This submission has been produced by the Springvale Monash Legal Service Inc and printed with financial assistance from the Danks Trust. This submission has been prepared in response to the fatal police shootings of individuals suffering from mental illness. We hope to encourage policy change with regard to police training to enable them to better deal with individuals suffering from mental illness in Victoria.

Title: Police Training and Mental Illness – A Time for Change
Author: Springvale Monash Legal Service Inc
Artwork: Chris Maplestone

© Springvale Monash Legal Service Inc. 2005

This material is copyright. It may be reproduced for legitimate educational or review purposes; copying for other purposes must be authorised by express permission of Springvale Monash Legal Service Inc.

Prepared by:
Ana-Mari Martínez
Cara Somerville
Carrela Quimbo
Cindy Chow
Deborah Jefferson
Garth Ananthapavan
Felicia Kusnadi
Helen Seremetis
Trang Nguyen

Promoted by:
Chris Best
Dominik Vulkovic
Fiona Calvert
Jessie Taylor
Krystal Bedggood
Norman Wittingslow

Coordinated by:
Dave Taylor

A Community Development Group Project of Springvale Monash Legal Service Inc.

For more information contact:

Dave Taylor
Community Development Officer
Springvale Monash Legal Service Inc
5 Osborne Avenue
Springvale VIC 3171
(03 9562 3144
www.smls.com.au
Police Training and Mental Illness – A Time for Change

1. EXECUTIVE SUMMARY

This report was initiated as a result of the increasing number of ‘police shootings’ of individuals suffering from a mental illness. In Victoria in 2004, three people suffering mental health problems were fatally shot by police.

A consistent theme prevalent in the literature referred to for this report, was the need for police to be given adequate training to deal with individuals suffering from a mental illness, particularly in crisis situations.

Current police training methods do not appear to include sufficient negotiation skills to deal with individuals suffering from a mental illness in general as well as in potentially violent and life-threatening situations or skills in recognizing symptoms of mental illness.

The general sentiment appears to be that the current level of police training with respect to individuals suffering from a mental illness is inadequate.

This report aims to provide an impetus for discussion in this area by the police, government agencies and community groups, hopefully leading to improved initiatives and reform.

The report addresses the following:
- national and Victorian statistics of fatal police shootings
- typical crisis situations leading to fatal police shootings
- prevalent mental illnesses, symptoms, treatment and patient management.
- the regulatory framework governing the interaction between Victoria Police, Department of Human Services and individuals suffering from a mental illness
- current police training methods to deal with people suffering from a mental illness
- national and international developments in police training and mental illness
- the Memphis Model, a United States police training initiative

The report concludes with recommendations for reform, based on the Memphis Model, and includes:
- core training for all police officers in mental health issues
- the establishment of a specialized police taskforce providing immediate response to crisis situations involving individuals suffering from a mental illness
- adoption of codified guidelines for situations involving individuals suffering from a mental illness, the police and government agencies.
- review of the current legislation and procedures that govern police actions and the use of force in crisis situations involving individuals suffering from a mental illness.

2. GLOSSARY OF TERMS

ASM …………………………………….Area Service Manager
CAT …………………………………….Crisis Assessment Team
CATT …………………………………...Crises Assessment and Treatment Team
CIT ………………………………………The Memphis Crises Intervention Team
CM ………………………………………The Case Manager
CSO ………………………………….…Community Service Officer
CTO …………………………………….Community Treatment Order
DCS …………………………………….Director of Clinical Service
DMS –IV ………………………………..Diagnostic and Statistical Manual of Mental Disorders
DHS ……………………………………..Department of Human Services
MCU ……………………………………Mobile Crises Unit
OC ……………………………………..Oleoresin Capsicum (spray)
3. POLICE SHOOTINGS: OVERVIEW AND CASE HISTORIES

3.1 AN AUSTRALIAN OVERVIEW:


An AIC Australia-wide study, Police Shootings 1990-1997 reported that 75 people were fatally shot in confrontations with police between 1990 and 1997.1

33 died from self-inflicted wounds and 41 were shot by police officers.2

Of these 41 deaths, the greatest number, 21 occurred in Victoria.3

The report states that almost half the persons involved were under the influence of drugs or alcohol, one third of the victims suffered from depression or some other form of mental illness and one fifth had been involved in a domestic altercation.4

These police shootings often occurred in a ‘community setting’, such as a beach, a public street, outside the individual’s home or sometimes a private property.5

All these fatalities are recorded as “deaths in custody” and occurred while the police were ‘detaining’ or attempting to ‘detain’ in custody” and occurred while the police were in a ‘community setting’, such as a beach, a public street, outside the individual’s home or sometimes a private property.6

Because of operating effectively, while using minimum force and with minimal risk of harm to any person.

