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DISCUSSION AND REVIEW PAPER

On the Uncanny Similarities Between Police Brutality and Client Mistreatment

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Abstract

Direct-care staff are responsible for carrying out behavior-analytic services in a culture that perpetuates systemic racism and other problematic systems that can lead to the mistreatment of clients. Limited data exist on factors that influence the mistreatment of clients, so behavior analysts must look to better studied comparison contexts as a way to identify risk factors. Police brutality is one context where problematic systems are apparent. Therefore, examining variables known to affect police brutality offers one way to identify aspects of direct-care staff's implementation of behavior-analytic treatment that may harbor similar systems. The purpose of this article is to examine variables associated with police brutality as risk factors for the mistreatment of clients in direct-care settings. The primary risk factors discussed include racial bias, the warrior mentality, a lack of transparency and accountability, and ineffective intervention. This article concludes that the field of behavior analysis needs sensitive data collection methods and systematic evaluation of risk factors to better protect clients from mistreatment.

Keywords Diversity · Mistreatment · Direct-care staff · Racism · Police brutality · Warrior mentality

On April 29, 2020, authorities responded to an alleged incident involving a 16-year-old African American boy named Cornelius Fredericks (Romine & Sturla, 2020). Reports stated that Cornelius had thrown part of a sandwich at someone with whom he shared a residence. In response to the alleged incident, authorities confronted Cornelius, which apparently provoked further food throwing from the teenager. When Cornelius began throwing food the second time, one of the authorities pushed him with two hands, which caused the teenager to fall onto the ground. At that time, at least three responders proceeded to use "significantly disproportionate" restraining techniques on Cornelius (Romine & Sturla, 2020). While at least three adults were restraining the teenager, he repeatedly cried out, "I can't breathe" (Romo, 2020). Despite Cornelius's cries for help, the restraints continued for approximately 12 min until he became unresponsive. The authorities then failed to provide cardiopulmonary resuscitation and delayed calling medical assistance for an additional 12 min. As a result, Cornelius suffered "restraint asphyxia," which led to a fatal heart attack 30 hr later (Romo, 2020).

This heartbreaking and disturbing story replays itself far too often. Whether it be with George Floyd, Elijah McClain, or others (see Wedell et al., 2020), authorities have repeatedly escalated situations, used inappropriate restraints, and ignored pleas for help, leading to death. What sets Cornelius's story apart from this group is that he died at the hands of *direct-care staff* in a state-licensed residential treatment program (Romine & Sturla, 2020). The "authorities" who responded to the alleged sandwich-throwing incident were not the police; they

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—Denisha Gingles, Guest Editor

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were trained youth counselors employed to protect and provide therapeutic services to Cornelius (Romine & Sturla, 2020).

The treatment facility that Cornelius resided in, Lakeside Academy, in Kalamazoo, Michigan, is a program for 12- to 18-year-olds placed in foster care (Romine & Sturla, 2020). According to the facility's website, the program "helps the student focus, first, on their present behaviors, then on the underlying motivation or precursors to such behaviors" (Lakeside Academy, 2009). The adolescents who were eligible to receive services were those with a history that included issues such as aggression, a low degree of empathy, noncompliance, and poor coping skills.

No behavior analysts appear to have been employed at Lakeside Academy, and the program did not claim to be behavior analytic. However, the scope and focus of Lakeside Academy will not be unfamiliar to many behavior analysts. Similar to Lakeside, behavior analysts work with a wide range of clients beyond those with autism spectrum disorder and developmental disabilities (Slocum et al., 2014) and often depend on direct-care staff to implement treatment programs and interventions (Parsons et al., 2012; Parsons & Reid, 1993). Therefore, the killing of Cornelius Fredericks must be acknowledged as relevant to the work that behavior analysts do because many likely work in settings like that which served Cornelius.

The systems that enable police brutality are not isolated to police interactions (Alang, 2018). Instead, police interactions are considered a microcosm of systemic racism and other nefarious systems (Subica, 2018). Cornelius's story illuminates uncanny similarities between police brutality and the mistreatment of clients by direct-care staff. That is not to say that the mistreatment of clients by direct-care staff is even remotely as problematic or deadly as police brutality. Rather, it is merely acknowledging that direct-care work is not immune to the systemic issues that permeate all aspects of the culture and that those issues can affect care. Thus, because behavior analysts are responsible for supervising and supporting direct-care staff who carry out behavior-analytic treatments (Macurik et al., 2008), they must critically evaluate systemic issues that can lead to mistreatment, abuse, and violations of their clients' welfare. By identifying and acknowledging these risk factors, behavior analysts can better protect and serve their clients, support direct-care staff, and develop interventions to ensure that what happened to Cornelius Fredericks never happens to their clients.

