Policing people who appear to be mentally ill
Letter of transmittal

To

The Honourable the President of the Legislative Council
And

The Honourable the Speaker of the Legislative Assembly

This report is presented to Parliament in accordance with section 28(2) of the Police Integrity Act 2008. It sets out the findings of an Office of Police Integrity (OPI) review into Victoria Police encounters with people who appear to have a mental illness.

In thanking all those consulted throughout this review, I am particularly grateful to mental health service consumers who shared their insights and experiences with my review officers. Their participation has enabled greater insight into the nature of police encounters with people who appear to have a mental illness.

Ron Bonighton AM

ACTING DIRECTOR, POLICE INTEGRITY
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter of transmittal</td>
<td>3</td>
</tr>
<tr>
<td>Executive summary</td>
<td>7</td>
</tr>
<tr>
<td>Glossary of terms</td>
<td>10</td>
</tr>
<tr>
<td>Recommendations</td>
<td>11</td>
</tr>
<tr>
<td>Background to this review</td>
<td>12</td>
</tr>
<tr>
<td>OPI’s review</td>
<td>12</td>
</tr>
<tr>
<td>Methodology</td>
<td>12</td>
</tr>
<tr>
<td>Natural justice</td>
<td>13</td>
</tr>
<tr>
<td>Historical context</td>
<td>14</td>
</tr>
<tr>
<td>Deinstitutionisation</td>
<td>14</td>
</tr>
<tr>
<td>Mental Health Act 1986</td>
<td>14</td>
</tr>
<tr>
<td>Mental illness in the community</td>
<td>14</td>
</tr>
<tr>
<td>Policing people with a mental illness</td>
<td>15</td>
</tr>
<tr>
<td>Police authority under the Mental Health Act 1986</td>
<td>15</td>
</tr>
<tr>
<td>Criminalisation</td>
<td>16</td>
</tr>
<tr>
<td>Perceived shifts in prevalence</td>
<td>16</td>
</tr>
<tr>
<td>Police shootings</td>
<td>17</td>
</tr>
<tr>
<td>Project Beacon</td>
<td>18</td>
</tr>
<tr>
<td>2005 OPI review</td>
<td>18</td>
</tr>
<tr>
<td>Charter of Human Rights and Responsibilities Act 2006</td>
<td>18</td>
</tr>
<tr>
<td>Victorian initiatives 2006–2009</td>
<td>18</td>
</tr>
<tr>
<td>Models for responding to people who appear to be mentally ill</td>
<td>20</td>
</tr>
<tr>
<td>Models used in other jurisdictions</td>
<td>20</td>
</tr>
<tr>
<td>Police-based police response model – the ‘Memphis Model’</td>
<td>20</td>
</tr>
<tr>
<td>Police-based police response model – the ‘Birmingham Model’</td>
<td>21</td>
</tr>
<tr>
<td>Mental health based mental health response model – ‘Crisis Assessment and Treatment Teams’</td>
<td>22</td>
</tr>
<tr>
<td>Co-responder model</td>
<td>22</td>
</tr>
</tbody>
</table>
Appendix One: Recommendations from the Victorian Auditor General Office's review

Appendix Two: Victoria Police's ten operational safety principles

Appendix Three: Chief Commissioner’s response

Appendix Four: Secretary of the Department of Health's response

Appendix Five: Chief Executive Officer of Ambulance Victoria’s response
Executive summary

This report sets out the findings of a review by the Office of Police Integrity (OPI) into the way Victoria Police responds to people who appear to have a mental illness. In 2009 the Victorian Auditor General’s Office completed a review into interagency coordination, preparedness and effectiveness in responding to mental health crises. OPI’s review follows on from the Auditor General’s report and assesses whether more could be done to enhance Victoria Police’s responses to people who appear to have a mental illness.

The interaction between police and people who appear to be mentally ill is a well-established one. In Victoria the over-representation of people who have a mental illness in fatal police shootings is extensively documented. Although this over-representation remains concerning, it overshadows the more routine nature of interactions between police and people who appear to have a mental illness. These interactions are remarkably frequent. According to recently published research, police in Victoria report that in any average week they regularly come into contact with people who appear to have a mental illness.¹ Fifty percent of police reported this occurs one to two times a week, with more than a third of police reporting between three and ten encounters. As well as occurring frequently these interactions are often time consuming and complex in nature.

This is not unique to Victoria. As this report sets out, the relatively high proportion of police encounters with people who appear to have a mental illness is in large part the product of deinstitutionalisation. Beginning in the 1960s in Victoria, deinstitutionalisation rapidly escalated in the 1980s and 1990s. Whilst well intentioned, as has been the case internationally, the closure of institutionalised settings did not occur in tandem with adequate provision of community based mental health services. This has led to at times dramatic consequences. An unacceptable over-representation of mentally ill persons in fatal shootings by Victoria Police in the late 1980s and 1990s attests to this.

Victoria Police responded to these concerning statistics effectively in the form of Project Beacon in 1996. The key message underpinning the philosophy of this intervention was that the success of an operation will primarily be judged by the extent to which the use of force is avoided or minimised. Following this initiative the effectiveness of this message has at times waned. This review and previous reports by OPI have emphasised this: while it is important to learn lessons, it is incumbent on Victoria Police to ensure that these lessons are remembered.

¹ Police Responses to the Interface with Mental Disorder (PRIMeD) 2012 Policing Services with Mentally Ill People: Developing Greater Understanding and Best Practice (PRIMeD) 2012 p9
The review included an examination of academic literature about established best practice in delivering policing services to people who appear to have a mental illness. Different models used by police in other jurisdictions are considered in this report.

In a context of finite resources to respond to people who appear to be experiencing a mental health crisis, innovative service delivery is required to ensure that responses are effective and efficient. On this measure, Victoria Police has delivered positive initiatives on a trial basis which have improved responsiveness to people in these situations. The Police Ambulance and Clinical Early Response (PACER) program has constituted a unique and effective way to provide onsite assistance to people who appear to have a mental illness while also easing the strain on emergency departments and other mental health services.

Notwithstanding this the original PACER program has concluded and its future status is uncertain. A variation was recently trialled in conjunction with the Alfred Hospital and a similar pilot is currently underway at Eastern Health. Any long-term commitment beyond the life of these pilots by the Department of Health or Area Mental Health Services remains uncertain. This emphasises the need for Victoria Police to further consider other frameworks or models to respond to people who appear to have a mental illness. PACER is only one such model. The current position of the Department of Health requires Victoria Police to consider other alternatives.

This review considered the recommendations arising from a large scale collaborative research project between Monash University, the Victorian Institute of Forensic Mental Health (Forensicare) and Victoria Police. The ‘Police Responses to the Interface with Mental Disorder’ project investigated Victoria Police practices, policies and procedures in dealing with people who appear to have a mental illness and interactions with other mental health services. One of the key recommendations arising from this project was the establishment of a dedicated facility where people experiencing mental health crises can be taken for immediate assessment and care. OPI’s review has considered the merits of this recommendation. The establishment of such a facility could promote better care and emergency treatment for people who have an acute mental episode in metropolitan Melbourne, while easing the strain on resources that police and some emergency departments currently experience.

Although this review focused on the police response to people who appear to be mentally ill, the findings of this review indicate that there is still room for improving the understanding across agencies about the different roles and responsibilities police, paramedics, hospital emergency department staff and mental health practitioners have in these situations. Police have a key responsibility to ensure the safety of people threatening harm to themselves or others. Where the person threatening harm appears to be mentally ill, the focus of any response should be on health and harm minimisation principles. In this context health practitioners have a primary responsibility to respond. The role of police is to support their response. For example, police may be required to take action to ensure the safety and welfare of not only
the person appearing to be mentally ill but also mental health service providers, paramedics, staff in hospital emergency departments and members of the public in the vicinity of the person.

Experience demonstrates the best responses to people experiencing a mental health crisis in the community require multi-agency cooperation and collaboration at a local, regional and state level. Ensuring cooperation across health, welfare, community support and emergency services and the provision of professional, timely and safe responses to people who have a mental illness and their carers is not the sole responsibility of police. It is a whole-of-government issue requiring whole-of-government consideration and response.
### Glossary of terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESTA</td>
<td>Emergency Services Telecommunications Authority</td>
</tr>
<tr>
<td>OPI</td>
<td>The Office of Police Integrity</td>
</tr>
<tr>
<td>OTST</td>
<td>Operational Tactics and Safety Training</td>
</tr>
<tr>
<td>PACER</td>
<td>Police, Ambulance and Clinical Early Response</td>
</tr>
<tr>
<td>Section 10</td>
<td>The powers entrusted to police and Protective Services Officers under the <em>Mental Health Act 1986</em> to apprehend a person for assessment where they constitute a risk of harm to themselves or others</td>
</tr>
</tbody>
</table>
Recommendations

OPI recommends that:

• Victoria Police continue to enhance its general education and training on responding to people who appear to be mentally ill and give consideration to introducing specialised training in relation to improving responses to these members of our community.

• The Victorian Government’s Interdepartmental Liaison Committee comprising representatives from Victoria Police, Ambulance Victoria, the Department of Health and consumer and carer groups consider the deployment of a mental health professional to provide 24/7 clinical support at the Emergency Services Telecommunications Authority.
Background to this review

This report sets out the findings of a review undertaken by the Office of Police Integrity (OPI) into the way Victoria Police responds to people who appear to have a mental illness. In 2009 the Victorian Auditor General’s Office completed a review into interagency coordination, preparedness and effectiveness in responding to mental health crises. OPI’s review follows on from the Auditor General’s report, examining whether more could be done by Victoria Police to enhance its responses to people who appear to have a mental illness.

OPI’s review

This report considers:

• the historical context of police encounters with people who appear to have a mental illness

• models from different jurisdictions for improving the police interface with people who appear to have a mental illness

• the current context in Victoria

• the nature of police encounters with people who appear to have a mental illness

• the preparedness of Victoria Police in responding to people who appear to have a mental illness

• innovative service delivery models.

Methodology

For this review OPI engaged with Victoria’s statewide mental health consumer consultant network seeking accounts from people who have a mental illness and their carers of their experience with police. Those who provided feedback to this review were generally very positive. Some accounts of individual experiences are included in the narrative of this report. OPI review officers also consulted with:

• a number of Victoria Police staff from metropolitan and regional areas

• Area Mental Health Services

• emergency department clinicians

• Crisis Assessment and Treatment Teams

• Ambulance Victoria
• mental health advocacy organisations
• mental health service consumers and carer networks
• the Victorian Auditor General’s Office
• New South Wales Police Force Mental Health Intervention Team officers
• Mental Health and Drug and Alcohol Programs Unit, New South Wales Department of Health.