Between 1994, with the introduction of Project Beacon, and the time of writing (January 2005) there have been 11 fatal police shootings in Victoria.7

Five shootings have taken place since 2000; the first in April 2000, the second January 20028 and the final three took place in 2004.

All these incidents involved persons suffering from a mental illness.

3.2 CASE HISTORIES

The following cases have been sourced from Victorian newspapers.

They typify the problem and provide examples for a ten year period, from 1994 to 2004.

3.2.1 Case A

“A” lived in a homeless women’s shelter in inner city Victoria. She had a recent history of psychiatric problems and had been a resident of a drug and alcohol rehabilitation hostel. Police were called to the women’s shelter when “A” started wielding a hatchet and allegedly threatened a female passer-by.

“C” died from gunshot wounds. The coroner stated, “Standing back and taking a non-confrontational approach should not be seen by police as displaying weakness or a failure to take control on their part.”15

3.2.2 Case B

“B” suffered from schizophrenia and had stopped taking his medication in recent weeks. He began stabbing himself. Concerned and frightened family members called the police.

“B” wielded a knife with a 12.5 centimetre blade at police officers. The police officers ordered him to drop his knife. “B” charged at them with his knife and a senior constable fired four shots.

“B” died from gunshot wounds. It was later discovered that “B” had stabbed himself nineteen times while experiencing an acute schizophrenic attack. The coroner found that he had no control over his actions and that in his state of mind he could not have known what he was doing.13

3.2.3 Case C

“C” had fought schizophrenia for most of his life. When he was 14 years old, he became disturbed, often wandered and complained of hearing voices. From then on his life was filled with psychotic episodes, outbursts with vivid hallucinations, constant voices, delusions, depression and shock treatment.

Police were called to a residential care facility where “C” lived. He had had a violent outburst and he had threatened to kill people. He had locked himself in his room and was talking loudly to himself.

Four police officers entered his room and overpowered him. A senior constable pinned him down with a knee at the base of the neck, in a restraint technique known as the three point hold. This hold caused “C” to suffer a heart attack. “C” died.

The coroner found that the four police officers had used inadvisable and unnecessary methods to apprehend “C”. The coroner also criticized senior police who commented at the inquest that members should not show weakness. The coroner stated, “Standing back and taking a non-confrontational approach should not be seen by police as displaying weakness or a failure to take control on their part.”15

1 Australian Institute of Criminology (AIC) Report: Police shootings 1990-1997
2 An AIC Australia-wide study, Police Shootings 1990-1997
3 An AIC Australia-wide study, Police Shootings 1990-1997
4 An AIC Australia-wide study, Police Shootings 1990-1997
5 An AIC Australia-wide study, Police Shootings 1990-1997
6 An AIC Australia-wide study, Police Shootings 1990-1997
7 An AIC Australia-wide study, Police Shootings 1990-1997
8 An AIC Australia-wide study, Police Shootings 1990-1997
9 An AIC Australia-wide study, Police Shootings 1990-1997
10 An AIC Australia-wide study, Police Shootings 1990-1997
11 An AIC Australia-wide study, Police Shootings 1990-1997
12 An AIC Australia-wide study, Police Shootings 1990-1997
13 An AIC Australia-wide study, Police Shootings 1990-1997
14 An AIC Australia-wide study, Police Shootings 1990-1997
15 An AIC Australia-wide study, Police Shootings 1990-1997
Mental health relates to an individual's emotions, thoughts and behaviour. A person of good health is generally able to function effectively in everyday life, however, for those suffering a mental illness, everyday functions are difficult. Distress and anxiety often interfere with the daily life of individuals suffering from a mental illness.

4.1 MENTAL ILLNESS AND CRIME

A significant problem attached to individuals suffering from mental illness is the community's misguided association of mental illness with crime. A commonly held stereotype is that they are generally violent people who commit a significant number of crimes.17

Henderson, of the Mental Health Coordinating Council, argues passionately against this stereotype. She argues that the stereotype is founded upon a combination of the following:

- A public misconception and misunderstanding about what a mental illness is;
- exaggerated media depictions and discrepant findings in various studies that have inherent methodological inconsistencies.18

Research has suggested that there is no inherent link between mental illness and a person's capacity to commit a crime.19 There is however, a strong causal link between mental illness and incarceration.20 The lifetime crime prevalence of people with a mental illness is approximately 4% of psychiatric patients, which is unlikely to be higher than the general population.21 People with a mental illness are more likely to commit the same crimes, or to be harmed - than they are to harm others.22 For example, a person who has schizophrenia is 2,000 times more likely to commit suicide than they are to harm someone else.23

