

2017

# CIT Metro Handbook





# CIT Metro

## CIT Metro Weekly Outline

### **I. Monday**

- a. Introduction
- b. Clinical Disorders
- c. Intervention Strategies
- d. Personality Disorders
- e. Psychotropic Meds

### **II. Tuesday**

- a. Children's Issues
- b. Suicide Assessment
- c. Autism Awareness
- d. Developmental Disorders
- e. VA/UNI – Site Visits

### **III. Wednesday**

- a. Age Related Disorders
- b. Substance Abuse and Co-Occurring Disorders
- c. USH Site Visit

### **IV. Thursday**

- a. Non-Psychiatric Behaviors
- b. Voices Simulation
- c. CIT Procedures/Civil Commitment Laws
- d. Lunch with Consumers
- e. Interventions/Scenario Training

### **V. Friday**

- a. Scenario Trainings
- b. Officer Perspective
- c. State Exam

### **VI. Glossary**

### **VII. Appendix**



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## **I. Monday**

### **a. Introduction**

#### **i. Program Goals**

1. Officer and Consumer Safety
2. Developing a network of CIT law enforcement officers within Salt Lake County
3. Establish a system that includes law enforcement as a team member of mental health care

#### **ii. 5 Legs of the CIT Program**

1. Police training
2. Community collaboration
3. Accessible crisis system
4. Behavioral health staff training
5. Family/consumer advocate, collaborate, and educate

#### **iii. Instructor Contact Info:**

1. Sgt. Jodie Sampson (385)226-2376
2. Det. Brandee Casias (385)222-6879
3. Det. Cooper Lanvatter (801)518-6836
4. Det. Joseph Taylor (801)518-3560
5. Det. Ryan Carver (801)509-1446

### **b. Clinical Disorders**

- i. People are made up of biological and environmental factors
- ii. Mental illnesses are abnormalities and disturbances in thinking, feeling, and acting.
- iii. The three degrees of mental illness: mild, moderate, and severe.
- iv. Categories of mental illness: mood disorders, anxiety disorders, substance abuse disorders, psychotic disorders, and personality disorders
- v. Adjustment disorder is attributed to occurrences in the course of living which are significantly stressful and



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difficult to resolve with typical problem-solving behaviors.

- vi. Schizophrenia is characterized by delusional thoughts, auditory hallucinations, onset in late adolescents or early young adult years, disorganized thinking and irrational thoughts. Schizophrenia is classified as a thought disorder.
- vii. Persons who hear auditory hallucinations such as "hearing voices" may utilize techniques such as playing music through headphones at a high level to reduce the annoyance
- viii. Anxiety disorder is a sense of fear and apprehension, accelerated heart rate, shortness of breath, tightness in the chest, tremor, worry and nervousness, avoidance behaviors.
- ix. Mental illnesses includes: Disturbances in the human process or experience of thinking (cognition), feeling (emotion) and / or actions (behavior). They may be mild, moderate or severe and short term (acute), medium in duration or long term (chronic). They may be genuine biological, biochemical or genetic illnesses for which the afflicted person has no more fault than for conditions like diabetes cancer or appendicitis.
- x. Bi-Polar Affective Disorder is very much a biological illness and some of the most effective treatments are medications, which affect chemical processes in the brain and tends to show up in family lines more frequently than chance suggesting a genetic family link. It also results in poor judgment sufficient to lead to such problems as sexual indiscretions, frivolous spending, efforts to assume positions of public importance, etc.



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## **c. Intervention Strategies**

- i. Your brain: reptilian, midbrain, neocortex
- ii. Crisis mindset
- iii. Stigma Cycle
- iv. Empathy vs. Sympathy
- v. “ABC” stands for Achieve contact; Boil down to essentials; Constructive action
- vi. Officers and consumers can be effected by any mental health issue
- vii. Persons effected by mental illness are generally not dangerous but are less predictable
- viii. “DBEAT” is an acronym representing CIT safety considerations that stands for distance, back-up, empathy, awareness, and time
- ix. PTSD flashbacks are generally sort in duration
- x. Officer safety is paramount and should always be utilized when dealing with persons afflicted with mental illness

## **d. Personality Disorders**

- i. Anti-social personalities appear to be predators of one type or another and display little guilt or remorse for their offenses
- ii. One of the characteristics of Borderline Personality Disorder is recurrent suicidal behavior, gestures or threats and self-mutilating behavior

## **e. Psychotropic Meds**

- i. Bi-polar disorder is treated with mood stabilizers such as Lithium, Depakote, Lamictal, and Latuda
- ii. It typically takes 2 – 6 weeks for most medications to take effect
- iii. Medications for schizophrenia are over 70% effective in treating psychotic symptoms of the illness



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- iv. Possible side effects of medications include sedation, stimulation, nausea, and movement disorders
- v. Anxiety disorders are typically treated with Ativan, Klonopin, Valium, Librium, Serax, Xanax, and other Benzodiazepines

## **II. Tuesday**

### **a. Children's Issues**

- i. Children are not mini-adults
- ii. Impacts on mental health: environment, genetics, temperament, intelligence, phobias, trauma, culture.
- iii. Myths about mental illness
- iv. Behaviors by age group
- v. What to look for
- vi. Children/youth's diagnoses can change over time
- vii. When children and adolescents are in crisis, it usually presents as a behavior problem, such as verbal or physical aggression

### **b. Suicide Assessment**

- i. Definitions of: suicide, suicide attempt, suicidal ideation
- ii. Suicide statistics
- iii. Military and Law Enforcement risks
- iv. Myths about Suicide
- v. Risk factors include significant alcohol and/or drug abuse, Male gender, formerly, but not currently, married
- vi. Pseudo-suicidal gestures are a phenomenon which tends to occur among more immature, attention seeking personalities, prone to dramatic displays of emotion and selecting rather non-lethal means with a built-in element of rescue.
- vii. Appropriate suicide assessment questions include asking the person if they wished they were dead or





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could go to sleep and not wake up and asking if they had thoughts of killing themselves

viii. As a first responder, it is just as important to take care of your emotional wellbeing as it is to wear your vest

## **c. Autism Awareness**

- i. Behaviors: nervous ticks, strange behaviors, agitation, anxiety, may not recognize uniforms or your authority, and they may have an attraction to water
- ii. Officer response: talk directly to them in a soft voice, keep your hands in front of you and maintain officer safety

## **d. Developmental Disorders**

- i. Cognitive level should be taken into consideration when communicating with a person who has an intellectual disability
- ii. Grade level or education achievement is not a reliable method for identifying the presence of an intellectual disability

e. VA/UNI – Site Visits

## **III. Wednesday**

### **a. Age Related Disorders**

- i. Caregivers may experience compassion fatigue or secondary trauma
- ii. Talking about real actions and objects is the best way to communicate with persons affected with dementia
- iii. Persons with Dementia/Alzheimer's often have cognitive (thinking) impairments that can increase their level of confusion

### **b. Substance Abuse and Co-Occurring Disorders**

- i. Symptoms of substance abuse: withdrawal and changes in behavior



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- ii. Substance abuse qualifiers: mild, moderate, and severe
- iii. In Utah, it is estimated that 75-85% of all crime is substance abuse related.
- iv. Substances you may see: alcohol, methamphetamine, narcotics and opioids, cocaine, hallucinogens, inhalants, sedatives, cannabis, GHB, date rape drugs, ecstasy.
- v. Alcohol withdrawal is likely to have the most serious consequences for its victim.
- vi. Methamphetamine may produce a psychotic disorder that is almost impossible to distinguish from paranoid schizophrenia on observation.
- vii. Most of the criteria for diagnosing substance abuse and dependencies involve assessing how the use impacts the life functioning of the individual.
- viii. A co-occurring disorder can be described as a person having a substance dependence and a co-existing psychiatric disorder.

## c. USH Site Visit

## **iv. Thursday**

### **a. Non-Psychiatric Behaviors**

- i. Some medical conditions can present as psychiatric conditions
- ii. EMS conducts the initial on site medical screening

### b. Voices Simulation

### **c. CIT Procedures/Civil Commitment Laws**

i.

### **d. Lunch with Consumers**

- i. Families sometimes call law enforcement on their mentally ill family members because they are desperate and feel that is the only avenue left to get their loved one treatment





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- ii. Most individuals with severe mental illness can remember what their life was like before the illness
- iii. The National Alliance on Mental Illness (NAMI) is a resource for anyone
- iv. Some very talented and creative individuals, throughout the course of history, were afflicted with some form of mental illness

## **e. Interventions/Scenario Training**

- i. Understanding yourself and your physical, spiritual, and emotional wellbeing
- ii. Know how to deescalate yourself after each encounter – both on and off duty
- iii. Anger is a secondary emotion; validate your primary emotion
- iv. Eat, sleep, exercise, have a hobby, practice mindfulness; don't forget to process – BREATHE

## **v. Friday**

- a. Scenario Trainings
- b. Officer Perspective
- c. State Exam
- d. Chief's Perspective/Graduation



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## **VI. Glossary**

### **Anxiety Disorders**

Anxiety disorders represent a condition in which worry, anxiety or fear are prominent symptoms. Disorders include obsessive compulsive disorder, panic attacks and phobias. Typically, a person's anxiety levels are so high that day to day functioning becomes difficult.

### **Antisocial personality disorder**

Antisocial personality disorder, sometimes called sociopathy, is a mental condition in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others. People with antisocial personality disorder tend to antagonize, manipulate or treat others harshly or with callous indifference. They show no guilt or remorse for their behavior.

Individuals with antisocial personality disorder often violate the law, becoming criminals. They may lie, behave violently or impulsively, and have problems with drug and alcohol use. Because of these characteristics, people with this disorder typically can't fulfill responsibilities related to family, work or school.

### **Bipolar Mood disorder**

People with bipolar mood disorder experience recurrent episodes of depressed and elated moods. Both can be mild to severe. The term 'mania' is used to describe the most severe state of extreme elation and over activity. There are 2 separate diagnoses for bipolar disorder, known as bipolar 1 and bipolar 2, related to the severity of the manic episode, known as "mania" or "hypomania". During both mania and hypomania an individual feels or acts abnormally happy, energetic, or irritable; often making poorly thought out decisions with little regard to the consequences. The need for sleep is usually reduced. During



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periods of depression there may be crying, poor eye contact with others, and a negative outlook on life.

## **Blue Sheet**

Emergency application for commitment with certification. Allows an MD or DE to temporarily hold a person for 24 hours for evaluation.

## **Borderline Personality Disorder**

Borderline personality disorder (BPD) is a serious mental disorder marked by a pattern of ongoing instability in moods, behavior, self-image, and functioning. These experiences often result in impulsive actions and unstable relationships. A person with BPD may experience intense episodes of anger, depression, and anxiety that may last from only a few hours to days.

Some people with BPD also have high rates of co-occurring mental disorders, such as mood disorders, anxiety disorders, and eating disorders, along with substance abuse, self-harm, suicidal thinking and behaviors, and suicide.

## **Civil Commitment**

Civil Commitment is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment in a hospital (inpatient), or in the community (outpatient).