The review was also informed by:

• an inspection of Victoria Police documents and reviewed policies
• preliminary and final evaluations of the Police, Ambulance and Clinical Response (PACER) pilot
• Memoranda of Understanding between emergency service agencies in Victoria
• a review of literature on policing responses to people with a mental illness.

Natural justice

A draft copy of this report was forwarded to the Chief Commissioner, Ken Lay, the Secretary of the Department of Health, Dr Pradeep Philip, and the Chief Executive Officer of Ambulance Victoria, Mr Greg Sassella. Their responses are attached as Appendices Three, Four and Five.
Historical context

Deinstitutionalisation

The nature of contemporary police encounters with people who appear to have a mental illness is informed by historical shifts in mental health policy. From the 1960s and 1970s it was recognised internationally that institutional care unjustifiably isolated and segregated people with a mental illness and that people with a mental illness had a right to be treated in the community.

Mental Health Act 1986

This shift in mental health policy was reflected in Victoria in the Mental Health Act 1986. The Mental Health Act 1986 provides a rights-based approach to mental illness along with a framework for deinstitutionalisation. It recognises the inherent rights of people with a mental illness to live and be treated within their community.

Deinstitutionalisation rapidly occurred following the proclamation of the Act in 1987. It resulted in the closure of institutions such as Willsmere, Larundel, Mont Park and Royal Park, Aradale, Mayday Hills, Lakeside and Brierly. The move towards community treatment was welcomed. Yet as OPI’s review demonstrates it brought about some unforeseen consequences.

Mental illness in the community

Mental illness and substance abuse disorders have been described as constituting a global public health problem of enormous proportions. Recent statistics have demonstrated that 45 percent of Australians at some point in their lifetime have experienced an anxiety, mood or substance abuse disorder. Over a 12 month period 14 percent of the population experienced an anxiety disorder, six percent experienced an affective disorder, and five percent experienced a substance abuse disorder. Globally it is estimated that almost 25 percent of the world’s population will experience a psychiatric or addictive disorder during their lives, with mental illness constituting a leading cause of disability. In Victoria almost one in five people experience mental illness annually.

---

3 Ogloff J, Thomas S, PRIMed presentation
4 Wood J and others 2011 p1
5 VAGO (2009) Responding to Mental Health Crises in the Community pvii
Policing people with a mental illness

Police are often the first point of contact when somebody is experiencing a mental health crisis. During such crisis, people with mental illness may constitute a threat of physical harm to either themselves or others. In these instances police are required to use their discretion to respond to such persons in the most appropriate way. Associated with the use of discretion is an over-representation in the use of force against people with mental illness, including fatal police shootings.

Given the prevalence of mental illness in the general community it follows that police must regularly encounter people with a mental illness. The closure of mental health institutions and the subsequent inadequate provision of community based mental health services have contributed to this. This reality is not unique to Victoria. Research internationally identifies inadequate planning and service provision following deinstitutionalisation and a lack of foresight by policy makers regarding the impact of these changes upon police services.6

Different studies internationally and across Australia have sought to quantify these encounters. Despite some discrepancy between the studies they reveal these encounters are common and time-consuming. There is also some evidence the number of encounters has been steadily increasing over recent years.

A survey of police officers in Sydney found that police on average spend around ten percent of their time dealing with people who appear to be mentally ill. Three quarters of participants reported that they had dealt with such people in the past month.7 A Victorian study found that police reported around one fifth of potential offenders they encountered appeared to have a mental illness. The findings of these studies are broadly consistent with comparative studies internationally.8

Police authority under the Mental Health Act 1986

Police authority in relation to people who appear to have a mental illness is derived from section 10 of the Mental Health Act 1986. This enables police and protective service officers to apprehend a person where they have reasonable grounds for believing that a person who appears to be mentally ill may constitute a serious risk of harm to themselves or others. In apprehending such persons police may enter premises and use such force as is reasonably necessary to secure the person.

---


7 Godfredson JW, Ogloff JP, Thomas SDM & Luebbers S 2010 ‘Police discretion and encounters with people experiencing mental illness’ Criminal Justice and Behaviour 37(12) (Godfredson and others 2010) p1392

The purpose of apprehension is to facilitate the examination of the person by a registered medical practitioner or assessment by a mental health practitioner. This is required to occur as soon as practicable.

Criminalisation

Since deinstitutionalisation police have at times resorted to using arrest powers as an imperfect solution to deal with a person experiencing a mental health crisis in the community. This phenomenon in effect criminalises people with mental illness through the use of police cells rather than psychiatric facilities.\(^9\)

While there may be a tendency to be critical of police for this trend it has been exacerbated by inadequate health service accessibility alongside the use of more rigorous legal standards for involuntary treatment. While the right of people with mental illness to not be subject to involuntary treatment has been progressively recognised, this has created a quandary for police in responding to instances of antisocial behaviour where it is a manifestation of mental illness.\(^10\)

During the course of this review OPI consulted experts from Victoria’s specialist borderline personality treatment service (Spectrum). The experts offered the view that mental illness does not in itself legitimise wrongdoing. While criminalisation of people with mental illness is to be avoided, these experts emphasised that legal sanctions can at times play an important role in modifying behaviour.

As a consequence issues arising from encounters between police and the mentally ill are complex, historically informed and not simply the result of actions by police agencies. It is too simplistic to see the issues associated with police encounters with the mentally ill as a problem on the part of policing organisations alone. Other agencies, legal frameworks and mental health service providers all contribute to the frequency and outcomes of these encounters.

Perceived shifts in prevalence

During the course of this review perceived shifts in the prevalence of mental illness were brought to OPI’s attention. Some police identified borderline personality disorder as increasing in prevalence. Borderline personality disorder is a condition that causes people to suffer extreme emotional pain – often precipitated by what others may regard as relatively minor life difficulties. For sufferers of borderline personality disorder these difficulties can be experienced as intensely traumatic. This commonly manifests in self harm or threats of self harm which can be alarming and periodic in nature. Other stakeholders consulted were of the view that more is now known about such conditions, leading to a rise in diagnoses. Notwithstanding this there was

---

\(^9\) See Cordner D 2006 *People With Mental Illness* US Department of Justice p8

\(^10\) Teplin & Pruett 1992 p141
consensus that dealing with people who have borderline personality disorder can be more time consuming for police.

‘Excited delirium syndrome’ was identified by police as an emerging risk. The term has been coined in association with deaths following the use of Tasers and chemical sprays. Its use has been the subject of medical and legal controversy with a lack of consensus about its existence as a medical entity. It generally manifests in a highly agitated state and the sufferer can rapidly transition between consciousness and unconsciousness. It can closely resemble the effects of chronic illicit stimulant use. While debate continues about whether the underlying syndrome or the use of force precipitates death, where death does occur it generally takes the form of cardiac arrest.

Some police OPI spoke to indicated they believed deaths in these situations were often inevitable. This view is unsatisfactory. These situations are medical emergencies that require immediate medical intervention. Mental illness also has a strong relationship with drug and alcohol usage. Dual diagnoses of mental illness and substance abuse are common and the effects of drug and alcohol usage can resemble mental illness. The effects of this upon emergency service responses are apparent. For example recent data from Ambulance Victoria shows that callouts to people using crystal methamphetamine (‘ice’) rose more than one hundred percent in 2011. In these callouts, the affected person may be in need of both physical and mental health service treatment. With increases in the prevalence of the use of such substances there is a further strain on emergency services including mental health services.

In spite of potential shifts in the prevalence of mental illness and the finite resources available to respond to such conditions, mental health stakeholders consulted during the course of this review emphasised the risks associated with over-diagnosis or over-medicalisation of people who appear to be behaviourally disturbed or acting anti-socially. While community debate is warranted about further investment in mental health services that are more reflective of the prevalence of mental health problems in the community, measures should be taken to avoid unnecessarily diagnosing people with a mental disorder or excusing anti-social behaviour on the basis that a person is psychologically disturbed or drug or alcohol affected.

Police shootings

It is perhaps not surprising that in the context of deinstitutionalisation there has been an increase in the frequency of encounters between police and people who appear to have a mental illness. This has led to damaging consequences in Victoria. As outlined in OPI’s 2005 review 17 of the 32 people fatally shot by Victoria Police between 1990 and 1996 were considered to have had a mental disorder at the time of the shooting.


12 Medew J ‘Prescription drugs, alcohol wreak havoc’ The Age 8 May 2012 p3
Although some identify deinstitutionalisation as a contributing factor in the over-representation of people with a mental illness in fatal police shootings, the trend was not replicated in other Australian jurisdictions. The over-representation of mentally ill persons in fatal police shootings was a systematic and collective failure by Victoria Police during the 1990s.

Project Beacon

Victoria Police rightly recognised through its initiation of Project Beacon in 1996 that some fatal police shootings were preventable deaths in which inadequacy of police training played a large part. The cornerstone of this initiative was the philosophy that the success of an operation will be primarily judged by the extent to which the use of force is avoided or minimised. This was given meaning through the enunciation of ten safety principles which Victoria Police still use.13

2005 OPI review

In 2005 OPI completed a review into fatal shootings by Victoria Police. While Project Beacon was successful in initiating a renewed focus on preventing and minimising force, OPI’s 2005 report found a gradual shift in attention since the implementation of Project Beacon [that] could allow the re-emergence of a culture among police which is overtly reliant on firearms.14 The report identified a decline in adherence to minimising the use of force and the safety first principle.

OPI’s 2005 review reinforced the view that reform aimed at minimising the use of fatal force should not only arise as a reactive response to controversy, but should be part of continuous improvement strategies for police practice.

Charter of Human Rights and Responsibilities Act 2006

The Charter of Human Rights and Responsibilities Act 2006 requires public authorities to protect and promote twenty specific rights of Victorians. These are based on the principles of freedom, respect, equality and dignity. The principles must guide the treatment and response to people including those with a mental illness.

Victorian initiatives 2006–2009

In its 2006 Business Plan Victoria Police identified mental health as one of its priority areas. It undertook to enhance its responses to mentally ill persons as a strategic service delivery commitment.

