SESSION THREE: TRAUMA INFORMED CARE FOR THE CRIMINAL JUSTICE PRACTITIONER

Criminal Justice Webinar Series

January 12, 2022
2:00 - 4:00 pm
VIRTUAL SESSION

Criminal Justice Coordinating Council for the District of Columbia
CJCC

Background

On January 12, 2022, the Criminal Justice Coordinating Council (CJCC) convened a webinar entitled "Trauma-Informed Care for the Criminal Justice Practitioner."

The webinar was designed to explore trauma and trauma-informed care services for District criminal justice practitioners. Criminal justice practitioners are not immune to trauma and their responsibilities expose them to different forms of trauma including: historical, secondary, and other forms of complex trauma. Not only must they respond to work-related trauma, but other stressors as well, including social unrest, community violence and escalating homicides. Consequently, CJCC undertook the task of exploring the realities and implications that trauma presents to agency partner practitioners, including clinicians, police officers, intake personnel, etc. The goal of the dialogue was to explore the following: what is trauma; what are the implications of trauma; what challenges does trauma present to agency partners and their employees; what policies and programs are in place or being developed to respond to the health and welfare of practitioners; and how does the criminal justice system, i.e., institutions, procedures, policies, and architecture, contribute to or exacerbate trauma experienced by practitioners and the clients they serve.

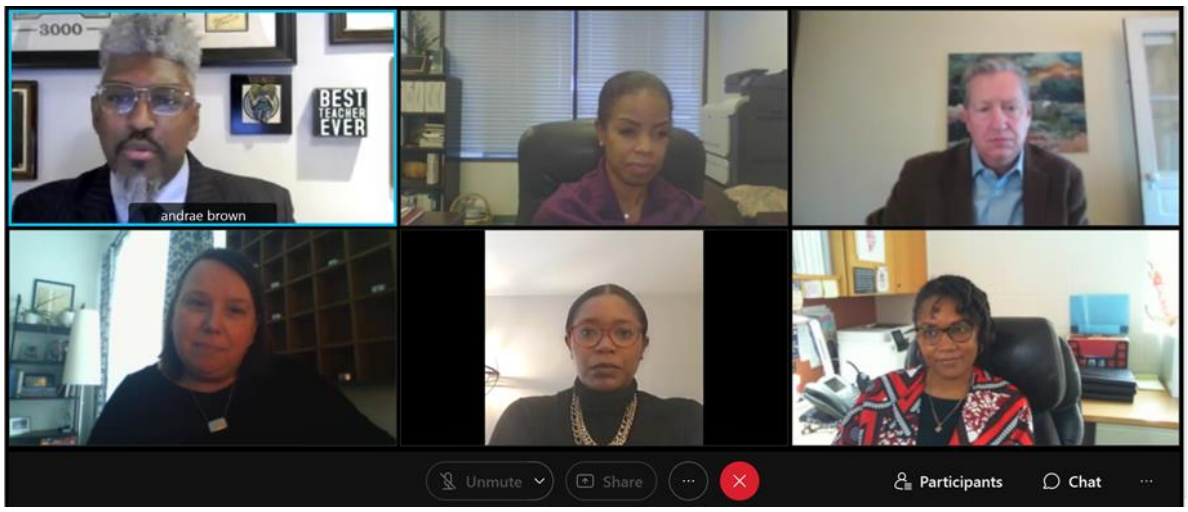
CJCC Executive Director Mannone Butler commenced the discussion and welcomed the webinar attendees, moderator, and panelists to the program. She highlighted the challenges that trauma presents to criminal justice agencies, practitioners, and clients (youth and adults), who are touched by the criminal justice system. Director Butler outlined the discussion framework and introduced the moderator. She stated that he has served as a consultant and provided clinical therapy for violence interrupters for the Office of the Attorney General (OAG), and that he utilizes his trauma expertise to support service providers. Further, she highlighted that the panel included partner agency clinicians who possess extensive expertise and would share valuable insights and context regarding trauma-informed care and related services.

