LAW REFORM COMMITTEE

Inquiry into warrant powers and procedures

Melbourne — 28 January 2005

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Ms F. Calvert;

Mr D. Vukovic;

Mr D. Kaufmann; and

Mrs M. Kaufmann, Springvale Monash Legal Service

The CHAIR — Welcome to this hearing of the parliamentary Law Reform Committee. Our hearings are governed by the Parliamentary Committees Act, which means that any evidence you give today is subject to parliamentary privilege. You will receive a transcript of the evidence, and you will have an opportunity to review it and to indicate whether there is any part of your evidence that you want to give on or off the record; of course at any point we can indicate that in the course of this verbal presentation.

Once you have corrected the transcript it is our policy to publish it on our web site and to make it available to other stakeholders and obviously to the public. Thank you for taking the time to come and present to us. If you would like to introduce your team and who will be doing the presentation, we would appreciate that.

Mr TAYLOR — My name is David Taylor. I am the community development officer at Springvale Monash Legal Service. Briefly this project came about through a case study of a police shooting of a mentally ill person. The community development project consists of a group of final-year law students who research and conduct certain projects aimed to assist the community. This project targets the mentally ill and policing. Margrit and David Kaufmann are very interested stakeholders in this project, being the parents of Mark, whose death brought this project about. We have two students presenting today, Fiona and Dominik.

Overheads shown.

Ms CALVERT — First of all, on behalf of Springvale Monash Legal Service I would like to thank you for giving us the opportunity today to speak to you about police training in respect of the mentally ill. Just a brief background to the report, as David mentioned the report was prepared by nine Monash University law students as part of a community development program at Springvale Monash Legal Service. The report was initiated by three concerns, the first being the increase of interaction following the deinstitutionalisation of individuals with mental illness, the increase in the number of fatal police shootings of individuals suffering from a mental illness, and the fatal police shooting of a former Monash University student, Mark Kaufmann.

The objectives of the report are to highlight the high incidence of fatal police shootings of individuals suffering from a mental illness, to highlight the inadequacies in the current level of police training and the inadequacies of communication between police and the mental health services and to provide recommendations for policy reform.

Topics discussed today are also found in the report. They are: police shooting statistics, case studies, mental illness statistics, police and Department of Human Services and their relationship, police training, national and international developments with respect to this training, the Memphis model and our recommendations.

As to the statistics regarding police shootings, between 1990 and 1997 there were 41 people fatally shot by police in Australia; 21 of these shootings occurred in Victoria. Approximately a third of the victims were suffering from a mental illness at the time. All shootings occurred while police were attempting to detain the said individual. In a broader period of time and directly related to Victoria, between 1985 and 2004 there were 30 fatal police shootings in Victoria. Nine of these occurred in 1994, with 6 of those 9 having a history of mental illness. Since Project Beacon was introduced in September 1994 there have been 11 fatal police shootings; 3 of these occurred in 2004. Dominik will be discussing later Project Beacon.

The following are three case studies, two of which are identified in the report. The first relates to Mark Kaufmann, which is not identified in the report as the Coroner's findings have not yet been published. Mark was in his mid-20s at the time of the incident. He was from a stable family background and had been educated at Wesley College and Monash University. In 1998 he developed symptoms of schizophrenia. He was treated for two years with anti-psychotic medication.

The incident occurred in January 2002 at the family home in Glen Waverley. Both the crisis assessment and treatment (CAT) team and the police were requested to attend; however, the CAT team refused to attend until the scene was secure. Approximately 10 police officers attended, including members of the special operations group. Without going into too much detail, Mark was fatally wounded from shots fired at him by a traffic operations police officer. There is some discrepancy as to whether Mark was approaching the door of the family home or approaching the police officer at the time of the shooting.

This slide shows case history A, which involved a 41-year-old female. She had a history of psychiatric illness and had made threats of violence to persons unknown to her on the day. The police were called, and while they were present, the woman, who was holding a hatchet, lunged at two police officers. She died as a result of five shots fired in rapid succession by police. This shooting occurred within 2 minutes and 20 seconds of police attending.

The police spokesperson at the time stated that: "In many circumstances police have had to make split-second decisions about what approach they take to people who are armed and dangerous. We are trying to do the best we can to find out whether there is any defect in our training policies and procedures". The Coroner found that police had had insufficient training with respect to the use of firearms on persons suffering from mental illnesses. Shortly after this finding Project Beacon was established.

This slide shows case history B — a male with a long history of schizophrenia. He had ceased taking his medication two weeks prior to the incident. On the day in question he had made threats and acted violently towards people in the residential care unit where he was living, although he had had no previous history of violence. Both the police and CAT team were requested to attend; however, the CAT team were unable to attend immediately as they were assisting police at another scene where the offender was in possession of explosives. There was some indication that the CAT team would be able to attend after the earlier scene had been resolved.

Police had restrained B in a three-point restraint. This is where an officer would place his knee between the two shoulder blades of the offender and put pressure on the back of the offender's neck. The weight of the officer can then be used to restrain the person. The Coroner found that B suffered a cardiac arrest, which was brought on most likely by the restraint technique used.

The Coroner found that police should have been aware that a person suffering from a mental illness, such as B, would be frightened if tough tactics were employed and would be more likely to react aggressively and defend himself. The Coroner stated that there was a need for police to wait rather than intervene unless immediate intervention was required to prevent actual or imminent violence. In this case the Coroner stated that there was no such actual or imminent violence, and they could have waited until the CAT team could attend.

The following slide sets out some statistics on mental illness. Twenty per cent of all adults are affected by some form of mental disorder every year. Three per cent of these adults are affected by a severe mental illness, such as schizophrenia, bipolar disorder and some forms of anxiety and depression.

The community and the police have a misconception about mental illnesses and their characteristics. There is a misconception that individuals suffering from mental illness are generally violent and commit a substantial number of crimes. However, there is no inherent link between mental illness and a capacity to commit a crime. It is in fact more likely that such a person would be harmed rather than do harm to others.

