C O R R E C T E D V E R S I O N

LAW REFORM COMMITTEE

Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers

Melbourne — 30 April 2012

Members

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Commander A. Dickinson, Operations and Coordination Department, Victoria Police.

The CHAIR — Welcome, Commander.

Cmdr DICKINSON — Ashley.

The CHAIR — Ashley, my name is Clem Newton-Brown. I am the chair of the Law Reform Committee. This is one of several committees that Parliament sets up which have people from both sides of politics on them. We are given inquiries to undertake and then to recommend legislative change at the end of our inquiries. Thank you for your contribution. We record all your evidence, and you are given a transcript at the end of the hearing, within a week or so. If there are any mistakes or changes, they can be rectified. Anything you say in this room is covered by parliamentary privilege. Could you start by giving us your name, your professional address and who you represent, and then launch into your submission?

Cmdr DICKINSON — I am Commander Ashley Dickinson from Victoria Police, and I am currently the Community Engagement Adviser to the Chief Commissioner's Office. The submission that Victoria Police was making, if that is what the right term is, was in respect of three questions that were posed to us, and that is the basis of the response I have had put together on my behalf. Is that the format that you want me to deliver this information in?

The CHAIR — Yes, just speaking to the gist of your submission rather than reading your submission is more helpful.

Cmdr DICKINSON — Okay. The first question posed to us was how Victoria Police raises disability awareness amongst new and existing police officers. There is a whole series of those. I will give you the bones. You can pick over them if you want to, and I will try to elaborate, should you want more detail.

Obviously we do it through the training — we do a lot of work around that. There is the instruction we give our members through policy. There is an additional body of information that members receive. There are service responses, which is the creation and promotion of options and referrals, that members are provided with. That often comes from various people, including many organisations and community groups outside the force. We have an information hub where we centralise a lot of key information around working with people with a disability, and we have a network of liaison officers across the state. There are about 110 of those who provide information. They would also provide a lot of guidance to members at a local level in particular. There is effectively a kind of hierarchy of knowledge in the organisation.

That was the basis of the response in relation to the first question. I do not know whether you want me to continue with the other questions or whether you pick over that one first.

The CHAIR — On average, how often would someone who is on the street as an officer come across people with mental disability?

Cmdr DICKINSON — I could not give you a specific time or a frequency in terms of days, but there are a number of pieces of information that build a little bit of the background for us. One is the traditional 1 in 5 figure, which is what we would say would be the interaction within the normal community. In the case of police officers, though, that figure is obviously much higher. We have not done, to my knowledge, any specific work around what that number is, and it will vary a lot by location and circumstance. But bearing in mind that most of our interactions are triggered by response, and, apart from traditional crime, a lot of antisocial behaviour or behaviour that attracts people's attention will often be by people who suffer some form of mental illness or intellectual disability. So the frequency is quite high. We know also that in ourselves the frequency of people who present with multiple issues — and often one of those issues will be a mental health issue, not always but quite often — is very high. It ranges to 70 per cent-plus.

Mrs PETROVICH — Seventy?

Cmdr DICKINSON — Seventy-plus. That can be a whole mixture of things. The reason they are there, of course, may not be because of a mental illness or unwellness that could trigger that, but that is often part of their make-up, I guess, as well. The presentation of people and the interaction we have with people who fit into the category you are looking at is significantly higher than in other places, and often people who are suffering in that way trigger concern by other people in the community, and that is what prompts the calls. That is how that

kind of comes about, but it is very high. Not all of them result in an arrest; a lot of them are quite harmless and insignificant types of contact. Nevertheless, they are often just triggered by the state of their mental health.

The CHAIR — Is there an issue with police being unaware that they are dealing with someone with a mental illness, rather than somebody who is drug affected or alcohol affected?

Cmdr DICKINSON — I am not sure exactly what you mean. For members?

The CHAIR — Well, some of the people who have made an appearance have suggested that their sons or daughters have been drawn to the attention of the police because of the way they act or behave, and getting that information across to the investigating officer can sometimes be difficult because the nature of the illness is that they cannot explain themselves properly. Is that an issue?

Cmdr DICKINSON — I think the short answer is probably yes, but having said that, we have a raft of things that are going on within the force that are really trying to address a lot of the issues. The distinction between a person with a mental illness and a person who is drug affected often is a matter for a clinician or a practitioner, much more so than for a police officer.