4.2 DIAGNOSING MENTAL ILLNESS

In Australia, mental illness is diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) which was published in 1994 by the American Psychiatric Association. The DSM-IV is divided into 5 axes:

1. all diagnostic categories excluding personality disorders and mental retardation;
2. personality disorders and mental retardation;
3. general medical conditions;
4. psychosocial and environmental problems and 5. current level of functioning.24 Axes one and two encompass the classification most relevant to this submission, that is, abnormal behaviour vis-a-vis mental illness.25

Also relevant is the Mental Health Act 1986 (Vic) (the Act). Under this Act, “a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.”26

4.3 TYPES OF MENTAL ILLNESS

Twenty per cent of people over the age of eighteen in Australia are affected by a mental disorder every year. The most prominent mental illnesses in Australia and Western society are anxiety disorders and depression.27 Three per cent of adults are affected by severe mental illnesses. Severe mental illnesses include schizophrenia, bipolar disorder, and various forms of depression and anxiety disorders.28

The majority of people with a mental illness do not have a family member with the same mental illness. Research indicates that a predisposition to schizophrenia and bipolar disorder may be inherited; however, inheritance may be one of many possible causative factors.29

It is important to note that the underlying causative factors of mental illnesses have yet to be fully identified or understood.30 It has been postulated that possible underlying causes of mental illness include biochemical imbalances, traumatic life events, substance abuse, hormonal disruption, or physical illness.31

4.3.1 Schizophrenia

Schizophrenia affects approximately 1% of Australians.32 The symptoms of schizophrenia manifest in various ways to interfere with a person’s everyday functioning. These include disturbances in “thought, perception and attention; motor behaviour; emotion and life functioning.”33 Contrary to public perception, a person with schizophrenia does not have a split personality.34

Schizophrenia is a condition which affects a person's mental functions, culminating in distorted thoughts and perceptions.35 People with schizophrenia often become alienated from others and reality; many lapse into a form of ‘fantasy life’ consisting of delusions and hallucinations.36

The cause of such alienation is not necessarily mental illness.37 Some of the causes include traumatic events, substance abuse, hormonal operations of the brain.38 The result of the abnormal functioning is that the person experiences extremes in emotions, such as extreme elation and severe depression. The person may become so incapacitated that they are unable to distinguish reality from fantasy.39

People with bipolar disorder may experience extreme elation, become reckless and have delusions of grandeur, believing they exert a position of importance or influence that is not founded in reality.40

They also experience the opposite extreme in emotion. They may experience severe feelings of helplessness and depression culminating in an inability to concentrate or make decisions.41

4.3.2 Bipolar Disorder

Bipolar disorder affects 2% of the population.42 The onset of bipolar disorder usually occurs in a person's twenties, occurring equally in men and women.43 Bipolar disorder is so severe that research has shown that twelve months after patients are released from hospital, 76 percent of those are evaluated as “impaired” and 52 percent display symptoms so severe that the original diagnosis of bipolar disorder is still appropriate.44

Bipolar disorder affects the normal operation of the brain.45 The result of the abnormal functioning is that the person experiences extremes in emotions, such as extreme elation and severe depression. The person may become so incapacitated that they are unable to distinguish reality from fantasy.46

People with bipolar disorder may experience extreme elation, become reckless and have delusions of grandeur, believing they exert a position of importance or influence that is not founded in reality.47

They also experience the opposite extreme in emotion. They may experience severe feelings of helplessness and depression culminating in an inability to concentrate or make decisions.48
The causative factors of bipolar disorder are not entirely understood. Like schizophrenia, SANE Australia propose that there is a link between hereditary and other factors which may trigger bipolar disorder. Researchers have demonstrated that there may be a genetic predisposition to develop bipolar disorder.\(^{50}\) Patients may respond satisfactorily to treatment, which can reduce, or in some instances, eliminate the symptoms of bipolar disorder. The usual form of treatment involves both medication and community support programs.\(^{52}\)

### 4.3.3 Depression

Depression afflicts approximately 20% of Australians. Of those, approximately 6% will endure an acute form of the illness.\(^{51}\) The onset of depression occurs in the mid-to-late twenties, with depression occurring quite frequently amongst young adults. Depression is two to three times more common in women than in men.\(^{53}\) The difference between being sad or depressed is hard for one to ascertain the reason for concern (phobia).\(^{59}\)

56  SANE Fact Sheet: Anxiety Disorder: www.sane.org
59  Ibid

For those who improve, whereby they no longer fulfill the diagnostic criteria for depression, feelings of depression may linger for many years. Twelve per cent of people who have depression develop ‘chronic depression’ where an episode of depression may last longer than two years.\(^{57}\)

People with depression may experience feelings of extreme sadness and may become tearful for seemingly no reason. Sleep patterns may become irregular and disjointed. A person may experience a total loss of interest and motivation culminating in a loss of pleasure when participating in leisure activities.\(^{58}\)

