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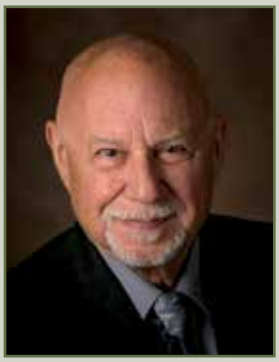
Police Violence, Racial Injustice, and Police Burnout After Floyd's Death



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The death of George Floyd in May 2020, as well as numerous other violent and tragic encounters with police caught on camera, have sparked increased awareness and interest in police violence, racial injustice, and the need for police reform. In addition to implicit racial bias and systemic racism, police burnout has been cited as one contributor to police violence, and police burnout may be rising currently in relation to increased demands on police officers during periods of civil unrest, especially in larger metropolitan areas.

Statistics related to police violence, racial injustice, and police burnout yield alarming and puzzling findings. For example: Police officers have killed 781 people in 2020; Black people are about twice as likely as white people to be killed by police; the majority of Black, Asian, and Hispanic Americans do not want a reduction of police presence in their neighborhoods; police officer suicides increased 25 percent from 2018 to 2019; and the number of police officers killed this year surged 28 percent compared to the same period last year. (For more statistics, and links to the statistics reported here, visit *www.amhca.org/viewdocument/statistics-related-to-police-violen.)*

In this article, three forensic mental health experts, all who hold leadership positions with the National Board of Forensic Evaluators (NBFE), propose that clinical mental health counselors (CMHCs) can play an important role in preventing and addressing police violence by:

1. Conducting "fitness for duty" evaluations to detect signs that police recruits and police officers are not psychologically prepared for the rigors of policing,
2. Responding alongside police officers to calls for police assistance that involve individuals with mental illness or who require verbal de-escalation, and
3. Providing psychoeducation, psychological first aid, coping skills training, supportive counseling, and/or trauma treatment in an effort to offset, prevent, or mitigate police burnout.

STRATEGY #1:
The CMHC's Role in Conducting Fitness-for-Duty Evaluations (By Dr. Norman Hoffman)

In my work as a forensic mental health evaluator, I am contracted with seven police departments and fire stations. Over the past 15 years, I have been asked to conduct evaluations for police recruits, police officers, and firefighters who require evaluations for their ability to continue to perform their duties.

A fitness-for-duty evaluation (FDE) is not a standard psychological or forensic mental health evaluation. It is a specialized inquiry conducted by specially trained and qualified mental health professionals. These evaluations are conducted in response to complaints regarding

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first responders. They may include police officers, firefighters, emergency medical services (EMS), deputies, etc. They are usually referred for reported inability to perform official duties safely and effectively because of suspected mental illness or significant deterioration in cognitive abilities. Also, after a shooting, departments are mandated to conduct an FDE to determine if the officers involved are fit to return to their previous duties.

REASON FOR EVALUATION

After an incident, either on or off the job, where an officer's judgment or behavior raises concerns about the officer's ability to perform their duties safely, an FDE may be requested. This evaluation may also be requested when an officer's performance level or behavior on or off the job results in doubts about the officer's competence from a supervisor, co-worker, or the public. Occasionally, a law enforcement officer's behavior raises concerns that the officer may have one of the following issues: anger-management; arrest; domestic violence; erratic or unusual behaviors; excessive absenteeism, citizen complaints, or force; fighting; instability; problem with daily duties; serious, flagrant sick-leave abuse; shooting incident; and substance use or abuse.

Unfortunately, most evaluators are untrained, ill-equipped, and lack the proper skills and experience to conduct these highly specialized evaluations. Basic skills and understanding of forensic mental health evaluation are taught in the certification training process described by the National Board of Forensic Evaluators (NBFE), which partners with the American Mental Health Counselors Association (AMHCA).

