



August 17, 2018

As a non-profit mental health organization, we are limiting our comments to those features of the draft decree guiding reform of the Chicago Police Department to which our expertise is most relevant. In general, we support the document created by ACLU Illinois, Equip for Equality, Communities United, Community Renewal Society, One Northside, and Next Steps.

While the consent decree has admirably addressed the need for psychological expertise in many aspects of the changes it recommends, it is either vague or inadequate around several important points that, if they are not addressed, could deeply undermine the efforts being made here. The culture change sought here is difficult, and most of our criticisms relate to ways that well-meaning policies can be undercut by how they are presented, how they are delivered, and how actively the people affected by them are involved in the evolving process of change.

### **The Crisis Intervention Program**

The program's goal is stated in the decree as follows:

*The use of trauma-informed crisis intervention techniques to respond appropriately to individuals in crisis will help CPD officers reduce the need to use force, improve safety in police interactions with individuals in crisis, promote the connection of individuals in crisis to the healthcare system, and decrease unnecessary criminal justice involvement for individuals in crisis. CPD will allow officers sufficient time and resources to use appropriate crisis intervention techniques to respond to and resolve incidents involving individuals in crisis.*

We believe it falls short of being able to achieve these goals in the following ways:

- 1) The goal, after four years, of 75% of calls identified as crises being attended by CIT-trained staff is inadequate. It should be 100%. CIT needs to be perceived as a primary intervention, not an add-on. In the long run, officers not suited to responding appropriately to individuals in crisis need to be identified as the exception, not the other way around.
- 2) The violence reduction program and CIT training conceptually have considerable overlap and should be presented explicitly as different levels of the same training, thus strengthening the perception of a CPD cultural shift towards conflict resolution and away from confrontation, aggressive restraint, and punishment.
- 3) Without adequate resources for alternative response options, the program can't have the community impact it seeks. **911 operators must have alternatives for calls that don't require a police response, and officers must have alternatives other than arrest and hospitalization.**
- 4) The decree must clearly address what happens to individuals in crisis who have also committed a crime. Emotional assessment and intervention must remain an

integral part of how an individual is handled before, during, and after being charged with a crime.

- 5) Data collection and assessment must be a substantial part of the program, including collection of data on all calls requiring CIT dispatch whether it happens or not, feedback from CPD personnel involved in calls, and feedback from community programs and resources who have been provided as alternatives to arrest and hospitalization. Particular efforts need to be made to avoid this requirement becoming just a further routine paperwork burden, but to engage personnel in seeing themselves as actors in improving their effectiveness through their reportage.
- 6) Community organizations and mental health professionals need to be actively pursued to participate in CPD's intervention and referral process, so that referrals options are as robust as possible. CPD's efforts to identify appropriate and substantial options and to identify when they are absent can aid efforts beyond CPD to develop and maintain adequate and appropriate social and mental health safety nets.

### **Mental Health Resources for CPD personnel**

Stigma has long surrounded the use of mental health services by police and other first response personnel, in part because the very nature of the job pulls for defenses against the normal feelings of fear, helplessness, and hopelessness which arise in the course of the workday. If CPD understaffs and underfunds its counseling department, provides limited insurance coverage for therapy, and has few accessible treatment options in the community, the message to officers is that they shouldn't be having the problems they have. The decree makes several changes that attempt to address these problems, but it needs to go further.

1. The increase in counseling staff from 3 to 10 is minimal at best. A successful culture change is going to mean many more officers will seek mental health services, and the counseling department needs to be prepared for this success. For such a small number of clinicians to handle the issues that come up in such a large department, they can readily become another implicit source of pressure on officers to develop or maintain unhealthy defenses against the emotional states the job evokes—the less officers need, the more manageable counselors' jobs are. This is in no way intended as a criticism of the counselors, but a general observation of what happens when clinical staff are subject to vicarious trauma. We recommend providing the counseling staff with at least an hour of supervision weekly from an external source that allows them to focus on the clinical aspects of their work rather than the procedural, and we recommend continuing to evaluate and expand the resources this department has. In addition, we recommend a peer consultation group, something which has been found to be useful and supportive for therapists working in high stress environments who are at risk for secondary trauma themselves.
2. Ongoing program modifications based on data collection and assessment, which includes aggregated service usage information as well as feedback from clinical staff, is crucial to allowing this service to function effectively as the first line of response to problems that expectably arise for CPD personnel. As with CIT implementation, staff who provide services to officers need to experience

- themselves as active participants in the shaping of an effective program and engaging them in discussions to identify and implement successful strategies and problem areas matter enormously in accomplishing this.
3. In general, we have questions about the adequacy of supervision for both clinical staff and those involved in providing peer support. CPD needs to ensure that mental health staff have access to senior supervisors whose sole function is to support them in providing good assessment and treatment rather than in fulfilling policy requirements. These resources may need to come from external sources.
  4. Trauma is a major mental health problem that CPD must address among its staff. It is crucial that the Department appreciate that short-term manualized treatments for PTSD are problematic when they are all that is offered to those who have suffered trauma, or even have to be tried first before anything more substantial as if they should be enough. This is especially important in the current climate, where the American Psychological Association is not adequately considering complex trauma or evidence bases other than randomly controlled trials in its PTSD treatment guideline. With trauma in particular, where shame is an integral part of the traumatized individual's emotional response, to be undertreated is to potentially reinforce feelings both that "I should be able to handle this better" and "therapy is worthless." There is considerable evidence that the VA's focus on short-term interventions, for instance, leads to high drop-out rates, dissatisfaction, and persistence of symptoms.<sup>1</sup> With these things in mind, the decree needs to make explicit the availability of clinical services that are open-ended and represent a variety of kinds of interventions and theoretical orientations, including psychoanalytic therapy, trauma-informed CBT, and somatic therapies.

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<sup>1</sup> Brian Sharpless and Jacques P. Barber, "A Clinician's Guide to PTSD Treatments for Returning Veterans," *Professional Psychology: Research and Practice* 42, no. 1 (2011):8-15.  
Zac E. Imel; etal., "Meta-Analysis of Dropout in Treatments for Posttraumatic Stress Disorder," *Journal of Consulting and Clinical Psychology* 81, no. 3 (2013): 394-404.  
Jason C. DeViva, "Treatment Utilization Among OEF/OIF Veterans Referred for Psychotherapy for PTSD," *Psychological Services* 11, no.2 (2014): 179-84.