just in the hospital https://bit.ly/3bKnzH8
- Considered an OSHA issue
- JCAHO refers to it as Sentinel Event Alert 59
- Rates are increasing
  - And we are increasingly vocal about what we experience
- BUT restraint and seclusion is one of the avenues where MOST LIKELY to be harmed and inflict unintentional harm on patient

https://www.osha.gov/Publications/OSHA3826.pdf
https://www.osha.gov/Publications/osha3148.pdf
https://bit.ly/2vJIs4W - JCAHO

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RESPONDING TO IN-HOUSE EMERGENCIES

- "Do No Harm" vs "To Protect and Serve"
  - Often disconnect between training/approach of medical/MH/security
- Emergency Response Teams
  - Primarily security, but sometimes anyone on staff responds
  - Need consistency in training/skill set
  - Need "point person" for every event
  - White coat can make a difference
- Improved reporting/documentation
  - Look for trends
  - Consider reporting NEAR restraints use, too

https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.56.9.1115

https://bit.ly/2ue5IYn

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RESTRAINT AND SECLUSION

- Restraint free is possible
  - But very different setting between PES/ED and BHU/inpatient
- 6 Core Strategies
  - Leadership toward organizational change
  - Use of data to inform practice
  - Workforce development
  - Use of seclusion/restraint prevention tools
  - Consumer roles in inpatient settings
  - Debriefing techniques

https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use

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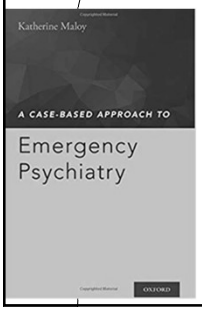
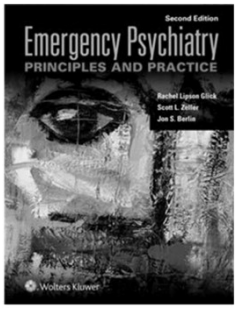
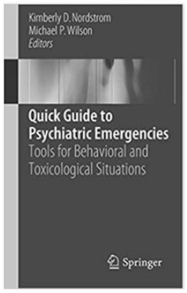
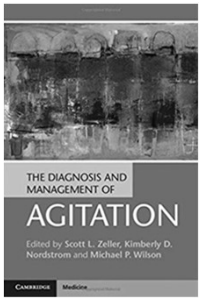
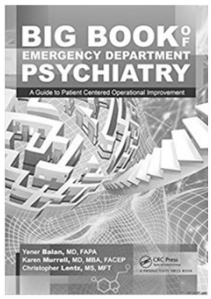
RESOURCES:

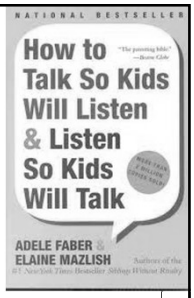












- Big book of emergency department psychiatry by Balan, Murrell, Lentz
- Case based approach to emergency psychiatry by Maloy
- Diagnosis and management of agitation by Zeller, Nordstrom, Wilson
- Emergency Psychiatry: Principles and Practices by Lipson Glick, Zeller, Berlin
- Quick Guide to Psychiatric Emergencies: tools for behavioral and toxicological situations by Nordstrom, Wilson
- How to talk so kids will listen and listen so kids will talk by Faber and Mazlish

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FOR YOUR LISTENING PLEASURE

- "Flip the Script" Invisibilia Podcast https://www.npr.org/player/embed/485602601/486026312
- "That escalated quickly: the agitated patient in the ED" ACEP Frontline https://podcasts.apple.com/us/podcast/that-escalated-quickly-the-agitated-patient-in-the-ed/id1063793120
- "The Upset Patient Protocol" ERCAST http://blog.ercast.org/the-upset-patient-protocol/
- "Art of the chemical takedown"- reports from around the world http://blog.ercast.org/art-chemical-takedown/
- Suicide Assessment https://emergencysuicide.wordpress.com/traaped-silo-safe-mnemonic/
- "Psychiatric Emergencies" EM Basic http://embasic.org/psychiatric-emergencies-part-1/ and http://embasic.org/psychiatric-emergencies-part-2/
- "Vitamin H: Haldol for Psychosis" SGEM http://thesgem.com/2013/09/sgem45-vitamin-h-haloperidol/
- "Ketamine: How to use it fearlessly for all it's indications" SMACC https://www.smacc.net.au/2015/12/ketamine-how-to-use-it-fearlessly-for-all-its-indications-by-reuben-strayer/
- If you want to read- ACEP Guidelines for adult psychiatric patients http://www.annemergmed.com/article/S0196-0644(17)30070-7/fulltext

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PROJECT BETA PAPERS

- Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup https://escholarship.org/uc/item/55g994m6
- Psychiatric Evaluation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychiatric Evaluation Workgroup https://escholarship.org/uc/item/9t41z4rb
- Medical Evaluation and Triage of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup https://escholarship.org/uc/item/8811121hx
- The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup https://escholarship.org/uc/item/5fz8c8gs
- Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup https://escholarship.org/uc/item/0pr571m3
- Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry https://escholarship.org/uc/item/9253b2hz

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RESOURCES

- Special Considerations in the Pediatric Psychiatric Population
  - Santillanes, Genevieve et al., Psychiatric Clinics, Volume 40, Issue 3, 463 - 473
  - https://www.psych.theclinics.com/article/S0193-953X(17)30047-3/fulltext
- The Use, Safety, and Efficacy of Olanzapine in a Level I Pediatric Trauma Center Emergency Department Over a 10-Year Period.
  - Cole JB1, Klein LR1, Strobel AM1, Blanchard SR1, Nahum R1,2, Martel ML1.; Pediatr Emerg Care. 2020 Feb;36(2):70-76.
  - https://www.ncbi.nlm.nih.gov/pubmed/28697164/
- Approach to the Agitated Emergency Department Patient
  - Gottlieb, Michael et al.; Journal of Emergency Medicine, Volume 54, Issue 4, 447 - 457
  - https://www.jem-journal.com/article/S0736-4679(17)31215-5/fulltext
- Trends in Mental Health and Chronic Condition Visits by Children Presenting for Care at U.S. Emergency Departments
  - Jacqueline Grupp-Phelan, MD, MPH,a Jeffrey S. Harman, PhD,b and Kelly J. Kelleher, MD, MPHc
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1802106/

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RESOURCES

- Restrain and seclusion
  - https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf
  - https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-2.pdf
  - https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-4.pdf
  - https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice-/sma18-5065
- Psychiatric Advanced Directives
  - https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-(PAD)
  - https://bit.ly/2uh3W8S
  - http://www.bazelon.org/our-work/mental-health-systems/advance-directives/

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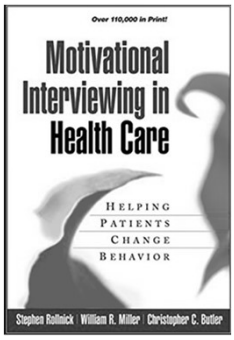
The Voice of Emergency Mental Health Professionals



THANKS!

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