Many evaluators not familiar with the needs of law enforcement generally use inappropriate testing tools. It is imperative that the evaluators use appropriate testing tools, ones related to the reason for referral. Following is an example of what should be utilized when a police department requests an FDE:

REASON FOR REFERRAL (EXAMPLE):

Mr. Jonas Jones (not his real name) is being referred for an FDE to determine if he is fit to return to duty following a shooting incident. Since the incident, he has exhibited signs of extreme anxiety, depression, and difficulty concentrating.

The following instruments are suggested for evaluators: clinical interview; psychosocial self-report; Beck Anxiety Inventory; Beck Depression Inventory; Personality Assessment Inventory, Law Enforcement, Corrections, and Public Safety Selection Report, or MMPI-2 Personnel—Law Enforcement Interpretive Report; Trauma Symptom Inventory (TSI), or Posttraumatic Stress Diagnostic Scale (PSD).

The report derived from the FDE should include the reason for the referral, which of the above testing instruments were used, and conclude with recommendations about the officer's fitness for duty along with any restrictions. In addition to being easy to read and free of psycho-jargon, the recommendations should flow logically from the findings laid out in the report.

SUGGESTED OUTLINE FOR FDE REPORT:

- Professional heading
- Demographics
- Interview dates
- List of sources
- List of collateral sources
- Identifying data
- Reason for referral
- Summary of significant data
- Psychosocial self-report
- Review of records
- Collateral reports
- Personality assessment and test results
- Mental status examination
- Diagnoses
- Clinical formulation
- Conclusion
- Recommendations

BEST PRACTICES FOR CMHCS CONDUCTING FDES

The FDE should not be written by a client's therapist or by a CMHC who has a biased opinion. It should be a comprehensive assessment that searches for the facts, which the client alone cannot acquire. The evaluator should examine multiple sources and data points when forming an unbiased conclusion that leads to sound, succinct recommendations. In closing, the recommendations must indicate if the client is fit to return to duty. If not, the evaluator may assist the department with other options.

STRATEGY #2:
The CMHC's Role in Responding Alongside Police Officers (By Ekom Essien)

With more attention being given to the manner in which police interact with the public and enforce the law, little has been said in news reports about the ways in which a person's mental stability can impact the outcome of an interaction with the police. However, this is extremely important considering that when a person is experiencing a mental health or substance-use-related crisis, police are often the first to respond to the call for help.

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Many mental health professionals instruct clients, or loved ones of clients, to call 911 in the event of a mental health crisis. This practice highlights the importance of law enforcement officials being specially trained in managing people who may be experiencing a mental health or substance-use-related crisis. As CMHCs, we should lead the effort with these two considerations:

1. **How police officers' mental health stability affects their job performance.** It is easy to focus more on the uniform and the job and neglect the fact that police officers are also human beings, subject to the same psychological processes that all people experience.
2. **The efforts already being made to improve police interactions with the mentally ill.** CMHCs should examine how to enhance or improve those efforts by increasing the presence of CMHCs in partnership with law enforcement. Police departments can use our unique expertise as CMHCs when responding to mental-health-related calls.

HUMANIZING POLICE OFFICERS

Police officers are authority figures who deal with human interactions that pose a threat to the life, liberty, and safety of others. Many interactions between the police and the public are experienced as adversarial. However, police officers are people; they have families and friends, get sick, have hobbies, and experience events that may affect their daily functioning. As such—and especially because they experience violence, abuse, and death on the job—it is imperative that counseling or other mental health/substance-use-treatment services are available to law enforcement officials.

Police officers also have personal biases and a subjective worldview, like everyone else. Just as CMHCs are trained to be aware of their own personal biases and subjective worldview in relation to their clinical work, police officers should be trained to have such self-awareness when interacting with the public.

A common perception is that police interact with all individuals as if they are a potential threat. This may be thought reasonable, considering the dangers that officers face on the job. The problem is that someone experiencing a mental health crisis may not have committed a crime, and the only threat they may pose is increasing others' anxiety. Police presence is often interpreted as a sign that someone is "a bad person" or is "in trouble," when, in fact, a person may simply need help.