The purpose of this article is to examine variables associated with police brutality that are risk factors for the mistreatment of clients by direct-care staff. To that end, four issues are emphasized, along with considerations for preventing and remedying each. Following a review of each risk factor, a discussion summarizes the issues, recommendations, and future directions.

Two important caveats must be acknowledged before discussing risk factors for mistreatment. The first caveat is that disparaging or ridiculing direct-care staff or their role is not the aim of this article. Direct-care staff are an underappreciated yet vital aspect of effective behavior-analytic services (Reid et al., 2012). As previously stated, the goal of the article is to critically examine and acknowledge *systems* associated with police brutality that can be found across all environments. Direct-care arrangements are no exception and, thus, must be evaluated. For the purposes of this article, we refer to direct-care arrangements broadly, which would include residential programs, in-patient or out-patient treatment, school, and center-based programs. The second caveat to this article is that the issues discussed are not well reported or studied. Risk factors that can lead to mistreatment are inherently opaque and difficult to measure, similar to police brutality (see Knox et al., 2019). Therefore, the content of this article, admittedly, goes beyond existing data with the hope to inspire measurement, evaluation, and consideration of essential variables yet to be consistently examined in behavior analysis.

Risk Factors for Client Mistreatment

Each risk factor discussed in this section does not necessarily operate in isolation to cause mistreatment of clients. Instead, all of the variables discussed are more likely to interact in combination to create toxic amalgamations that increase the likelihood of client mistreatment and abuse. Therefore, each variable should be examined and considered separately for a complete understanding, but with the qualification that no single factor necessarily causes mistreatment.

Racial Bias

Racial bias is a commonly discussed variable associated with police brutality (Goff & Kahn, 2012) and is widely acknowledged to impact all aspects of society (Amodio & Mendoza, 2010; Carter et al., 2017; Gilliam et al., 2016). Therefore, racial bias must be acknowledged as a potential issue in direct-care interactions. Like all of the risk factors discussed in this article, little to no data exist on racial bias in applied behavior analysis settings (Arhin & Thyer, 2004; Matsuda et al., 2020). This lack of data may be due to difficulties defining or conceptualizing bias (Amodio & Mendoza, 2010; Carter et al., 2017; Gilliam et al., 2016) or an aversion to the discussion of racial biases (Howell et al., 2015; Sukhera et al., 2018). However, using a behavioral perspective to define bias as something that people do rather than something that people possess enables empirical evaluation of the subject (De Houwer, 2019). This article uses De Houwer's (2019) definition of racial bias, which is "behavior that is influenced

in an implicit manner by cues that function as an indicator of the social group to which others belong" (p. 835).

Several variables may exacerbate racial bias in direct-care interactions. These variables are often related to the contextual control produced by racist policies (Matsuda et al., 2020). Racist policies used in this context refer to any arrangement that produces racial inequity (Kendi, 2019). The first variable that may produce more racial bias is the settings where direct-care staff are employed. Many applied settings are likely to have a history of implementing racist policies and practices, either actively or tacitly. For instance, an extensive research base has repeatedly identified racial disparities in disciplinary practices administered in public schools (Office for Civil Rights, 2014; Sugai et al., 2012). Specifically, Black students receive disciplinary actions at more than three times the rate of their K–12 White peers (Gilliam, 2006; Office for Civil Rights, 2014). When Black students are targeted more frequently for disciplinary actions, they are at risk for missing more instruction, contacting more aversive contingencies, being placed in more restrictive settings, and being placed in an adversarial role against direct-care staff and other personnel tasked with carrying out the discipline.

A second variable related to racial bias pertains to the generalizability of research completed with primarily White participants. Research evaluating special education evidence-based practice (EBP) found that demographic variables (i.e., race, ethnicity, nationality, or socioeconomic status) were commonly unreported in published research on the topic (Brodhead et al., 2014; Li et al., 2017; West et al., 2016). For the studies that reported demographic variables, it was evident that the vast majority of the participants were White. When marginalized groups are left out of or not identified in research evaluating and establishing EBPs, important cultural and idiosyncratic variables are likely missed, which reduces the generalizability of the findings to those populations.

A third risk factor related to racial bias is a lack of diversity among the direct-care workforce. Although no data are available to determine the extent of the issue for direct-care staff specifically, data reported by the Behavior Analyst Certification Board (BACB) indicate that 71.82% of Board Certified Behavior Analysts and doctoral-level Board Certified Behavior Analysts are White, whereas only 3.6% are Black (Behavior Analyst Certification Board, 2021). Workforces that are homogeneous and fail to reflect the clients they serve will produce many issues, including missing or misunderstanding critical cultural variables (Madkins, 2011). The missing and misunderstanding of cultural variables can further diminish the relationship between clients and the staff that serve them (Eddy & Easton-Brooks, 2011).