There seems to be a possible connection between the increase in police shootings and the deinstitutionalisation of individuals suffering from a mental illness. Because of the lack of training, which Dominik will identify later, police are responding inappropriately to crisis situations involving individuals with mental illnesses.

The following is a discussion of the relationship between the police and the Department of Human Services. The *Victorian Police Manual* states that police are permitted to use appropriate action when an individual suffering from a mental illness is threatening harm to themselves or to others or is engaging in criminal activity. The manual recommends that police should request assistance from CAT teams when such a threat is imminent. However, the CAT teams do not have sufficient staff to allocate to these crisis situations. For example, in case study B the CAT team had four members on duty that day in the region. Two members were already assisting police at the earlier scene, and the other two members were assisting at home visits for individuals who would otherwise have been institutionalised.

Section 10(1) of the Mental Health Act states that police may apprehend a person who appears to be mentally ill. This effectively requires police to make a diagnosis of the offender's mental state. However, as Dominik will raise later, there seems to be an inadequacy in the training of police for them to do this. In addition, in September 2004 a protocol was established between the police and the Department of Human Services. It provides guidelines for the police and mental health services staff. The protocol recommends that in high-risk situations trained police negotiators, special operations group members or police psychiatrists should be present and the police should be requesting urgent assessment of the individual by mental health services staff.

However, some situations escalate far too quickly for all these people to be present on site. Thus there is a necessity for police to be trained to be able to identify the characteristics of mental illnesses. In addition, research suggests that police and mental health services staff are underresourced to be able to have such experienced people present at those scenes.

Dominik will now present the second half of our discussion, which relates to police training and current practices in other states and international developments.

Mr Vukovic — I will give you just a quick summary of what I will be covering. First I will be covering police training procedures in Victoria and what has happened with those police training procedures in response to the deaths of individuals with mental illnesses in crisis situations such as those Fiona was talking about, especially in Victoria, since this is the state that concerns us at the moment. Then I will be talking about national policy development regarding training procedures and also management structures designed to deal with crisis situations — for example, communication between mental health agencies and workers and police at the scene of a crisis situation involving an individual who has a mental illness. The relevant policy models we will be looking at are those in Victoria, New South Wales and Queensland. We will also be looking at international developments, particularly in the United States, which has developed what is known as the Memphis model which has been closely followed in New Zealand. We will be evaluating that.

Firstly we will cover recruitment training in Victoria, which involves 20 weeks at the police academy. It is very general training, pertaining to operational duties, police procedures, firearms training, marching and water safety. The challenge with that particular type of training is that it is very general. It does not provide officers with communications skills to de-escalate potentially violent crisis situations involving a mentally ill person who is having an episode.

In 1994 Project Beacon was established. Its purpose was to respond to the spate of police shootings that Fiona was talking about. In total there were nine police shootings and six of the victims were individuals who had suffered from mental illness. Project Beacon involved the implementation of specialised training procedures. Its primary focus was on minimum use of force and the preservation of life. It included operational tactics and negotiation training with offenders and, most importantly training in the avoidance of violent confrontations. An evaluation of Project Beacon shows that it did focus on de-escalating violent confrontation. However, it did not address crisis situations involving mentally ill individuals. So the response of Project Beacon was quite limited.

The force response unit was also formed. Its aim was to provide specialised training to elite groups so that they could deal with the crisis situations that ordinary police officers could not deal with. The training included hostage/siege situations, negotiations training again and suicide intervention. In evaluating the effectiveness of the force response unit we find again that it focuses on physical training to stabilise a volatile situation. There is however a lack of behavioural training that is required for police officers to de-escalate a crisis situation involving an individual suffering from a mental illness or experiencing an episode.

In the national developments the crisis intervention ad hoc advisory group was formed. Its purpose was to inform the federal government and to provide expert advice to Australian police and health ministers on the development of better practices for managing crisis situations involving mentally ill people.

The last report of the crisis intervention ad hoc advisory group was the Whiteford report [produced in 1998 by Dr Harvey Whiteford]. This report focused on a safety, facilitating agency cooperation with police, information sharing between agencies and the development of crisis response teams. That report was soon followed by the Wooldridge report, produced by Dr Michael Wooldridge. This report focused on strengthening the link between police and mental health services. Dr Wooldridge's report also focused on the fact that greater police access was needed to mental health agencies before attending a crisis so that they could get as much information as possible about a situation.

He therefore proposed that mental health workers be available 24 hours a day, seven days a week so that police could access them any time they needed. He also proposed a greater involvement of mental health agencies and workers in the actual crisis situation involving a mentally ill individual having an episode.

In evaluating those two reports, we see that they both focus on developing the link between mental health agencies and the police, which is very important, obviously, in the transfer of information in a crisis situation. However, the reports fail to recognise the economic and administrative costs of having police access to mental health agencies 24 hours a day, seven days a week. The Wooldridge report supports a segregated system, where mental health agencies are more involved in the crisis situation involving the mentally ill person. It does not identify improvements in police training as an important factor. That usually leads to a situation where police may attend a crisis situation and seek information but are inadequately trained to execute that information and implement it to de-escalate a potentially violent situation involving an individual who is mentally ill.

Now we look at particular policy developments in Victoria. There are not many current developments, because the police shooting of mentally ill people is a rather dormant issue unfortunately. However, a report was produced by the Department of Justice which released a statement in May 2004. It concerned the treatment of mentally ill individuals in the criminal justice system. The report was entitled 'New Directions for the Victorian Justice System 2004–2014'. The aim of the report was to investigate the treatment of mentally ill individuals in the criminal justice system itself.

It focused on two main issues. The first was the fact that there are between three and five times more mentally ill people in the criminal justice system than in the community itself. To explain that issue, it followed up with another: the use of the bandaid approach by the criminal justice system when punishing offenders with mental illnesses for their crimes. They do that rather than providing treatment for the illness that may be underlying the criminal act in the first place.