Panel Introduction

The moderator, Dr. Andrae Brown, Heru Consulting, offered that the goal of the discussion was to unpack and deconstruct some of the experiences with trauma occurring across the District. He proceeded to introduce the panelists, including:

- Richard R. Bebout, PhD, Chief of Crisis Services, Department of Behavioral Health (DBH)
- Beth Jordan, M.D., Director, Medical Services, Department of Corrections (DOC)
- Diana Karczmarczyk, PhD, MPH, MCHES, Director of Employee Well-Being Support, Metropolitan Police Department (MPD)
- Kenya Key, Psy.D., CCHP-MH, Deputy Director of Health Services, Department of Youth Rehabilitation Services (DYRS)

- Dr. Katara Watkin-Laws, PhD, Acting Chief Psychologist, Child Guidance Clinic- Court Social Services Division (CSSD)

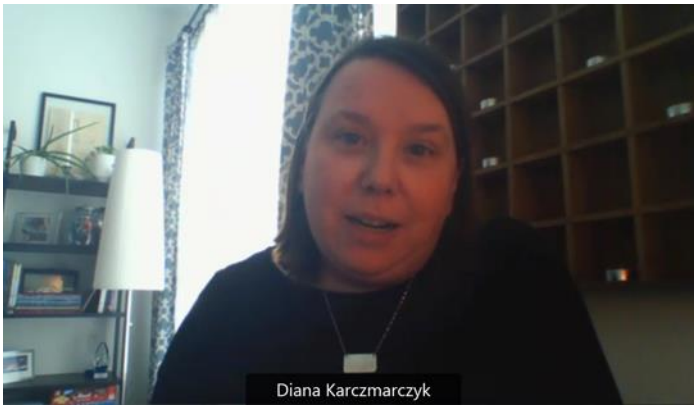


Panel Discussion

Dr. Brown commented that the goal of the conversation was to think about and deconstruct issues in a way that looks at the intersection of race, class, gender, sexual orientation, and different elements related to trauma. Additionally, he explained the discussion would delve into some of the power dynamics and dimensions of trauma. He asked Dr. Bebout to outline his responsibilities and to define trauma.

Dr. Bebout started his remarks by citing the statistic that "across America, a child is shot every hour," highlighting the extent to which trauma is occurring across our nation and in the District. In his new role as Chief of Crisis Services, he is responsible for: overseeing behavioral health diversion responsibilities; working with the Office of Unified Communications (OUC) to overhaul emergency 911 operation calls; implementing the new 998 National Suicide Prevention Help Line; strengthening partnerships with criminal justice partners; facilitating pre-arrest diversion activities; and ensuring that persons with mental and behavioral health challenges are not placed in jail or detention when there are better and more appropriate options.

Dr. Brown inquired regarding what is trauma; how does it relate to toxic masculinity; whether traumatic experiences interfere with a person's ability to self-regulate their behavior; and how and if trauma precludes clients from seeking help. Dr. Bebout offered that in dealing with persons who have experienced trauma, it is critical to stop asking people what is wrong with them, and ask instead what happened to them. He offered that trauma experienced for long periods of time or multiple occasions in succession can result in permanent harmful changes in our brains and an inability to return to a personal emotional or psychological baseline. Regarding toxic masculinity, Dr. Bebout explained that men experience challenges coding their experiences with trauma. Finally, he offered that trauma-informed care involves a fundamental assumption that people we encounter have experienced trauma throughout their lives, and it is important to help them develop coping skills to self-regulate their responses to trauma.



Dr. Karczmarczyk "Dr. K", commented that she is the first person to assume her current position. She indicated that Chief Robert Contee, Metropolitan Police Department (MPD), created the position, and she fulfills her duties as a health professional and not as a clinician. Her position and office are a consequence of cumulative events occurring within and across the District, i.e., political protests, social strife, gun violence, homicides, and a toxic environment that poses mental and physical threats to the well-being of police officers. To illustrate her point, she indicated that her approach to the job is predicated on a comprehensive wellness perspective; and her responsibilities include looking at situational challenges as opportunities that can be addressed and viewed through a system-wide lens. She stressed that utilizing this approach is vital to developing programs and services that can be tailored to transform the landscape that affects MPD's workforce.