The risk factors listed previously related to racial bias and racist systems are not an exhaustive list of the many likely present in direct-care settings. Many racial biases and racist systems exist and must be examined. However, a full treatise on this topic is beyond the scope of this article. The three risk factors discussed were examples used to illuminate the importance of considering racial bias and racist systems in direct-care settings to help prevent client mistreatment. If direct-care staff are serving clients in a context that supports or enables racial biases, they will likely be affected by and participate in that culture.

The field of behavior analysis must recognize and adapt to the increasing diversity of individuals seeking behavior-analytic services (Conners et al., 2019). Thus, ignoring culturally relevant variables in practice or training is setting up treatment to fail (Ala'i, 2019; Conners et al., 2019; Zarcone et al., 2019). Therefore, behavior analysts must support both direct-care staff and their clients by creating and supporting antiracist policies that will counteract systems that support racial biases. By removing the contextual control that racist policies create, racial biases may decrease (Matsuda et al., 2020) and be more easily identified and targeted for intervention.

Warrior Mentality

The term *warrior mentality* is derived from the concept of the warrior cop (Stephens, 2020). A warrior cop is a police officer who relishes the dangerous aspects of their job and adopts the mentality of a warrior by embracing and glorifying physical altercations. Although this issue with policing is less commonly talked about, it is nevertheless an issue that contributes to police brutality (Balko, 2013; Gross, 2020). Whether the issue of the warrior mentality is due to motivating operations, rule-governed behavior, or some other complex variable, it seems apparent that someone who holds physical altercations in high regard will likely find their way to one.

Risk factors associated with the warrior mentality include attaching special status to individuals who have experienced physical altercations and the use of excessive/aggressive gear (Balko, 2013). In policing, special status is on display in the use of terms to describe officers who have experienced physical altercations (e.g., vets or veterans) versus those who have not (e.g., rookies, or the more condescending "pups"; Balko, 2013). Excessive and aggressive gear is on display in the progressive militarization of the police force (Bauer, 2014).

In direct-care work, specific terminology to describe experience with physical altercations may be less common, but status differences do exist. In programs that treat clients who target staff with physical aggression, status indicators can be observed through at least three outcomes:

- assignment of favorable clients or tasks after physical altercations. This may take the form of assigning direct-care staff to interesting or favored clients.
- increased social attention and recognition from peers and supervisors. This may take the form of praise for enduring physical aggression from a client. In some cases, this may

even be obtained through social media when direct-care staff post statuses or photos displaying injuries acquired on the job.
- assignment of a reduced workload in the form of paid leave or alternative work assignments when one has been involved in physical altercations.

The use of excessive gear is also less common among direct-care staff, but it is not unfounded. For example, direct-care staff working with nonaggressive children may wear arm pads and other bite-resistant gear because they have needed it with other clients in the past. Like excessive police gear, excessive protective gear can be rationalized by the need to protect the worker (Balko, 2013; Gross, 2020). Although the need to protect the worker is valid, it can be overused and problematic. Issues can derive from several factors related to excessive gear, including behavior change of the direct-care staff themselves when they wear unnecessary gear (Zimbardo, 2004) and the stigmatization of clients who must work with overly guarded staff.

Factors that contribute to establishing and maintaining a warrior mentality in direct-care staff are not inherently problematic if well controlled. In fact, many of the risk factors of the warrior mentality can be functional and help lead to better client services in some situations. However, despite good intentions, these practices can be warped and harmful. For example, providing paid time off to direct-care staff who have been injured by a client is a necessary condition for protecting the staff's health and safety. Still, providing time off can also unintentionally incentivize behaviors that lead to physical altercations with clients. Therefore, programs that involve any of these practices should establish policies that account for risk factors and prevent the development of a warrior mentality.

Lack of Transparency and Accountability

Reforms aimed at addressing police brutality occur predominantly only after high-profile cases garner attention from the news or social media (Human Rights Watch, n.d.). In part, this is due to the limited information shared with the public and the lack of leverage afforded to groups tasked with monitoring interactions (Human Rights Watch, n.d.; Morton, 2018). Efforts to improve transparency and accountability are a necessary step toward preventing police brutality even though they are often opposed by police (Morton, 2018). For example, body cameras are meant to accomplish undiluted transparency of police interactions but are often subverted by police selectively using them to show the ideal police interaction (Taylor, 2016). When body cameras are used properly, objective evaluation of interactions is possible. However, when body cameras are only used selectively, transparency and accountability are diminished, and issues are more likely to continue.