## **Delusion**

A belief that is false, fanciful or derived from deception. In psychiatry, a false belief strongly held in spite of evidence that it is not true, especially as a symptom of a mental illness.

## **Depression**

Clinical depression involves a persistent lowering of mood. This plays out in a variety of symptoms that include feeling extremely sad or tearful, sleeplessness, feeling guilty and worthless, loss of energy



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and motivation, loss of pleasure, and impaired thinking and concentration. Everyday functioning can become extremely difficult.

## Early Intervention

In mental health, diagnosing and treating mental illnesses early in their development. Studies have shown early intervention can result in higher recovery rates. However, many individuals do not have the advantage of early intervention because the stigma of mental illness and other factors keep them from pursuing help until later in the illness' development.

## Hallucinations

Hallucinations are sensations that appear to be real but are created within the mind. Examples include seeing things that are not there, hearing voices or other sounds, experiencing body sensations like crawling feelings on the skin, or smelling odors that are not there. Hallucinations can be a feature of [psychotic disorders](#) such as [schizophrenia](#) and are also very common in drug-induced states and in drug withdrawal. This occurs with a number of different [drugs](#). People who are seriously ill, such as those with [liver](#) or [kidney failure](#), can experience hallucinations. High fevers can also produce hallucinations in some people. Hallucinations can accompany other psychotic symptoms such as [delusions](#) and disconnection from reality. They can be temporary or persist over the long term, depending upon the exact cause.

## Inpatient Care

Inpatient Care is the care of patients whose condition requires admission to a hospital. Patients enter inpatient care mainly from previous ambulatory care such as referral from a family doctor, or through emergency medicine departments. The patient formally becomes an "inpatient" at the writing of an admission note. Likewise, it is formally ended by writing a discharge note.



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## **Mental Health**

Mental health has to do with how you feel about yourself, how you feel about others, and how you are able to balance problems with appropriate coping skills.

## **Mental Illness**

Mental Illness refers collectively to all diagnosable mental disorders. These disorders are based upon symptoms that are severe enough to affect a person's ability to work, maintain relationships and care for themselves. Can refer to a disease of the brain with predominant behavioral symptoms as in acute alcoholism or a disease of the mind or personality that results in abnormal behavior as with hysteria or schizophrenia. Can refer to any psychiatric illness listed in Current Medical Information and Terminology of the American Medical Association or in the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

## **NAMI (National Alliance on Mental Illness)**

The largest grassroots mental health organization in the United States, dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need.

## **Narcissistic Personality Disorder**

The hallmarks of Narcissistic Personality Disorder (NPD) are grandiosity, a lack of empathy for other people, and a need for admiration. People with this condition are frequently described as arrogant, self-centered, manipulative, and demanding. They may also concentrate on grandiose fantasies (e.g. their own success, beauty, brilliance) and may be convinced that they deserve special treatment. These characteristics typically begin in early adulthood and must be



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consistently evident in multiple contexts, such as at work and in relationships.

People with narcissistic personality disorder believe they are superior or special, and often try to associate with other people they believe are unique or gifted in some way. This association enhances their self-esteem, which is typically quite fragile underneath the surface. Individuals with NPD seek excessive admiration and attention in order to know that others think highly of them. Individuals with narcissistic personality disorder have difficulty tolerating criticism or defeat, and may be left feeling humiliated or empty when they experience an "injury" in the form of criticism or rejection.

## **Outpatient Care**

Outpatient Care describes medical care or treatment that does not require an overnight stay in a hospital or medical facility. Outpatient care may be administered in a medical office or a hospital, but most commonly, it is provided in a medical office or outpatient surgery center.

## **Pink Sheet**

Emergency application for involuntary commitment without certification. Peace officers or mental health officers may use this form to temporarily hold an individual up to 24 hours.

## **Post-Traumatic Stress Disorder**

PTSD is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event.

It is natural to feel afraid during and after a traumatic situation. Fear triggers many split-second changes in the body to help defend against danger or to avoid it. This "fight-or-flight" response is a typical reaction meant to protect a person from harm. Nearly everyone will experience a range of reactions after trauma, yet most people recover from initial symptoms naturally. Those who continue to





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experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened even when they are not in danger.

## **Psychiatry**

Psychiatry is a branch of medicine that deals with the science and practice of treating mental, emotional or behavioral disorders.

## **Psychosis**

A serious mental disorder characterized by defective or lost contact with reality, often with hallucinations or delusions, causing deterioration of normal social functioning.

## **Psychotherapy**

Psychotherapy is a form of therapy that emphasizes substituting desirable responses and behavior patterns for undesirable ones.

## **Recovery**

Recovery is the personal process that people with mental health conditions experience in gaining control, meaning and purpose in their lives. Recovery is the process of realizing that you would not want to be anyone other than who you are today.

## **Residential Treatment**

Residential Treatment is intensive and comprehensive psychiatric treatment in a campus-like setting, usually for a minimum of several months.

## **Schizophrenia**

Schizophrenia is a cognitive disorder often characterized by abnormal social behavior and failure to recognize what is real. It affects approximately 1% of the world's population, equally between men and women, and is present in all cultures and countries. Schizophrenia can have "positive" symptoms, including delusions,



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hallucinations, and disorganized thought, speech or behavior. It can also have “negative” symptoms, including a flattening in emotions, lack of drive, and social withdrawal. Statistics show that 80% of patients will go off their medication at least once as they begin to “feel better”. Also, 50% of patients will attempt suicide, with 10% actually committing suicide.

## **Schizoaffective Disorder**

Schizoaffective Disorder is an illness that displays some of the psychotic symptoms of schizophrenia along with the mood extremes associated with bipolar disorder.

## **Stigma**

A Stigma is a mark of shame or discredit, or a sign of social unacceptability.

## **System of Care**

A System of Care is a partnership of mental health, education, child welfare and juvenile justice agencies as well as teachers, children with serious emotional disturbances and their families and other caregivers. These agencies and individuals work together to ensure children with mental, emotional and behavioral problems and their families have access to the services and supports they need to succeed. Together, this team creates an individualized service plan that builds on the unique strengths of each child and each family. The plan is then implemented in a way that is consistent with the family's culture and language.

## **Therapy**

Therapy is the treatment of physical, mental or behavioral problems that is meant to cure or rehabilitate.

## **White Sheet**



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A notice to the courts for an involuntary commitment proceeding. Can be filled out by social workers in inpatient settings or family members through the court system.



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## VII. Appendix

- a. CIT International information
- b. Maps
- c. PTSD Handout
- d. Pink Sheets
  - i. Adult
  - ii. Youth
- e. 911 Checklist
- f. Crisis Cycle
- g. Law Enforcement CIT Tools
- h. Utah Department of Health Statistics
- i. Caring Connections – Grief Resources
- j. Caregiver Burnout
- k. Age Related Issues
  - i. Aging Resources by County
- l. NAMI Resources
- m. County Mental Health Resources
- n. VA Medical Center Resources
- o. Intellectual Disabilities Resources
- p. Checklist for Law Enforcement
  - i. Common Traits
  - ii. Screening Questions
- q. Tips for Communicating with a Psychotic Individual

# CIT INTERNATIONAL



[www.citinternational.org](http://www.citinternational.org)

\*\*\*\*\*  
**CIT International, Inc.** is a membership organization with the primary purposes to: facilitate understanding, development, and implementation of **Crisis Intervention Team (CIT)** programs throughout the United States and in other nations worldwide; promote and support collaborative efforts to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families, and communities; and, reduce the stigma of mental illness. **CIT International** works to accomplish this by: raising public and stakeholder awareness through education and outreach; establishing and disseminating recommended standards for developing, implementing and sustaining crisis intervention programs; providing assistance to communities interested in developing CIT programs; supporting research and evaluation of CIT programs; and, partnering with CIT programs in various localities to hold International CIT Conferences.

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## JOIN THE MOVEMENT!

### COMPLIMENTARY ONE-YEAR MEMBERSHIP TO ALL CIT GRADUATES!

(The regular \$25 Individual Membership Dues is Waived for one-year for all CIT 40-hour course graduates within 90-days of graduation)

During this Membership Drive, applications may be submitted  
on-line at [www.citinternational.org](http://www.citinternational.org) or mailed to:

**CIT International, Inc.,**  
211 S. Highland Street, Box 71, Dept. 2, Memphis, TN 38111

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

AGENCY / AFFILIATION: \_\_\_\_\_

**CIT COURSE INFORMATION:** I am a CIT 40-hour Course Graduate within the last 90-days.

Dates Attended: \_\_\_\_\_ Location: \_\_\_\_\_

(CIT International, Inc. is a non-profit 501(c)(3) organization)

## The Value of Joining CIT International

- Only organization dedicated exclusively to the CIT program.
- Committed to the belief CIT is *the* most effective, efficient, and successful jail diversion program.
- Working to advance CIT programs worldwide.
- Membership makes you a participating partner on the Team!
- Membership is not only about the benefits received. It is also about your ideas, input, and involvement you bring to the organization.
- Membership provides an intangible value of being a significant part of a worthwhile international movement.

## The Benefits of Joining CIT International

- Partnership in an international movement to improve: the effectiveness of law enforcement, the lives of persons coping with mental illness, and the services of mental health providers
- Receive an individually numbered membership card
- Receive the quarterly newsletter, *The Team*
- Receive discounted registration for **CIT International** sponsored conferences
- Receive advice and support on issues facing your local CIT program
- Gain access to member-specific website information at: **[www.citinternational.org](http://www.citinternational.org)**
- Gain opportunity to network with other **CIT International** members around the globe
- Participate in the **CIT International** awards program



**[www.citinternational.org](http://www.citinternational.org)**

**THE CIT FAMILY THANKS YOU!**  
**(CIT International, Inc. is a non-profit 501(c)(3) organization)**





George E. Wahlen Department of  
Veterans Affairs Medical Center  
VA Salt Lake City Health Care System  
500 Foothill Drive  
Salt Lake City, UT 84148  
801-582-1565

