**Public Comments Regarding CPD’s Crisis Intervention Training Program Policies**

These revised Special Orders relating to individuals in crisis and other mental health incidents make several important changes, including implementing recommendations previously made by the Chicago Council on Mental Health Equity (CCMHE). We support those revisions, including using person-first language in these policies; adding guidance on recognizing a variety of indicators of crisis; the emphasis on de-escalation techniques; and providing officers with the list of mental health programs and resources for referral. However, further changes are needed in several important areas covered by this group of policies.

***The policies must be revised to promote important CIT program goals and functions.***

A critical issue is the continued failure to incorporate and further the CIT program’s principles and objectives of (1) promoting community-based solutions for crisis calls and (2) reducing criminal-system involvement of people in crisis. This group of policies continues to prioritize arrest and hospitalization as the primary forms of police response. The policies fail to include adopted diversion as a way of *avoiding* arrest or hospitalization. CPD must do so to achieve the CIT program’s core objectives, as set forth in the Consent Decree (paragraphs 85 and 88).

This occurs most problematically in the new Section on Programs and Resources (S04-20 Sec. VIII). This section serves the important function of giving CPD officers specific resources for mental health referrals. But instead of encouraging these resources as a method of diversion**,** the policy **restricts** their use to situations where there is no offense, ordinance violation, or even a citation, and no other grounds for taking the individual into custody. CIT is supposed to be a diversion program, which means that CPD must encourage officers to use these alternative methods **instead** of criminal charges, citations, or custody.

Likewise, to achieve these goals of the CIT program, Special Orders Nos. 04-20, **“**Recognizing and Responding to Individuals in Crisis,” and 04-20-04, “Mental Health Transport and Related Duties Matrix” should be further revised to facilitate diversion of individuals in crisis from arrest or hospitalization wherever possible. Giving out referrals can be helpful, but it does not come close to meeting the agreed upon CIT objectives as set forth in the Consent Decree.

***Meaningful guidance must be provided to officers on the ADA’s requirement to make reasonable accommodations for individuals with mental health disabilities.***

Another recurring problem is that this group of policies repeatedly refers to the “People with Disabilities” directive (S02-01-01) as providing guidance on recognizing and accommodating persons with mental disabilities. However, the current draft of that directive (posted on February 1, 2023) says nothing about mental disabilities and fails to provide needed guidance to assist officers in what can be complex and challenging interactions with people who have mental disabilities. Until the People with Disabilities policy is overhauled to comprehensively address mental disabilities, the Department should not rely on it. All of the policies in this series cover officer interactions with people who are experiencing functional impairments as a result of mental and behavioral health conditions that would meet the definition of disability under federal law. At a minimum, each of these policies should include that the Americans with Disabilities Act can require police in these interactions to make reasonable modifications to their policies and procedures to accommodate the needs of people with mental and behavioral health disabilities.

***Additional comments specific to particular provisions of Special Order S04-20, “Recognizing and Responding to Individuals in Crisis.”***

In Section VII, the policy makes some improvements to the guidance for situations where non-CIT certified officers are dispatched, but additional guidance is needed for situations where non-police responders or “co-responders” are also on the scene. Consistent with CIT goals and objectives, the policy should state that police officers must defer to those alternative response providers and avoid escalating the situation with their presence.

Additionally, clear policy directives need to be developed to give police guidance on how to transfer an incident over to alternative non-police response options when officers find an incident that does not require a criminal system response. This includes but is not limited to developing policy for police to hand calls over to City’s alternative response teams where a criminal-legal response is not required and/or the mental health responders are better suited to respond in a manner consistent with the City and the CPD’s goals of reducing the criminalization of mental illness.

Similarly, where non-CIT certified officers are dispatched—in lieu of CIT certified officers or alternative responses teams—the policy should give specific guidance for those officers. In circumstances where indicators of crisis are present (see Sec. V), behaviors such as not obeying commands, walking away, and even what may appear as potentially aggressive behaviors can be very strong cues of the need for special intervention by non-police mental health responders or the CIT team.

Next, the policy sets forth the definition of “individuals in crisis,” which gives the full scope agreed upon under the Consent Decree. We appreciate some improvements in this and related language from prior drafts. Unfortunately, the substantive provisions of the policy under Sections V, VII and VIII continue to use different terminology that is narrower than the CIT program established under the Consent Decree, suggesting a more limited application of this policy.

For example, Sec. V is meant to provide officers with guidance on how to recognize when an individual is in crisis. Yet, the current language suggests that officers are to make a distinction between people experiencing acute psychiatric symptoms (and other mental health conditions) and those having behavioral or substance abuse related symptoms. This is confusing and could be misinterpreted to suggest an inappropriate evaluation by the officers. For clarity and consistent application of the full scope of the definition of “individuals in crisis,” further revision is needed. We have previously suggested the following language: *one or more of the follow cues "can be indicative of a need for mental health, substance abuse, or intellectual / developmental disability services and not non-compliance."*

Likewise, Sec. VII references "mental health calls" and Sec. VIII refers to "individuals with mental health and substance abuse disorders." These suggest a more narrow scope than the CIT program definition of “individuals in crisis” and should be revised for consistency.

The policy also introduces new undefined terminology. Specifically, Section VII.A. and Section I change "certified CIT officer" to "designated CIT officer." The former is a defined term under the Consent Decree, but “designated CIT officer” is not, and it is not explained or defined in this policy. We are unclear on its meaning.

Finally, the policy does not adequately address interactions with Youth (defined in the Consent Decree as ages 13-24). Other than including SASS (Screening, Assessment and Support Services for adolescent psychiatric emergencies) in the alternative response options, this policy does not give specific guidance on engaging with Youth, as recommended by the CCMHE. This policy should be revised to comply with the Consent Decree’s requirements for interactions with Youth, including avoiding arrest through alternative responses and specific notification requirements if juveniles are arrested.