Behavior-analytic programs often have several measures in place to establish transparency and accountability. For instance, individualized education program goals are intended to improve accountability for treatment monitoring and progress (U.S. Department of Education, 2004; Jung, 2007). Additionally, various state laws, BACB ethical policies, and organization policies require extensive documentation of services and treatment progress. Nevertheless, transparency and accountability are still risk factors for the mistreatment of clients by direct-care staff and something that must be targeted for improvement.

Therapy and service observation by outsiders (e.g., guardians or other service providers) is a helpful strategy for improving transparency and accountability by candidly demonstrating services and allowing feedback from stakeholders. However, some organizations might prepare direct-care staff before visitors arrive at the program. By alerting direct-care staff of visitors, organizations are knowingly or unknowingly affecting the behavior of that staff. Most organizations that forewarn staff about visitors are not likely doing so to cover up mistreatment but rather to ensure that everything is impeccable during visits. Nevertheless, disparities between a genuinely transparent and representative observation and a contrived observation are created when staff are prepared for visits. By occasioning, supporting, or encouraging less than genuinely representative samples of work, a program is actively diminishing their transparency and accountability in the same way that police selectively use body-camera footage.

Truly embracing transparency and accountability is a vulnerable act because it exposes organizations to critical feedback. However, that vulnerability is essential to providing the best services possible and reducing the likelihood of client mistreatment. Therefore, efforts should be made in every program to ensure that all aspects of treatment be transparent and accountable. Seeking reviews or consultation from stakeholders or independent review committees and continuously engaging in open conversations with staff and consumers are simple ways to improve transparency and accountability.

Ineffective Intervention

Effective strategies aimed at de-escalating situations while forbidding dangerous techniques such as the use of choke holds are another essential aspect of preventing police brutality (McKesson et al., 2016; Peeples, 2020). Although effective strategies for policing are quite different from effective strategies for direct-care staff, the premise that effective strategies prevent mistreatment and abuse holds. This is why de-escalation trainings are necessary for direct-care staff working in many settings. Additionally, this is why popular de-escalation trainings for direct-care staff, such as Safety-Care and the Mandt System, advocate for the proactive use of positive behavior interventions and supports and other effective

strategies (The Mandt System, n.d.; QBS, n.d.). Had the direct-care staff who worked with Cornelius Fredericks used appropriate proactive strategies, Cornelius may have never thrown food in the first place. Or, had the direct-care staff effectively intervened, Cornelius may not have escalated and thrown food a second time. Finally, had the direct-care staff used effective de-escalation strategies with Cornelius, they may not have used procedures that caused his death. Therefore, behavior analysts need to prepare direct-care staff with effective interventions to remediate risk factors brought on by ineffective procedures.

Discussion

The systemic issues that lead to police brutality are not isolated to that context alone. The factors that led to the killings of George Floyd, Breonna Taylor, Elijah McClain, and so many other victims of police brutality can be recognized in the killing of Cornelius Fredericks by direct-care staff. Therefore, it is important that behavior analysts not only serve the community at large by contributing to the ending of police brutality but also look closer to home and evaluate whether their practices harbor systems that put their clients at risk for mistreatment.

The purpose of this article was to examine variables associated with police brutality that are risk factors for direct-care mistreatment of clients. To that end, four risk factors were identified and summarized: racial bias, the warrior mentality, a lack of transparency and accountability, and ineffective interventions. Each risk factor discussed should be considered individually, although combinations of the risk factors likely exponentially increase the likelihood of mistreatment. For example, direct-care staff who work in programs with institutionalized racial biases, who have developed warrior mentalities, who are not held accountable because of a lack of transparency, and who are not given effective interventions to implement are at serious risk of committing client mistreatment. Even less inclusive combinations of factors still present an elevated risk of mistreatment.

The impact of the risk factors on individual staff is likely to vary, but it is important to remember the famous quote "A bad system will beat a good person every time" (Deming, 1993). Direct-care staff with the best of intentions, at no fault of their own, are susceptible to risk factors related to mistreatment due to the systematically created contingencies within their work environments. Therefore, it is the responsibility of behavior analysts to address and remedy risk factors for client mistreatment.

This article conceptualizes risk factors for client mistreatment by examining issues known to affect police brutality, but the empirical basis is limited, so important risk factors may have been missed. Acknowledgment of risk factors associated with mistreatment is important, but to move the field forward, behavior analysts must begin to collect data and study these issues. Once the field begins to take data on these variables, better interventions and systems can be created and supported. By analyzing systems that can lead to mistreatment, behavior analysts will better protect their clients from mistreatment and prevent tragedies like that which befell Cornelius Fredericks from occurring in behavior-analytic programs.

Declarations

Conflict of interest We have no known conflicts of interest to disclose.

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