The recommended reforms focused on: the treatment of mentally ill offenders once incarcerated; the incorporation of mental health services in the justice system; distinguishing mentally ill

offenders from criminals; and providing mentally ill offenders with appropriate mental health care rather than punishing them for the crime.

This brings us to an important issue in police training. We see important parallels with police training because at the moment the police do not distinguish between a crisis situation involving an individual who is not mentally ill and one involving an individual who is mentally ill. As Fiona was saying before, those two different situations require two different approaches. While the physical approach may work when you are dealing with a non-mentally ill individual, a behavioural approach is required more often when dealing with an individual who is having a mental episode. In the latter situation, it means that the police must be skilled in communicating verbally in order to de-escalate the situation, rather than applying force.

Now we will look at policy developments in New South Wales, which are also very relevant, considering that in a way New South Wales is similar to Victoria but has gone about implementing some sort of policy changes to deal with these situations. In 2001 a New South Wales Legislative Council inquiry found that the community had a high regard for police in their conduct when dealing with people with mental illnesses. In 2002, a memorandum of understanding was introduced between New South Wales police and New South Wales health.

These two initiatives followed on from the Wooldridge report and supported many of the issues that were considered important in the Wooldridge report, discussed earlier, including the cross-communication between police and health agencies. A New South Wales select committee also assessed the current crisis assessment and treatment team (CATT). As Fiona was saying before, that team is supposed to come to a scene when there is a potentially violent situation involving an individual who is having an episode. The findings of the report support the CATT team being more involved in the crisis situation and also the continuation of a segregated system between the police and the CATT team, approaching the mental episode situations where there is a potential for violence.

Although there is an increase in the flow of information between the two bodies, the segregated systems would actually lack congruency and efficiency. Once they have received the correct information, police would still lack specialised de-escalation skills to deal effectively with individuals who have a mental illness. There are also key obstacles preventing police handling of mentally ill persons. As we have discussed, they include the plurality of the procedures and the resulting limited mental health training for police and the limited access to mental health workers.

The police have also recently stated that mental health workers are reluctant to work outside business hours, would not be called out on overtime and would not attend if it was suspected that person had some sort of condition — for example, a personality disorder or a drug-induced psychosis. There are also situations following that where the CAT team, due to financial restrictions, was unable to replace a member who had gone on leave. These are all really due to a lack of resources in this particular area, which the New South Wales government is trying to address.

We can now look at the potential impact the New South Wales policy will have on the Victorian government's future policy direction. As we said before, the issue has been quite dormant in Victoria, and there has been a lack of a predetermined position, but this may in itself provide an opportunity for Victoria to pursue a more effective model.

We will now look at police developments in Queensland. There is a particular model known as the Queensland Health Logan district strategy, and this differs from the New South Wales model. Not only does it implement the development of a network between mental health agencies and police, it also encourages specialised training of police officers themselves so they are able to deal specifically with these situations.

In conclusion, referring to the different policies around Australia, there is a common practice at the moment — as Fiona explained — to deinstitutionalise mentally ill patients. We can also see a pattern of limited funding and resources for mental health and public housing which results in many mentally ill individuals having nowhere to live or to seek help. They are provided with only limited assistance from the CAT team. This therefore causes an increase in police power and responsibility because police are now having to more often interact with these individuals who suffer from mental illness.

As we have seen, the training does not always provide the necessary skills for them to be able to do that effectively in a situation that has the potential to turn violent. Therefore in a situation where police, without specific training, are confronted with mentally ill persons, there is usually an escalation of violence which threatens not only the safety of the mentally ill person but also the police officer attending the scene.

Finally, we will look at a policy development in the United States, which is known as the Memphis model. The Memphis model was actually developed by the Memphis police department in Tennessee. It was implemented by the Memphis police department in response to community outrage over the fatal police shooting of a 27-year-old known as Joseph Robertson, who was mentally ill. The Memphis model has achieved great success in numerous other US cities that have implemented this model.

We have researched this model because many comparisons and parallels can be drawn with the situation in Victoria and New South Wales. Before the model was implemented police lacked the required skills to deal and assist in situations that involved an individual who suffered from mental illness. Police training did not incorporate the skills to control and de-escalate a potentially violent situation. This led to the distrust of police by family members of the mentally ill and various community groups. Police responses often ended in arrest and injury to either the officer or the individual who was suffering the mental episode.

The Memphis model departs radically from the New South Wales model, which was supported by the Wooldridge report. In this case the Memphis crisis intervention team, or the CIT, was formed in 1988. The CIT consists of police officers who have undertaken voluntary special training. In addition to performing their day-to-day duties as patrol officers, they are also on call to respond to any situation in relation to mental illness, and usually take control of the actual scene while the other officers who are not trained in that particular area obviously follow their orders.

Let's juxtapose the police training under the Memphis CIT model with that which we have discussed concerning the Victorian model. As a result of the implementation of the Memphis model we have seen a shift in the public perception of mental illness and a recognition of it as an illness and not a crime, therefore making that very important distinction. Police are offered specialised 40-hour training programs by a range of specialists, including mental health providers, legal experts, family advocates and mental health consumer groups. This occurs throughout their policing career. Training also exposes officers to widespread interaction with mentally ill people, most of all with a particular focus on communication. Master role-playing techniques are also used and verbalisation skills are developed to diffuse crisis episodes.

Other advantages of the Memphis model are that the crisis response has been immediate. Arrest and the use of force has greatly decreased and under-served consumers are identified by officers and provided with care rather than force. Patient violence and use of restraints in the hospital emergency room (ER) following the crisis has also decreased. Officers are also better trained and educated in verbal de-escalation techniques.

From the graph we can see that during the periods 1985 to 1997 there was a sharp decrease in the number of officer injuries during crisis situations. We can particularly see that the decrease began in 1988 when the Memphis model was actually implemented.