Dr. K shared two points that she has learned since assuming this role. The first point is that historically, suicide has been the primary cause of death for police officers, which is an indication of the level of trauma experienced by police. However, since the start of the pandemic, COVID has become the leading cause of death for police. Further, she indicated that during a police officer's career, they will have experienced 188 significant traumatic or critical incidents, i.e., homicides, drownings, assaults, etc., each of which can inflict personal pain and duress. When questioned about the public's perception that police are robotic and devoid of feelings in their interactions with the public, Dr. K offered that on the one hand the public expects officers to respond to a request for assistance in full command of their emotions regardless of the events they witness. The reality, however, is that officers have their own trauma. Further, all too often MPD officers sublimate their feelings and experiences because of a culture that demands stoic and dispassionate responses when they are confronted with victims who experience tragic or chaotic circumstances. Dr. K offered that this culture and attitude pervades police departments, including DC, which is undertaking a culture shift. However, efforts are being promoted across

police departments that urge officers to pursue self-care and to take advantage of employee assistance programs available for matters related to addiction, alcoholism, depression, and anxiety. Further, and very importantly, departmental programs are being well received by officers. Finally, a disturbing point offered regarding police officers is that upon retirement, and within five years, there is a high incidence of and probability of death.

Dr. Watkins-Laws offered that in her work with youth under court supervision, there is hope that circumstances related to employee trauma and its implications will change as administrators and policymakers commit resources to programs to address trauma and its consequences. She highlighted that the nature of the work she and her colleagues perform contribute to anxiety for clients and criminal justice professionals respectively, because invariably, staff work with detained youth, interact with family members, and internalize the stress associated with the many pitfalls and tragedies that are common to the work they perform. From her perspective, she shared that it is important to appreciate that the trauma criminal justice practitioners encounter has wide-ranging trauma effects, and it is important for them to become attuned to how different traumatic stimuli affect them, and to have colleagues upon whom they can rely and communicate with to provide useful feedback regarding their responses to different stimuli and situations.

Dr. Watkins-Laws emphasized it is important for staff to connect the dots regarding cause and effect regarding their responses to personal trauma that may cause personal and unexpected triggers in certain situations. Additionally, it is important for staff to engage colleagues with whom they work to receive support and provide a temperature check on behaviors or responses that may indicate underlying challenges they are experiencing. Dr. Watkins-Laws also cited the importance of staff obtaining proper emotional, mental, and physical rest to regenerate themselves.

Dr. Key shared that the most important part of this discussion is understanding that her work and the work of her colleagues is not something that they must deal with, but rather it is work that they must truly "be about." Additionally, the work they perform must be reflected in the culture within which they operate because otherwise everyone suffers. And the work they aspire to do will suffer as well. Therefore, it is paramount to approach trauma and trauma responses through clinical practices and policies. She also explained that there is value in exploring architectural design and its visceral and harmful effects on clients and staff. Consequently, at DYRS, space has been configured to support "peace rooms" where staff can retreat to regroup in a hospitable space that promotes tranquility, which in turn enables them to return to their duties refreshed.

Dr. Brown noted that detention facilities are designed to traumatize persons and spur modified behavior. He inquired regarding how to reconcile punitive aspects of detention/prison in relationship to rehabilitation. Dr. Key offered that notwithstanding the penal nature of being incarcerated and the ensuing trauma caused, if practitioners are doing what they are charged to do in a correctional environment their work does not have to cause harm.

A final point raised by Dr. Key related to the geography of the District and its Wards and tightly knit communities. Given that reality, it is not uncommon for DYRS staff to know victims of trauma, the perpetrators of trauma, related family members, and clients. Consequently, the typical six degrees of separation of association and interaction we are familiar with is seemingly reduced to two degrees. The result is that all too often, some staff, i.e., credible messengers involved in supporting mentoring and restorative justice efforts, experience vicarious trauma across families and community members due to the nature of their dangerous and stressful work and those relationships. In those instances, it becomes critical to support the employee as they deal with their trauma.

Dr. Jordan shared her perspective working for the Department of Corrections. She offered that DOC started doing trauma-informed care in 2016 when they opened a men's step-down unit, which was a new development from the acute men's unit at the jail. Subsequently, the Department brought in two leading national experts that had formerly worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a program named Trauma Addiction Mental Health and Recovery (TAMHR), a psychoeducational group designed to look at the role of trauma. The method employed focused on changing the conversation from what clients did to what happened to them. Given that only 30% of the population had been sentenced, the goal was to move from a custody perspective to a care model.