POLICE–CMHC PARTNERSHIP MODELS

In response to problems in the interactions between police officers and people who have mental health or substance-use-related problems, many U.S. police departments have altered the way they train officers, using strategies such as:

- Partnering with local and national mental health organizations such as the National Alliance on Mental Illness (NAMI) to educate police officers about how a mental illness may affect a person's interactions with law enforcement.
- Establishing diversion programs, such as a Crisis Intervention Team (CIT) program, which have made incredible strides in reducing arrests of people who are mentally ill. These programs also serve to improve officer attitudes toward mental illness. Based on a model developed in Memphis, TN, the CIT model has been adopted by many law enforcement departments across the country. CIT typically involves partnership between mental health and substance use counseling professionals, law enforcement, and mental health advocates or other community organizations.
- Pairing CMHCs with Emergency Medical Services (EMS) and local police when the situation is determined to be mental-health-related, often referred to as mobile response teams (MRTs) or crisis teams. MRT models have been adopted by many U.S. city and county governments (e.g., Atlanta, Dallas, and these four Florida areas: St. Petersburg, Orlando, Okaloosa County, and Walton County). While news coverage doesn't often highlight the efforts of a community and its law enforcement to better meet the needs of the mentally ill or those who have problems with addiction, a growing amount of research supports the efficacy of such programs at reducing recidivism and reducing incarceration of those who are mentally ill and/or have substance use disorders.
- Making fitness-for-duty evaluations (FDEs) conducted by CMHCs mandatory at regular intervals for all officers (see previous section, "Strategy #1," written by Dr. Hoffman).
- Incorporating mental-health-related courses taught by qualified CMHCs into the police training curriculum. The courses should include subjects that encourage introspection and self-awareness, crisis prevention, verbal de-escalation techniques, and non-physical intervention. The trainings can begin while officers are in the academy and recur quarterly, semiannually, or annually.
- Establishing a phone number for mental health emergencies through which a police dispatcher can alert a mental health unit composed of mental health counselors, police officers, and even EMS.
- Altering police funding: Given that most of the current CMHC-police partnership programs function on a volunteer basis or with limited funding from not-for-profit organizations and grants, implementing consistent, reliable, comprehensive services can be difficult. Since "defunding" the police has been a recent topic of the protests, reallocating funds to CMHC-police partnership programs might better serve communities and law enforcement.

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STRATEGY #3: The CMHC's Role in Treating Police Officers (By Aaron Norton)

REFLECTING ON EXPERIENCES SHADOWING POLICE OFFICERS IN THE AFTERMATH OF RACE RIOTS

From the ages of 14–25, I attended a criminal justice academy magnet program rather than a traditional high school, spent six years in my city's police explorer program (where I participated in weekly training sessions with officers, shadowed 911 operators, rode in uniform with and observed police officers on patrol, etc.), and worked for five years in correctional programs for youthful offenders.

These experiences have had a profound impact on my career path as a CMHC. They happened in the aftermath of my city's 1996 race riots, which were sparked by the shooting of a young Black man by a white police officer. When I rode along with officers, I saw that people often approached or surrounded officers, sometimes while yelling threats and sexist, racist, or hateful slurs towards officers of various races, ethnicities, and genders. These reactions were not precipitated by any threatening or disrespectful behavior on the part of responding officers. Officers seemed to attract anger simply by "showing up" after being called to a scene.

A 2018 *Counseling Today* article by Jessika Redman, DBH, NCC, CO-LPC, FL-LMFT, encouraged CMHCs to consider law enforcement officers a "special population (like military and paramilitary personnel and other first responders) who experience coexisting medical and behavioral health issues with links to job-related stressors." The article cited research identifying factors that contribute to mental health impairment of officers (e.g., shift work, long hours, unpredictable schedules, exposure to critical incidents, being the frequent focus of public attention and criticism, various physical demands, high rates of on-the-job injuries).