What I can tell you is that with some of the studies that have been done with Forensicare and with other people one of the things they found was that in 7 out of 10 cases when police officers took somebody to a hospital because they perceived that they had a mental illness or an intellectual disability, they were right. Whatever it is — and maybe that is the standard for the normal community; I do not know — it suggests that in most cases members get that piece of work right. But we do not train our members to be clinicians or practitioners — that is clearly not our role — but we want them to be aware if somebody is behaving, in a sense, abnormally or in a way that would attract attention and concern for other people. As I said, that same presentation can be made by a person who is drug affected as it can be by a person with a mental illness. Of course many mental illnesses, and this is me being a quasi-whatever, are actually triggering that sort of behaviour particularly in our younger people because of the type of behaviours they practise with drugs and other things.

Mrs PETROVICH — So in many cases your officers would not be trained in specifically identifying those issues that would perhaps be drawing those people to the attention of the police. But I suppose the school of hard knocks or perhaps working with the community — —

Cmdr DICKINSON — That is certainly part of it, but there are courses within the force that do actually, I guess, alert them. I am always a little bit cautious about when you say somebody is trained in mental health because we are actually not.

Mrs PETROVICH — It is a big field.

Cmdr DICKINSON — But what we do is provide a lot of information to our members over a whole series of steps at various times through their career so that hopefully they will become more aware. So when a person starts to talk or behave in a specific way our members might say, 'Look, this is a bit dubious. What's going on here? There is something going on. I don't think this person's hooked on it' or whatever — however you want to describe it. I guess you try to ingrain that so the members are initially alert to that sort of situation because obviously you cannot necessarily tell. Many people in the community have got various degrees of mental illness and lead perfectly normal lives; in fact most probably do.

The CHAIR — So what is the protocol then if police are picking up somebody who they suspect has a mental illness? They have picked them up and obviously they have committed a crime, but then they pick up the fact that maybe there is a mental illness. Do the people go through the process of being interviewed and charged and everything and then go to a hospital, or do they go straight to a hospital? What is the process?

Cmdr DICKINSON — It depends, really, on the state of their mental health. If a person is so unwell or it appears that they are not cognisant of what is going on, then we have powers under the Mental Health Act, which you would be well aware of, with which we can take people directly to a hospital and have them assessed in some form or another and possibly admitted to an institution or whatever. Alternatively, if a person is of a disposition that they are still quite comfortable in terms of conversation and seem to have some level of understanding, we have methodologies and processes in place to interview those people and potentially charge

them or treat them as witnesses or victims or whatever they may be. That is done primarily at the police station, where we would use an ITP, an independent third person, through the Office of the Public Advocate.

That person would then facilitate the communication and may or may not give advice on whether or not the person is unfit. If we think the person is unfit to be interviewed, then we have a capacity to contact the forensic medical officer and that person, who is a practitioner, will come and assess the person and say, 'Yes, they are fit for interview' or 'No, they are not' and, depending on what the outcome is, that will determine the next course of action. So it rarely is a catch-all answer, but it depends very much on the nature of the person's behaviour and their general condition at the time and how it unfolds. Some people can deteriorate quite badly once they are in custody. You have to deal with that accordingly. There is also the fact that having a mental illness is not a licence to commit crime. Unfortunately our prisons are full of people like that, and that is where the dichotomy comes in. Where a person sits on that continuum determines how conscious they are of their behaviour in terms of their guilt with which they commit their crimes and whether they have the capacity for guilt or otherwise and things of that nature.

Mrs PETROVICH — Just on that point, we actually heard from the previous submission about charges being withdrawn through the process because the person was not viewed as having a serious issue with their health and was not put through that other process. Do you think justice is really being served in many of those cases because of lack of assessment?

Cmdr DICKINSON — I think that is absolutely an issue. It is a very substantial issue, I am sure. There are many people who take the opportunity to push themselves into a category where they might think they are going to get better treatment. This is obviously something that people have done since the court system started. It is a bit of a vexed question, but I think it is absolutely incumbent on the judiciary and those involved in the legal process to have a clear view of the mental capacity of the person in the case of an alleged offender.

Mrs PETROVICH — At the moment they do not seem to. There does not seem to be that process.

Cmdr DICKINSON — Some seem not to. I think there is a capacity to slide through the system, depending on who represents you, the seriousness of the crime, the attitude of the magistrate and the attitude of the police. All sorts of things come into play, and people want to say, 'Well, I'll plead guilty and get it over and done with' and walk out and pretty much everybody else is happy.

The other part of the equation that is absolutely critical, in my view, is the position of the victim. In some cases that is overlooked. I understand that you sometimes have a kind of tension in the legal system where you have a person who is alleged to have committed an offence and a victim who feels quite aggrieved in some cases that they have been made a victim. Somewhere in the middle someone is making a determination that is going to lead to unhappiness on one part.