---

13 See Appendix Two
14 Office of Police Integrity 2005 Review of Fatal Shootings by Victoria Police
This commitment led to the development of Victoria Police’s Peace of Mind strategic approach to the provision of services for people with or affected by mental disorders. The strategy addressed three core areas:

- Knowledge and information
- Internal and external partnerships
- Training

In 2007 a five year collaborative research project between Monash University, the Victorian Institute for Forensic Mental Health (‘Forensicare’) and Victoria Police commenced. This project investigated Victoria Police practices, policies and procedures in dealing with mentally ill persons and interactions with other mental health services. The findings of the project have informed OPI’s review and are considered later in this report.

In 2009 the Government released Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019. The Strategy takes a whole-of-government approach to dealing with mental illness. It includes a range of programs and services that reflect the spectrum of mental illness. There is a strong emphasis upon shared responsibilities and partnerships.

One outcome of interagency mental health protocols has been the operation of a state-wide Interdepartmental Liaison Committee and local Emergency Service Liaison Committees. These committees bring police, ambulance, mental health services, carers and consumers together at a regional and state level to monitor and improve interagency liaison, communication and information.15

Following on from the Government’s announcement of its ten year reform strategy, the Victorian Auditor General’s Office reviewed interagency responses to mental health crises in the community late in 2009. The review found that while the Department of Health’s Victorian Mental Health Reform Strategy 2009-2019 articulated a commitment to improve mental health services, there were inconsistencies in the extent to which responses to mental health crises met the standards set out in the Mental Health Act 1986. The review included a range of recommendations to improve interagency effectiveness, preparation and appropriateness and coordination. These recommendations are set out at Appendix One.

In 2009 OPI completed a review into the use of force by and against Victoria Police. This review was prompted by concern about the slow progress by Victoria Police in implementing recommendations from OPI’s 2005 review. While Victoria Police had accepted in principle 49 of OPI’s 55 recommendations in the 2005 review, the 2009 review found that regrettably, in the years since the OPI recommendations were made, Victoria Police continued to lose strategic focus on safety and avoiding the use of force.16

---

15 Department of Health 2010 Department of Health and Victoria Police, protocol for mental health p33, 34
16 Office of Police Integrity 2009 Review of the Use of Force by and against Victorian police p11
Models for responding to people who appear to be mentally ill

Reforms aimed at improving encounters between police and persons with mental illness broadly reflect the principles of community policing. Community policing embodies an inclusive philosophy based on encouraging partnerships between police and the community to solve problems of crime and disorder.\(^{17}\) While community policing initiatives vary across jurisdictions, they generally embrace two central tenets: a problem solving approach to operational problems, and the use of community partnerships to accomplish these operational objectives.\(^{18}\)

In the case of mental illness, community policing strategies have been precipitated by a growing recognition that *the traditional police response to people with mental illness has often been ineffective, and sometimes tragic.*\(^{19}\)

Given this recognition a more community-oriented response to mental illness by police is based on a greater recognition of the needs of the mentally ill, as well as a better understanding of the underlying factors that lead to encounters between mentally ill persons’ and police and the criminal justice system.

Models used in other jurisdictions

A range of police organisations, generally in the United States and Canada but also in Australia have developed innovative models to improve the interface between police and people who appear to have a mental illness. OPI's review has included consideration of whether Victoria Police should implement any of these models.

**Police-based police response model – the ‘Memphis Model’**

A police-based police response model consists of specially trained police officers who provide first line response to calls and act as liaisons to the mental health system. The model originated in Memphis and is often referred to as either the Memphis or Crisis Intervention Team model.\(^{20}\)

Participation by police within the program is voluntary. Typically police who are successfully selected are provided with 40 hours training. When mental health-related

---

17 Putt J (ed) 2010 *Community Policing in Australia* Australian Institute of Criminology p2
19 Cordner D (2006) *People With Mental Illness* US Department of Justice p1
calls are received a Crisis Intervention Team is dispatched and given the authority of officer in charge, irrespective of rank. These officers are responsible for:

- assessing a situation
- resolving it through de-escalation and negotiation
- transportation to emergency psychiatric services
- provision of treatment referrals or arrest where appropriate.

The Memphis Model’s success has been underpinned by strong partnerships with local advocacy groups and health providers. The Memphis Police Department has an agreement with a psychiatric emergency department that offers a no-refusal central drop off to police. All referrals are immediately accepted and officer waiting time is minimised.

The training program is significant but it is only one component of the Memphis Model. The model itself has been described as representing an organisational intervention that represents a shift in operating practices in relation to persons with mental illness. Its success requires large scale changes to police operations as well as the forging of partnerships with the mental health community. Because of this it can be difficult to implement.

New South Wales Police’s Mental Health Intervention Team is the closest example of the Memphis Model in an Australian jurisdiction. It is discussed in more detail in a later section of this report.

Although critics of the Memphis Model point to the relatively small size of the police service and police service area, the Memphis Model has proven to be best practice in terms of effectiveness at linking people with mental illness to mental health resources. Seventy-five percent of calls in Memphis led to a treatment disposition, usually through transportation to the psychiatric emergency centre. It has also been effective in improving police perceptions about readiness and preparedness.

### Police-based mental health response model – the ‘Birmingham model’

A police-based mental health response model integrates mental health workers within a police organisation. Similar in certain respects to the Memphis Model, the model involves mental health clinicians working as civilian employees of the police department.

21 Cited in Watson AC and others 2008, p363
22 Cited in Watson AC and others 2008, p363
24 Borum and others 1998 p401
25 See Williams Deane M, Steadman HJ, Borum R, Veysey BM & Morrissey JP 1999 ‘Emerging partnerships between mental health and law enforcement’ Psychiatric Services 50(1) p100
The Birmingham Police Department (US) has a program that resembles this model. It employs Community Service Officers to assist police in responding to mental health crises and provide crisis intervention and follow-up assistance. They are civilian police employees with professional training or qualifications in social work or related fields.

Upon recruitment Community Service Officers participate in a six-week classroom and field training program. In addition to responding to mental health emergencies, they also attend to various social service-type callouts such as family violence, transportation or shelter needs, or other general assistance.

The viability of this model is likely to depend in large part on the availability of trained mental health professionals employed within the police agency. This underscores the importance of a multi-agency commitment to satisfactory coverage and resourcing issues.

**Mental-health based mental health response model – ‘Crisis Assessment and Treatment Teams’**

A mental-health based mental health response model consists of mental health professionals responding to mental health crises. Typically called mobile crisis units, in many respects they resemble Crisis Assessment and Treatment Teams in Victoria. In a US study comparing three different responder models, this model was found to be more likely to lead to excessive response times, in part impacted by a general shortage of mental health services.

While it is foreseeable that these problems could be addressed through greater resourcing, another central problem associated with this model is a general lack of consultation and collaboration between police and mental health services. While it attempts to prevent police from having to respond to mental health crises, practice demonstrates that police will continue to have a role to play in such crises. Mental health crises often constitute either public nuisances, threats to the safety of individuals, or disturbances to police. As a consequence, police are regularly called to such scenes.

Attesting to this is the large body of research which emphasises the need for collaboration and trust in interagency responses. Attempts to remove police from involvement in responding to people who appear to be mentally ill not only fails to promote interagency collaboration and trust, but may actively harm it.

**Co-responder model**

The ‘co-responder model’ is a hybrid that entails a multi-disciplinary response to mental health crises. The model originally arose in Los Angeles in the 1980s as a

---

26 Steadman HJ and others 2000 pp647-8
27 Steadman HJ and others 2000 pp648-9
28 Zealberg JJ, Christie SD, Puckett JA, McAllhany D & Durban M 1992 ‘A mobile crisis program: Collaboration between emergency psychiatric services and police’ *Hospital and Community Psychiatry* 43(6) p612
response to difficulties in linking people with mental illness to appropriate services. Alongside this limitations on police officers’ time and a lack of awareness about community mental health resources were significant factors. In response to this an approach was developed pairing specifically trained police officers with mental health professionals who together provide a secondary response.29 While collaboration with mental health services underpins each of the models for responding to mental health crises, the co-responder model encompasses a multi-disciplinary, collaborative approach in a more tangible sense. The model consists of sworn police officers responding in tandem with mental health professionals in order to maximise their respective skills. It also maximises mental health and criminal justice information. The police officer is able to access mental health records, while the mental health professional can access criminal justice data about, for example, arrest records, warrants, prior police contacts and so on.

29 Schwarzfeld M, Reuland M & Plotkin M 2008 'Improving Responses to People With Mental Illness: The Essential Elements of a Specialised Law Enforcement-Based Program' Council of State Governments Justice Centre (Schwarzfeld M and others 2008) pviii
The current context in Victoria

Critical incidents
Police encounters with people who appear to be mentally ill can occur in numerous ways.

At one end of the spectrum is Victoria Police’s Critical Incident Response Team. This component of Victoria Police’s Force Response Unit, which includes the Special Operations Group, provides a high level specialised response to potentially volatile situations. Such situations include sieges, threats of suicide and hostage situations that may involve someone who appears to be mentally ill. The training provided to members of these teams is resource intensive and includes qualified negotiation and alternative force strategies. When these specialised response units are activated the situation has often been effectively managed by primary police responders who have used de-escalation or containment skills to enable the arrival of a secondary specialist response.

Data provided by Victoria Police reveals that between 2010 and 2011, 47 percent (324 of 685) Critical Incident Response Team callouts were related to mental illness. Of these 29 percent involved drug and alcohol use in addition to mental illness.

The focus on this report however is on the more routine encounters with people who appear to have a mental illness and the effectiveness of Victoria Police in adequately preparing its members for these encounters. These encounters usually involve other government agencies.

Interagency agreements
Interagency responsibilities to people who appear to have a mental illness are set out in agreed protocols between Victoria Police, the Department of Health and Ambulance Victoria. The protocol between Victoria Police and the Department of Health was revised in 2010.30 It affirms Ambulance Victoria has primary responsibility for the transportation of people experiencing acute mental illness.

Police assistance may be requested where there is a high risk of harm. The protocol distinguishes between police assistance and police transportation. Use of a police vehicle for the purposes of transportation should only occur as a last resort where all other options are unavailable.

As this report sets out the practice differs from the protocol. Police are commonly required to transport people for mental health assessment, despite this being at odds with the agreed protocols.

The police transport of people who appear to be mentally ill is at odds with the rights, dignity and interests of people requiring mental health assessment. The safety of such people warrants transportation in an ambulance to an appropriate mental health facility. While some Crisis Assessment and Treatment Teams consulted during this review indicated a preference for mental health assessments to occur in police cells to avoid clogging up emergency departments, a person experiencing a mental health crisis does not belong in a police cell. That person’s safety, wellbeing and dignity are not and cannot be properly catered for in a police cell or a divisional van.