The Memphis model also has other advantages. There is recognition and appreciation of officers by the community because they can now effectively deal with and interact with people suffering from a mental illness. There is also a reduced stigma and perception of the danger attached to mental illness, as Fiona said previously. It also provides relief to an overburdened criminal justice system which, just like the police training system in Victoria at the moment, does not distinguish between offenders who are suffering from a mental illness and offenders who are not suffering from a mental illness. Therefore, they are not provided with any treatment to treat the underlying causes of the crime. There is also a great deal of cost savings.

In conclusion, the effective method of dealing with mentally ill patients in a way that provides the support they need, the Memphis model provides a method where the police officer is actually adhering to their needs and respecting them. The mentally ill require special attention, care, treatment and service, and the Memphis model is basically put there to serve this point. The Memphis model also offers an immediate, humane and calm approach. This reduces the likelihood of officers suffering physical injury during the confrontation, and also reduces the risk of injury to the individual who is suffering from the mental illness.

We can summarise by saying there are three models: the first is the Victorian model; the second is the New South Wales model; and the third is the Memphis model. As we have seen, the issue in Victoria up to date has been relatively dormant and we do not recommend that this particular position is followed. The New South Wales model, which undertook many of the suggestions in the Wooldridge report, such as greater communication between mental health services and police, also resulted in a reduction in police shootings of mentally ill people in New South Wales. However, something more needs to be added to this — a second prong — which is an increase in the quality of training of police officers, which is more specialised to allow them to deal with situations involving an individual who is mentally ill and where there is the potential of a violent outcome.

We therefore recommend that the training of police officers should, as seen in the Memphis model, be provided by mental health workers, consumers of the mental health system and also police psychologists. In addition we would also recommend that the police take part in programs where they are able to interact with mentally ill people so they can understand what a mentally ill person is going through when they are suffering an episode. Therefore police will also be trained in de-escalating potentially volatile situations peacefully and using a verbal communication approach rather than a physical and forceful approach, which is likely to cause more fear and volatility in the individual. We believe that following these recommendations will assist in reducing harm to police officers, the individual and members of the public.

Springvale Monash Legal Service is not directly advocating the Memphis model. We are aware there are many differences between the US and Australia. For a start Memphis is only the second-largest city in Tennessee with a population of 640 000 and a police force of 2095. However, the model shows that alternatives can work and there is a possibility that we can adapt many of the important points we have discussed today into a Victorian model which will well benefit the community and your members. Thank you.

Ms CALVERT — I would like to invite any discussions or questions members of the committee may have in relation to the report.

The CHAIR — Mr and Mrs Kaufman, do you want to add anything at this point in terms of your experience of the system?

Mr KAUFMANN— Yes, thank you. First of all, if we can present the sticky wicket, if you like. We have just gone through a coronial inquest into the death of our son. The findings are still to be handed down so I am not too sure how much detail I should go into. But one thing that

was blatantly clear throughout the inquest was that the assertions put forward during this submission have validity.

There is a great lack in the mental health system as to its effectiveness on an after-hours or even during-hours basis. There is gatekeeping of mental health services whereby, probably due to the restrictions on the money supply, the triage nurses and the CAT teams cannot be relied on to react in the same manner at all times. It is very much a matter of luck whether you happen to get the right CAT team at the right time and whether a service will be available. This is a problem for the police as well. They never know what sort of reception they will get either.

I do not know how wide this submission is and whether the committee is taking into account mental health services, but from our point of view it is half the reason why our son died, the other half being police methods and attitudes. To stick with the mental health part first, I would say a lot of it has to do with deinstitutionalisation and putting the patients — read in modern speak 'clients', and we hate that word — back on the street and back in the care of carers. Our son was lucky enough to have a family to come home to and which was prepared to take him, so he had that much going for him.

The biggest problem with deinstitutionalisation is in the patients' rights area. There has been an overemphasis on patients' rights whereby if someone is not in immediate danger to himself and others and does not wish to take medication, then there is not a lot you can do about it. Our son took off after taking medication for two years. He was away out of sight for three months before he came home on the fatal day where he was off his medication, and there was nothing we could do about it. There was no-one we could call who could enforce any sort of remedial action because the law just did not allow it.

Part of the problem we had, I suppose, even while he was under supervision, was that it was very much influenced by the availability of beds and hospitals. When the decision to deinstitutionalise was taken it was assumed that everyone would be happily catered for out in the community. This works somewhat for a compliant patient; it does not work for patients that are not compliant.

Mrs KAUFMANN — And one tends to forget that the people who care for these mentally ill are not trained to care for mentally ill; they do it because they love them, because that is what they want. They do not give them the same care that they would get in a psychiatric institution. Now I am not emphasising, and we are not saying that we should go back to institutionalisation because that in itself has problems of course, but I mean if one wanted to be sarcastic one could say it is a lot cheaper for the government to have people out in the community because the families look after them. Families sometimes have to fight to get a carers pension, if they do so, because they find that it is very difficult to manage.

That is one thing. But where is the support for these people, the people who care for these mentally ill? It is not there. And, yes, we are told that it is there, but when the client — again, an absolutely terrible term — is discharged from mental health, then that help and support system that the parent and the carer is supposed to have gotten is gone. You have your GP, who is very understanding if you are lucky, and you have the mental illness fellowship or people like this, but that is not what you need. You need medical backup, and the medical backup is not there because of patients' rights having swung too much the other way. So that is a big problem.

We have friends upcountry who at the moment are going through an absolutely disastrous time with their son who has an acquired brain injury, and I would like to bring that to your attention mainly for the following reason. I will quote what the lady has written. They spoke to Brian from Latrobe Regional Hospital mental health, asking for help. 'Well, what do you want me to do?', he said. They spoke to triage at Traralgon in the event that they should have to call the police. She wrote that they were very reluctant to take that road 'because of our circumstances and not

wishing our son to be shot'. The police are not trained to deal with the mentally ill — and this is only one example.