Mrs PETROVICH — Okay, thank you.

Mr NORTHE — Ashley, in terms of the police systems and databases, if, for example, you picked up a person who had committed a crime and they had an intellectual disability, on your systems would you be able to identify if that person had been before you before and had some form of impairment?

Cmdr DICKINSON — If they had been involved with us before and we were aware of that, we would have that recorded. We have a three-part process. We do not have access to mental health records per se. Unless you have had contact with us we do not know anything about you at all, including whether you have been institutionalised or whatever. However, if you have come into contact with the police and we have had some form of interaction in some way or another and if we also have some knowledge that you have an intellectual disability, we will generally have recorded that information. We would say that is information we have obtained through our investigative process, so we keep it.

We have also created a facility quite recently whereby people who have a mental illness are able to actually volunteer that information. That came about because we had some consumer groups come to us and say, 'We are worried about Peter, our client. He has been in custody for a long time, and he has been let out now. We are frightened that if something goes wrong, if the neighbours ring up, the police will rush around there and all hell will break loose, and this bloke will end up dead on the footpath'. We say we can record that if you want us to do that. So we do that, and it is completely voluntary, and again they can put that information with us and we

will put it on our system, and it will be their information but we will use it and they can take it off the system up to the point where we use it, and then we use the knowledge and we would say that it is our information.

I do not know what the frequency of the uptake of that was but I know that some people have done it. It becomes particularly relevant in a series of circumstances, I guess particularly with an ageing population — a lot of people with dementia, Alzheimer's and all sorts of other things. We have people ringing up, and not only elderly but young people as well — schizophrenics or parents of schizophrenics — and they say, 'We are worried about our son. He is going to wander off and what will happen?'.

Already we have seen instances where people go hundreds of kilometres and suddenly they turn up somewhere else with no history, nobody really knows them and you do not know much about this character or this person and you wonder what it is, what is going on. So they say, 'We're happy to give you the information' even though they might not like the concept of a police record per se, but it can actually be quite useful; so it is potentially a very positive aspect.

Mr NORTHE — For you guys as well.

Cmdr DICKINSON — Well, it is. I am guessing that our Chief Commissioner would not want me to be advocating for a whole lot more work in that sense, but I thought when it came up and we started to do it, it was actually very good because a lot of perception around that sort of information is very negative. However, because we are one of the very few 24/7 response agencies, it made perfect sense to me. What you are looking for is a better outcome for everybody. There is no mileage in it for us for any reason other than that.

Mr NORTHE — We have heard evidence from others in previous meetings whereby the notion of somebody with an intellectual disability registering or having an identification card was not only beneficial for that particular person but for the police to identify them, and it would be fair to say, without speaking out of school, that some groups have some issue with that being compulsory — that notion — but if you could maybe have a voluntary register for all those types of afflictions, if you like, it may be better for all.

Cmdr DICKINSON — Yes. We are well aware of the stigma that people say is attached to it, and we respect that completely, but you see the desperate attitude of these people when they are looking for one of their loved ones in one form or another, and it is pretty desperate stuff.

Ms GARRETT — We have had a lot of evidence before in this inquiry, and I think it is fair to say that particularly some of the parents have had some terrific experiences with the local police. We had one in particular whose son has an intellectual disability compounded with Asperger's et cetera, whose son's manifestation of behaviour is to wander and steal, and the police have been absolutely critical in assisting that family to respond to these situations and also highlighting that the very interactions can sometimes trigger more extreme reactions — from the individual being in a room and so on. But we have also had evidence that people's interaction with the police has been less than helpful and all of those other factors. Do you feel that with some of this training and so on you are trying to move towards a more even standard across the board? Or how do you get best practice out of that region to another region?

Cmdr DICKINSON — That is a really good question. Just a little bit of background: I have been involved with, for instance, the ITP program for nearly 20 years, which is way too long in many respects. When I started as the liaison officer between the police and OPA I would get anything from three or four to a dozen calls a week about people trying to understand what this was about. Now I do not get any, and I attribute that to just that slow burn of knowledge across the state. Members start to realise that using an ITP is not a negative thing, it can be a positive thing, because you get the best evidence, and I think the same is applying with the mental health issues more generally.

We have to start trying to educate members' broad base. We are starting to do that and we have done that already with the mental health first aid. We have nearly 1500 members who have been trained in the mental health first aid, which is a very highly regarded course. That is many more than other jurisdictions and things of that nature. We have not been able to train everybody and we probably won't, but we do train all members through the office of training — they get 4 hours now, as a unit, in mental health — and everybody does that twice a year, so that they will all go through some aspect of training as well as other things.