During and after the 1996 riots in St. Petersburg, officers had to contend with not only the usual policing stressors and traumas, but also racial tension and civil unrest. Anyone who chooses to become a police officer has to develop a thick skin, but in the aftermath of the race riots, it seemed that hatred and anger were directed at officers at every call, hour after hour, day after day. As my young mind struggled to make sense of the problems I encountered—including child abuse, drug overdoses, premature death, domestic violence, suicide, and gang violence—I thought about the cumulative effect of such exposure for the officers, many of whom worked far too many hours a week with little sleep and low pay under stressful, dangerous conditions.

Clearly some officers suffered from low morale and burnout, but I also noted effective coping strategies—exercise, faith/spirituality, quality time with loved ones, a creative (and sometimes dark) sense of humor, reminders of their belief that they were "making a difference," and in-group comradery. I remember meeting one officer who would stop whenever she saw a stray dog, talk to it, and give it a biscuit. She told me that on some days she doesn't feel like she's making a difference, but then she sees a stray dog and finds a way to feel helpful.

I also remember rare occasions in which I witnessed police actions that I thought were unethical, unnecessary, unwise, or perhaps even illegal. I felt very uneasy riding with one officer in particular because of his misdirected and intense anger. I remember thinking, "This man should not be a police officer."

I wrote an article on my ride-along experiences at a teacher's request, not realizing it would make me a target for a Black rights group in my community that erroneously assumed that one paragraph was about a Black man. That paragraph was actually about a white man, and the article was published in the same issue as a very passionate antiracism editorial I wrote. I wanted so badly to convince the activists that I was on their side, but they didn't seem to want to listen.

When I was being falsely accused, I noticed an uncomfortable sensation in the pit of my stomach. The sensations I experienced in my body then reminded me of how I felt when I would exit a police car and automatically be labeled a racist. They were also like what I experienced at 19 years of age when I was illegally detained by a police officer who physically assaulted one of my passengers, falsely accused us of wrongdoing, and yelled slurs at me. (It was a case of mistaken identity, though I was unable to convince the officer of it.)

I have come to recognize this physical sensation as a signal that I am sensing injustice. I felt a profoundly intense version of it when I watched the footage of George Floyd's death and subsequent videos of officers aggressing against nonviolent protestors. I also noticed it when watching footage of protestors yelling angry slurs (sometimes even sexist and racist ones) at officers of various genders, races, and ethnicities, or marching while yelling "Shame!" or "F—k the police!" or "Good cops are dead cops" in the faces of officers standing silently by in non-aggressive postures.

These life experiences (and others), coupled with my education, clinical experience, and research, led me to believe:

- Though most officers do good work and are well-intentioned, some were either never psychologically fit for a career in law enforcement or became unfit over time.
- Police officers have very difficult, stressful jobs, and they can benefit from training, education, guidance, coaching, and sometimes therapeutic intervention from CMHCs.
- Such intervention can reduce the likelihood of trauma, burnout, and excessive use of force.

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During and after periods of civil unrest, racial tension, and riots, the majority of protestors and activists are peaceful, but the righteous anger and indignation felt by oppressed people and their advocates is sometimes misdirected in ways that unfairly victimize police officers, their supporters (e.g., defacing "back the blue" murals, which recently happened in the Tampa Bay Area), and community members (as occurs with looting, for example).