Feelings of anxiety, loss of appetite, weight gain, physical discomfort and impaired thinking and concentration are also recognised symptoms of depression.\(^{59}\)

There are manifold causes of depression. The possible causes of depression may include:

- A reaction to stressful life events, such as bereavement.
- Depression may be a part of another mental illness, such as bipolar disorder.
- Depression may also be unrelated to outside events. It may be caused by a chemical imbalance in the brain.\(^{59}\)
- It has been hypothesised that there is an interrelation between heredity, biochemical imbalance and stress.\(^{51}\) It is also believed that certain personality types are more susceptible than others to depression.\(^{54}\)
- More susceptibility personality types include people who are ‘sensitive’ and ‘emotional’. People who are perfectionists and those who rely heavily on others may also be prone to depression. They often find it difficult to alter their expectations in response to changing events and are vulnerable if disappointed.\(^{61}\)
- Many people respond satisfactorily to treatment. Treatment may reduce and, in some people, eliminate the symptoms of depression altogether. The usual form of treatment involves a combination of medication, personal therapy and community support.\(^{62}\)
- In extreme cases, electroconvulsive therapy is also used.\(^{55}\)

#### 4.3.4 Anxiety Disorders

Anxiety disorders affect approximately 10% of Australians.\(^{60}\) The onset of the anxiety disorders usually occurs in the early twenties, often triggered by a sequence of major life events.\(^{67}\)

Anxiety disorder is an umbrella term which covers:

- generalised anxiety disorder\(^{69}\)
- obsessive compulsive disorder\(^{70}\)
- social anxiety disorder\(^{70}\)
- post traumatic stress\(^{71}\)
- panic disorder\(^{72}\) and
- phobias.\(^{73}\)

The underlying experience in these disorders is extreme anxiety. A person may experience anxiety so severe that they are unable to partake in day to day life. A person may experience more than one anxiety disorder at any one time.\(^{74}\)

People with an anxiety disorder experience feelings of extreme distress and anxiety for no obvious reason. During an episode a person may become immobilised by their fear.\(^{75}\)

A person may experience:

- Persistent, disproportionate, uncontrollable and unrealistic worries, often about minor things (generalised anxiety disorder);\(^{70}\)
- Uncontrollable thoughts and impulses (obsessions) and repetitive and monotonous behaviours or ‘mental acts’ (compulsions) (obsessive compulsive disorder);\(^{70}\)
- Severe discomfort over social situations (social anxiety disorder);\(^{76}\)
- Repeated panic attacks which involve a ‘sudden onset physiological symptoms’, such as heart palpitations and dizziness together with fear and ‘feelings of impending doom’ and agoraphobia (panic disorder);\(^{77}\)
- An extreme fear and avoidance of common objects or situations that, in reality, do not give rise to any real cause for concern (phobia).\(^{78}\)

The cause of anxiety disorders are not fully understood.\(^{79}\)

Like depression, it is believed that certain personality types may be prone to anxiety disorders. Heredity and learnt responses may interweave; a person may ‘learn’ ‘causes’ which can be defined as symptoms of anxiety disorder through interaction with their families. There is, as yet, no conclusive research to suggest that anxiety disorders are due to biochemical processes.\(^{80}\)

Treatment often involves education and counseling with the aim of trying to understand why a person feels anxiety over a particular event, situation or object.\(^{81}\) Medication is also sometimes implemented to aid in controlling panic attacks and/or anxiety levels.\(^{82}\)

Treatment is aimed at people changing the way they perceive events/situations/ objects and giving people effective tools to deal with events/situations/objects that cause them anxiety.\(^{83}\)

### 4.4 SUBSTANCE - RELATED DISORDERS - ILLICIT DRUGS AND ALCOHOL

People who abuse drugs and/or alcohol may suffer serious consequences across a broad spectrum of their lives. They may lose important personal relationships with family and friends. They may also show a decline in work performance and lose their job. Extreme and far reaching economic consequences may flow from this, such as the loss of a home.
Further, SANE Australia note on their website that 64% of patients in psychiatric in-patient wards have or have had a drug problem.86

Extreme use of illicit substances is divided into two categories: substance abuse and substance dependence.

4.4.1 Illicit Drugs

In 2001, a survey found that the most used illicit drug is marijuana, with 16.9% of Australians (14+ age) reporting to have used an illicit drug over the past 12 months, consisting mainly of cannabis. Further, 37% of the same population have used an illicit drug at least once in their lives.87

The rate of use of marijuana, as for most illicit drugs, has steadily increased over the last decade.88

Amphetamines were used by approximately 4% (214 years of age) and 1% (≥14 years of age) used heroin or cocaine.