Frequency of general duties encounters

People with a mental illness are significantly over-represented in police custody data. A 2010 Victorian study found that three-quarters of detainees met the diagnostic criteria for at least one mental disorder at the time they were in custody, with one quarter having had a prior admission to a psychiatric hospital.\textsuperscript{31}

In addition to their prevalence, these encounters often constitute the more complex and time-consuming incidents that police attend.\textsuperscript{32} While there is little by way of empirical evidence for this, the time spent carrying out such tasks is anecdotally reported to be highly significant.\textsuperscript{33} Because of this police have been referred to as ‘streetcorner psychiatrists’, ‘psychiatric medics’, ‘forensic gatekeepers’ and ‘amateur social workers’;\textsuperscript{34} denoting the complex range of functions they are required to fulfil regarding mentally ill persons, and the services to which they are required to refer such persons.

Risks associated with such encounters

A range of risks are associated with encounters between police and people who have a mental illness where police lack appropriate training and skills. These encounters can be dangerous for both police and the person with a mental illness. Most assaults against police occur when a person is under the influence of drugs or alcohol, experiencing an acute mental health episode, or presents with a combination these risk factors.\textsuperscript{35} These encounters may be even more serious for people with mental illness. Studies examining the over-representation of people with a mental illness in police fatalities have often produced stark results.

For example a 2010 Victorian study of police fatalities over a fifteen year period revealed a high prevalence of clinical disorders among people fatally shot by police. People with

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{31} Baksheev GN, Thomas SDM & Ogloff JRP 2010 ‘Psychiatric disorders and unmet needs in Australian police cells’ Australian and New Zealand Journal of Psychiatry 44 pp1043-51
\item \textsuperscript{32} Schwarzwelder M and others 2008 pvii
\item \textsuperscript{33} Baksheev GN, Warren LJ, Ogloff JRP and Thomas SDM 2012 ‘Correlates of criminal victimisation among police cell detainees in Victoria, Australia’ Police Practice and Research 13(4)
\item \textsuperscript{34} McLean N & Marshall LA 2010 ‘A front line police perspective of mental health issues and services’ Criminal Behaviour and Mental Health 20(1) pp62-7. See also Teplin & Pruett 1992
\item \textsuperscript{35} Watson AC and others 2008 p360; Cordner D 2006 People With Mental Illness US Department of Justice p5
\end{itemize}
\end{footnotesize}
severe mental illnesses such as psychosis and schizophrenia were significantly over-represented. The notion of ‘suicide by cop’ was identified as one factor contributing to the over-representation of people with a mental illness in fatal police shootings. Such incidents involve individuals behaving in a deliberately threatening way with the intention of precipitating police to fatally wound them. Depending on how it is defined it has been reported to account for anywhere between ten and forty-six percent of police shootings.36

While such a phenomenon may well exist this is not to say that these fatalities are inevitable or that there is little police can do to prevent or minimise their occurrence. Training in de-escalation, negotiation and the use of less fatal forms of force all contribute to minimising the phenomenon.

People who have a mental illness are also over-represented in crime victimisation data. In spite of popular assumptions to the contrary people experiencing a mental disorder are much more likely to be a victim of crime than a perpetrator.37

The role of police discretion

While force may be justified in some of these encounters, the exercise of police discretion is particularly relevant to many of these encounters. In line with other law enforcement decisions, police are required to use their discretion in selecting the most appropriate disposition in a given situation. One significant factor impacting upon police use of discretion is structural constraints regarding hospitalisation and other alternatives.

Research has demonstrated that the more procedural steps between the street and the hospital, the less likely police are to make an emergency apprehension. This supports the proposition that police tend to be ‘acutely aware’ of the limited number of psychiatric placements available to them. Alongside this they have a strong grasp of the stringent nature of admission criteria.38 Given these intrinsic challenges, responding to people who appear to have a mental illness is often perceived as a frustrating experience for police. It is commonly time consuming and may appear futile where hospitalisation does not eventuate. Associated with this is the way police understand their own judgments to be perceived by mental health clinicians. Where police transport mentally ill persons for assessment, release from hospital can be regarded as a personal slight against their judgment. This often demonstrates a lack of understanding regarding the principle of community care and can breed a perception of unwillingness by medical professionals to ‘do something’. In this context police can be discouraged from initiating hospitalisations.

36 Kesic D and others 2010 p464
38 Teplin and Pruett 1992 pp140-145; Green TM 1997 ‘Police as frontline mental health workers: The decision to arrest or refer to mental health agencies’ International Journal of Law and Psychiatry 20(4) p482
While people with a mental illness are over-represented in arrest data, this only tells part of the story regarding police discretion to charge. Throughout the course of this review health professionals commonly evoked the distinction between ‘mad’ and ‘bad’ people to distinguish between interagency responsibilities. A person who is ‘mad’, according to this logic, is the responsibility of hospitals. If a person is conceived as ‘bad’ the responsibility lies with police.

One problem with this rationale, aside from its potential to belittle people with a mental illness, is that it oversimplifies the more complex nature of this issue. Research demonstrates that arrest may be the only disposition immediately available to police to bring a situation under control. Where a person does not appear to meet the high threshold required for involuntary hospitalisation, but the person’s behaviour is too public to be ignored, police are likely to arrest.39

In addition the rationale is unhelpful where a person may be considered both ‘mad’ and ‘bad’. This review has found that in such instances police are routinely expected to take responsibility in spite of the person’s mental health status.

While mental health legislation generally outlines the responsibility of police regarding the protection of people who are threats to themselves or others it is well recognised that this framework can be difficult to apply in practice. As a 2010 Victorian study concluded:

> Given that most encounters between police and people experiencing mental illness do not involve people who meet civil commitment or criminal arrest criteria, police officers must often exercise considerable discretion. This discretion is particularly evident in what [elsewhere has been] termed “low-visibility” encounters, for example, when there is no victim or when the victim does not wish to pursue charges.40

This study surveyed Victorian police officers about their understanding of mental illness. After watching three filmed scenarios police were surveyed about how they would probably respond to each situation, and how they would ideally respond. They were given the option to:

- walk away
- handle the matter informally
- call for the assistance of a Crisis Assessment and Treatment team, or
- apprehend the person using section 10 powers.

39 Teplin and Pruett 1992 p147
The survey found a number of discrepancies between how participants were likely to respond and how they would ideally respond. This distinction illustrates the complex factors which arise from interagency protocols and service demand.

Generally, police officers with enhanced knowledge of mental illness were more likely to refer to psychiatric services. These officers are described as ‘knowing what they do not know’. The finding corresponds with other studies that have found more experienced officers were the least likely to invoke restrictive criminal justice or mental health involvement because of the perceived ineffectiveness of these outcomes.41

The desirability of police training

The Victorian study was also significant for what it found regarding the desirability of police training. Surveyed police who lacked an enhanced knowledge of mental illness and mental health services tended to be more pejorative and confident. These officers were interpreted in the study as less likely to ‘know what they do not know’, and therefore walk away from a situation.

Participants were also asked what additional training they would like. Almost 22 percent indicated they would like some further training. Fifty-seven percent of participants wrote none, while 19 percent did not answer. The authors interpret this as follows:

The relatively small proportion of surveyed police officers who would like further training lends weight to the suitability of a model whereby police officers who volunteer for specialised training as a result become ‘in-house’ specialists.42

That a majority of police did not nominate a preference for further training does not necessarily indicate that these individuals would not benefit if it was mandatory. Instead it is more likely to underpin a general frustration that police have regarding their engagement with people who appear to have a mental illness, and the lack of access to mental health services. In this context further training is likely to be perceived as extending, rather than minimising, their engagement with people with a mental illness.

To the extent that a portion of police nominate a desire for further training it is reasonable to assume that these police, generally speaking, demonstrate a greater interest in dealing with mentally ill persons and would therefore be more suitable than their colleagues in performing roles in a specialist crisis response team.

41 Godfredson and others 2010 p1401
42 Godfredson and others 2010 p1403
Tensions in an interagency context

Inefficiencies persist in the way emergency and treatment services function. When a person experiences a mental health crisis, police are often the first called to the scene. If there is a risk to public safety this is as it should be. However challenges persist in an interagency context. Government policy recognises the desirability of transporting people experiencing mental health crisis in an ambulance. But in reality all too often police undertake this responsibility. Processes for prioritising ambulance dispatches put medical emergencies above mental health crises. This underestimates the impact of stigmatisation that comes through being transported by a marked police vehicle.

During the course of OPI’s review mental health service consumers were invited to provide feedback about their experiences with police during mental health crises.

One consumer told OPI review officers:

*I felt belittled and degraded. The police officers and paramedics were arguing in front of me about who had responsibility for transporting me for assessment.*

While there are tensions in articulating interagency responsibilities via memoranda of understanding this experience conveys the stigmatising potential where these tensions play out in the presence of people experiencing a mental health crisis.

Crisis assessment

Inefficiencies and lack of availability mark police perceptions of Crisis Assessment and Treatment Teams. Police can experience long delays in waiting for their arrival – so much so that they are sometimes colloquially referred to as ‘Call Again Tomorrow’ teams. With a burgeoning workload there is an increased perception that Crisis Assessment and Treatment Teams lack the capacity to deliver upon the primary intention that underpinned their establishment in 1987.

In the context of deinstitutionalisation Crisis Assessment and Treatment Teams were introduced to provide mobile crisis assessment in the community. Various stakeholders consulted throughout the course of this review emphasised that the work of these teams has progressively moved away from mobile crisis assessment to community-based treatment and case management services. This leaves a gap in responding to mental health crises in the community.

Given the demanding workload of Crisis Assessment and Treatment Teams police are often called to fill the void. In order to arrange for the assessment of people who appear to be mentally ill, emergency departments often constitute the only practical site for assessments to be conducted, aside from police cells.

In this respect emergency departments have come to operate as gateways to mental health assessment and treatment services. This practice adds to the pressure experienced
by emergency departments. At the same time there is a cultural tendency to see mental health assessments as distinct from and less urgent than other emergency medicine responses. This leads to delays in conducting assessments. From a mentally ill person's perspective this does not accord with the dignity and rights to which they are entitled. From a police perspective it leads to a poor use of resources where police, who could be responding to calls for police services, have to remain with the person in hospital emergency department waiting rooms for lengthy periods of time. While these tensions characterise metropolitan areas they can be more pronounced in regional and rural areas where mental health clinicians may be on call and located considerable distances from their worksites.