But people are frightened out there. They do not know where to turn. They do not have a place to turn. She says then that she was informed by Traralgon hospital that there were no beds available even 'if we did bring our son in'. Where is this person meant to turn? There are no beds; the police do not know how to deal with them. You would say, rightly so, that she can call a CAT team. We have been there, done that. It was not any good. And do you know why? In this particular case the person has become quite violent, and has also now turned to taking marijuana because it lessens the symptoms that he is suffering from. If the CAT team knows that the person is violent or takes drugs, they will not come, see you and help you. Then where do you go? Nowhere! It is a disaster.

I have made a copy of this letter from my friend for some of you and I would like to take it away because it makes interesting reading. That is only one example of a person in desperate, desperate need with nowhere to turn to. Also from that point of view she rang everywhere to see if she could get an expert or a psychiatrist specifically trained in medication to help their son.

She tried everywhere, but she could not get anyone to speak to, nor to see their son, because — would you believe? — it is January and everyone is on holidays. So what happens on weekends, or on holiday times? Invariably things go wrong either at night time or on the weekends. What happens then? Services are shut. We found that ourselves.

Mark was in trouble. He was in deep depression; we needed help. The mental health service that he was allocated to was shut. We rang Upton House. They said, 'Try such-and-such', but there was no help; then we were told, 'Try such-and-such', but no help. We finally managed to contact our GP who was kind enough to come and do a home visit.

But what I am saying is that the mental health service provided is not good enough; it is inadequate. I do not know whether it is because of a lack of funding or whatever it is, but it is not working. The other problem is that there are protocols between mental health and police; they both have protocols on how to deal with the various situations when they happen, but the problem we have found — and again, the inquest has not concluded or its findings have not come out — but found from listening to the evidence given is that, yes, the protocols exist, but the people down the line do not know about the protocols. Is it because they have not read it or because they have not been taught about it? I do not know. So therefore they do not follow them. It is not good for the top people to make a protocol that the people at the lower or bottom end, the ones out there facing situations, are not following.

Mr KAUFMANN — The interaction between the mental health people and the police is subject to a protocol that came out about six months ago. At the inquest when the police, both at the higher and lower echelon, as well as the mental health triage people were questioned about this some six months later, no-one knew about it. So where aspects of this Memphis model work from the bottom up rather than top down, it has some merit.

Switching from the mental health area, which is a political sleeper if you like, to police, we found — and when the transcripts are available from the inquest you would be able to check me out on this — the police believe they have things perfectly under control; they have their systems in place, their procedures and their protocols; they are very confident that they know what they are doing and that they have the situation under control. As was pointed out, whether you are mentally ill or a diehard criminal, you get the same protocol, you get the same system, and you get the same result.

Just to make one slight correction to the earlier presentation — sorry! — the SOG were not there; they were on the way, but they were not there.

Ms CALVERT — Okay. Sorry.

Mr KAUFMANN — But had they arrived, they also gave evidence as to how they would have handled it; you would not want to survive it, believe me. They had various resources and they were going to handle it in exactly the same way as they would any criminal. There was no negotiator called, which was not part of the protocols that the police are under. It was never really explained why a negotiator was not called.

Our case may have been somewhat different to others in that there were no civilian witnesses to the shooting. The only witnesses were police witnesses — and again reading of the testimony given showed that it was very much a closed shop. As their training dictates, they operate as a team, and that goes all the way. This is pretty touchy ground, but we called the police because we were a Joe Bloggs family in average suburbia, out in the leafy south-eastern suburbs and we had every confidence in my friend Mr Plod.

I had previously disarmed Mark that night. He was of average height and build, and I am rather small. When the police turned up it was like World War III: there were police everywhere and cars and traffic barriers — it just escalated out of sight.

Mrs KAUFMANN — It is very frightening for a person suffering from mental illness anyway to be confronted with all that. I think one good thing in favour of the Memphis model is that the police that do the specialist training are not chosen; they are doing it only because they have actually volunteered. So it is the mindset that is right to start off with. They say, 'Yes, I am interested to go into that specialist training because I would like to help the mentally ill'.

Let's face it, so many of us know somebody who suffers in one way or another with a mental illness. So why can we not stand up and do more for them? There is a lot of mental illness about — even just depression — and most of it is not talked about. But I think that is the right way to go: you need volunteers from the police who have the right mindset.

I have one more point on the crisis assessment team. The name is really very misleading, because if they do not come out in crisis, when do they come out? Their role in situations such as Mark's has to be carefully reconsidered, because their non-attendance but expected attendance leads to total confusion and can ultimately lead to lives being lost rather than saved.

Mr KAUFMANN — Police attitudes have changed over time. They changed with the Beacon report, and that was a good thing, but I think now we are ready for the next step. The next step is calling. There are a lot of angry people out there, and we are not talking about crims' families. They fight their own wars and good luck to them — they certainly get enough media space, but that is not what we are on about. We are talking about one in five people being touched by mental illness at one stage in their lives; at any one time — pick a figure, maybe 1 in 50 — they will have parents and siblings, who are voters. The services in the bush are behind those in the city.

Mrs KAUFMANN — Deplorable.

Mr KAUFMANN — And to me it is the big sleeper; it is something that has not been addressed for so long. We thought we had fixed it with the Burdekin era, we thought we fixed it with Beacon, but these incidents are rising. I do not think it is good enough to say we fixed that a decade ago and there is no need to look at it again.

We brought up the Memphis model at the inquest. Some of the echelons said, 'There is that much stuff floating around we cannot look at it all'. Some people said, 'Well, okay, maybe it is worth work looking at', but on balance I would have to say there was resistance, because they are very confident in their current systems and maybe too comfortable in them. There are a lot of people that have been there that have made the same mistakes before, and these are the people that are getting up to give evidence to back each other up.