But what you see sometimes at the heart of your question is the fact that many consumers of mental health will group together around services, and we have not got an even distribution of services across the state, and consequently you do not have the same issues across the state because of that. Most will be in the metropolitan area, which is what we want generally to happen, and many of those will be isolated into half a dozen or a dozen areas. And the same thing happens to our members. Because they then do not use those services and they do not see those people, they do not pick up on a lot of stuff, and that is why you get some dissonance between them.

You go to some more remote places — and I have been to places and I say, 'Have you ever used an ITP?'. And they say, 'A what?'. They have never even heard of it and they would never have used one; they would have nobody in the town who would require it, or if they do, they do not come to our attention. So you have places like that as well. So you have a very uneven distribution, and really the body of the work is focused in the metropolitan area. We try to train all our members the same but it is really absorption and all sorts of other things like that as well.

The CHAIR — Do you have more to go?

Cmdr DICKINSON — Yes. Our second question — we have probably covered most of it anyway. The use of support services once a person has been identified — I think we spoke a good deal about that, and certainly we train our people around the OPA stuff and also things like sexual assault and the difficulties that people have often being credible, I guess in a sense, when you are a victim of mental health and a victim of a sexual assault and things like that. They are horrible situations for anybody but compounded more by people with some form of mental illness.

The use of LEAP — we have spoken a bit about that. The third question is the coordination between the disability sector and Victoria Police in managing responses. This comes back a little bit to your question, Jane, about the various levels. We have, at a local level, liaison between local police and disability services in the local area, and we actually find that the level of those local services — not the police service but the health service — will really dictate the level of interaction. We found when we started doing some a few years ago and said to people, 'Why don't you go down to the hospital?', everybody was saying, 'The van is tied up for hours et cetera, so why don't you go down and tell them that this is a problem?'. Having a mental patient in the back of a police van or sitting in a hospital waiting area with 40 other people is not necessarily a really good idea for anybody.

So they have developed many local initiatives around protocols, phone calls and relatively simple things that can streamline that sort of process as well. They have also developed forms where we can fill out a lot of information and forward it ahead, effectively, so that they know we are coming with a person, and this comes back to the point I made earlier about getting it right most times — that practitioners know that when we come with somebody and say they are mentally unwell, we are probably going to get that part of it right, so they are ready to receive it.

We have tried a number of processes at various divisional levels. There were two in particular that I had to write down: PACER, which is Police, Ambulance and Crisis assessment team Early Response; and PACT, which is the Police And Community Triage for people who are intercepted by members, and who might have a mental illness. Both of those were out in the eastern suburbs. The PACER trial went for a good deal of time, and the PACT process is still running, to some degree.

Whilst I think the overall outcome was that they were very good, they are very difficult for us to manage in the sense of the utilisation of your resources. They are quite labour intensive, and also for other agencies as well — and I am certainly not speaking on their behalf — but when you have a very disjointed demand for service, it is very hard to have dedicated resources because people say, 'Why aren't you helping us?' and we say, 'We are waiting for the next mental patient to come through the door' and that might be two days from now. It is a difficult process when you do it, because there is no flat line of service, the demand effect. It just challenges a little bit.

At a statewide level we have a number of significant liaison committees with DHS. We meet with them regularly; we have an IDLC with them. As part of our mental health project a couple of years ago, or more than that now, we started what we call an expert advisory group with members from the Coroners Court, DHS, some

consumer groups and other people — Orygen and people like that — that sit with us on a fairly regular basis and provide us with a lot of information and also a lot of advice about where we should be taking some of these issues and what we should be doing. That has been an incredibly valuable process in terms of, apart from anything else, basically legitimising what we are doing, which has been very useful as well. So there you go.

You would have figured out by now that I can probably talk underwater, so if you want me to keep going — —

The CHAIR — All right. Thank you very much for coming. It has been really helpful.

Mr NORTHE — I was going to ask: just in terms of the process or procedure of what you do in dealing with people with intellectual disability or otherwise, is there anything you can suggest to the committee that we can make recommendations on at the end of the day? That is what we are here to do.

Cmdr DICKINSON — I guess the strongest piece of assistance we can get, if I can put it that way, is just at the level of cooperation that we sometimes seek in periods of high demand — for instance, when people run out of CAT teams and things like that. Again, you get to that position where you do not know what the demand is for service. I have been reminded by my colleagues at DHS that CAT teams are not necessarily emergency; they are for other reasons. The problem, I guess, you are left with when the police are called to an emergency situation and somebody has a mental illness of some description is that you are kind of crossing the border between a criminal matter and a health issue. That is the real tension, and more often than not it will be the police matter that will be resolved first, but sometimes I think you may be able to defuse the situation if you have a mental health person there as well. How you facilitate that in a very meaningful way, I do not know. I am very conscious of the resourcing and all sorts of stuff.