Ambulance Victoria has primary responsibility for transporting people for mental health assessment. The Auditor General’s 2009 review recommended that police divisional vans only be used where there is a clear policing or safety need. In spite of this the use of ambulances has been inadequate. Too often police are in the position of having to fulfil this function because of the absence of suitable ambulance transports. This is undesirable for police and mental health service consumers.

Victoria is not unique in the experience of these challenges. Further innovation is required to improve the delivery of services to mentally ill persons. Such innovation needs to be consumer oriented, while also delivering gains in resource allocation and the avoidance of unnecessary duplication.
The preparedness of members of Victoria Police

Throughout the course of this review mental health service consumers were consulted about their experiences in dealing with Victoria Police officers in the context of their mental illness. The views of consumers were generally positive. Often police were nominated as a preferred responder over ambulances or Crisis Assessment and Treatment Teams because of their readiness to respond.

The experiences and perceptions provided to OPI through these consultations have been used to inform OPI’s findings regarding the preparedness and appropriateness of Victoria Police in responding to people who appear to have a mental illness.

The history of police training

The impact of Project Beacon clearly attests that police training can play an important role in minimising the risks that arise in encounters between police and people with a mental illness. As OPI has previously stated the 1990s Project Beacon was an innovative and nation-leading project … that changed Victoria Police practices. Despite this OPI’s 2005 and 2009 reviews identified a declining emphasis upon the ten safety principles and their rationale. Since 2002 a number of reviews warned Victoria Police that it was not effectively managing the risks associated with the use of force and that it seemed to lack the will or capacity to implement solutions to effectively address the identified problems.

Following a police shooting that resulted in the death of a fifteen year old boy in 2008, Victoria Police initiated a review of eleven fatal police shootings. The findings of this review, echoed by the presiding coroner in the subsequent inquest, observed the following:

- A majority of those shot by police were vulnerable on the basis of their psychological state or use of drugs and alcohol.
- Communication techniques and presumptions about rationality when dealing with obviously irrational people were recurring features – such as the constant yelling of commands at an irrational person.
- Police opted to engage the person too quickly, resulting in the armed person advancing on police and breaking the cordon and not allowing the creation of time in order to garner more resources to help manage the situation.

43 Office of Police Integrity 2009 Review of the Use of Force by and against Victorian police p9
44 Office of Police Integrity 2009 Review of the Use of Force by and against Victorian police p14
• Police failed to make use of all information to inform risk assessment and method of approach.

• There was a lack of planning to create time and better determine a course of action that can be communicated to the other members, rather than reacting independently to each other.

• The more tactical and planned a critical response is, the better chance to reduce resorting to lethal force.

• Although five of the incidents reviewed were classified as ‘suicide by cop’, police are not specifically trained to deal with this.\(^45\)

The most significant finding arising from this internal review by Victoria Police was a declining emphasis on the ten operational safety principles. While OPI's 2005 and 2009 reviews into the use of force identified these concerns, reform by Victoria Police was too incremental and slow.

It is noted that Victoria Police has improved its commitment to address training relating to vulnerable persons since 2008. However the multiple reviews into use of force by Victoria Police demonstrate a troubling cyclical pattern. It is important that Victoria Police does not simply react to crises. It must learn from past mistakes and implement strategies to ensure the lessons are not forgotten. Reforms to improve responses to people who appear to have a mental illness and reduce the use of fatal force need to be sustained.

Current operational training

Mental health training that Victoria Police officers presently receive is embedded in Operational Tactics and Safety Training (OTST). All police are required to attend two days of OTST twice a year in order to maintain accreditation. This training includes a module on vulnerable persons. While this is welcome history suggests that the agenda of OTST can become too crowded. In the context of the roll-out of semi-automatic pistols and Tasers, OPI has concerns about the extent to which the module may become vulnerable to being overlooked or replaced in future, as has happened in the late 1990s following Project Beacon. It is incumbent upon Victoria Police to ensure that this does not occur.

Owing to the crowded OTST agenda, the Victoria Police Education Department has recently embarked on the use of e-learning. Police will be required to complete an e-learning module on vulnerable persons prior to their attendance at OTST. This is a pragmatic initiative. However, throughout the course of this review police who were consulted tended not to offer a favourable opinion of e-learning in general. This suggests a need to more effectively promote the benefits of e-learning to rank and file police.

\(^{45}\) Cited in Coroners Court of Victoria 23 November 2011 Inquest into the Death of Tyler Jordan Cassidy para 418
This review included an assessment of the vulnerable persons e-learning package as it currently stands. While those behind its development generally demonstrated a strong commitment to ensuring that it be as successful as possible OPI has some concerns with aspects of the package. It includes a component on the controversial ‘excited delirium syndrome’ discussed earlier. At the same time there is no emphasis upon borderline personality disorder – a disorder that police and others have identified as increasingly associated with the more complex and time-consuming of police encounters.

While e-learning can be usefully incorporated to provide an additional layer of training it should not be used as a substitute for interactive learning. Face-to-face role-playing scenarios are considered a requisite component of effective training regimes in the context of mentally ill persons.

It was also brought to OPI’s attention during the course of this review that the delivery of mental health training to police within the OTST framework risks reaffirming the perception of a connection between mentally ill persons and the use of force. This is a valid concern. Victoria Police needs to emphasise throughout the training package that this assumption is not a valid one.

A further concern relates to the absence of consumer participation. The principle of mental health service consumers contributing not only to educational design but also to delivery is paramount. Such participation provides an opportunity for police to understand these encounters from the perspective of the person with mental illness. More significantly it enables police to interact with such people when they are not in crisis. Police from New South Wales who have undertaken the Mental Health Intervention Team four day training program have consistently identified this as one of the most enriching aspects of the course.

Support for including consumers in Victoria Police training came from carers and consumers OPI review officers spoke to. One mental health service consumer told OPI that:

I have had generally good experiences with police, except for one occasion which was a terrible experience. I had taken unauthorised leave from the psychiatric hospital where I was an in-patient to go home. I was asleep in my bedroom in my parent’s house when I was woken by police who came into my room and dragged me out of bed. I sleep in the nude so didn’t have any clothes on. I was handcuffed before I knew what had happened. It was extremely distressing. I kept on asking them to leave the room so I could get dressed. It was only after I had continued to express my distress that I was allowed to put on underpants while they were watching me. I was taken out of my house in my underpants and put in the back of a divisional van and taken back to hospital. By the time we arrived I was highly distressed, frightened and agitated. I had to be man-handled out of the van. As a result I was recorded on the mental health database as resistive and non-compliant despite having no previous record of being resistant. That is now part of my mental health record and continues to prejudice mental health workers against me.
My sister had told police that I wasn’t violent but they ignored her. I want police to be better trained so they understand the consequences of their actions and can respond in a sensitive and non-confrontational manner when dealing with people like me.

Legitimate practical difficulties arise in imbedding mental health consumers into OTST. Given that all police are required to attend two days of training on a twice yearly basis, OTST runs year-round. On almost any given day some police will be undertaking this training. It may therefore be difficult to ensure sufficient numbers of consumers are available to participate in each course. Notwithstanding this more needs to be done to ensure all police have the benefit of engaging with mental health consumers and their carers in some training capacity. In addition to training based on de-escalation and minimising the use of force, police would also benefit from educational training about mental health in general and mental health service providers in particular. Previous reviews including the Auditor General’s 2009 report have demonstrated that police can have a poor understanding of the role and functions of Crisis Assessment and Treatment teams and Ambulance Victoria. This is often a shared misunderstanding. Throughout this review it was enlightening to hear of some initiatives undertaken within particular regions to address this, including interagency patrolling and other strategies. However more could be done by both Victoria Police and Area Mental Health Services to facilitate and promote these initiatives.

In summary OPI considers in the context of training and education Victoria Police should:

- Undertake an evaluation of its use of e-learning technology and whether it is an effective and comprehensive tool in engaging police about mental illness.

- Consider ways of incorporating contemporary psychiatric research and practices into its curriculum on mental illness, for example incorporate information regarding borderline personality disorder and reconsider using the term ‘excited delirium syndrome’.

- Consider strategies to promote the participation of mental health service consumers in training delivery.

Recruits and Public Safety Officer training

Police recruits and public safety officers receive identical training through the Police Academy in responding to people who appear to have a mental illness. Some concern was expressed to OPI about possible risks associated with public safety officers and their powers under the Mental Health Act 1986. OPI is currently satisfied that sufficient consideration has been given to ensure that public safety officers will be accountable.
As public safety officers are progressively deployed in the near future, OPI considers that Victoria Police should:

- Closely monitor the use of section 10 by these officers.

Mental Health Liaison portfolios

Victoria Police has a dedicated mental health liaison portfolio program. The objective of the program is to provide a link between police and local emergency services. This includes participation in regional Emergency Service Liaison Committees.

Throughout this review OPI met with several police holding the mental health liaison portfolio. While some police demonstrated commitment to the role there was inconsistency. Some liaison officers indicated they didn’t have a particular interest in the portfolio, others identified a lack of organisational commitment to equipping police in these roles with the skills and attributes the position requires, and a lack of clarity about the role.

The collaboration with other local emergency services that underpins the mental health portfolio role requires a strong advocate and effective negotiator. In one region that OPI visited where relationships between emergency services were poor there was a lack of support provided to the mental health liaison officer to improve the situation. This was in spite of recognition by police and local mental health services that tensions could be easily reduced. There is a case to put that the mental health liaison role could be more effectively achieved where the incumbent is of a higher rank such as inspector. While OPI does not recommend that Victoria Police restrict the portfolio to police of the rank of senior-sergeant or above, senior officers need to closely monitor and support those officers who hold the portfolio in their region.

There is also a need for more effective liaison between portfolio holders. While there is some networking facilitated by the Victoria Police Mental Health Unit at present, many of the issues OPI has identified regarding interagency tensions across the regions are not unique. There is no need to ‘reinvent the wheel’ in remedying inefficiencies or tensions between agencies. More strategic liaison opportunities between these portfolio holders should foster problem-oriented solutions that have been successfully developed across the state.

OPI considers that Victoria Police should:

- Review the allocation of Mental Health Liaison Officer portfolios and develop further strategies to prepare and support officers holding this portfolio.
Innovative service delivery

A lack of resources to meet the demand for mental health services is a feature not unique to Victoria. Jurisdictions across the world have struggled with this challenge. This reality requires agencies to work more intelligently to develop innovative services that are less resource intensive and enhance consumer outcomes.