Dr. Jordan emphasized that the current program is for women who have mental health conditions and or substance use disorder issues. Although there is no program specifically designed for employees, corrections officers co-facilitate the training and she believes that through their participation they can adapt the principles to their lives. The program is a 15-module psychoeducational approach, based on understanding trauma, looking at trauma, and how to respond to trauma.

Dr Jordan also commented that daily Corrections work can be very traumatizing for the staff because they are subjected to abuse, physical altercations, and harassment. In some instances, generations of family members have worked in the jail and experience different forms of stress that affects them. Additionally, the corrections community is small, and the city is small. And

stress and conflicts can arise once persons are released from detention and they or their family members encounter corrections officers. Consequently, residual tensions could possibly remain and present harmful risks. Finally, Dr. Jordan commented that trauma-informed care co-facilitated at work by officers can assist them in understanding the factors that contribute to someone's volatile responses while incarcerated.

Questions and Answers

Below are panelists' responses to questions posed by audience members.

How are the officers connected to MPD care? Is the support 100% voluntary or are officers mandated?

Therapy is provided by the MPD employee assistance program. Dr. K's role and approach is to analyze health and wellness from a systems perspective and not as a clinician. Additionally, MPD offers different policies and procedures, including self-care plans and chaplaincy programs that officers can utilize.

Are there Peer-to- Peer Programs set up across various agencies?

MPD is creating its own peer support team and they are relatively new to the peer-to-peer space.

Please comment on health plans and contacts after release for youth and adults, and whether there is acknowledgment of a trauma experienced by being incarcerated, and from a non- criminal standpoint.

According to Dr. Watkins-Laws, CSSD youth demonstrate separation anxiety when being processed at intake; especially after being arrested and being isolated from their family members. Other expressed symptoms include an inability for youth clients to sleep.

Dr. Key offered that "at the end of the day, jails and detention centers are not therapeutic environments…Our work is to ensure that we are not jailing and incarcerating people unnecessarily. We shouldn't have this many people behind bars. If someone is not a public safety risk, there is no reason for us to be subjecting them to further incarceration and subjecting them to additional trauma."

Has trauma-informed care for officers been observed to affect their empathy towards how they approach the community? And is this measured in any way?

Measuring empathetic reactions with community members is certainly something MPD would be interested in. However, MPD needs financial support to be able to expand and act on this metric and really find meaningful opportunities to make an impact on their interactions with the public.

Dr. Watkins-Laws commented that criminal justice practitioners are in business because there are numerous challenges presented to the system. Consequently, their work involves detention, providing care, and ensuring public safety.

In circumstances where individuals are incarcerated because there is no place to put them to receive the treatment they require, where else can we place them? Are we creating new spaces for folks that are different than where they are?

DYRS takes extra care to ensure that young people who are not public safety risks are not kept in confinement. They are connected to tailored community resources and foster housing is sought.

Has MPD incorporated trauma-informed care across the Department and does MPD include de-escalation as a part of the health training for new recruits?

De-escalation training is part of training at the Academy. Dr. K is working to deliver trauma informed training for new recruits, and the existing workforce.

Dr. Bebout, please provide additional information regarding your new duties?

Dr. Bebout explained that he is responsible for redirecting calls to 911 away from an automatic law enforcement response, expanding first aid training, doubling the number of crisis intervention officers (CIOs), and ensuring cadets are properly trained in mental health matters when they graduate from the academy. He will also be implementing the new 988 Suicide Prevention Hotline in July. The real goal is to prevent the incarceration of persons with mental health and behavioral health issues who would be better served by receiving treatment as opposed to being put in jail. Other goals include: aligning a system of care, strengthening partnerships with first responders and criminal justice partners, and expanding pre-arrest diversion activities.

Conclusion

Director Butler expressed that the goal is to have follow up conversations that build upon the issues raised in the webinar, and to consider convening a conference. Additionally, the goal is to identify what resources are available and what's needed to support trauma-informed services. Dr. Brown thanked everyone for participating, and actively engaging in a thoughtful conversation. Director Butler acknowledged partners in attendance and thanked the panelists for participating, and the CJCC staff responsible for organizing the event.