To University of Utah Medical Center  
and Primary Childrens Medical Center

Mario Capecchi Drive

Foothill Drive Entrance

Foothill Drive

To Research Park  
and University  
Park Hotel  
Wakara Way

## Patient Information Map as of 8/18/14

To Downtown  
Salt Lake City

5th South Entrance

Patient  
Parking  
Enter

Guardsmans Way Entrance,  
enter from Guardsmans Way,  
645 So. at 1580 East

Employee  
Parking  
Lot 14

Valdez Drive

Fracker Street

Kisters Street

Wahlen Way

Hall Street

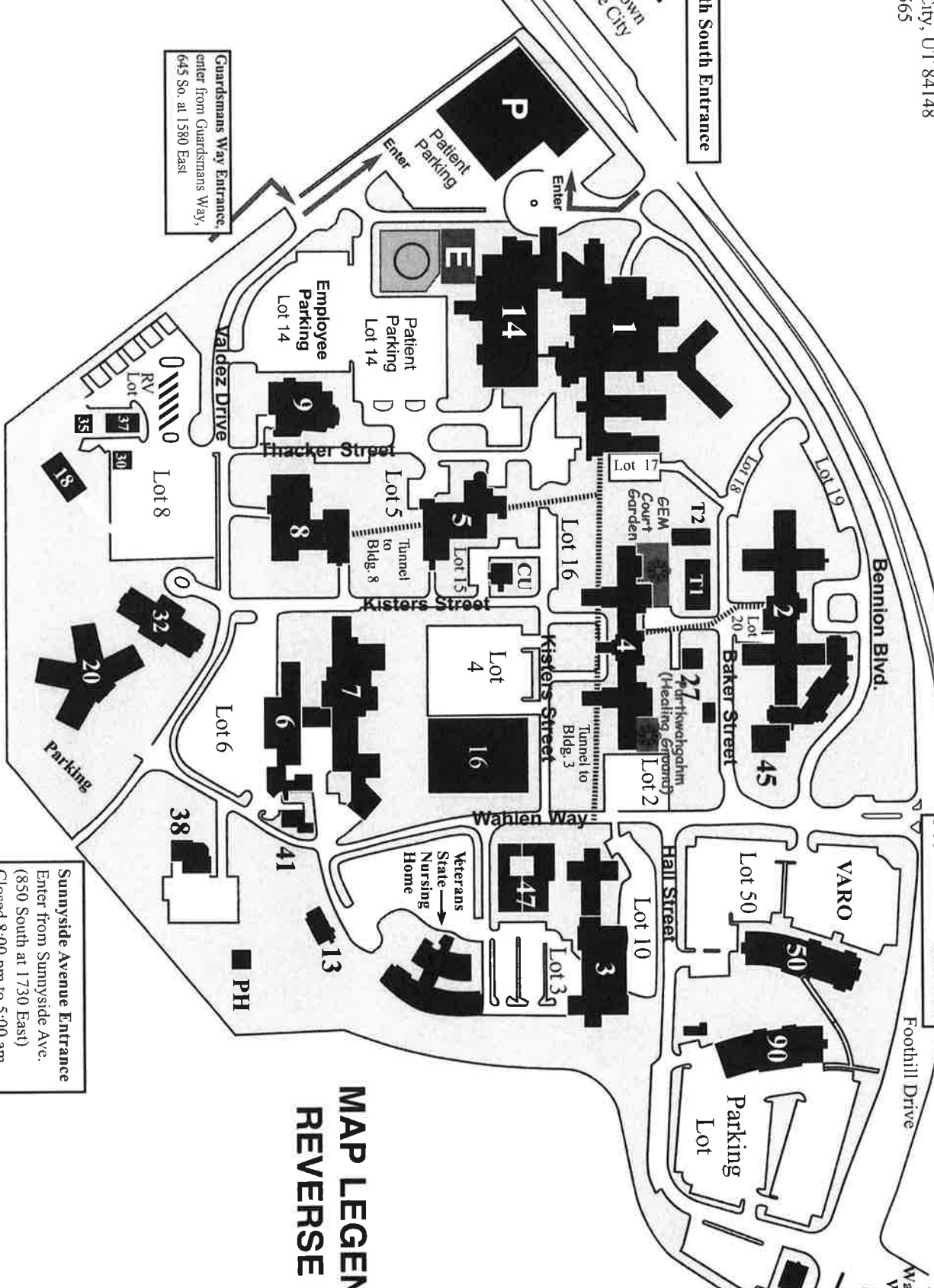
To Parley's  
Canyon  
and I-80

Corner Bakery  
Cafe

## MAP LEGEND ON REVERSE SIDE

= Main Patient Parking

Sunnyside Avenue Entrance  
Enter from Sunnyside Ave.  
(850 South at 1730 East)  
Closed 8:00 pm to 5:00 am  
Monday through Friday  
Closed weekends & holidays



## **What is Posttraumatic Stress Disorder (PTSD)?**

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after you have been through a traumatic event. A traumatic event is something horrible and scary that you see or that happens to you. During this type of event, you think that your life or others' lives are in danger. You may feel afraid or feel that you have no control over what is happening.

Anyone who has gone through a life-threatening event can develop PTSD. These events can include:

- Combat or military exposure
- Child sexual or physical abuse
- Terrorist attacks
- Sexual or physical assault
- Serious accidents, such as a car wreck.
- Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake.

After the event, you may feel scared, confused, or angry. If these feelings don't go away or they get worse, you may have PTSD. These symptoms may disrupt your life, making it hard to continue with your daily activities.

## **How does PTSD develop?**

All people with PTSD have lived through a traumatic event that caused them to fear for their lives, see horrible things, and feel helpless. Strong emotions caused by the event create changes in the brain that may result in PTSD.

Most people who go through a traumatic event have some symptoms at the beginning. Yet only some will develop PTSD. It isn't clear why some people develop PTSD and others don't. How likely you are to get PTSD depends on many things. These include:

- How intense the trauma was or how long it lasted
- If you lost someone you were close to or were hurt
- How close you were to the event
- How strong your reaction was
- How much you felt in control of events
- How much help and support you got after the event

Many people who develop PTSD get better at some time. But about 1 out of 3 people with PTSD may continue to have some symptoms. Even if you continue to have symptoms, treatment can help you cope. Your symptoms don't have to interfere with your everyday activities, work, and relationships.

## **What are the symptoms of PTSD?**

Symptoms of posttraumatic stress disorder (PTSD) can be terrifying. They may disrupt your life and make it hard to continue with your daily activities. It may be hard just to get through the day.

PTSD symptoms usually start soon after the traumatic event, but they may not happen until months or years later. They also may come and go over many years. If the symptoms last longer than 4 weeks, cause you great distress, or interfere with your work or home life, you probably have PTSD.

There are four types of symptoms: reliving the event, avoidance, numbing, and feeling keyed up.

### **Reliving the event (also called re-experiencing symptoms):**

Bad memories of the traumatic event can come back at any time. You may feel the same fear and horror you did when the event took place. You may have nightmares. You even may feel like you're going through the event again. This is called a flashback. Sometimes there is a trigger: a sound or sight that causes you to relive the event. Triggers might include:

- Hearing a car backfire, which can bring back memories of gunfire and war for a combat veteran
- Seeing a car accident, which can remind a crash survivor of his or her own accident
- Seeing a news report of a sexual assault, which may bring back memories of assault for a woman who was raped

### **Avoiding situations that remind you of the event:**

You may try to avoid situations or people that trigger memories of the traumatic event. You may even avoid talking or thinking about the event.

- A person who was in an earthquake may avoid watching television shows or movies in which there are earthquakes
- A person who was robbed at gunpoint while ordering at a hamburger drive-in may avoid fast-food restaurants
- Some people may keep very busy or avoid seeking help. This keeps them from having to think or talk about the event.

### **Feeling numb:**

You may find it hard to express your feelings. This is another way to avoid memories.

- You may not have positive or loving feelings toward other people and may stay away from relationships
- You may not be interested in activities you used to enjoy
- You may forget about parts of the traumatic event or not be able to talk about them.

### **Feeling keyed up (also called hyperarousal):**

You may be jittery, or always alert and on the lookout for danger. This is known as hyperarousal. It can cause you to:

- Suddenly become angry or irritable
- Have a hard time sleeping
- Have trouble concentrating
- Fear for your safety and always feel on guard
- Be very startled when someone surprises you

### **What are other common problems?**

People with PTSD may also have other problems. These include:

- Drinking or drug problems
- Feelings of hopelessness, shame, or despair
- Employment problems
- Relationships problems including divorce and violence
- Physical symptoms

### **Can children have PTSD?**

Children can have PTSD too. They may have the symptoms described above or other symptoms depending on how old they are. As children get older their symptoms are more like those of adults.

- Young children may become upset if their parents are not close by, have trouble sleeping, or suddenly have trouble with toilet training or going to the bathroom
- Children who are in the first few years of elementary school (ages 6 to 9) may act out the trauma through play, drawings, or stories. They may complain of physical problems or become more irritable or aggressive. They also may develop fears and anxiety that don't seem to be caused by the traumatic event.

### **What treatments are available?**

When you have PTSD, dealing with the past can be hard. Instead of telling others how you feel, you may keep your feelings bottled up. **But treatment can help you get better.**

There are good treatments available for PTSD. Cognitive-behavioral therapy (CBT) is one type of counseling. It appears to be the most effective type of counseling for PTSD. There are different types of cognitive behavioral therapies such as cognitive therapy and exposure therapy. A similar kind of therapy called EMDR, or eye movement desensitization and reprocessing, is also used for PTSD. Medications can be effective too. A type of drug known as a selective serotonin reuptake inhibitor (SSRI), which is also used for depression, is effective for PTSD.

**EMERGENCY APPLICATION  
FOR INVOLUNTARY COMMITMENT WITHOUT CERTIFICATION  
TO**

\_\_\_\_\_  
**Local Mental Health Authority**

\_\_\_\_\_, 20\_\_\_\_

To The Director:

I, \_\_\_\_\_, a duly authorized mental health or peace officer have  
observed \_\_\_\_\_, in conduct which leads me to believe that there is  
probable cause that \_\_\_\_\_, is mentally ill and that there is substantial  
likelihood of serious harm to self or others unless taken into protective custody pending  
proceedings for examination and certification. I hereby make application for commitment of  
the said proposed patient to: \_\_\_\_\_.

\_\_\_\_\_  
Local Mental Health Authority

I took the proposed patient into protective custody under the following circumstance(s):

(a) Statement of facts which called proposed patient to attend of officer: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(b) Specific nature of danger: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(c) Summary of observation upon which the statement of danger is based: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Names and addresses of persons to be notified of placement in custody of local mental health  
authority:

Guardian: \_\_\_\_\_  
Address Phone

Adult Family: \_\_\_\_\_  
Address Phone

Other: \_\_\_\_\_  
Address Phone

\_\_\_\_\_  
Signature of Mental Health Officer or Peace Officer

## INSTRUCTIONS

If a duly authorized peace officer observes a person involved in conduct that gives the officer probable cause to believe that the person is mentally ill, as defined in Section 62A-15-602, and because of that apparent mental illness and conduct, there is a substantial likelihood of serious harm to that person or others, pending proceedings for examination and certification under this part, the officer may take that person into custody. The peace officer shall transport the person to be transported to the designated facility of the appropriate local mental health authority pursuant to this section, either on the basis of his own observation or on the basis of a mental health officer's observation that has been reported to him by that mental health officer. Immediately thereafter, the officer shall place the person in the custody of a local mental health authority and make application for commitment of that person to the local mental health authority. A person committed under this section may be held for a maximum of 24 hours, excluding Saturdays, Sundays, and legal holidays. At the expiration of that time period, said person shall be released unless application for involuntary commitment has been commenced pursuant to Section 62A-15-631.



**62A-15-629. Temporary commitment -- Requirements and procedures.**

(1) (a) An adult may be temporarily, involuntarily committed to a local mental health authority upon:

(i) written application by a responsible person who has reason to know, stating a belief that the individual is likely to cause serious injury to himself or others if not immediately restrained, and stating the personal knowledge of the individual's condition or circumstances which lead to that belief; and

(ii) a certification by a licensed physician or designated examiner stating that the physician or designated examiner has examined the individual within a three-day period immediately preceding that certification, and that he is of the opinion that the individual is mentally ill and, because of his mental illness, is likely to injure himself or others if not immediately restrained.