PACER

One such innovation is known as the Police, Ambulance and Clinical Early Response (PACER). PACER was developed in Victoria in 2007 as an interagency trial to improve emergency service responses to people who appear to have a mental illness. It came about through a local partnership between police in Moorabbin and medical practitioners at Southern Health following a study tour that examined a range of models operating across the United States. Working as a co-responder unit comprising a police officer and mental health clinician the PACER crew provided a secondary response unit to respond to callouts that appeared to involve mentally ill persons.

Designed to improve emergency services responses to psychiatric crises in the community, the trial consisted of a PACER team rostered together for an eight hour shift based at Moorabbin police station. General duties police provided primary response to incidents and called for PACER support where an incident appeared to be associated with mental illness.

The inclusion of a mental health clinician as part of the PACER crew, meant a mental health assessment could be conducted onsite. This avoided the often long delays that consumers and police experience waiting for assessments to occur in emergency departments. This in turn eased the strain experienced by emergency departments. Dispositions available to PACER crews included the arrangement of transportation to an emergency department, mental health facility, police station, or a person’s residence and the ability to make follow-up care arrangements in a community context.

Another benefit of a multidisciplinary crew was the accessibility of both health and police data. Privacy concerns prevent police from accessing information about a person’s health records and mental health practitioners from accessing police information. A team consisting of both a member of police and a clinician is equipped to access timely information and use this to identify an appropriate disposition in the consumer’s best interests.

Department of Health evaluation

Following a positive evaluation by Victoria Police, the Auditor General endorsed the PACER model and recommended its trial continue. This culminated in an independent
evaluation commissioned by the Department of Health in 2011. The final report of this evaluation was made public in May 2012.

As the final evaluation report sets out, over the course of the 16 month trial period PACER activity encompassed the following:

- 783 requests for assistance
- a maximum of nine cases in any one shift
- an average of two cases per shift
- an average duration of PACER attendance of one hour 19 minutes
- provision of onsite advice and/or assessment in 78 percent of cases
- the use of section 10 powers for 37 percent of cases
- transportation was not required for 64 percent of cases
- the primary response unit was cleared by PACER in 53 percent of cases.\(^{46}\)

**Efficiency of PACER**

When assessed against the timeliness of usual service provision for mental health crises, the evaluation found that PACER appeared to offer a clear improvement on timeliness for client access to mental health assessment. It also indicated a more effective use of police time.

When assessed on the extent to which PACER facilitated interagency sharing of information and contributed to improved client outcomes, it was found that PACER enabled *a wider range of opportunities for mental health input to management of a mental health crisis*.\(^{47}\) This is demonstrated by the fact that onsite mental health assessment was facilitated by PACER in two thirds of cases.

The PACER evaluation also demonstrated favourable findings in relation to transportations where they were required. This included an improved use of ambulances as the preferred mode of transportation for mental health patients. There was also an apparent reduction in the use of emergency department services.

**Effectiveness of PACER**

The cost effectiveness of PACER was more difficult to accurately ascertain. The evaluation applied a sensitivity analysis which found that PACER intervention was cost-effective when compared with usual service delivery. As the report identified,
**PACER appears to be a more cost effective model for the most conservative scenario.** This finding does not account for other benefits that the evaluation identified, such as:

- Better outcomes for people experiencing mental health crises, including their human rights and access to treatment.
- The avoidance of costs associated with inappropriate police transportation and emergency department referrals.
- The possibility for reduced use of force.
- The community benefit arising from first responder units being made available for other purposes.

**Transferability of the PACER model**

The evaluation of PACER considered the extent to which PACER is a transferrable model. Throughout OPI's consultation with police, mental health clinicians and others around the state, views were also sought about the desirability of such a program in a variety of settings.

A lack of collaboration is often the central factor underpinning weaknesses in interagency coordination and effectiveness. One of the distinct advantages of the PACER model is that it was established through close collaboration. The activities of the PACER crews themselves are inherently collaborative. Stakeholders consulted throughout OPI's review reaffirmed this. The identified benefit was not only for the PACER crew and mental health consumers: first responder police who call PACER to a scene are able to observe and learn more sensitive and consumer-oriented approaches to mental illness.

Despite these advantages four barriers were identified which limit the transferability of the PACER model. They are:

- funding and resource constraints
- cultural and organisational differences between participating agencies
- geographic realities
- workforce restraints.

These constraints have been borne out following PACER's trial period. While police rostering to PACER was provided ‘in kind’, the provision of a mental health clinician was at the expense of the Department of Health. Despite Victoria Police’s preference to see PACER continue it concluded in 2011. It is currently uncertain whether the Department of Health will enable the program to be reinstated in the future. The
Secretary of the Department of Health has informed OPI of concerns about the model which include:

- **The PACER model made inefficient use of the time of a senior mental health clinician.**
- **Up to 48 percent of PACER attendances were for welfare concerns (rather than mental health concerns).**
- **The cost effectiveness analysis was based on incomplete data.**

A variation of PACER has recently been piloted by Victoria Police in conjunction with the Alfred Hospital and, more recently, Eastern Health. The variation involves a mental health clinician being collected from the hospital by police rather than specifically rostered onto a PACER crew and working out of a police station. The model is enabled by the geographic nature of the area and appears to be a pragmatic compromise to ensure a continuation of the model. However, in OPI’s consultations with the Alfred Hospital it was suggested that the pilot would not continue beyond its initial trial period. The decision to discontinue the pilot was not based on a negative perception of the trial but the view that it has some resource implications for the hospital.

These uncertainties regarding the status and potential transferability of PACER have led OPI to question whether the model may be inherently vulnerable. It requires the participation and investment of a diverse group of stakeholders. This is itself not problematic. Indeed it reflects the Victorian Government’s commitment to a whole-of-government response to mental illness. The Department of Health has indicated a commitment to support the front-end of mental health services. In the context of limited resources it does not currently see PACER as a priority. Given this, Victoria Police’s commitment to PACER may be misplaced.

**Filling the void of innovative service delivery**

The decision whether or not to invest in PACER in the future is a matter for the Department of Health or Area Mental Health Services. Prioritising resource allocation in the context of competition for funding between services is challenging. These challenges are likely to increase given an aging population and the growing problem of mental illness in the Victorian community.

The discontinuation of funding support for PACER may relieve some health resource challenges but it exacerbates the challenges experienced by Victoria Police and may reduce the overall quality of the provision of services to people who appear to have a mental illness. The fact remains that where health services do not have the resources to invest in these programs or decide not to, the onus often falls on police. Where a

---

49 Letter from Secretary Department of Health to Acting Director, Police Integrity dated 30 August 2012.
person is experiencing a mental health crisis and appears to constitute a risk of harm to themselves or others police will always have a role to play.

The Victorian Government has identified the need for a whole-of-government response to mental illness. Whether PACER is one such whole-of-government initiative is a question for policy makers and legislators. Notwithstanding this OPI recommends further consideration of how to translate the whole-of-government principle into tangible programs for mental health services that reflect this. Until then police will need to continue to fill the void.

A Mental Health Intervention Team in Victoria?

As noted in the PACER evaluation:

… the experience of police involved in the PACER project demonstrates the impact of developing a small cadre of specially trained staff and having pathways or networks for their knowledge and experience to be promulgated throughout an agency.\(^{50}\)

In addition to examining the PACER model, OPI’s review included an examination and in-depth consultation with New South Wales (NSW) Police’s program for responding to people who appear to have a mental illness. This program – the Mental Health Intervention Team – is another established model which enshrines the development of a unique pool of police equipped with specialist training and education about mental illness and the mental health sector.

Overview of the NSW Mental Health Intervention Team

The NSW Mental Health Intervention Team is another model for delivering a more effective primary response to people who appear to have a mental illness. The program consists of a dedicated unit of operational police who facilitate a program of intensive training of select police. These police undertake a four day program that includes lectures by specialist practitioners, engagement with mental health service consumers, and intensive role playing.

The course was initially offered to police at the rank of inspectors. After having completed the training, these officers were responsible for identifying police in their respective regions who would be appropriate for inclusion in the program. Suitable individuals could be those who show leadership potential or those whose skills in mental health warrant further improvement. The objective is to train ten percent of police. Consideration is currently being given to the development of a smaller and less intensive complementary program that would aim to train 50 percent of police.

The principle behind the Mental Health Intervention Team is that police who have completed the program become advocates for a more sensitive approach to mental

\(^{50}\) PACER Evaluation 2012 p55
illness. They are identifiable by a unique badge they wear. At scenes where a person appears to have a mental illness, these officers constitute officers in charge.

The Mental Health Intervention Team itself consists of operational police in uniform. This is a deliberate strategy to emphasise the centrality of mental illness to operational policing. Members of the Team regularly participate in patrols in order to prevent a perception that their roles remove them from the ‘reality’ of frontline policing.

The Team includes a clinical nurse. One of the advantages of the position is that it enables a more effective point of liaison with mental health services. The nurse’s role was initially funded by the NSW Department of Health for five years. NSW Police has now committed to funding it on an ongoing basis.

**The NSW Mental Health Intervention Team evaluation**

The pilot’s evaluation was generally highly favourable. It found:

- The program compared favourably with established best practice.
- Strong relationships were developed between the Mental Health Intervention Team and other stakeholders.
- The training led to an increase in the use of de-escalation techniques, with officers reporting that they gained a better understanding of mental health.
- The training led to a significant and sustained increase in officers’ confidence in dealing with mental illness.
- Mental health workers perceived an improved understanding of mental health amongst police that they engaged with.

In addition the program demonstrated significant improvements in the use of ambulances in transportations for mental health assessments. The underlying principle is that mental health is a health issue and police have a role to play only where public safety warrants it. Approximately 90 percent of all transportations are now conducted by ambulance. In Victoria this figure is approximately ten percent.

Some members of Victoria Police have attended the NSW intensive program but were not persuaded the program warranted adoption in Victoria. At present Victoria Police maintains its view that PACER represents a more effective model. However a Mental Health Intervention Team in Victoria is not mutually exclusive with PACER. Given PACER’s current status and the current position of the Department of Health, OPI recommends that Victoria Police re-evaluate its position on the implementation of a Mental Health Intervention Team.

---

Information and privacy

Section 120A of the Mental Health Act 1986 prescribes the circumstances in which information can or cannot be shared about a person’s mental health treatment history. The principle of confidentiality is an important one – particularly for people who have a mental illness and risks associated with stigma. The Act requires confidentiality about a person’s mental health service history unless the provision of such information is in the client’s interest.