It is a little bit scary. They say mental illness is on the rise, but I think perhaps it is more that recognition is on the rise. I think we now need to recognise that we have to do something more about it and the way services are delivered. Our health budget or skills or mindset is that we want them in the community and we will give them the backup they need — nice theory. However, this just means that the police will be the frontline, whether they like it or not. I am sorry for them, because this is not what they are trained for. They are going to be called again and again to these situations, and they are going to be the first called. Quite often you do not know that it is a mental illness problem until after the event. People who could recognise that it could be a mental illness problem or know it is a mental illness problem and have training to deal with it — it has to be the police because nobody else is going to do it.

Mrs KAUFMANN — But they need training.

Mr KAUFMANN — They need the training to make them capable. It is a difficult area. We dealt with it for four or five years, we continue dealing with it with friends. It is the one people like to put in the too-hard basket but it is not going away. We implore you, we beg you, to take steps to see that something happens, something that will transport us beyond where we have got so far because there are too many problems out there.

Mrs KAUFMANN — It is heartbreaking to lose someone you love — I can tell you that much. Thank you for giving us the time.

Mr KAUFMANN — Indeed, thank you very much. In conclusion, can I say that we endorse the report, and we are very grateful for the opportunity to put our views to you. We certainly hope that out of the inquest and out of this, that some good comes out of all this and some progress can be made. Thank you very much.

Mrs KAUFMANN — We are also grateful to the Springvale Monash Legal Service for all the work it has done on our behalf.

The CHAIR — Thank you very much for having the courage to come and talk to us at what is obviously a very difficult personal time; we appreciate it.

We will open up the briefing for general questions. Perhaps I could go back and direct a couple of questions to the legal service. I was interested in whether, as a result of the work you have done, you have had any communications with the police about your findings and whether they agree with your analysis and recommendations. Has there been any dialogue at all?

Mr TAYLOR — We have, in preparation of this report, liaised with a number of police officers — you will see that in the footnotes and references. One of the situations, being a fairly small legal service, is actually getting access to things and being able to reach right up to the top to speak to the police officers who actually make the immediate decisions. We spoke to quite a number of trainers and got quite a bit of information from them about it. They were fairly supportive. Last Friday we presented this report to Senior Sergeant Paul Mullett of the Police Association. His comments in short about it were that there is a protocol, which we mentioned, between the Department of Human Services and the police, and in a utopian world it would all be carried out but practically it is not.

He made the comment that they need about another 1100 police officers and he assumes that DHS would probably want a similar figure to actually be able to adhere to things like the protocol and carry them out in the best manner. In answer to your question, we have liaised with some police officers. I mentioned it also to Christine Nixon, who spoke at our annual general meeting. She was certainly very interested in this as well; that was late last year.

The CHAIR — It seems one of the inherent problems is, putting aside the question of resources and training, when there is a crisis situation happening right now wherever it is, whether

it is in a public place or at a suburban home, the only people who are realistically closely available in those circumstances are the police. Someone has to be there within 5 or 10 minutes because no-one knows how dangerous the situation is but certainly it is dangerous enough for someone to feel under imminent threat and they ring the police who have officers on duty 24 hours a day, seven days a week. I can imagine it would be much harder, even with protocols and more resources in CAT teams, to mobilise people who have other things that they are responsible for and who are only going to be called out occasionally to these kinds of incidences.

Mr TAYLOR — The Wooldridge report commented on recommendations of having 24/7, 365-days-a-year CAT team availability, which financially and resource-wise is not practical. The only organisation we have been able to see which operates in Australia and has that sort of coverage is the police. As we have said previously, situations like the deinstitutionalisation of the mentally ill mean they land in the lap of police.

It would be fantastic to have CAT teams being able to run around and service clients at any given time but they would have to have police powers to do that — they would have to be able to enter a premises with police powers to be able to contain a situation until the police turn up. As you can well imagine, there is a gross conflict of interest between those two parties because they are not police officers. I do not think we could ever try to give them that sort of authority.

The CHAIR — They seem to defer to the police as well — they are saying the police are trained to handle these situations, particularly where someone has a knife or a weapon. They say they are kind of a backup, they might be part of the communication but they expect the police to handle the violent confrontation. Given that you see the Memphis model as an effective model, do you have any assessment of what additional costs were involved in training police, working on police attitudes towards people who are mentally ill and implementing the policies and procedures which led to the kind of success that you described? Do we know what the additional costs were?

Mr TAYLOR — I should imagine that the costs would be somewhat considerable. In the Memphis model the Memphis police have partnered up with the University of Memphis to do this; you will find that on the web site. For us to do that, we, being a community legal service, probably lack the resources to actually go right in and almost design a curriculum for police training, firstly because we have restricted information on the intricacies of police training and secondly, being a community organisation struggling for funding, we do not have on hand experts who can do this type of stuff.

We have built a concept, we have mapped out a concept which is probably the most cost-effective way, which can also probably ensure the most humane treatment of the mentally ill and also hopefully prevent deaths. Remembering the statistics there, Victoria Police have caused — have been involved in — about half of the fatalities in the nation. It is a fairly strong figure, the 21/41 figure, I think it was — 41 people fatally shot by police, with 21 of those being in Victoria, between 1990 and 1997. Three people who were mentally ill were shot by police in 2004.

With regard to the administration and the cost, it would obviously cost quite a bit. It would take some time to bring in, it would involve strong partnerships. We have outlined in the report partnerships that would be needed — community involvement; involvement from consumers, being mentally ill people who will be able to advise police; you would need involvement from academics and mental health workers.

Mr Vukovic — I was going to mention that one of the main differences with the Memphis model is it was strongly supported by the community. Like Mrs Kaufmann was saying, the police officers were volunteers — they wanted to do this and volunteered for these specialist positions. Therefore, looking back, we would probably recommend that there needs to be more community awareness throughout Victoria as to what mental illness is. The common, average layperson does not know much about mental illness — they associate it with violence and danger.

As Fiona was saying, when a police officer attends a scene they are only required to make a layperson's assessment.

Mr LUPTON — Could you tell us approximately how many of the Memphis police are involved in the crisis intervention teams, how many volunteers there are?