(b) Application and certification as described in Subsection (1)(a) authorizes any peace officer to take the individual into the custody of a local mental health authority and transport the individual to that authority's designated facility.

(2) If a duly authorized peace officer observes a person involved in conduct that gives the officer probable cause to believe that the person is mentally ill, as defined in Section **62A-15-602**, and because of that apparent mental illness and conduct, there is a substantial likelihood of serious harm to that person or others, pending proceedings for examination and certification under this part, the officer may take that person into protective custody. The peace officer shall transport the person to be transported to the designated facility of the appropriate local mental health authority pursuant to this section, either on the basis of his own observation or on the basis of a mental health officer's observation that has been reported to him by that mental health officer. Immediately thereafter, the officer shall place the person in the custody of the local mental health authority and make application for commitment of that person to the local mental health authority. The application shall be on a prescribed form and shall include the following:

(a) a statement by the officer that he believes, on the basis of personal observation or on the basis of a mental health officer's observation reported to him by the mental health officer, that the person is, as a result of a mental illness, a substantial and immediate danger to himself or others;

(b) the specific nature of the danger;

(c) a summary of the observations upon which the statement of danger is based; and

(d) a statement of facts which called the person to the attention of the officer.

(3) A person committed under this section may be held for a maximum of 24 hours, excluding Saturdays, Sundays, and legal holidays. At the expiration of that time period, the person shall be released unless application for involuntary commitment has been commenced pursuant to Section **62A-15-631**. If that application has been made, an order of detention may be entered under Subsection **62A-15-631(3)**. If no order of detention is issued, the patient shall be released unless he has made voluntary application for admission.

(4) Transportation of mentally ill persons pursuant to Subsections (1) and (2) shall be conducted by the appropriate municipal, or city or town, law enforcement authority or, under the appropriate law enforcement's authority, by ambulance to the extent that Subsection (5) applies. However, if the designated facility is outside of that authority's jurisdiction, the appropriate county sheriff shall transport the person or cause the person to be transported by ambulance to the

extent that Subsection (5) applies.

(5) Notwithstanding Subsections (2) and (4), a peace officer shall cause a person to be transported by ambulance if the person meets any of the criteria in Section **26-8a-305**. In addition, if the person requires physical medical attention, the peace officer shall direct that transportation be to an appropriate medical facility for treatment.

Renumbered and Amended by Chapter 8, 2002 Special Session 5  
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[Sections in this Chapter](#) | [Chapters in this Title](#) | [All Titles](#) | [Legislative Home Page](#)

Last revised: Friday, February 08, 2008

Except as provided in Section 26-8a-308, only an ambulance operating under a permit issued under Section 26-8a-304 may transport an individual who:

- (1) is in an emergency medical condition;
- (2) is medically or mentally unstable, requiring direct medical observation during transport;
- (3) is physically incapacitated because of illness or injury and in need of immediate transport by emergency medical service personnel;
- (4) is likely to require medical attention during transport;
- (5) is being maintained on any type of emergency medical electronic monitoring;
- (6) is receiving or has recently received medications that could cause a sudden change in medical condition that might require emergency medical services;
- (7) requires IV administration or maintenance, oxygen that is not patient-operated, or other emergency medical services during transport;
- (8) needs to be immobilized during transport to a hospital, an emergency patient receiving facility, or mental health facility due to a mental or physical condition, unless the individual is in the custody of a peace officer and the primary purpose of the restraint is to prevent escape;
- (9) needs to be immobilized due to a fracture, possible fracture, or other medical condition; or
- (10) otherwise requires or has the potential to require a level of medical care that the committee establishes as requiring direct medical observation.

Download Code Section Zipped WP 6/7/8 26\_09026.ZIP 2,465 Bytes

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*Last revised: Thursday, November 29, 2007*

**26-8a-308. Exemptions.**

(1) The following persons may provide emergency medical services to a patient without being certified or licensed under this chapter:

- (a) out-of-state emergency medical service personnel and providers in time of disaster;
- (b) an individual who gratuitously acts as a Good Samaritan;
- (c) a family member;
- (d) a private business if emergency medical services are provided only to employees at the place of business and during transport;
- (e) an agency of the United States government if compliance with this chapter would be inconsistent with federal law; and
- (f) police, fire, and other public service personnel if:
  - (i) emergency medical services are rendered in the normal course of the person's duties; and
  - (ii) medical control, after being apprised of the circumstances, directs immediate transport.

(2) An ambulance or emergency response vehicle may operate without a permit issued under Section 26-8a-304 in time of disaster.

(3) Nothing in this chapter or Title 58, Occupations and Professions, may be construed as requiring a license or certificate for an individual to perform cardiopulmonary resuscitation and use a fully automated external defibrillator if that individual has successfully completed a course that includes instruction on cardiopulmonary resuscitation and the operation and use of a fully automated external defibrillator that is conducted in accordance with guidelines of the American Heart Association, American Red Cross, or other nationally recognized program by a person qualified by training or experience.

(4) Nothing in this chapter may be construed as requiring a license, permit, designation, or certificate for an acute care hospital, medical clinic, physician's office, or other fixed medical facility that:

- (a) is staffed by a physician, physician's assistant, nurse practitioner, or registered nurse; and
- (b) treats an individual who has presented himself or was transported to the hospital, clinic, office, or facility.

Amended by Chapter 62, 2000 General Session

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[Sections in this Chapter](#)[Chapters in this Title](#)[All Titles](#)[Legislative Home Page](#)

*Last revised: Thursday, November 29, 2007*

**STATE OF UTAH**  
**TO THE LOCAL MENTAL HEALTH AUTHORITY**  
\_\_\_\_\_ **COUNTY**

**IN THE MATTER OF:**

**PETITION FOR COMMITMENT  
OF PHYSICAL CUSTODY OF  
CHILD TO THE LOCAL MENTAL  
HEALTH AUTHORITY**

\_\_\_\_\_  
Child (person under 18 years of age)

\_\_\_\_\_  
County

I, \_\_\_\_\_, a responsible person who has reason to know, depose and say:

\_\_\_\_\_, DOB: \_\_\_\_\_, residing at: \_\_\_\_\_,  
Minor

is to the best knowledge and belief of the affiant, mentally ill and should be committed to the physical  
custody of \_\_\_\_\_, pursuant to the provisions of Utah Code Annotated  
Local Mental Health Authority

62A-15-703 (2003).

Such belief is based upon person knowledge to the following facts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dated this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Affiant Signature

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

Instructions: ["Child" means a person under 18 years of age.] UCA 62A-15-701(1) "A child may receive services from a local mental health authority in an inpatient or residential setting only after a commitment proceeding, for the purpose of transferring physical custody, has been conducted in accordance with the requirements of this section. That commitment proceeding shall be initiated by a petition for commitment..." UCA 62A-15-703(1)(2) The completed form is filed with the Local Mental Health Authority.



## 911 Checklist

Hold this list in your hand when you dial

911 so you can follow the suggested guidelines:

Give the dispatcher the following information:

- your name
- Address where law enforcement should go
- List any weapons that are present
- Name of your love one
- Age
- Height and weight
- Clothing description
- Diagnosis
- Drug use (current or past)
- Medications (on or off)
- Prior violent behavior
- Details about past delusions or hallucinations
- Triggers
- Things that have helped in the past

Keep in mind: you are asking an unknown professional to come to your home to help you resolve a crisis. They will have NO information about the situation/individual unless you inform them.

### Helpful Non-Emergency Numbers

MCOT/Crisis Line: 801-587-3000

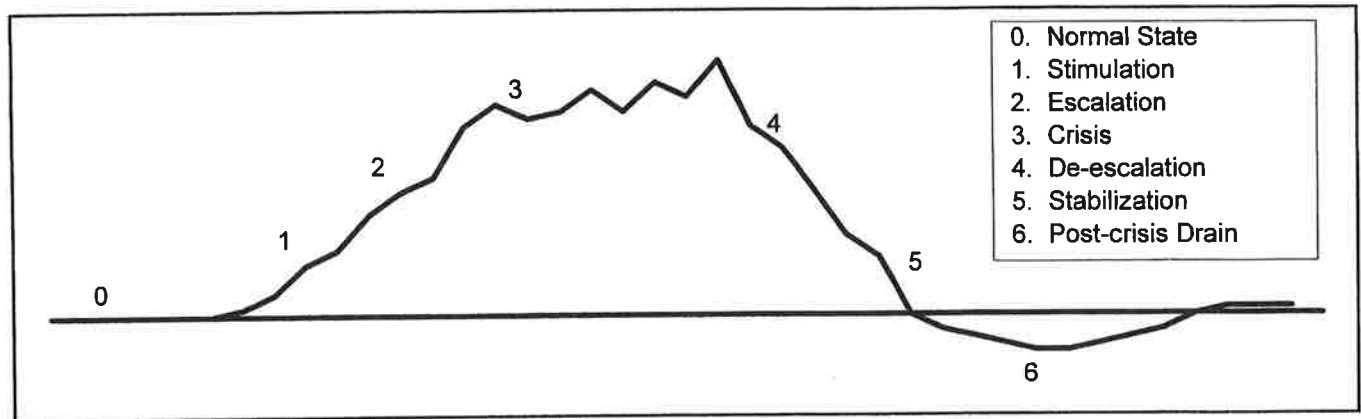
NAMI: 801-323-9900

Suicide prevention: 1-800-273-TALK (8255)

# Crisis

An upset in an individual's baseline level of functioning  
with substantial decreases in perception and ability to reason and understand.

## Crisis Cycle



### 0. Normal State

- 100 % perception and ability to reason / understand at baseline level
- Acts as an adult
- Can problem solve
- Officer is calm

#### Officer's Actions

- Standard intervention techniques

### 1. Stimulation – Internal / External

- 50 – 75% perception and ability to reason / understand
- Acts as a teenager
- Agitated, experiences anxiety
- Officer is calm

#### Officer's Actions

- Standard intervention techniques

### 2. Escalation

- 5 – 24% perception and ability to reason / understand
- Acts as an 8-year old having a tantrum
- Experiences fear and frustration
- Officer is anxious

#### Officer's Actions

- Use sentences less than five words
- Make one immediate request
- Repeat continually
- Body language and voice calm but firm

### 3. Crisis

- 0 – 5% perception and ability to reason / understand
- Acts like terrible two's
- Out of control, experiences anger
- Officer is fearful / frustrated

#### Officer's Actions

- Use firm, one sentence commands
- Repeat continually

### 4 - 6. De-escalation / Stabilization / Post-crisis Drain

- May cycle up at points of de-escalation
- May experience post-crisis depression

#### Officer's Actions

- Use same techniques down as up





## Law Enforcement CIT Tools

**Main goal is Officer and Consumer safety  
While producing a more permanent solution**

### A,B,C's

- A- Achieve contact: build a rapport, and humanize experience
- B- Boil Down to Essentials: is this a mental health call, a criminal call, or both?
- C- Constructive action: Transport to jail, transport to hospital, screen call, leave at home (various outcomes)

### Tools

- **Paraphrasing**: rephrase with your words. "what I hear you saying is" (let them correct you if you're not accurate)
- **Emotional Labeling**: Everyone's reality is their own don't tell them what you THINK they feel. Instead say "you seem upset, you appear angry, or you seem agitated"
- **Encourager use**: Helps gain information by letting the person know you are listening. "nodding of the head, eye contact, saying uh huh, filler words"
- **Mirroring**: This is a tool where you gain more information from a person you are interviewing by repeating the last word or mirroring behavior. For example; John says "I am not sure how I feel." Then the officer says "how do you feel?" and then John expands on his feelings. Mirroring body language such as posture, calmness, reflects to the consumer what you want.
- **Reassuring**: People in crisis often time are not calm and need to be reassured that we are there to help.

