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The nature and extent of police use of force in encounters with people with behavioral health disorders☆

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ABSTRACT

Previous research studies have examined the treatment of people with mental illnesses by the police. Much available data support the adoption of the Crisis Intervention Team (CIT) model. A key issue in CIT development has been reduction in the use of force by CIT officers, and it is suggested that such adoption does accomplish such reduction. However, to date, scant research compares variation in police use of force by CIT officers across populations with mental illnesses, co-occurring disorders, and substance abuse disorders, as compared to their non-disordered peers. Using data from the Portland Police Bureau, a police agency in which all patrol officers have been trained in the CIT model, we analyze whether police use-of-force differs across these groups. Police use-of-force data were collected for 4211 incidents from the Portland Police Bureau from 2008 to 2011. Results indicate that people perceived as having comorbid behavioral health disorders were generally more likely to have force used against them, and more likely to be perceived as resistant, than people that were perceived as having only substance use disorder, only mental health disorders, or no apparent behavioral health disorders. People with co-occurring disorders are more likely to be perceived as violently resisting police officers and have force used against them. Further, people with no perceived disorders are more likely to have a firearm pointed at them in use-of-force encounters, but also the least likely to be perceived as resisting.

1. Introduction

Researchers, practitioners and policy makers have long been concerned with the deaths and injuries of individuals with mental illnesses at the hands of the police (Engel & Silver, 2001; Teplin, 1984). While the police use of force in encounters with this population should be part of the national conversation on police tactics, it must be noted that only a small proportion of encounters between officers and citizens involve individuals with mental illnesses (Kesic, Thomas, & Ogloff, 2013; Deane, Steadman, Borum, Veysey, & Morrissey, 1999). These encounters seldom end in violence, as police use of force is relatively rare (Hickman, Piquero, & Garner, 2008). Further, research suggests that people with mental illnesses largely view their encounters with the police as procedurally just (Livingston et al., 2014). When force *is* used, it is usually in response to behaviors that include resisting officer requests, acting disrespectfully toward officers, attacking officers, possessing a weapon, or fleeing, but not symptoms of *mental illness* (Garner & Maxwell, 2002; Kesic et al., 2013; Engel & Silver, 2001).

Criminal justice research indicates that citizens with *co-occurring* mental illnesses and substance use disorders are more resistant and disrespectful to the police (Watson et al., 2010; Novak & Engel, 2005). Resistance is an important factor in these encounters. Officers may use more force against a person who is resistant in order to gain control, however, and in that way mental illness may indirectly influence the police decision to use force (Rojek, Alpert, & Smith, 2010). Crisis Intervention Teams are one method that police have used internationally to enhance outcomes, in particular with this population (Watson, Morabito, Draine, & Ottati, 2008; Helfgott, Hickman, & Labossiere, 2015). Recent research on use of force presents a nuanced and complicated picture of how and in what circumstances police—specifically CIT officers interact with people with mental illnesses and when they decide to use force (c.f. Schulenberg, 2016; Morabito & Socia, 2015).

2. Review of the literature

A conflicting picture exists detailing how people with mental illnesses interact with the police (Johnson, 2011; Kesic et al., 2013; Kerr, Morabito, & Watson, 2010). Kerr et al. (2010) examined the proportion of officer–subject encounters involving a person with mental illness in

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which an injury occurred in four districts in Chicago, Illinois. They found that in most encounters that required the use of force, physical resistance was the only significant predictor of the proportion of calls with injuries (Kerr et al., 2010). It is clear that resistance triggers the police use of force but the relationship between illegal drugs and alcohol and mental illness as well as their influence on resistant behavior are less clear. In fact, Johnson (2011) found that in police encounters, people with mental illnesses tend to resist more than people without diagnoses, and they are also frequently under the influence of illegal drugs and alcohol. Conversely, Kesic et al. (2013) suggest that people with mental illnesses who encountered the police were less likely to be under the influence of alcohol or to resist compared with those without signs of mental illness.

There are a number of explanations for these different findings. First, mental illness is not a static condition, and people with diagnoses are not symptomatic all of the time (Morabito & Wilson, 2015). Thus, a person could be "known" to the police as having a mental illness but be asymptomatic during an encounter and not be resistant. Another explanation is that it may be that drugs and alcohol are driving the police use of force rather than mental illness. Much of the research combines mental illness and substance abuse, rather than differentiating between different disorders (Kaminski, Digiovanni, & Downs, 2004). This makes it impossible to disentangle the effects of mental illness and drug use on the outcomes of police encounters based on the existing literature. In fact, we are aware of no study that compares use of force by CIT members of a police department in the management of incidents involving citizens who have co-occurring disorders, those who have only mental health or only substance use disorders, and those perceived as having no disorders in a department using Crisis Intervention Teams. This study provides such data.