Treatment often involves a combination of withdrawal programs, self help programs and support groups, counselling and in the extreme, medication.89

4.4.2 Alcohol

Approximately 39.5% of Australians (214 years of age) drink alcoholic beverages at least once a week.90

At a minimum, 8% (males) and 4% (females) consumed alcoholic beverages at a rate known to be dangerous to health.91

In 1996 Australia was ranked 20th in the world for per capita consumption of pure alcohol; 9th for beer and 17th for wine consumption.92

4.4.3 Substance dependence

Substance dependence is characterised by a person developing a tolerance to the substance whereby the person requires more of the substance to reach a desired effect.

A person may experience withdrawal symptoms when they desist use of the substance, or decrease its amount, such as unwanted and unpleasant physical and mental effects.

Substance dependence is also characterised by the person using larger amounts of the substance or for a longer time than intended.

The person is unable to control the use of the substance and/or persists in the use of the substance despite obvious deterioration in health.93

4.4.4 Substance abuse

Substance abuse is a less severe diagnosis.

The diagnosis of substance abuse necessitates that a person demonstrate difficulty in undertaking everyday activities.

A person will be unable to complete specific duties expected of them, for example, go to work or look after their children. Furthermore, a person will expose themselves to dangers to which they would not ordinarily do so. This includes, for example driving a vehicle or operating heavy machinery while under the influence of alcohol.94

Substances that are most commonly abused, in descending order, include alcohol, cigarettes, marijuana, cocaine, hallucinogens and heroin.

4.5 MANAGEMENT OF MENTAL ILLNESS

4.5.1 The Client Services Model

The provision of mental health services for people with a mental illness is through a government initiative launched in 1994 called Improved Access Through Coordinated Client Care. The initiative provides a framework for a “consistent approach to case management of individuals suffering from a mental illness to ensure a coordinated system of client care that is consistent with international best practice”.95 The framework is founded upon the Client Services Model.

The Client Services Model establishes a system of support for persons suffering from a mental illness who voluntarily seek assistance from a public mental health service or patients who have been referred by an agency to an area mental health service (known as involuntary patients). The Model charts the functions undertaken from receipt through to case closure.

The Model encompasses four stages:

- receipt,
- duty,
- intake and
- service delivery.96

The first three stages cover initial contact by the patient with the public mental health service system. These stages enable patients to be matched with the appropriate public mental health service, with referrals being made to more suitable agencies where necessary. Service Delivery sees the appointment of a case manager to the patient.

It is at the Service Delivery stage that the patient is assessed thoroughly and goals are established to enable the individual to function effectively in day to day and future activities. Typically when the patient’s condition has improved to the point where they no longer need treatment, the case will be closed.

The intended advantage of a model is that people suffering from a mental illness are optimally treated in an environment that permits contact with the rest of society.97

4.5.2 The Case Manager (CM)

The Client Services Model provides various levels of decision makers who are each responsible in some way to consumers of the mental health system, however, ultimately it is the Case Manager who is legally responsible. The Case Manager is responsible for coordinating the services delivered to that client.

S/he will be responsible for ensuring that the client has access to the range of area mental health services required and negotiating for other services when required. Apart from their general responsibility to patients, case managers will be legally responsible for any clinical treatment they provide as well as for coordinating the system of care provided to a client.98

4.5.3 Director of Clinical Service (DCS)

Reporting to the Area Service Manager is the Director of Clinical Service (DCS). The DCS takes responsibility for clinical leadership, however the job description also involves the delegation of day to day decision making, the appointment of suitably qualified case managers and the monitoring and reviewing of delegated decision making.99

4.5.4 The Area Service Manager (ASM)

The Area Service Manager (ASM) is responsible for the overall running of the public mental health service (community health service) in a particular region. Their role is to ensure that each community health service has correct procedures in place for daily operations.100

4.6 INVOLUNTARY PATIENTS AND THE COMMUNITY TREATMENT ORDER

4.6.1 Voluntary and Involuntary Patients

Patients with a mental illness are classified as voluntary or involuntary patients. Voluntary patients are those who actively seek assistance from an area mental health service. Involuntary patients are those who have been compulsorily admitted into a mental health service to receive treatment for a mental illness.101

The distinction is significant only in respect of the type of treatment provided, as the obligations owed to both patient types is the same.