- **Respectful:** Not everyone we deal with will respect us, but it is important that we be the responsible one and show respect to the humans we encounter each day.
- **Reliable:** Be credible, believable, and trustworthy. YOU will encounter these people many times.
- **Relatively simple:** People in a crisis mindset are overwhelmed and have reached their boiling point. This is why keeping things in simple steps helps bring people back to their calm point.
- **Resonating Calmness:** Again if someone is at boiling point they will feed off your response. So keep voice low and at a controlled pace, loud enough to be heard, yet soft enough to de-escalate.
- **Distance:** Artificial distance (tables, chair, door, car door, any barriers). Real (actual distance). Know your officer safety.
- **Grounding:** Using tactile (5 senses) sensory input to help people realize where they in the moment. To help bring the person to the now. For example, “what are you standing on, can you feel the carpet, what is in front of you, can you smell that food, and so forth.”

## **D.B.E.A.T**

- **D-** Distance (real and artificial)
- **B-** Back-up (Officer back, EMS, Mental Health)
- **E-** Empathy (The ability to put yourself in another's position the best you can)
- **A-** Awareness (be aware of all your surroundings)
- **T-** Time (not all calls need to be rushed)

# Utah Suicide Facts

**8th**

leading cause  
of death for  
Utahns<sup>1</sup>



Utah ranks  
**7th**  
in the nation<sup>2</sup>



**10**  
suicides  
a week<sup>1</sup>

**1 in 15**

Utah adults have had serious  
thoughts of suicide<sup>3</sup>

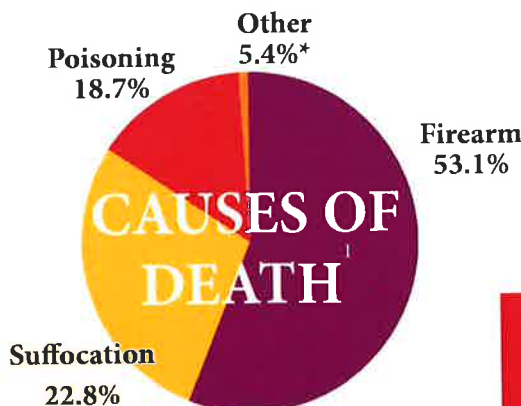
Enough to fill the Energy Solutions Arena **13** times.



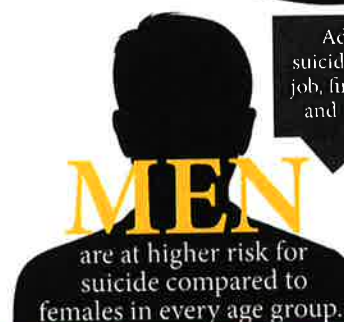
## EVERY DAY IN UTAH...



ARE TREATED FOR SUICIDE ATTEMPTS<sup>1</sup>



\*Other includes cut/pierce, drowning, fire, and fall.



Adult males who die by  
suicide are more likely to have  
job, financial, substance abuse,  
and relationship problems.<sup>1</sup>

Each suicide costs an average of  
**\$1 million**  
in medical and work loss costs.<sup>2</sup>



For more information visit:  
[www.health.utah.gov/vipp](http://www.health.utah.gov/vipp)

1. Utah Department of Health Indicator-based Information System for Public Health, 2011
2. Centers for Disease Control and Prevention Web-based Injury Statistics Query and Reporting System, 2005, 2010
3. Substance Abuse and Mental Health Services Administration National Survey on Drug Use and Health, 2008-2009
4. Utah Department of Health Violence and Injury Prevention Program Utah Violent Death Reporting System, 2006-2010





# Utah Youth Suicide Facts

**2nd!**  
leading cause  
of death for  
ages 10-17<sup>1</sup>

In 2011,  
enough Utah  
students  
seriously consid-  
ered attempting  
suicide to fill  
740 classrooms<sup>2\*</sup>

Utah ranks  
**5th**  
in the nation for  
youth suicide  
deaths<sup>3</sup>

\*Based on an average classroom size of 30 students

**In an average classroom size of 30...**



**8** will report feeling sad and hopeless<sup>2</sup>



**4** will have seriously considered suicide<sup>2</sup>



**4** will have made a suicide plan<sup>2</sup>

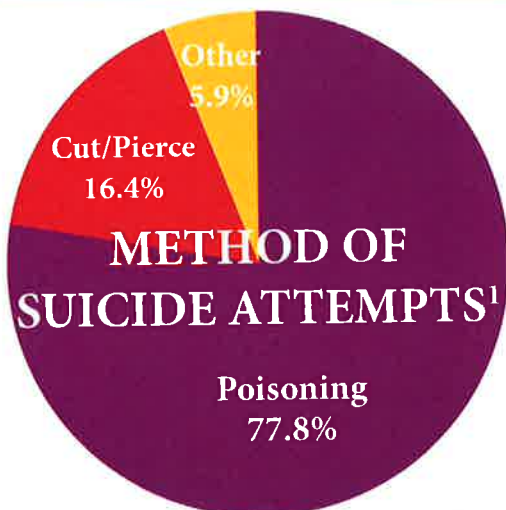


**2** will have attempted  
suicide one or  
more times<sup>2</sup>



**1** will have had  
medical treatment  
for a suicide attempt<sup>2</sup>

**598 YOUTH ATTEMPTED SUICIDE IN 2011<sup>1</sup>**



7 out of 10 youth  
suicide attempts are girls<sup>1</sup>



7 out of 10 youth  
suicide deaths are boys<sup>1</sup>



<sup>1</sup>Other includes fall, fire/flame/smoke, firearm, motor vehicle traffic other & unspecified, and suffocation.



For more information visit:  
[www.health.utah.gov/vipp](http://www.health.utah.gov/vipp)

1. Utah Department of Health Indicator-based Information System for Public Health, 2011
2. Youth Risk Behavior Survey, 2011 and USOE public high school enrollment, school year 2011-2012
3. Centers for Disease Control and Prevention Web-based Injury Statistics Query and Reporting System, 2010



# Caring Connections: A Hope and Comfort in Grief Program

## Supportive Groups and Counseling

**Caring Connections: A Hope and Comfort in Grief Program** offers a number of **bereavement support groups**, each tailored for a specific kind of grief, which run for 8 weeks in length. Groups are offered throughout the year. The focus of these groups is on "adjusting to the death of a family member or close friend". Separate groups are available for children and adolescents. The groups are small in order to allow each person full participation in the group activities and discussions. There are separate groups for adults surviving the death of a loved one due to suicide, homicide or traditional.

The group leaders are expert professional in the area of grief and bereavement. Through education and comfort from leaders and others experiencing grief, group members grow stronger in managing their own sorrow and pain.



For some people, group meetings are not the best mode for assisting with grief. **Caring Connections and Comfort in Grief Program** has licensed professionals who can provide individual or family counseling for grieving people.

If you have any questions about counseling services, group meetings, or participation in group meetings, contact **Caring Connections: A Hope and Comfort in Grief Program**, Monday through Friday at 5 Beth Vaughan Cole or one of her associates will return your call.

## Caring Connections Faculty

The faculty from Caring Connection: A Hope and Comfort in Grief Program give public lectures in grief and dying, managing stress, grief and the holidays, etc. Please watch for their public lectures. If you are interested in a speaker for your group on any of these topics please call.

- Kathie Supiano, MS, LCSW
  - o Bereavement Coordinator for the University of Utah Hospitals and Clinics
  - o Works with the hospital staff to implement programs to meet the grief and bereavement patients, families, and staff.
  - o If you have any questions about hospital programs, contact Kathie Supiano at 801-581-2

The University of Utah Hospital has a specific program addressing **perinatal bereavement**. Parents who have lost a child due to stillbirth, miscarriage, or death during infancy can call 801-585-2766 for more information.

## Contact Caring Connections

### Mailing Address:

University of Utah College of Nursing  
10 South 2000 East  
Salt Lake City, UT 84112-5880

**Telephone:** 801-585-9522

### Fax:

**Email:** [caringconnections@nurs.utah.edu](mailto:caringconnections@nurs.utah.edu)

**Web site:** <http://www.nurs.utah.edu/caringconnections>

### **ISSUE: CAREGIVER BURNOUT / IMPENDING NEGLECT / ABUSE**

- Dysfunctional family / at risk dynamics / needs education on role of caregiving
- Needs education on role of caregiving, “stuck”, unsure what to do
- Frustrated with family who won’t help them
- Signs of self-neglect or neglect, no clear criminal issues can be substantiated
- Situation not likely to improve, but will get worse
- Not enough resources to pay bills, buy medication and care for mom while working

### **CAREGIVER SUPPORT PROGRAM**

- Offers family consults to find resources, support, answer questions
- No financial eligibility, but requires an intake - not an emergency service
- Coaching, classes, support groups, newsletters, information websites, etc.
- Information on coping w/ dementia, home safety, case management, etc
- Limited in-home services to lessen caregiver stress / concerns over care receiver

### **ISSUE: LOW-INCOME, SELF NEGLECT, NEEDS ASSISTANCE TO REMAIN INDEPENDENT**

- Needs not being met—without intervention, risk of neglect
- Little / no family or informal support
- Medicaid / low income
- Medical needs, physical and mental impairments
- Mobility issues

### **SENIOR COMPANIONS / VOLUNTEERS / LEGAL HOTLINE**

- In-home senior companions to help support needs
- Legal help for seniors, or low-income families supporting seniors with in issues of:
  - Guardianship / conservatorship
  - Power of attorney
  - Subsidized housing, other housing, landlord/tenant issues

### **ALTERNATIVES or WAIVER**

- Eligibility criteria – below poverty
- In-home services (personal care, homemaking, home adaptations, case management & supervision)

AGING SERVICES OFFERS SCREENING, ONE-ON-ONE ASSISTANCE  
PREVENTION AND HELPING MAINTAIN INDEPENDENCE, SAFETY  
ERR ON SIDE OF CAUTION –

**(385) 468- 3200**

## COMMUNITY ISSUES and RESOURCES to address them at Aging Services

### **ISSUE: THE FREQUENT FLYER**

- Repeated calls to 911, first responders
- Unclear mental status / cognitive functioning
- Lives alone---may be environmental issues
- Signs of self-neglect or neglect, no clear criminal issues can be substantiated
- Complaints from neighbors
- Situation not likely to improve – high-risk

### **OUTREACH & OMBUDSMEN**

- In-home visits to assess for services, eligibility for programs
- Screening for prevention / early intervention
- Referrals to companion / visitors
- Meals on wheels
- Transportation to medical
- Transportation to senior centers for meals & socialization
- Assistance w/ housing applications
- Advocacy and investigation into Nursing Home / Assisted Living complains, concerns, or issues of rights violations.