We have found, as I said, in those models that when we get them together, they kind of work okay, but it is just about how you do that and how you have those people who have that capacity to work constantly with us. You could not do it statewide, I do not think, because it just would not work. It would just be a waste of resources. At periods of peak demand, I do not know how you would structure it. Would you have a body of people who are on call or something like that? I do not know. Again, it depends on where the incidents are and all sorts of other things.

Mr NORTHE — I have been thinking the same thing, but how you actually deliver it from a practical sense is difficult, prospectively.

Cmdr DICKINSON — It is difficult. I think we are getting better at it. As I say, our members are getting better at that, and they are getting more training over time. I think that sort of level is slowly creeping up across the board. People today, when they come to the force, have a bit better of an understanding. It has had a lot of exposure in the media in the last two years in particular, so you tend to have a higher level of knowledge generally, which I think helps, but getting it right on every occasion is sometimes challenging. People behave really badly. As I said, you have all these issues around drugs and whether it is personality disorder and things like that.

Mrs PETROVICH — Ashley, thank you very much for your presentation. I think it helps us understand some of the difficulties our police are facing. You talk about the amount of time you may spend sitting in an emergency department or having a person in the back of the van. This is probably further to Russell's comment, really: is there a circuit-breaker or a way we can triage these people better to free up police time, and do we have statistics around how much police time is spent dealing with people with mental illness or disability?

Cmdr DICKINSON — I have been away for a while, but we were starting to capture some of that data. The frequency would vary considerably, and that is indicative of, I guess, the nature of the beast itself. You may go to a hospital and there is nobody in the waiting room, the doctor is there ready to see you straightaway, there is a bed if they need a bed, or all of those sorts of things. They keep that person. Everything gets done literally in minutes. In a sense it is no different to when anybody else goes to casualty. If you go there at the right time, if you go at 3 o'clock in the morning — straight in, unless it is down in the city. But if you go there at 10 o'clock in the morning and there are 40 people there, it is chaos. Of course the issue is what has the doctor stopped doing to see this person? How serious is the person they are going to walk away from? There is all that sort of tension in the health system as well that they would be better at describing than me, but it is that sort of tension within the whole system.

The other part of it, I guess, is that slightly broader recognition, in a sense, that it is actually not a police issue, and that is part of the problem. When you make a determination that this person is actually unwell, the last place you want them is in a police station, a police van or anywhere else, particularly a police cell. They need to get help, and anywhere other than what we have got is better.

Mrs PETROVICH — That is part of my point in that question, Ashley, that it seems to me that the police are actually making the majority of the decisions around how people are assessed. I think it is a matter of jurisdiction, perhaps, that we need to look at.

Cmdr DICKINSON — It is a very difficult problem. The frequency is significant, as I said. Many people are able to be re-medicated and go back on their way again and get on with their lives.

Mr NORTHE — I apologise for doing this, Mr Chairman, but in terms of the correction system, people with an ABI are overrepresented compared to, I guess, people with a mental impairment. How does Victoria Police do its assessment of people with an ABI? Is there a particular tool that you use to undertake that?

Cmdr DICKINSON — We would not do an assessment. We would treat a person exactly the same as we would treat anybody else. So if they presented as though they needed some assessment for mental capacity, we would do that in whatever form, whether it is an interview with an ITP, whether it is a forensic medical officer or if the person was bad enough, directly to a hospital to be assessed and section 10 or whatever.

Ms GARRETT — Just on that point. Was it 70 per cent that have an ABI? It was some huge amount.

Dr KOOPS — I think it was 40 per cent.

Ms GARRETT — It was 40 per cent. Also, they were not being diagnosed until they were in prison, which just goes to all of our points. You are not trained doctors, but somewhere they are butting into the justice system with the police, the courts or whatever and ending up within the corrections system undiagnosed.

Mr NORTHE — And then being diagnosed within.

Cmdr DICKINSON — Part of that, I think, is that there is a lot of stigma attached to it for a lot of people, particularly young people, and I guess one of the issues is how you educate young people or how you educate the parents of young people to say, 'What you are doing with your health is potentially going to have a very serious mental health issue. If you lose control of your mind, you could end up in all sorts of horrible situations'.

The CHAIR — Thanks very much, Ashley. That was really helpful.

Cmdr DICKINSON — You're welcome.

Committee adjourned.