4.6.2 Community Treatment Order

Through a Community Treatment Order (CTO), an involuntary patient may be provided with the necessary treatment in an area mental health service, where the patient’s psychiatrist believes that the patient is capable of effectively living in the community while receiving treatment.102 It is an alternative to involuntary hospitalisation for the treatment of a person’s mental illness. A CTO is not granted to a person in prison or a psychotic in-patient. It is an order which permits an involuntary
4.7 RESPONSIBILITY FOR A PERSON SUBJECT TO A CTO

4.7.1 The Monitoring Psychiatrist
Where a CTO is granted, the treating psychiatrist must supervise the operation of the CTO and undertake the responsibilities and duties expected of the psychiatrist as required under the Mental Health Act 1986 Vic (The Act). The monitoring psychiatrist's role is not a passive one. S/he must not only remain informed but also be active in the administration of the CTO. This is achieved through communication between the supervising medical practitioner as well as the case manager and also with direct contact with the person subjected to the CTO.106

The monitoring psychiatrist must ensure that: (the following is a non-exhaustive list)
• The supervising medical practitioner is able to contact him/her to discuss issues arising from the CTO;
• There is an appropriate system in place to assess the progress of the patient on the CTO;
• Evaluation is given to reports submitted by the supervising medical practitioner; and
• The duration of the CTO is appropriate, with changes to the length of the CTO being implemented or revocation of the order when required.107

4.7.2 The Supervising Medical Practitioner
The supervising medical practitioner is responsible for the daily clinical management of the person who is subjected to a CTO. The supervising medical practitioner is a delegate of the monitoring psychiatrist, and as such, any fundamental alterations to the treatment regime must be first discussed with the monitoring psychiatrist.108

The supervising medical practitioner should: (the following is a non-exhaustive list)
• Participate in discussion with the monitoring psychiatrist and case manager regarding the progress of the person subjected to a CTO;
• Be contactable by the person subjected to the CTO in order to discuss treatment plans and other issues raised by the person;
• Make sure that the person has an understanding of the requirements of a CTO;
• Regularly evaluate the person’s physical and mental health. Where there has been a significant change, discuss the change with the monitoring psychiatrist; and
• Make regular reports to the monitoring psychiatrist regarding the progress of the person subjected to the CTO.109

4.7.3 The Case Manager
The role of the case manager is one of ‘specialist input’. The case manager reports on the person’s treatment requirements and to further make certain that the person received appropriate attention from both the monitoring psychiatrist and the supervising medical practitioner.110

The case manager should: (the following is a non-exhaustive list)
• Ensure that an appropriate individual treatment plan is developed and maintained. To ensure that the plan is the most suitable, discussion should be had with the person subjected to the CTO, close family members or carers as well as the supervising medical practitioner;
• Be contactable by the person subjected to the CTO in order to discuss treatment plans and other issues raised by the person;
• Educate and inform the person’s primary care givers as to the requirements of the CTO, the appropriate medical treatment and the person’s progress;
• Organise appointments of the person subjected to the CTO by the supervising medical practitioner and monitoring psychiatrist.111

4.7.4 The Area Mental Health Service
The area mental health service is responsible for the development and maintenance of an appropriate system to foster the administration of CTOs.

An appropriate system should identify best practice procedures for completing mandatory paperwork, as required by the Act, maintenance and review of patient progress reports and important dates for persons subjected to a CTO.112

4.7.5 Criticism of the Mental Health Service System
Community support services are crucial in assisting persons with mental illness to avoid relapse. In particular they are helpful in assisting persons with mental illness to establish and maintain a long-term stability in their life through adequate planning.

Susan Henderson, in her article, Mental Illness and the Criminal Justice System,113 is highly critical of the public mental health services system. She argues that the system allows many people who experience an acute episode requiring hospitalisation or a high level of support back into the community too soon without support plans in place or any stable and/or supported accommodation.114 She blames this problem on the structure of the mental health system.

The system consists of many separate layers of administrative decision making with arbitrary service divisions that are inaccessible and inappropriate for treatment where there are complex disorders involved.115 This premature de-institutionalisation of persons with mental illness places a burden on other community structures to deal with individuals suffering from mental illness, such as increased reliance on the police for crisis management.
5. THE REGULATORY FRAMEWORK & CONSUMERS OF THE MENTAL HEALTH SYSTEM

5.1 PROTOCOL BETWEEN VICTORIA POLICE AND THE DEPARTMENT OF HUMAN SERVICES MENTAL HEALTH BRANCH

The protocol is based on the principle that people with a mental illness should receive the best possible care in the least restrictive and intrusive manner, and in providing for their care, and protection of members of the public, any restrictions on their rights, privacy and dignity are kept to the minimum necessary in the circumstance.116

The aims of the protocol are to establish clear guidelines for police and mental health services staff on handling situations where either agency has requested assistance from the other and to promote a standard of care to individuals suffering from a mental illness in situations that require involvement of both police and mental health staff.117

The protocol codifies clear guidelines when dealing with these situations.

The interactions between the police and mental health services fall into different categories including:
- non-urgent, consultation and
- urgent contact.