During the course of this review the lack of police access to mental health records was regularly cited as one of the key factors preventing a more prepared and tailored response to a person who appears to be mentally ill. While police have not requested access to mental health service records per se, the need for information to be conveyed to them in critical incidents was commonly identified.

During OPI’s consultations with mental health service consumers and their advocates this issue was canvassed. There was general consensus that where this information is provided to better prepare police to respond to a person who appears to have a mental illness this is in the best interests of the consumer.

There can be a poor appreciation of the spirit of the confidentiality provisions as set out in the Act. Some mental health clinicians understand that the provision of information may be in a consumer’s interests. Others demonstrated a blinkered approach to the principle of confidentiality and the circumstances in which this may be at odds with a consumer’s interests.

One of the distinct advantages of the PACER model has been that the PACER crew was equipped with both police and mental health records. This review has considered other avenues for appropriate information exchange.

The Australian Federal Police are currently in the process of deploying a mental health clinician within Canberra’s emergency services telecommunications centre. This enables access to health records that may be used to provide police with greater information prior to their arrival at the scene.

The recent relocation of Victoria’s Emergency Services Telecommunications Authority in one central location makes the employment of a mental health clinician within this centre viable.

In summary OPI recommends that Victoria Police should:

- Reconsider its position on the implementation of a Mental Health Intervention Team resembling the approach taken by New South Wales Police Force.
- Use the Interdepartmental Liaison Committee to give consideration to the employment of a mental health clinician at the Emergency Services Telecommunications Authority.
A way forward

In 2007 a comprehensive five year research project – Police Responses to the Interface with Mental Disorder – was initiated. The project has been a collaboration between Monash University, the Victorian Institute of Forensic Mental Health (Forensicare) and Victoria Police. It has investigated Victoria Police practices, policies and procedures in dealing with people who appear to be mentally ill and interactions with other mental health services.

Now in its concluding stages, the findings of the project are stark. Victoria Police detains a person under ‘section 10’ powers every two hours. These apprehensions generally result in transportations to emergency departments, and often very long delays awaiting a mental health assessment. On average these jobs take police two hours. One quarter take between 3.5 and 6.5 hours.\(^52\) As lead researcher and director of Forensicare Professor James Ogloff recently stated, *basically, hospitals struggle to accommodate these people, and emergency departments are not designed for them.*\(^53\)

Throughout the course of OPI’s review police, psychiatrists, mental health clinicians, consumers and their advocates have spoken with consistency about the need to improve the system in a way that promotes efficiency and the rights and experiences of consumers.

As OPI’s report has identified, the ‘Memphis Model’ is recognised as established best practice in policing people who appear to have a mental illness. The essential criteria that underpins its success has been the capacity for police or ambulance officers to transport patients to a dedicated facility for immediate specialist psychiatric assessment.

One of the key recommendations arising from the recent Victorian study is the creation of a dedicated psychiatric facility for the emergency assessment of people experiencing a mental health crisis. Of the almost 5000 section 10 apprehensions made by Victorian police every year *almost all of these cases originate in the context of a psychiatric crisis and all too often police cannot obtain the services or responses necessary to assist the individual.*\(^54\) What is lacking is a service or response for police and ambulance to use that bypasses hospital emergency departments.

The establishment of a specialised crisis response unit in metropolitan Melbourne would provide a safe form of short-term accommodation for someone in crisis. The benefit for mentally ill persons is that such a facility can improve the care available during times of crisis. It may also decrease the potential for people with a mental health crisis to be detained under ‘section 10’ powers.\(^52\)
illness to be criminalised. These people do not belong in police custody. Such an environment is neither respectful of their human rights nor safe for their health needs.

For police and emergency departments there are also tangible and efficient gains. The time that police spend waiting for mental health assessments to occur could be drastically reduced. Police could return to other jobs.

Such a facility would also benefit other health services. As articulated emergency departments function as a quasi gatekeeper to mental health services. Such a facility would go a long way to rectifying this anomaly. For Crisis Assessment and Treatment Teams it could mean they can more fully dedicate themselves to the role they now perform: community based treatment.

One further weakness requiring change is the role played by Ambulance Victoria in transporting people for a mental health assessment. In spite of the Auditor General’s 2009 recommendation that police should not use divisional vans unless there is a clear police or safety need, change has been too incremental. More work remains in ensuring the Memorandum of Understanding – which sets out the role of ambulances in transportation – is reflected in standard practice. Transporting someone who appears to be mentally ill is a health issue. Police have a role for ensuring the safety of the community and health workers where required. If necessary police could use their powers to search a person for weapons or even to assist to restrain the person before he or she was transported in an ambulance. Ambulance must maintain primary responsibility for ensuring the health and safety of the person who appears to be mentally ill. Any role for police has to be about providing back up to ensure the safety of others. Mental illness is a health problem. Safe dignified and respectful transport for people with a mental health problem happens best in an ambulance, not in the back of a divisional van.
Conclusion

This review has identified a strong commitment by police to improve responses to people who have a mental illness that is reflected in Victoria Police’s recently launched strategic plan and across the organisation from general duties police to Victoria Police Command who spoke to OPI review officers. There is no ‘one size fits all’ solution to improving responses to people who appear to have a mental illness.

Interagency coordination is critical at both a state and local level. More work is needed to ensure consistency. This includes ensuring that agreed protocols reflect reality. Currently this does not happen. Issues in ambulance availability, priority processes and a tendency to regard mental health crises as distinct from emergency medicine continue to result in too many transports for mental health assessments being undertaken by police using divisional vans.

The strain experienced by emergency departments also continues, emphasising the need to consider strategies that alleviate the use of emergency departments as a gateway to acute mental health services. The challenge for Government is to consider innovative service responses that relieves the pressure these services experience while improving the health outcomes for people with a mental illness. This could take the form of a designated facility that resembles the recommendation arising from the Police Responses to the Interface with Mental Disorder research project. It could take the form of a renewed investment in PACER.

During its operation PACER was found to be effective on a range of different measures. However it is a model that has proven resistant to sustained multi-agency commitment. The initial pilot is no longer operational and subsequent trials face an uncertain future. OPI therefore recommends that Victoria Police reconsider its position on a specialised training program resembling the Mental Health Intervention Team in New South Wales. The complex, resource intensive and time consuming nature of police encounters with people who appear to be mentally ill necessitates consideration of any models from other jurisdictions that appear to work.

Irrespective of the status of PACER, police will consistently be called upon as first responders where someone appears to have a mental illness and is behaving in a way that is a risk to themselves or others. The interests of public safety necessitate this. A secondary responder model can be effective in initiating interventions that bypass emergency departments. However this does not negate the imperative of ensuring that primary responders are effective, sensitive and well-skilled.

Equipping police to appropriately respond in the first instance to encounters with people who appear to have a mental illness is an essential component of improving

---

55 Victoria Police Victoria Police Blueprint 2012 – 2015 p5
outcomes for all. Mental health service consumer participation in police training will enhance police understanding of what happens when someone is experiencing a mental health crisis and is likely to better equip police to respond to these situations.

This review has identified there is a solid foundation for improving police responses to people who appear to be mentally ill based on the demonstrated commitment of Victoria Police. But police cannot achieve better outcomes for this vulnerable section of our community by themselves. This requires a renewed commitment to a whole-of-government response to mental health.
Bibliography


Cordner D 2006 People With Mental Illness Office of Community Oriented Policing Services US Department of Justice

Cotton D & Coleman TG 2010 ‘Canadian police agencies and their interactions with persons with a mental illness: A systems approach’ Police Practice and Research 11(3) pp301-314

Department of Health 2011 Victorian Health Priorities Framework 2012-202: Metropolitan Health Plan State of Victoria

Gillig PM, Dumaine M, Widish Stammer J, Hillard JR & Grubb P 1990 ‘What do police officers really want from the mental health system’ Hospital and Community Psychiatry 41(6) pp663-665


Godfredson JW, Thomas SDM, Ogloff JP, & Luebbers S 2011 ‘Police perceptions of their encounters with individuals experiencing mental illness: A Victoria survey’ Australian and New Zealand Journal of Criminology 44(2) pp180-95

Green TM 1997 ‘Police as frontline mental health workers: The decision to arrest or refer to mental health agencies’ International Journal of Law and Psychiatry 20(4) pp469-486


Laing R et al 2009 ‘Application of a Model for the Development of a Mental Health Service Delivery Collaboration Between Police and the Health Service’ Issues in Mental Health Nursing 30(5) pp337-341


Mental Health Legal Centre 2010 Experiences of the Criminal Justice System: The Perspectives of People Living with Mental Illness

Office of Police Integrity 2005 Review of Fatal Shootings by Victoria Police


Putt J (ed) 2010 Community Policing in Australia Research and Public Policy Series Canberra: Australian Institute of Criminology

Ritter C, Teller JLS, Munetz MR & Bonfire N 2010 ‘Crisis Intervention Team (CIT) training: Selection effects and long-term changes in perceptions of mental illness and community preparedness’ Journal of Police Crisis Negotiations 10(1-2) pp133-152

Scott R 2010 ‘Case commentary: The duty of care owed by police to a person at risk of suicide’ Psychiatry, Psychology and Law 17(1) pp1-24

Schwarzfeld, M., Reuland, M. & Plotkin, M. 2008 Improving Responses to People With Mental Illness: The Essential Elements of a Specialised Law Enforcement-Based Program, New York, Council of State Governments Justice Centre


Young AT, Fuller J & Riley B 2008 ‘On-scene mental health counselling provided through police departments’ Journal of Mental Health Counselling 30(4) pp345-361

Zealberg JJ, Christie SD, Puckett JA, McAlhany D & Durban M 1992 ‘A mobile crisis program: Collaboration between emergency psychiatric services and police’ Hospital and Community Psychiatry 43(6) pp612-615
Appendix One: Recommendations from the Victorian Auditor General Office’s review

- Department of Health and Area Mental Health Services demonstrate their effectiveness by:
  - Working together to develop and implement ways to measure demand for, and effectiveness of responses to, mental health crises.
  - Using this information to identify service gaps and areas for improvement.

- Victoria Police, as indicated in the Peace of Mind Strategy, develops and uses measures to evaluate their responses to mental health issues.

- The Interdepartmental Liaison Committee and Emergency Service Liaison Committees jointly review performance in responding to mental health issues.