### **SENIOR CENTERS**

Many seniors are isolated, bored, not eating well, and may have risky home lives.

- Socialization
- Nutrition – noon meal and some breakfast foods served
- Offer transportation within their assigned city areas
- Offer Health screening, flu shots, mental health options, podiatrists, etc.
- Activities – diversion, personal growth, community connection, purpose

### **ISSUE: JOBLESS / NEED ADDITIONAL INCOME**

- Retired at 65 and the economic world has changed
- Not enough retirement / pension / Social Security to pay basic needs
- Living in one area of house to conserve heat, lights, etc.
- Wants to stay independent and is still somewhat healthy

### **SENIOR EMPLOYMENT**

- Teach job / interview skills
- Job search assistance
- Employment counseling
- On-site computers

## Aging Related Issues - Tips for First Responders

Aging related challenges, such as hearing, mobility and cognitive impairments have symptoms that require some investigation. It is quiet easy to mistake a person with Cerebral Palsy, Parkinsons, Dementia person with drunk and disorderly conduct. You may assume through initial behaviors that the person is on drugs or is acting out to hurt you. Try the following behaviors and ask pertinent questions to determine the true cause of their behaviors.

How to Act	What to Say / Ask	What to Look for	Skills to Use
Slow down, act friendly / calm. Show your identification, point to your name badge as you state your name.	Hello, my name is _____. I am a (state your job). I am here to help you. I am here because (explain the situation). I look different than my picture because (state reason). (example: I'm in protective gear, etc.)	Wheel chair, walker, oxygen, hearing aids, hearing headphones by television, service animal, sign language.	Offer an arm to steady themselves, or to sit if needed. Point to objects to illustrate your words. Point to car, chair, bench, or equipment as you talk about it.
Communicate through your actions and emotions--not through your words.	Ask for communication devices: head pointers, alphabet boards, speech synthesizers, i-pads, etc.	Medical or Dementia Tags or Identification Brackets.	Look them in the eye. Use adult words / short sentences. Simple concrete words. Be honest / accurate to avoid emotional build up.
Find an open place to talk. Separate them from any other individuals involved to calm them.	Ask them to put down any objects in their hands that can be used to hurt themselves or you. And, ask them to turn down TV, Radio, etc.	Family calendars or information on fridge door or back of front door.	Give the person extra time to find words and respond, repeat questions calmly, in a friendly tone, as needed.
Avoid all aggressive speech and behavior. (Example: yelling commands, demands, or threatening tones and words.)	Ask for identification bracelet, name of family members, phone with numbers of family, address if still known, medication, etc.	Wringing hands, nervous eye movement, shuffling feet, swaying, fear.	If possible, give them a few minutes to rest, lower stress or relieve fatigue so they can communicate with you.
Offer constant reassurance. Individuals with dementia live in the moment--see and respond to what is in front of them at each moment. Example: "You were great", "Thank You for Helping Me", "I understand your concern", etc.	Explain and repeat simply what happens next, step by step: I am calling your daughter. I am taking you to meet your daughter at the hospital. As I said, we are...)	The person does not respond to direction. May need to take lightly by the elbow and guide the car.	Listen to their complaint fully, give them a chance to state their "emotions" out loud.



**DIVISION OF AGING AND ADULT SERVICES  
UTAH DEPARTMENT OF HUMAN SERVICES  
195 North 1950 West, Salt Lake City, Utah 84116  
PHONE: 801-538-3910  
TOLL FREE: 1-877-424-4640  
FAX: 801-538-4395  
Website: [hsdaas.utah.gov](http://hsdaas.utah.gov)**

**Director:**  
Nels Holmgren  
E-mail: [nholmgren@utah.gov](mailto:nholmgren@utah.gov)

**Assistant Director: OAA**  
Michael S. Styles  
[mstyles@utah.gov](mailto:mstyles@utah.gov)

**Assistant Director: APS**  
(vacant)

**AREA AGENCIES ON AGING**

January 27, 2011

**Bear River Area Agency on Aging**  
Box Elder, Cache, Rich

Michelle Benson, Aging Svcs. Dir.  
170 North Main  
Logan, UT 84321  
Phone: 435-752-7242 or  
1-877-772-7242  
Fax: 435-752-6962  
E-Mail: [michelleb@brag.utah.gov](mailto:michelleb@brag.utah.gov)  
Website: [www.brag.utah.gov](http://www.brag.utah.gov)

**Davis County Health Dept., Family  
Health and Senior Services Division**  
Davis

Sally Kershnik, Director of Family  
Health and Senior Services  
22 South State St -Clearfield UT  
84015  
PO Box 618 - Farmington UT 84025-0618  
Phone: 801-525-5000  
Fax: 801-525-5061  
E-Mail:  
[skershnik@daviscountyutah.gov](mailto:skershnik@daviscountyutah.gov)  
Website: [www.daviscountyutah.gov](http://www.daviscountyutah.gov)

**Five-County Area Agency on Aging**  
Beaver, Garfield, Iron, Kane, Washington

Carrie Schonlaw, Director  
1070 West 1600 South, Bldg. B  
(P. O. Box 1550, ZIP 84771-1550)  
St. George, UT 84770  
Phone: 435-673-3548  
Fax: 435-673-3540  
E-Mail:  
[cschonlaw@fivecounty.utah.gov](mailto:cschonlaw@fivecounty.utah.gov)

**Mountainland Dept. of Aging and  
Family Services**

Summit, Utah, Wasatch

Scott McBeth, Director  
586 East 800 North  
Orem, UT 84097-4146  
Phone: 801-229-3800  
Fax: 801-229-3671  
Website: [www.mountainland.org](http://www.mountainland.org)  
E-Mail: [smcbeth@mountainland.org](mailto:smcbeth@mountainland.org)

**Salt Lake County Aging Services**  
Salt Lake

Sarah Brenna, Director  
2001 South State, #S1500  
Salt Lake City, UT 84190-2300  
Phone: 801-468-2454  
Fax: 801-468-2852  
E-Mail: [sbrenna@slco.org](mailto:sbrenna@slco.org)  
Website: [www.aging.slco.org](http://www.aging.slco.org)

**San Juan County Area Agency on  
Aging**

San Juan

Tammy Gallegos, Director  
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Fax: 435-587-2447  
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[tgallagos@sanjuancounty.org](mailto:tgallagos@sanjuancounty.org)

**Six-County Area Agency on Aging**

Juab, Millard, Piute, Sanpete, Sevier,  
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Tooele

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**Uintah Basin Area Agency on Aging**

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**Council on Aging - Golden Age  
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Uintah County

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**Weber Area Agency on Aging**

Morgan, Weber

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# The Impact Of Mental Illness: Predictable Stages Of Emotional Reactions Among Family Members

(From the NAMI Family-to-Family Education Program)

## **I. DEALING WITH THE CATASTROPHIC EVENT**

**CRISIS/SHOCK:** Feeling overwhelmed, dazed. We don't know how to deal with it.

**DENIAL:** A protective response; We "normalize" what is going on, find reasons for what is happening that don't involve mental illness. We decide all this is not really serious, and/or there is a perfectly logical explanation for these events, and/or it will pass, etc.

**HOPING-AGAINST-HOPE:** The dawning of recognition, and the hope that this is not a *life* event, that somehow everything will magically go back to normal.

**NEEDS:** \*Support \*Comfort \*Empathy for confusion \*Help finding resources  
\*Early intervention \*Prognosis \*Empathy for pain \*NAMI

## **II. LEARNING TO COPE: "GOING THROUGH THE MILL"**

**ANGER/GUILT/RESENTMENT:** We start to "blame the victim" insisting that the loved one should "snap out of it". We harbor tremendous guilt, fearing that it really *is* our fault; we torment ourselves with self-blame.

**RECOGNITION:** The fact that a mental illness happened to someone we love becomes a reality for us. We know it will change our lives together.

**GRIEF:** We deeply feel the tragedy of what has happened to the person who is stricken; we grieve that our future together is uncertain. This sadness does not go away.

**NEEDS:** \*Vent feelings \*Keep hope \*Education \*Self-care \*Networking \*Skill training \*Letting go \*Co-operation from system \*NAMI

## **III. MOVING INTO ADVOCACY: "CHARGE!"**

**UNDERSTANDING:** We gain a solid, empathic sense of what our loved one is suffering. We gain real respect for the courage it takes for them to cope with this illness.

**ACCEPTANCE:** Yes, we finally say, bad things do happen to good people. It's nobody's fault. It is a sad and difficult life experience, but we will hang in there and manage.

**ADVOCACY/ACTION:** We can now focus our anger and grief to advocate for others and fight discrimination. We join public advocacy groups, we get involved.

**NEEDS:** \*Activism \*Restoring balance in life \*Responsiveness from system \*NAMI

**UTAH STATE HOSPITAL**

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**BEAR RIVER MENTAL HEALTH (Box Elder, Cache, Rich)**

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**CENTRAL UTAH COUNSELING CENTER (Piute, Juab, Wayne, Millard, Sanpete, Sevier)**

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**WEBER HUMAN SERVICES (Weber County)**

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***CIT Resource List  
for Aging Related Issues***

---

(385) 468-3200 SLCO Aging Services  
(385) 468-3217 E.V.A. Case Screening Panel  
(801) 538-3567 Adult Protective Services  
(801) 265-1944 Alzheimer's Association  
(801) 743-5656 Project Lifesaver (SLCO)  
[www.aging.slco.org](http://www.aging.slco.org) (choose caregiver)



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*(801) 350-4715 SL Regional Senior BH Unit*  
*1-800-273-8255 Vets in Crisis Hotline*  
*(801) 582-1565 x4025 Vets in Crisis / PTSD*  
*(801) 746-5561 x6327 Vets in Court System*  
*(801) 565-1565 x4165 VA Caregiver Support*  
*(801) 263-7100 UT Valley Mental Health*  
*(801) 326-4409 Grandfamilies*

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**BEAR RIVER MENTAL HEALTH SERVICES (Box Elder, Cache and Rich Counties)****BOX ELDER COUNTY COMMISSION****Phone**Commissioner Jeff Scott | 1 South Main Street, City, Utah 84302 | [jscott@boxeldercounty.org](mailto:jscott@boxeldercounty.org) | 435-734-3347**CACHE COUNTY COUNCIL**M. Lynn Lemon, County Executive | 199 North Main, Logan, Utah 84321 | [lynn.lemon@cachecounty.org](mailto:lynn.lemon@cachecounty.org) | 435-755-1850**RICH COUNTY COMMISSION**Commissioner Bill Cox | PO Box 125, Woodruff, Utah 84086 | [rcaging@allwest.net](mailto:rcaging@allwest.net) | 435-757-8248