COUNSELING INTERVENTIONS WITH POLICE OFFICERS

These beliefs play a role in my therapeutic work with police officers, sometimes through employee assistance program (EAP) work, and other times through insurance or private pay. Here are seven principles I have developed in my practice that I hope you will find helpful when working with officers:

1. **Learn about the psychological challenges of police work, what a "day in the life" of an officer is like, and police culture.** Some departments provide "ride-along" programs for educational purposes that are available to CMHCs who provide supportive counseling to officers. CMHCs can also learn by reading the accounts of police officers and clinicians who specialize in working with them or by participating in continuing education related to working with officers. When a CMHC doesn't have much knowledge or experience about police work and culture, it is important to demonstrate an interest in learning about these experiences from clients. Remember that the client is the expert on police work, not you.
2. **Provide psychoeducation on stress and burnout.** I think it is important to avoid coming off as "preachy" when providing this information. I recommend keeping it brief and relevant. CMHCs may also provide in-service trainings or workshops for police departments, either as a volunteer or perhaps through an EAP contract.
3. **Assess the client's stressors and coping strategies.** Assuming it is relevant to their presenting concerns, ask officers what they most like and dislike about their work, what are some of the challenges they are most concerned about, what has been helping them cope with the unique stressors they face, and what has not helped (i.e., coping strategies that may be self-defeating).
4. **Develop an individualized coping strategies plan.** I explain to clients that during times of unusual stress, it is common not to think naturally of effective methods for releasing pressure or managing stress, and that this problem can be remedied by having a written plan (often kept on a phone). The first items we add to this plan are those that the client has already identified as being helpful. If I do not think those strategies are sufficient (and the client agrees), then I offer the client a coping strategies checklist that can be used to generate ideas for strategies to add to the list. This plan will often include somatic quieting techniques (e.g., progressive muscle relaxation, deep breathing, the grounding 54321 technique, etc.), which that can be practiced regularly to de-stress, as well as adequate nutrition, exercise, sleep/rest, and meaningful interactions with social supports. This work can be thought of as stress inoculation therapy, prevention, and/or coping skills training.
5. **Avoid intensive trauma therapy if the officer is currently contending with unusually stressful circumstances.** Though therapies designed to treat trauma—such as prolonged exposure therapy, eye movement desensitization and reprocessing (EMDR), Accelerated Resolution Therapy (ART), Rapid Resolution Therapy (RRT), Emotional Freedom Techniques (EFT), etc.—may be very helpful for officers struggling with PTSD or similar symptoms, they also can sometimes trigger temporary increases in emotional distress. If an officer will have to leave a session with a CMHC to work a double shift in riot gear at a protest where he or she may have to endure intense emotional triggers, it may be best to hold off on initiating such treatments until after the more acute phase of civil unrest has subsided.
6. **Consider here-and-now approaches when intensive trauma therapy is contra-indicated.** Solution-Focused Therapy and Cognitive Behavioral Therapy (CBT) may be helpful approaches. I have found that many officers have responded well to Stoic principles that constitute the theoretical foundation of CBT. CMHCs can help officers identify, anticipate, and plan for triggers they will likely experience during their shift. We can also teach them a series of questions they can ask themselves (e.g., the ABCDE method of Rational Emotive Behavior Therapy) or counter-thoughts and cognitive reframes they can reflect on in moments in which they are triggered. Utilizing approaches such as Acceptance and Commitment Therapy (ACT) and Mindfulness-Based Cognitive Therapy (MBCT), we can help them to a) be aware of their emotional states and how those emotions manifest themselves in the body; b) detach from those experiences, as if observing them from a distance; and c) choose value-congruent behavioral reactions carefully. CMHCs who have appropriate training can also teach officers verbal de-escalation techniques that can be used when interacting with angry protestors or suspects.
7. **Make good use of the therapeutic relationship.** As with all therapies, the therapeutic relationship is likely the single best predictor of client outcome. Officers need to know that you are nonjudgmental, that you respect their expertise in their profession, that you are making an effort to understand the unique challenges of police work, that you are increasingly "getting it," and that you genuinely have their best interest in mind.