Although CAT/riape services will always give top priority to urgent referrals from police, they are not an emergency service.

A service will be classified as urgent where a police member forms the belief that a person suffers from a mental illness and any of the following are present:
- serious harm to others,
- imminent risk of self-harm,
- evidence of self-neglect
- serious threat to property or
- a person is displaying gross mismanagement of personal affairs.118

In these instances, the police may contact mental health services through the relevant CAT/riape staff, who then organise medical assessments as required.

In high-risk situations there is co-ordination of trained police negotiators, Special Operations Group (SOG) members or the police psychologist. The Police Forward Commander is responsible for managing the situation.120

Under section 10 (1) of the Mental Health Act 1986 Vc, a member of the police force may apprehend a person who appears to be mentally ill.

In order to apprehend a person pursuant to this section, the police officer must hold a belief that the person appears to be mentally ill and has reasonable grounds for believing that the person has harmed themselves or others.121

The police force member is not required to exercise any clinical judgement and need only make a lay judgment of mental illness, based on the person’s appearance and behaviour.122

Reasonable grounds are required for police to apprehend an individual suffering from mental illness. Section 120A of the Mental Health Act 1986 regulates the disclosure of information to police concerning clients of mental health services. This section has been amended by the Health Records Act 2001 to more closely align that Act.123

Where police initiate a referral for urgent assessment, they must remain present until the initial assessment is conducted. Given that police resources are limited, it is necessary to expedite the assessment process.124

An urgent situation arises where mental health services’ staff believe police attendance is required immediately, because of an imminent risk to persons or property. In such a situation, the following process should be followed:
- Call the Police Communications Centre (D04) direct on 000
- Tell the operator urgent police assistance is required.
- Provide details regarding where the assistance is required and the location of the relevant mental health staff.
- Inform the operator of the staff member’s name, telephone number and identify the mental health service.
- Explain the problem.
- Advise whether weapons are present.
- Advise whether the person is affected by alcohol or drugs.

• Provide whatever details are possible of the person involved that would enable police members to more accurately determine the nature of the situation.
• Advise who is present.
• Provide any other available information to assist police in making decisions about how to manage the situation.125

With this information the police will assess the urgency of the request and provide an estimated time of arrival to mental health services staff, according to their demands and priorities.126

District inspectors are responsible for ensuring ongoing support and co-operation between local service providers including Health Services.

The role of the Victoria Police Force involves uniformed general duties members performing any given task as it arises and will include contact with CAT services. Police are usually first at the scene of an incident and are able to call in other or more specialized units as the situation warrants.127

The protocol, released in September 2004, provides codified guidelines and the regulatory framework for urgent situations involving the police and mental health services.

5.2 WARRANT POWERS AND PROCEDURES


In this paper, the Mental Health Legal Centre raised concerns regarding the role played by police in assisting the Crises Assessment Team, in returning individuals to custody following the revocation of community treatment orders, pursuant to s14 (6) of the Mental Health Act 1986 Vc.

It has been suggested that police involvement often increases tension and causes trauma for clients, due to police practices. Consequently, it has also been suggested that law reform may be required with respect to the police procedures and practices in such situations.129

5.3 POLICE DEALINGS WITH INDIVIDUALS SUFFERING FROM MENTAL ILLNESS

The Victorian Police Manual outlines assistance that police officers must provide to “persons with specific needs”. One of the categories of people listed under this section deals with apprehension of persons suffering from a mental illness, rather than outlining any type of tactical approach or behavioural response. As such, this means that the police officers themselves should attempt to avoid potentially dangerous situations.130

The Department of Human Services has released Project Management Circulars, one of which deals with apprehension of persons suffering from a mental illness by a member of the police force under the Mental Health Act 1986.131

This deals with issues such as:
- What options police have when apprehending an individual who appears to be suffering from a mental illness.
- What a mental health professional

---

117 Ibid 1, p2 Background
118 Ibid 1, p1 Foreword.
119 Ibid 1, p6
120 Ibid 1, p9
121 Ibid 1, p10
122 Ibid 1, p11
123 Ibid 1, p17
124 Ibid 1, p18
125 Ibid 1, p18-21
126 Ibid 1, p21
127 Ibid 1, p76
129 Ibid 12, p68
131 Ibid
should do once contacted by police.

- What guidelines are appropriate for police and mental health services when handling situations where either agency has requested assistance from the other.

5.4 POLICE POWERS IN RELATION TO INDIVIDUALS SUFFERING FROM MENTAL ILLNESS

The police have the authority to apprehend a person who appears to be suffering from a mental illness if the member has reasonable grounds for believing that the person is likely to harm themself or others. This authority encompasses entry to premises and the use of reasonable force. Once the person has been apprehended, the member must have the person assessed by a medical practitioner.