2.1. Crisis intervention teams

The extent and quality of training provided to police officers with respect to managing encounters with persons with mental illnesses is an important variable affecting the outcomes of those encounters. Jurisdictions have developed various models for providing such training, the choice of which often depending on the nature of the locale and the resources available for training and staffing (Fisher & Grudzinskas, 2010; Helfgott et al., 2015; Wood, Swanson, Burris, & Gilbert, 2011). Over the last three decades one model in particular, the Crisis Intervention Team (CIT), has grown in popularity and has been adopted by police departments both national and internationally (Wood et al., 2011, Helfgott et al., 2015). CIT is now considered to be the most comprehensive model for managing episodes involving persons with mental illnesses, and has of become the most commonly adopted form of "pre-booking diversion."

CIT is a police-based approach in which a specialized cadre of officers receives extensive training in a wide range of responsive measures that enables them to better provide first-line response to people with mental illnesses (Watson et al., 2008; Dupont & Cochran, 2000). These officers are designated as the 'go-to' providers to go to incidents involving people who display symptoms of mental illness. CIT was developed in Memphis following the lethal shooting of a man with mental illness by a Memphis police officer. CIT officers are trained to recognize mental illness and provide linkage to available resources. When a CIT-trained officer responds to an incident involving a person with a mental illness, we might expect that fewer formal sanctions be employed. Rather, when there is no or minor illegal activity, police will employ other tools—such as de-escalation techniques—to resolve the situation. These techniques may be learned in officers' CIT training regimes.

One of the main goals of CIT is improve the outcomes of these interactions, specifically by reducing both the use of force and the subsequent injury to both police and citizens (Watson et al., 2008; Dupont & Cochran, 2000). More specifically, CIT training helps officers learn how to use de-escalation and negotiation tactics, transport the citizens to a designated emergency service provider, and/or refer them to suitable treatment (Watson et al., 2008; Dupont & Cochran, 2000).

While there is no definitive proof of the effectiveness of CIT, a vast literature has developed documenting the adoption and outcomes of CIT (c.f. Watson et al., 2008; Compton et al., 2014; Ellis, 2014). Some of the existing evidence suggests in fact that CIT training is related to police officers using less force on resistant citizens (Morabito et al., 2012) and that CIT-trained officers are more likely to report verbal engagement or negotiation as the highest level of force used (Compton et al., 2014). However, one problem is that CIT officers may not be available quickly enough to optimize response to mental health related incidents, as typically just 10% of a police department is trained (Watson et al., 2008). When that is the case, officers with less training and expertise are left to manage these cases. While there are states such as Ohio and Georgia that have elected to provide CIT training to departments across the state (Munetz, Morrison, Krake, Young, & Woody, 2006; Oliva & Compton, 2008), few departments have trained all officers. One exception to this is the Portland Police Bureau. This department has trained every police officer to respond to people with mental illnesses. Universal training is one way to avoid the problem of potentially not having a CIT trained police officer available to respond to calls for service involving people with mental illnesses.

2.2. The role of substance abuse

There is evidence to suggest that substance abuse may be related to the police use of force (Kaminski et al., 2004). For example, Morabito and Socia (2015) found that subjects are more likely to be injured when they are under the influence of alcohol or drugs, either alone or in combination with perceived mental illness, possibly because this can result in behavioral unpredictability. However, the exact relationship is somewhat unclear, with research suggesting that it is a combination of substance abuse related activity and hostile demeanor that result in the use of force during police encounters (Cordner, 2006; Kaminski et al., 2004; Terrill & Mastrofski, 2002). Indeed, the existing literature on drug impairment and force cites mixed results. Some evidence suggests that when a citizen is under the influence of drugs and alcohol, it does affect the outcomes of a police encounter (see Garner, Maxwell, & Heraux, 2002; Kaminski et al., 2004), whereas other studies find no relationship between alcohol use and force (Alpert & Dunham, 1999).

It is notable that most of the existing research focuses on outcomes of encounters where the citizen is under the influence of alcohol (a legal drug), combined with illicit 'street' drugs (see Engel, Sobol, & Worden, 2000; Garner et al., 2002)—without noting the presence of a mental illness. These distinctions are particularly relevant not only because mental illness and substance abuse are commonly co-occurring disorders (Abram, 1990), but also because without this distinction, it is impossible to provide guidance to police departments seeking to train officers in effective methods of responding to such encounters.

2.3. Police use of force data

Despite the interest in this issue and CIT, it has been difficult to measure police use of force in encounters with people with mental illness for two major reasons. First, the use of force generally is a relatively rare occurrence in police encounters with the public (e.g., Durose & Langton, 2013; Hickman et al., 2008). Force is not used in the vast majority of encounters with the police, and when force is used, it is generally at the lower end of the spectrum (Durose & Langton, 2013); therefore, it may not trigger formal documentation for every agency. This is not to say that knowledge of informal resolution lacks value. Knowing that police encounters with people with mental illnesses end without formal resolution also informs our understanding of these interactions. Police officers have limited discretion when responding to crimes of violence or violent individuals (Morabito, 2007). This means that for an incident to end informally, it likely does not involve violent

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