Mr TAYLOR — I have the impression that the figure is something like one in five had some training. There are the experts who have done the crisis intervention team training, which I think is quite extensive, but all police officers, I understand, have, since the Memphis model has been introduced, enhanced training with regard to mental illness. They are not simply, as I understand Victoria Police are, aware of the statistics that we presented to you earlier — the one in five, and one in 100 people will have schizophrenia — and they will actually be able to identify what the illness is. They would be able to identify that this person is suffering a psychotic episode, maybe they are schizophrenic, it is not someone who has maybe consumed too much of a certain substance that has brought about irrational behaviour. I think it is very important for police to be able to identify that in the treatment and handling.

I suppose another concern is if a police officer arrests someone who is acting erratically and it is a Friday and they are put in the police cells over the weekend, they could be sharing a cell with a number of, we could say, hardened criminals when they are mentally ill. There was the case of a person who held up a 7-11 store about 18 months ago. He was slightly disabled and he was put in a cell with someone who is now in Port Phillip Prison and serving another 13 years. He was battered and accused of quite a few heinous accusations and that was because he was put in a police cell.

This person was not mentally ill, he was more mentally disabled, but they would be concerned about stuff like that. People suffering from mental illness probably would not be able to withstand the rigours of being in police cells to the same degree as your average mentally healthy individual.

Mr DALLA-RIVA — I have a range of questions to a variety of people so if it is all right I will go through those and get some clarification. David andMargrit, thank you for your input. I was listening to the information that you provided, you said that there were 10 police and the SOG suggested that perhaps they would have had a similar outcome. I know the inquest has not been finalised in terms of its findings but I am curious and I need to know. Did Mark have an item or an article or a weapon that caused the cordoning off you mentioned?

Mr KAUFMANN — He had two kitchen knives. I do not want to give the impression that the same outcome would have happened with the SOG — he would have survived the SOG.

Mr DALLA-RIVA — The SOG said it would have dealt with it differently?

Mr KAUFMANN — Yes. They had stun guns for a start, long-range capsicum spray, batons, dogs and shields. When I say he would have survived, it would have been a traumatic experience — we have found that goes with mentally ill persons.

Mr TAYLOR — I spoke to a couple of psychiatrists and staff working at The Alfred and they said that because there was a period of time between when the first conflict occurred and when Mark was fatally shot — about an hour and a half — when someone is experiencing an episode I was told by a couple of psychiatrists there are actually lulls where the person is more lucid. A trained negotiator may have been able to identify those lulls and persuade Mark to put down the weapons, and then they could have tackled him a lot safer using a dog or something like that. The police were not necessarily trained to identify those things, that was a concern as well. My apologies for interrupting.

Mr DALLA-RIVA — No, that is good verification. Fiona mentioned case history A and said that was when project Beacon was established. I think your slide said it was 2004 but later on Dominik indicated that it was 1994.

Ms CALVERT — You are just questioning when project Beacon was established?

Mr DALLA-RIVA — That is right. Just in relation to that, we know that project Beacon was implemented in 1994 — I know that because I went through it — your statistics talk about 1990 to 1997 and 1985 to 2004; I was trying to write down furiously as you went through. Do you have any statistics about the number of fatal police shootings post project Beacon to 2004?

Mr TAYLOR — The last 10 years?

Mr DALLA-RIVA — The figures I have written down sort of take in the introduction of project Beacon. For example, from 1990 to 1997 there were four years preceding the project Beacon implementation.

Mr LUPTON — It is on page 6, I think.

Mr DALLA-RIVA — Is it?

Ms CALVERT — Project Beacon was introduced in September 1994. There were 11 fatal police shootings since 1994, and three of these occurred in 2004.

Mr DALLA-RIVA — Yes, okay. As I said, I was trying to write furiously.

Mrs KAUFMANN — It was interesting to see cases A and B and the recommendations of the findings by the Coroner. In both instances the Coroner sort of said, 'Police! Stand back, watch and wait. There is no hurry'. And do you know what? It appears to us, as our case shows, that nobody has learnt from that. What happens to recommendations from a Coroner? Are they listened to?

Mr DALLA-RIVA — One final discussion point: from your presentation, Fiona, I got the impression there was no correlation between someone with a mental illness and committing a crime which did not correspond to what Dominik said when he indicated that it's three to five times more likely to be involved in the criminal justice system. I am curious. You indicated there was no evidence, but there must have been some evidence. I am seeking clarification; I am not being critical.

Ms CALVERT — No, there is conflicting evidence. Dave, Dominik and I were discussing this the other day.

Mr TAYLOR — With this situation people suffering a mental illness are much more likely to harm themselves. Someone suffering from schizophrenia is about 2000 times more likely than someone who is not mentally ill to suicide. You could go to a host of different medical practitioners and you get varying views, but some people say, 'Yes, mental illness makes an individual more likely to commit crime'. Other people say, 'No, it does not at all'. I think that it is a very tricky question and one which we have tried to grapple over.

I am of a mind to say that people with a mental illness are more likely to be involved in substance abuse. Therefore I can say that there is a correlation between substance abuse and crime, so I can tie it in that way. But I think if you analysed some crimes versus others you would find that with substance abuse you have a high rate of mentally ill people, but if you looked at such things as violent offences or obviously things like fraud and stuff like that, I think you would be less likely to see mentally ill people. That is quite a tricky question which we agonised over the last week or so. As I said, you could happily find reports saying one way or the other.

Mr Vukovic — The important point that I brought up was that the Department of Justice released a statement and pretty much made the point that mentally ill people in the criminal justice system are treated exactly the same as other offenders without looking at the underlying reasons: do they need treatment; did they take the drugs to deal with the symptoms of mental illness, or the side effects of medications for mental illness as well? Obviously punishing them does not assist them in any way. Obviously in that circumstance they are likely to reoffend, and that may reflect why there are three to five times more mentally ill people in the criminal justice system than in the community.