- All agencies continue collaborative innovation by:
  - Continuing the PACER trial and acting on its evaluation.
  - Focusing on opportunities to address issues particular to regional/rural settings.

- Victoria Police complete enhancements to mental health training to:
  - Support interagency coordination and protocol compliance.
  - Improve consistency and quality of responses for consumers.

- Area Mental Health Services and Ambulance Victoria address training gaps for paramedic and Crisis And Assessment Treatment/triage staff.

- Each agency incorporates consumer experience and perspective in staff training.

- Department of Health, Area Mental Health Services, Victoria Police and Ambulance Victoria explore and trial opportunities for interagency training/learning opportunities.

- Ambulance Victoria, Department of Health and Victoria Police, work together to investigate and trial alternative transport solutions.

- Department of Health, with Area Mental Health Services, clearly articulates expectations for Crisis and Assessment Treatment service responsiveness to crises.
• Emergency Service Liaison Committees, supported and monitored by the Interdepartmental Liaison Committee, introduce protocols to minimise police delays at emergency departments.

• Police should not use divisional cars as mental health transportation unless there is a clear policing or safety need.

• Police should not use cells to detain persons under section 10 of the Mental Health Act 1986 unless there is a clear policing or safety need.

• The Interdepartmental Liaison Committee formalise and maintain communication, monitoring and reporting processes with Emergency Service Liaison Committees.

• All Emergency Service Liaison Committees and the Interdepartmental Liaison Committee incorporate consumer representation.

• Department of Health and Victoria Police support their review of the interagency protocol by:
  - Developing a communication strategy to educate stakeholders about the protocol.
  - Identifying regions/services where the protocol is not being followed and work with them to address the barriers.

• Department of Health and Ambulance Victoria review their joint protocol.
Appendix Two: Victoria Police’s ten operational safety principles

• Safety First – the safety of police, the public and offenders or suspects is paramount

• Risk assessment – is to be applied to all incidents and operations

• Take charge – exercise effective command and control

• Planned response – take every opportunity to convert an unplanned response into a planned operation

• Cordon and containment – unless impractical, adopt a ‘cordon and containment’ approach

• Avoid confrontation – a violent confrontation is be avoided

• Avoid force – the use of force is be avoided

• Minimum force – where use of force cannot be avoided, only use the minimum amount reasonable necessary

• Forced entry searches – are to be used only as a last resort

• Resources – it is accepted that the ‘safety first’ principle may require the deployment or more resources, more complex planning and more time to complete.56

Note: OPI understands these principles are currently under review.

56 Victoria Police Manual - Policy Rules – Operational safety and equipment
Dear Mr Bonighton,

Thank you for your letter dated 16 October 2012 and the opportunity to provide a response to your proposed report entitled Policing people who appear to be mentally ill. I would like to acknowledge the objectivity and thoroughness with which your Office conducted the review. I am aware that the team consulted a number of our personnel at all levels of the organisation, and researched widely in preparing this report. I therefore welcome this constructive contribution to our commitment to continuing to improve police responses in this critical area.

As this report recognises, Victoria Police has taken significant steps to improve our policies, practices and training since nominating mental health as an organisational priority in 2006. I am pleased that the report validates our approach to these improvements, such as the inclusion of consumers and clinicians in police training, the use of scenarios and external subject matter experts, and the regular updating of the curriculum, such as the development of a module on youth mental health in response to expert feedback that is currently being delivered. Likewise, the noting of our recent introduction of e-learning as a complement to skills-based training in the report, is an indicator of our intention to continue to innovate and to draw on the best knowledge and skills available to equip frontline police to respond to people who appear mentally ill.

While the grounds for use of police powers of arrest and powers to search are more limited than readers of this report may appreciate, the report nonetheless highlights the importance of close and effective service collaboration between police and health personnel. I therefore accept the recommendations in this report and its encouragement to maintain our focus on reviewing police practices and effectiveness and to working with our partner agencies in this effort.

Yours sincerely,

Ken D. Lay
Chief Commissioner

[Signature]

25 November 2012
Appendix Four: Secretary of the Department of Health’s response

31 OCT 2012

e2893080

Mr Ron Bonighton AM
Acting Director, Police Integrity
GPO Box 4676
MELBOURNE VIC 3000

Dear Mr Bonighton

Thank you for forwarding a draft copy of the Office of Police Integrity report to the Victorian Parliament titled Policing People Who Appear to be Mentally Ill for feedback and comments.

I have considered the report and fully support the commitment of Victoria Police to improving the police response to people who have a mental illness.

The Department of Health thanks the Office of the Police Integrity for their review and report into the way Victoria Police responds to people who appear to have a mental illness. Safeguarding the rights and dignity of people with mental illness is of critical importance.

Collaboration between areas of government is critical to assisting people with a mental illness to receive treatment, progress recovery, and participate fully in the community. The Department of Health and Victoria Police Protocol for Mental Health (2010) reflects the strengthening of cooperation between Victoria Police and the Department of Health and provides clear and practical guidance to police and clinicians on their respective roles and responsibilities when working together to respond to the needs of people with mental illness. The protocol encourages speedy responses when police apprehend a person under section 10 of the Mental Health Act 1986 (the Act), to ensure that the person in crisis is assessed as quickly as possible and police can be released to attend to other duties.

The Department of Health is also leading the drafting of a new Mental Health Bill, following extensive public consultations about the strengths and weaknesses of the current Act and what the community expects of mental health legislation for Victoria. The views of Victoria Police have been well represented in these consultations.
To strengthen treatment responses, the Victorian Government is investing strongly in a number of community and hospital-based services to ensure that people requiring mental health treatment and support receive care as early as possible in the onset of their illness. This will reduce both the likelihood of crises arising and the associated distress for the person in crisis and their family.

Mental health crisis assessment and treatment teams play a number of roles, including intensive, short-term community-based treatment as well as responding to crises. However, they are neither funded as, nor expected to be, an emergency service and as such are not as widely distributed as emergency services such as Ambulance Victoria or Victoria Police. For this reason, in many cases the most appropriate and safest option is for a person to attend an emergency department for a specialist mental health assessment. Funding has been provided over a number of years for enhanced crisis assessment and treatment services capability in major emergency departments. It is important that people who appear to have a mental illness, who may have also have physical health problems, are able to access holistic care and treatment in a health care environment.

A recent innovation in emergency mental health care has been the development of Psychiatric Assessment and Planning Units (PAPUs). PAPUs provide short-term assessment and treatment for people who need hospital-level care but who do not require a long admission to a mental health inpatient unit. These units will help to keep people experiencing a mental health crisis safe in an appropriate health care environment and will ensure more speedy access to mental health treatment in times of crisis. These units are particularly important in assisting with short term assessment and detoxification for people with a mental illness and comorbid alcohol and drug problems.

The Department of Health is also active in service redesign and development work that will improve the capacity of mental health services to respond better to people in crisis in the community. Particular attention is being paid to streamlining access and entry to services at times of crisis, and working closely with Victoria Police.

The Department of Health looks forward to continuing to work in partnership with Victoria Police to further improve the health outcomes for people with mental illness.

Yours sincerely

[Signature]

Dr Pradeep Philip
Secretary
Appendix Five: Chief Executive Officer of Ambulance Victoria’s response

Office of Police Integrity Report – Policing people who appear to be mentally ill

Ambulance Victoria (AV) has previously collaborated with the Victorian Auditor General’s Office review into interagency coordination in responding to mental health crises, and will support future interagency initiatives. AV has taken an active approach to enhancing its own response, via specialist training for its paramedic workforce, production of a research based discussion paper titled Ambulance Service Provision to People Experiencing Mental Illness, and through recent research collaboration with Turning Point.

Context
AV recognises that providing care and treatment to members of our community suffering mental health crises is an important role of ambulance, and the greater health system. A material portion of AV’s annual caseload can be categorised as people who appear to have a mental illness.

Based on 2011/12 caseloads, of the 37,367 (approx 7.5% of AV emergency workload) mental health patients attended by AV, 75% were transported to a hospital or health facility. The highest proportion of patients transported were presentations classified as psychosis (39.1%), substance-related (13.0%), and non-specific (20.7%). Whereas the highest proportion of cases not transported had a mental health presentation of ‘other’ (31.8%), social / emotional problems (29.0%) and anxiety (22.5%).

Some 19.5% of mental health patients attend by AV occurred with police present (7,100 patients). This caseload level reflects the extent of the interaction between Victoria Police and AV attending patients appearing to have a mental illness. Such extensive interaction between the agencies provides evidence to support the assertion in the report that a whole-of-government and multi-agency approach to mental health crises is justified.

Only 15% of the patients transported required active medical treatment by paramedics for their mental health condition. The relatively low portion of patients requiring treatment suggests that the transport responsibility for mental health patients warrants further review and that other organisations / services may be able to provide this function more effectively and appropriately for these patients.

OPI Recommendations
Victoria Police continue to enhance its general education and training on responding to people who appear to be mentally ill and give consideration to introducing specialised training in relation to improving response to these members of our community.

AV supports the principle of this recommendation.
The Victorian Government’s Interdepartmental Liaison Committee comprising representatives from Victoria Police, Ambulance Victoria, the Department of Health and consumer and care groups consider the deployment of a mental health professional to provide 24/7 clinical support at the Emergency Services Telecommunications Authority.

AV supports the assertions in the report that a multi-agency, whole-of-government response is required when working with, and caring for people who appear to have a mental illness. Such a whole-of-government response would encompass a broader mental health services delivery model.

Each of the Victorian Area Mental Health Services has such a triage clinician available 24/7 capable of performing this role in some way. Increased coordination and utilisation of these services should be considered.

Reconsider its position on the Implementation of a Mental Health Intervention Team resembling the approach taken by New South Wales Police Force.

AV suggests that further investigation into the NSW model, along with others, is required for agencies to form a considered position on the suitability of that model within Victoria.

AV has a substantial research and evaluation capability, with an extensive record of research collaboration with external institutions and agencies. The ability to generate insight from historical patient data contained within the Service’s clinical data warehouse would allow AV to make a contribution to further multi-agency investigations into intervention models.

The establishment of a dedicated facility where people experiencing mental health crises can be taken for immediate assessment and care.

In 2009 the Victorian Auditor General’s Office conducted an audit titled ‘Responding to mental health crises in the community’. A key finding of the audit was that patient management is likely to be improved through the availability of more mental health services, so that the need for ambulance assistance to respond to a crisis is minimised.

AV suggests that this recommendation be considered in terms of a broader mental health services delivery model and therefore involvement at Departmental level will be necessary.