Statistics related to police violence, racial injustice, and police burnout

- In 2020, 781 people have been killed by police officers, and in 2019, there were only 27 days in which police officers did not kill anyone. *(mappingpoliceviolence.org)*
- Of people killed by police, 50 percent are white and 25 percent are Black, even though only about 13 percent of the U.S. population is Black, meaning Black people, compared to white people, are about twice as likely to be killed by police. *(washingtonpost.com/graphics/investigations/police-shootings-database/)*
- Police disproportionately patrol neighborhoods with high concentrations of minority populations *(scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=3660&context=faculty_scholarship)*, sparking debate about whether this practice is a measure to protect citizens of neighborhoods with high crime rates (as many police departments contend), or whether it "elevates Black civilians' risk of lethal encounters with police."
- Despite the efforts of some activists to either "defund" the police or to reduce police presence in neighborhoods predominantly inhabited by minorities, the majority of Black, Asian, and Hispanic Americans do not want a reduction in police presence in their neighborhoods. *(news.gallup.com/poll/316571/black-americans-police-retain-local- presence.aspx)*
- The U.S. has the fifth highest per-capita rate of police killings in the world *(worldpopulationreview.com/country-rankings/police-killings-by-country)*, though it also has the highest rate of civilian gun ownership in the world *(worldpopulationreview.com/country-rankings/gun-ownership-by-country),* and 99.1 percent of all arrests take place without a civilian death. *(ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-29)*
- Much to his own surprise, data collected by economist Roland Fryer, Jr., PhD, from 10 major police cities in Texas, Florida, and California indicated that while police were 25 percent more likely to use non-lethal force against Black citizens, Black suspects were about 25 percent less likely to be shot by police than white suspects, challenging the conclusion that racial disparities in police shootings were primarily explained by an inclination to shoot Black suspects. *(nber.org/papers/w22399)*
- Fewer officers, one of the measures in some "defund the police" initiatives, does not mean less brutality, as officers may be more likely to use force when they are tired and/or overworked due to personnel reductions. *(kingcounty.gov/~/media/depts/auditor/new-web-docs/2017/kcao-overtime-2017/kcao-overtime-2017.ashx?la=en)*
- A recent study concluded that repeated exposure to high-stress service calls and ongoing exposure to stress without relief are two factors that contribute to adverse experiences among officers, but breaks between calls, breathing exercises, and mental health treatment can help. *(sciencedaily.com/releases/2020/08/200818142143.htm)*
- A study published in *Police Quarterly* in 2019, well before the current period of civil unrest, yielded findings that 19 percent of police officers were experiencing "severe levels of emotional exhaustion," and 13 percent were experiencing extreme levels of depersonalization. *(journals.sagepub.com/doi/10.1177/1098611119828038)*
- According to a 2019 epidemiological study, the rate of Post-Traumatic Stress Disorder (PTSD) is as high as 15 percent among police officers. *(ncbi.nlm.nih.gov/pmc/articles/PMC6358175/)*
- Police officer suicides increased by 25 percent in just one year from 2018 to 2019. *(abcnews.go.com/Politics/record-number-us-police-officers-died-suicide-2019/story?id=68031484)*
- ABC News reported in July 2020 that the number of police officers killed surged 28 percent this year compared to the same period last year, raising questions of whether civil unrest is related to increased violence against police officers. *(abcnews.go.com/US/police-officers-killed-surge-28-year-point-civil/story?id=71773405)*

For more about policing issues, see the article in the 2020 SUMMER ISSUE of AMHCA's quarterly magazine, *The Advocate Magazine,* on "Police Violence, Racial Injustice, and Police Burnout After George Floyd's Death," pages 18–22, at *connections.amhca.org/publications/advocatemag*. These statistics were compiled by **Norman Hoffman, PhD, EdD, LMHC, LMFT, Ekom Essien, LPC, NCC, CFMHE, CPCS, RPT-S,** and **Aaron Norton, LMHC, LMFT, MCAP, CCMHC, CRC, CFMHE.**