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<b>EMERY COUNTY COMMISSION</b>		
Commissioner James R. Nelson	PO Box 629, Castle Dale, Utah 84513	jnelson@co.emery.ut.us 435-381-2119
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<b>NORTHEASTERN COUNSELING SERVICES (Daggett, Duchesne, and Uintah Counties)</b>		
Derrick Tollefson, Board Chairman	1140 West 500 South, #9, Vernal, Utah 84078	
Uintah Basin Tri-County MH & SA		
Local Authority Board		
<b>DAGGETT COUNTY COMMISSION</b>		
Commissioner Karen Perry	PO Box 219, Manila, Utah 84046	kperry@daggettcountry.org 435-784-3218
<b>DUCHESNE COUNTY COMMISSION</b>		
Commissioner Kirk Wood	PO Box 270, Duchesne, Utah 84021	kwood@co.duchesne.ut.us 435-738-1132
<b>UINTAH COUNTY COMMISSION</b>		
Commissioner Darlene Burns	147 East Main, Vernal, Utah 84078	dburns@co.uintah.ut.us 435-781-5383
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<b>Pat Fleming, Director, SL Co Behavioral Health Services, 2001 South State, Suite S2300, Salt Lake City, Utah 84190-2250</b>		
<b>Lori Bays, Director, Salt Lake County Human Services, 2001 South State, Suite N2100, 84190-2450</b>		
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<b>GARFIELD COUNTY COMMISSION</b>		
Commissioner LeLand Pollock	PO Box 77, Panguitch, Utah 84759	leland.pollock@hotmail.com 435-676-1100
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<b>KANE COUNTY COMMISSION</b>		
Commissioner Jim Matson	76 North Main, Kanab, Utah 84741	jmatson@kane.utah.gov 435-644-4902
<b>WASHINGTON COUNTY COMMISSION</b>		
Commissioner Jim Eardley	197 East Tabernacle, St. George, Utah 84770	jeardley@washco.utah.gov 435-634-5700
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## SUMMIT/VALLEY MENTAL HEALTH (Summit County)

### SUMMIT COUNTY COMMISSION

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	Gary Larcenaire, Director, Valley Mental Health, 5965 South 900 East, Salt Lake City, Utah 84121		

## TOOELE/VALLEY MENTAL HEALTH (Tooele County)

### TOOELE COUNTY COMMISSION

Commissioner Shawn Milne	47 South Main, Tooele, Utah 84074	smilne@co.tooele.ut.us	435-843-3153
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	Victoria Delheimer, Regional Director, Rural Counties, Valley Mental Health, 1753 Sidewinder Drive, Park City, Utah 84124		
	Gary Larcenaire, Director, Valley Mental Health, 5965 South 900 East, Salt Lake City, Utah 84121		

## UTAH COUNTY SUBSTANCE ABUSE SERVICES (Utah County)

### UTAH COUNTY COMMISSION

Commissioner Doug Witney	100 East Center, #2300, Provo, Utah 84606	ucadm.dougw@state.ut.us	801-851-8100
CC:	Richard Nance, Director, Utah County Substance Abuse Services, 151 So. University Ave, Suite 3200, Provo, Utah 84606		

## WASATCH COUNTY FAMILY CLINIC

### WASATCH COUNTY COUNCIL

Mike Davis, County Manager	25 North Main, Heber City, Utah 84032	mdavis@co.wasatch.ut.us	435-657-3180
CC:	Richard Hatch, Program Manager, Wasatch County Family Clinic, 55 South 500 East, Heber City, Utah 84032		
	Todd Phillips, Finance Director, Wasatch Mental Health, 750 North 200 West, Suite 300, Provo, Utah 84601		
	Catherine Johnson, Child & Family Services Division Director, Wasatch Mental Health, 750 North 200 West, Suite 300, Provo, Utah 84601		
	Juergen Korbanka, Director, Wasatch Mental Health, 750 North 200 West, Suite 300, Provo, Utah 84601		

## WASATCH MENTAL HEALTH SERVICES (Utah and Wasatch Counties)

### UTAH COUNTY COMMISSION

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CC:	Juergen Korbanka, Director, Wasatch Mental Health, 750 No. 200 West, Suite 300, Provo, Utah 84601		

## WEBER HUMAN SERVICES (Weber and Morgan Counties)

Joe H. Ritchie, Chairman Weber Human Services Board	237 - 26 <sup>th</sup> Street Ogden, Utah 84401		
--	--	--	--

### MORGAN COUNTY COUNCIL

Councilman Daryl Ballantyne	PO Box 886, Morgan, Utah 84050	dballantyne@morgan-county.net	801-845-4011
Councilman Austin Turner	PO Box 886, Morgan, Utah 84050	aturner@morgan-county.net	801-829-6811
Councilman Tina Kelley	PO Box 886, Morgan, Utah 84050	tkelley@morgan-county.net	801-829-6811

### WEBER COUNTY COMMISSION

Commissioner Jan Zogmaister	2380 Washington Blvd., #360, Ogden, Utah 84401	jzogmaister@co.weber.ut.us	801-399-8590
CC:	Kevin Eastman, Director, Weber Human Services, 237 26 <sup>th</sup> Street, Ogden, Utah 84401		

**Salt Lake VA Medical Center**

**Contact Information**

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**24 Hour Response:**

- 1- VA Crisis Line: 1-800-273-8255
- 2- Come to Salt Lake City VA Emergency Room, 500 Foothill Boulevard, SLC, UT 84148

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**Quick response (to schedule an intake for outpatient mental health clinic)**

Call Salt Lake City VA Medical Center, 901-582-1565 and ask to have the operator page the "ACT" (pronounced act) team.

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**Walk-in assessments (During business hours 8 to 3:30 p.m.)**

Come to Salt Lake City VA, Building 16, 500 Foothill Boulevard, SLC, UT 84148 and request walk-in assessment

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**Points of Contact (Regular business hours, except federal holiday) for consultation**

- 1- Steve Allen, PhD  
Coordinator PTSD Clinical Team 801-582-1565, ext 2390
- 2- Lisa Stoddard, APRN  
Suicide Prevention Coordinator 801-582-1565, ext 6307

# **A Police Officer's Guide When In Contact With People Who Have Intellectual Disabilities**

THE ARC, MARCH 2005

About three out of every 100 people have intellectual disabilities (mental retardation), and as a law enforcement officer, there is a chance you will come in contact with a person who has this disability.

Title II of the Americans with Disabilities Act (ADA) of 1992 prohibits state and local governments from discriminating against an individual with a disability. Police municipalities, sheriff's departments, and state patrolmen are covered under title II, and are responsible for making sure programs, services and activities provided by police are readily accessible to and usable by people who have disabilities.

*(28 C.F.R § 35.150 [a]; The Americans with Disabilities Act Title II Technical Assistance Manual, U.S. Department of Justice)*

## **How do you make sure your activities are readily accessible to people who have mental retardation?**

In order to provide readily accessible services, there are some helpful tips and strategies to use whenever in contact with someone who has mental retardation.

### **1. IDENTIFY**

#### **What is an intellectual disability?**

People with intellectual disabilities (MR) have difficulty in their ability to learn. The effects of this condition vary considerably among people, just as the range of abilities varies among those who do not have mental retardation.

Most people with intellectual disabilities live independently in the community and may not appear to have a significant disability. Only a few people are seriously affected and have difficulty learning skills needed to live independently in the community, such as self-care and economic self-sufficiency. Whether the individual has a mild or severe disability, all people with mental retardation are covered under the ADA and may need assistance.

#### **Why is intellectual disabilities sometimes more difficult to detect than other disabilities within individuals?**

The majority of people with intellectual disabilities have mild mental retardation which makes it a difficult disability to identify.

Many people with intellectual disabilities want to be thought of as average. They may try to hide their disability in order to be liked or accepted by others, especially authority figures.

## 2. What is the difference between mental retardation and mental illness?

### **INTELLECTUAL DISABILITIES AND MENTAL ILLNESS ARE NOT THE SAME AND SHOULD NOT BE TREATED THE SAME.**

- Intellectual Disabilities refers to below average abilities to learn and process information, but mental **illness** refers to a person's thought processes, moods and emotions.
- Intellectual Disabilities generally occurs before a person reaches adulthood, but mental illness can occur at any time in a person's life.
- Intellectual Disabilities refers to below average intellectual functioning, but mental **illness** has nothing to do with intelligence. People with mental illness can have below average, average or above average intelligence.

#### **How can I tell if someone has Intellectual Disabilities?**

There is often no one way of knowing if a person has Intellectual Disabilities, but there are traits to look for in identifying an individual with this disability.

**NOTE:** A person exhibiting these traits does not necessarily mean the person has Intellectual Disabilities. If there is any question about someone having Intellectual Disabilities, assume the person does and use the tips in this brochure to ensure that your contact and communication with the person is clear, especially if the person is read his or her Miranda rights.

#### **Look for clues in the person's communication, behavior and reaction to police contact.**

##### **Communication**

The individual may...

- have limited vocabulary or a speech impairment.
- have difficulty understanding or answering questions.
- have a short attention span.

##### **Behavior**

The individual may...

- act inappropriately with peers or the opposite sex.
- be easily influenced by and eager to please others.
- be easily frustrated.
- have difficulty with the following tasks:
  - giving accurate directions.
  - making change.
  - using the telephone and telephone book.
  - telling time easily.
  - reading and writing.

**NOTE:** Someone with Intellectual Disabilities may be able to do only one of the above tasks while others may be able to do all of these tasks. These are only preliminary questions to check for the presence of a disability. Answers given by the person should not be used as incriminating evidence. Assume the person has Intellectual Disabilities if you notice any behaviors.

##### **Police Contact**

The individual may...

- not want disability to be noticed.
- not understand rights.
- not understand commands.

- have the tendency to be overwhelmed by police presence.
- act very upset at being detained and/or try to run away.
- say what he or she thinks others want to hear.
- have difficulty describing facts or details of offense.
- be the last to leave the scene of the crime, and the first to get caught.
- be confused about who is responsible for the crime and "confess" even though innocent.

### 3. SIMPLIFY COMMUNICATION

How do I talk to someone who has Intellectual Disabilities?

There are no hard and fast rules to use when talking to someone with mental retardation. The communication techniques below may be helpful, and can even be used to improve communication with people who have similar disabilities, such as traumatic brain injuries, learning disabilities and Alzheimer's disease.

#### Remember...

- Speak directly to the person.
- Keep sentences short.
- Use simple language, speak slowly and clearly.
- Ask for concrete descriptions, colors, clothing, etc.
- Break complicated series of instructions or information into smaller parts.
- Whenever possible use pictures, symbols, and actions to help convey meaning.

#### Be Patient...

- Take time giving or asking for information.
- Avoid confusing questions about reasons for behavior.
- Repeat questions more than once or ask a question in a different way.
- Use firm and calm persistence if the person doesn't comply or acts aggressive.
- When questioning someone with mental retardation, don't ask questions in a way to solicit a certain answer. Don't ask leading questions.
- Phrase questions to avoid "yes" or "no" answers, ask open-ended questions (e.g., "Tell me what happened.").

#### Keep In Mind...

- Don't assume someone with mental retardation is totally incapable of understanding or communicating.
- Treat adults as adults; don't treat adults who have mental retardation as children.
- When communicating with someone who has Intellectual Disabilities, give the him or her the same respect you would give any person.