What the paper suggested was that the criminal justice system should provide more care and involve the mental health agencies more, just so that there is not a bandaid approach which is slotting them together with other offenders and institutionalising them in jail.

Mr TAYLOR — Something which is very important is that if someone is deemed to be mentally ill to the degree where they are dangerous, they are put in somewhere like Thomas Embling Hospital. If they are mentally ill but they are not likely to cause trouble within the prison system or attack someone and they are not going to stand out and make a lot of noise, chances are that they will be kept within a normal prison environment and given medication. This medication is not really going to assist in the long term. It is more to placate them for that period of time until they are released. There are concerns with continuing care beyond that obviously once they are released from a correctional facility.

Mr KAUFMANN — I would like to add a bit to the statistics. Part of what came out of the inquest was that people like the Mental Illness Fellowship put mentally ill involvement with police at a very high figure, and the SOG expert who was giving testimony when asked what was his involvement with critical incidents that involved the mentally ill put it at about 5 per cent. There is a big difference there.

I think this goes more towards the fact that whether there is mental illness involved or not comes after the fact in a lot of cases — it is not a known during the offence — and the arrest is made, the police move on and file the report and it is only from then on that perhaps a mental illness is recognised. The statistics that show the involvement of the mentally ill in critical incidents are provided by the police reporting system, and they are based on the arresting officer's observations. He makes the arrest, he brings them in and that is it. He walks away and the follow-up information does not get back to the statistics. It is a bit of a conundrum.

Mrs KAUFMANN — Which reminds me, in our case the police were instantly informed that Mark was suffering from schizophrenia.

Mr DALLA-RIVA — I recall from my experience, and I can actually remember the number of incidents where I had involvement with people with mental illness in my time in the police — it is interesting that it is not many occasions, but you remember them. I agree with you in what you are saying. I agree with the submission. You are not adequately trained. I remember that back then. I recall that project Beacon did not adequately train us to deal with mental illness, so I thank you for your submission. It may be as I think Dominik or David indicated, one of you mentioned that we have done this, so where to from now?

The CHAIR — I have one question to Mr and Mrs Kaufmann. You mentioned that there are not a lot of options where patients are not taking their medication in the community, and the question about how do you enforce a regime of taking what you are prescribed. It seems to me to be a particularly vexed area, and I have had this raised with me a number of times by constituents. What would be your solution to that problem?

Mr KAUFMANN — In the case of Mark, he was seeing his GP on a somewhat regular basis, and Mark took the decision to come off medication based on a comment made by his case worker early in the piece that the likelihood of recidivism for schizophrenia was lower if he

continued his medication beyond just relieving the symptoms for a minimum period of two years. That two years stuck in his head. By the time he was turned over to the private system some nine months later he took that information with him, and that is the only thing he took with him. When the two years were up he told his GP, 'I am coming off'. The GP had no legal way to keep him on medication.

The CHAIR — What would you see as the legal way from your point of view?

Mr KAUFMANN — If it was the medical opinion of the GP that he should remain on medication.

Mrs KAUFMANN — It is patients' rights.

The CHAIR — If the client refuses to take the medication, in your view what should happen?

Mr KAUFMANN — Currently it is that you have got to get a couple of medical opinions to say otherwise, and also the person has to be shown to be a danger to himself or to others. If you are not a danger to yourself or to others, well first of all how do you predict that you may not be so later on down the line? One of the big factors in the current system is that carers are out of the loop unless it is with the explicit request of the client — here we go again.

If carers were listened to more, they could with the backup of a medical opinion say, 'No, it is in the patient's best interests that they go back or remain on medication', then that should be enforceable. Otherwise they should revert to an involuntary status, in which case they are back in hospital until they agree to the voluntary status, which means that they have to go back on medication.

Mrs KAUFMANN — The problem is that we are dealing with a mental illness, and once a patient goes off medication they can slide back into mental illness. When you are mentally ill, when you are suffering, you are not the first one to know that you need help. You are certainly the first one to say, 'I do not want help', and that is the big problem. That was the last thing that our GP said to Mark: 'Mark, remember that when you slide back and you become unwell you may not be the best one to judge whether you have to come and see a doctor'. He told us that, and we said, 'Yes, Mark, remember that. That is very true'. And that is the crux of the matter really, because by the time Mark had gone downhill again we then tried to confront him by saying, 'Mark, you should go and seek medical help'. He said, 'No way', and that is when he went off; that is when he ran away.

They cannot tell; they cannot help themselves. That is the problem and that is where David is right. The carer should have something to say. The picture that is presented to the doctors and the medical profession by the mentally ill may be quite a good picture. They are groomed and they look after themselves for the appointment, but then they come home and lock themselves in the room. The doctor does not see that.

Mr KAUFMANN — They can be quite cunning.

The CHAIR — Yes, I understand that.

Mr TAYLOR — It is probably important to consider that if someone had a physical ailment and they were not taking their medication; mental illness needs to be held in the same esteem as something for which you have to take antibiotics to fix yourself up physically.

The CHAIR — Thank you very much for taking the time to come and speak to us and present the results of your research. I think the work that the legal service and the students have done is tremendous. I hope it has been one of those things that will be very useful to you later on in your legal careers because it is a very good piece of grounding to be involved in, and I

commend you for being involved in it in addition to your studies. It has been very enlightening for us.

I also thank Mr and Mrs Kaufmann for sharing what has been a very difficult and painful experience for them, which obviously raises a number of major policy issues which we need to consider as a committee and need to be considered by the broader community. I thank both of you for your time as well.

Mr TAYLOR — Thank you for your time and for giving us audience so that we could present this to you. We do appreciate your taking the time out to hear what we had to say. I am sure that Margrit and David are also very pleased to be able to explain to you guys their situation. We do appreciate it, and I do thank John for helping to orchestrate this whole thing.

Mr LUPTON — I want to put on record my personal thanks also to the Kaufmanns for coming along. I was very impressed with the quality of the report. It has been very useful. Thank you.

Committee adjourned.