Most people who have the disability of mental retardation do not like being called "retarded" or even have the word "retardation" used in reference to their disability. When speaking to the individual, use the phrase "person with a disability."

### 3. PROTECT THE INDIVIDUAL'S RIGHTS

Although it's not an ADA requirement, when a person who is suspected of having mental retardation is questioned or interrogated about involvement in criminal activity, it's a good idea to have a guardian, lawyer or support person present to ensure that the individual's rights are protected.

#### Do people with Intellectual Disabilities understand the Miranda warnings?

People with Intellectual Disabilities often do not understand the Miranda warnings. In fact, many individuals with Intellectual Disabilities often answer yes after they are read the Miranda warnings even when they do not understand their rights.

People with Intellectual Disabilities usually want to please police officers and may appear to incriminate themselves even when innocent of any crime. They often fake greater competence than they actually possess. Because this puts people with intellectual disabilities at an unfair disadvantage when being questioned, you should not ask questions about criminal activity until the person's lawyer is present.

When reading the Miranda warnings to someone with mental retardation, or to others who may have difficulty understanding, use simple words and modify the warnings to help the individual understand. It's important to determine whether the individual genuinely understands the principles, protections and concepts within the warnings.

Ask the person to repeat each phrase of the Miranda warnings using his or her own words. If the person simply repeats the phrase word for word, check for understanding by asking questions that require the individual to use reasoning abilities and think conceptually. For example, you can say, "tell me what rights are, give me an example of a right you have, tell me what a lawyer is, how can a lawyer help you, why is a lawyer important, why do you want to talk to me instead of a lawyer, can you explain to me why you don't have to talk to me, etc." A person with intellectual disabilities may be able to recite the entire Miranda warnings, or even a simplified version of it, but he or she usually cannot understand its meaning or the implications of his or her responses.

It's not an ADA requirement, but you may want to videotape the interview and make sure questions are asked clearly and distinctly. Use open-ended, non-leading questions. Ask questions in a straightforward, non-aggressive manner. If you believe the person has mental retardation, let the individual's attorney know.

#### **4. KNOW THE RESOURCES**

Know what options are available for the person with intellectual disabilities other than jail, especially when the individual has not committed a crime.

Realize that you are not alone when you encounter people with mental retardation. Once you suspect that someone has intellectual disabilities, contact an agency in the community that can provide advice about how to best handle the situation.

Know and use alternatives to arrest when arrest is not the best response. For example, arrest is inappropriate when used to hold an innocent, lost person with intellectual disabilities in jail only because there seems to be no other alternative. Some alternatives to consider include contacting a parent or guardian, the place of residence, agencies on mental retardation, or an advisor or expert who is familiar with people who have this disability.

Know who to call so you'll know what to do when you encounter someone with intellectual disabilities. Obtain the phone numbers of these local agencies by looking under "Social Service Organizations" in the telephone book or contact your county's United Way 211 number. For more information on each organization, contact your state or local chapter of The Arc.

This document provides general information to promote voluntary compliance with the ADA. It was prepared under a grant from the U.S. Department of Justice. While the Public Access Section has reviewed its contents, any opinions or interpretations in the document are those of The Arc and do not necessarily reflect the view of the Department of Justice. The ADA itself and the Department's ADA regulations should be consulted for further, more specific guidance.

## **Checklist for Law Enforcement Officers**

### **Common Traits of People with Intellectual Disabilities**

■ **May not communicate at age level:**

- Limited vocabulary
- Difficulty understanding/answering questions
- Mimics answers/responses
- Unable to communicate events clearly in his/her own words
- Unable to understand complicated instructions or abstract concepts

■ **May not understand consequences of situations**

- Unaware of seriousness of situations
- Easily led or persuaded by others
- Naïve eagerness to confess or please authority figures

■ **May not behave appropriately:**

- Unaware of social norms and appropriate social behavior
- Acts younger than actual age, may display childlike behavior
- Displays low frustration tolerance and/or poor impulse control
- May "act out", become emotional, or try to leave if under pressure

■ **May have difficulty performing tasks**

- Inability to read or write
- Inability to tell time
- Difficulty staying focused and easily distracted
- Awkward/poor motor coordination

■ **May be unable to move from abstract to concrete thought.**

Most people can move from concrete to abstract thinking without effort. For people with mental retardation, this is often difficult, if not impossible. If a word has both a concrete and an abstract meaning, the person will say "yes" they understand (concrete meaning) even when you are using the abstract meaning (wave vs. waive).

■ **May deny having a disability.**

The hurt and stigma associated with the term mental retardation is so strong that people will deny having the disability even when it is against their self-interest to deny it.

■ **May have real memory gaps.**

Memory impairment is a basic symptom of brain damage, and people with mental retardation are more likely to have these gaps than others.

■ **May have problems with receptive and expressive language.**

There is often a large difference between someone's ability to understand and ability to speak. People with mental retardation can mimic expressive language well, but may have minimal understanding of what is being said to them. They may pick the wrong meaning of a word that can be used in different contexts, e.g. "right" could mean:

- right / wrong      - right / left
- having rights      - knowing how to write.

■ **May have a short attention span.**

Like memory gaps, people with mental retardation are more likely than others to have difficulty staying focused.

■ **May be eager to please.**

People with mental retardation do not communicate on equal footing and have learned that life is easier if you say "yes" to people who are seen to be authority figures.

## Checklist of Law Enforcement Officers SCREENING QUESTIONS FOR INTELLECTUAL DISABILITIES

1. Did you ever attend special classes in school?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Comment: \_\_\_\_\_
2. Have you ever received Mental Health or DD services?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Comment: \_\_\_\_\_
3. Do you get any kind of social security check?  
(SSI=blue envelope; SSDI = brown envelope)  
Yes \_\_\_\_\_ No \_\_\_\_\_ Comment: \_\_\_\_\_
4. Did you ever participate in Special Olympics? Yes \_\_\_\_\_ No \_\_\_\_\_  
Comment: \_\_\_\_\_
5. Have you ever had a job? Yes \_\_\_\_\_ No \_\_\_\_\_  
Where? \_\_\_\_\_  
How many hours per day/week, Comment: \_\_\_\_\_
6. Do you ever hear voices or see things other people don't see or hear? Yes \_\_\_\_\_  
No \_\_\_\_\_ Comment: \_\_\_\_\_
7. Where are you now?  
Correct \_\_\_\_\_ Incorrect \_\_\_\_\_ Doesn't know \_\_\_\_\_  
Comment: \_\_\_\_\_
8. What season is this?  
Correct \_\_\_\_\_ Incorrect \_\_\_\_\_ Doesn't know \_\_\_\_\_  
Comment: \_\_\_\_\_
9. How many months are there in a year? Correct \_\_\_\_\_ Incorrect \_\_\_\_\_ Doesn't know \_\_\_\_\_  
Comment: \_\_\_\_\_
10. What does "Waive your rights" mean? Correct \_\_\_\_\_  
Incorrect \_\_\_\_\_ Doesn't know \_\_\_\_\_  
Comment: \_\_\_\_\_
11. What is the difference between a plea of "guilty" and a plea of "not guilty"?  
Correct \_\_\_\_\_ Incorrect \_\_\_\_\_ Doesn't Know \_\_\_\_\_  
Comment: \_\_\_\_\_
12. What does it mean to "serve time"?  
Correct \_\_\_\_\_ Incorrect \_\_\_\_\_ Doesn't know \_\_\_\_\_  
Comment: \_\_\_\_\_
13. How many minutes are there in one and one and a half hours?  
Correct \_\_\_\_\_ Incorrect \_\_\_\_\_ Doesn't know \_\_\_\_\_  
Comment: \_\_\_\_\_



14. Explain to me what "rights" are. Correct\_\_\_\_ Incorrect\_\_\_\_ Doesn't know\_\_\_\_
15. Explain how a lawyer can help you. Correct\_\_\_\_ Incorrect\_\_\_\_ Doesn't know\_\_\_\_
16. Ask the person to identify the following coins as you put them on the table:  
Nickel, Quarter, Penny, Dime. Correct: \_\_\_\_\_ Incorrect\_\_\_\_\_
17. Ask the person to identify the coin worth the most and the coin worth the least.  
Correct\_\_\_\_\_ Incorrect\_\_\_\_\_
18. Ask the person to write the following after you say it: "Call mom at home."  
Correct\_\_\_\_\_ Incorrect\_\_\_\_\_
19. Set out two quarters, three dimes, four nickels and seven pennies. Ask the person to count out \$ .86. Correct\_\_\_\_\_ Incorrect\_\_\_\_\_
20. Ask the person to read the following: "Go to the store and buy bread, milk and sugar."  
Correct \_\_\_\_\_ Incorrect \_\_\_\_\_

### **OBSERVATION QUESTIONS**

21. Does the person act or talk in a strange manner? Yes\_\_\_\_\_ No\_\_\_\_\_
22. Does the person seem unusually confused or preoccupied? Yes\_\_\_\_\_ No\_\_\_\_\_
23. Is the person's speech hard to understand? Yes\_\_\_\_\_ No\_\_\_\_\_
24. Does the person's vocabulary seem limited? Yes\_\_\_\_\_ No\_\_\_\_\_
25. Does the person have difficulty expressing him/herself?  
Yes\_\_\_\_\_ No\_\_\_\_\_
26. Is the person's appearance unkempt or inappropriate for the weather?  
Yes\_\_\_\_\_ No\_\_\_\_\_ Other Comments: \_\_\_\_\_



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# Communicating with a Psychotic Individual

1. **Consider the goal of the interaction**
  - a. **Cooperation should be the primary goal**
2. **Be Mindful of Emotions**
  - a. **Be aware of how the other might be feeling**
  - b. **Be aware of your own feelings**
3. **Be aware of non-verbal communication (i.e. eye contact, facial expressions, gestures, posture, proximity, etc.)**
4. **Be aware of our verbal communication (i.e. tone, pitch, rhythm, volume, inflection, etc.)**
5. **Don't expect reasonable responses**
6. **Learn and Evaluate experiences**

## DO

- "2 Sentence Rule." Keep your communication simple, clear and brief.
- Ask only ONE question at a time.
- Stick to the current issue rather than bringing up "old issues."
- Stay calm.
- Minimize other distractions.
- Pay attention to nonverbal behavior - both the message that you are sending with your body language and that of the patient.
- Help the patient identify his/her feelings by suggesting several choices (e.g., are you feeling angry, sad or worried right now?)
- Show empathy or caring for his/her feelings.
- Acknowledge what you have heard him/her express. You may wish to normalize that emotion and share a similar experience that you have had in the past.
- Decide together on a regular time for communication. Choosing a low stress time when both of you are apt to feel at your best is important.

## DON'T

- Don't try to argue patients out of their delusional or false beliefs.
- Avoid giving advice unless asked - or if the person cannot make the decision on his/her own.
- Avoid interrupting each other.
- Don't talk down to the patient (e.g., "you are acting like a child").
- Avoid name calling.
- Don't generalize ("always" or "never").
- Don't yell or shout.
- Don't personalize the patient's behavior. Recognize that the symptom may be part of the mental illness and may have nothing to do with you.