Victorian Police Manual Rule 12.6.1.4 provides that where police are in a situation where an individual suffering from a mental illness is threatening harm to themselves and/or others or is engaging in criminal activity, police are permitted to use appropriate action. This includes the power to detain and/or use of weapons.

6. POLICE TRAINING

6.1 RECRUIT TRAINING

In order to graduate as a qualified police officer, applicants must undergo twenty weeks of intensive training at the Victorian Police Academy in Glen Waverley.

The main objective of this training is to assist recruits in gaining the knowledge, skills and confidence to perform operational duties as probationary constables. Furthermore, recruits are required to undertake academic subjects to complement operational and physical training. These include law and police procedures, communication skills, information technology and keyboarding. Physical training encompasses marching, water safety, defensive tactics, firearms training and physical education.

To graduate as a probationary constable, one must satisfy the criteria in all aspects of the course, and exhibit appropriate personal qualities, temperament and attitude to be an effective member of the police.

At a brief glance, it becomes obvious that recruits’ initial twenty weeks training is relatively general. That is, its purpose is wide-ranging and operational, rather than specific in nature. The functions of police have been stated as:

1. Protection of life and property;
2. Preservation of the peace;
3. Prevention and detection of crime;
4. Performance of duties prescribed by law; and
5. Provision of help and assistance to those in need of it in accordance with community expectations and the law.

Again, the functions are somewhat general. It also appears that in order for these functions to be fulfilled, a police officer must be adequately trained to adhere to them.

The main focus of this discussion paper is the interaction of police with people suffering a mental illness. As such, it is necessary to examine how police training addresses this interaction and whether it is adequate to meet the police objectives, stated above.

6.2 SPECIALISED TRAINING

6.2.1 Project Beacon

Having corresponded with a Training Instructor at the Police Training Academy in Glen Waverley it was noted that approximately seven years ago all police officers had to undergo specialised training under ‘Project Beacon’. This encompassed operational tactics and negotiation with offenders; containment option where the potential for violence is high.

The Police Training and Mental Illness – A Time for Change.
These guidelines relate to all life threatening incidents and are aimed at minimising the threat to all persons, including the public and the police.142

Project Beacon was hailed as a success because it resulted in the improvement of the management of potentially violent incidents and reduced the number of violent incidents involving police officers.143

While Project Beacon was commendable, it is submitted that police training that focuses on the circumstances of individuals suffering from mental illness as well as communication skills will further ensure the reduction of violent incidents.

6.2.2 Operational Safety And Tactics Training
In further discussion with the Training Instructor, it was revealed that all Operational Police must now undergo ‘Operational Safety and Tactics Training’ every six months. This training encompasses tactics training, including negotiation and communication skills. It also involves additional training in the use of batons, Oleoresin Capsicum Spray (OCS), handcuffs and regulations firearms.144

The officer in charge of the facility where training occurs states that the aim of the training is to set up “situations in a realistic environment and practice the physical human skills”.145 These are the type of situations which are most likely to be encountered in everyday suburban settings. The scenarios used have been based on data collected from Use of Force forms, coronial comments and community crime trends.

Overall, the main objective of this training is to regularly renew and update police officers’ skills when it comes to tactical communication and negotiation. Furthermore, it aims at producing proficient operatives, in order to reduce the use of force in these types of scenarios.

Although a violent situation involving an individual suffering from a mental illness is indicative of a situation where “Operational Safety and Tactics Training” would be required, the Training Instructor at the Academy indicated that training in regard to the mental illness only a small component.146

Quite generally, as this is the only information that has been made available, specific training to deal with individuals suffering from mental illness involves:

• 140 minutes of instructional contact per recruit regarding the Mental Health Act. This training includes dealing with intellectual disability, the requirements to call independent third persons, involuntary admissions to treatment facilities and transport and certification of individuals suffering from a mental illness.

• This theory training is supplemented by 80 minutes of additional interaction with a worker from Midwest Area Mental Health Services, which covers dealing with persons suffering mental illness and is primarily designed to provide constables with an appreciation of, and dispel myths about, schizophrenia, bipolar disorders and other mental illnesses.

• Additional similar ongoing training is provided at Probationary Constable level (up to 2 years after graduation).147

Again, this is rather general in nature and seems to aim at giving police officers an ‘awareness or appreciation’ that someone is suffering from a mental illness, rather than training them to communicate and negotiate with these people.

6.2.3 Force Response Unit
Another area of specialised training comes from the ‘Force Response Unit’. These are members of the police who are specially trained to deal with situations where local police are unable to adequately respond to. This unit includes, “trained negotiators for situations involving siege/ hostage incidents, barricaded persons, suicide intervention and incidents involving individuals suffering from a mental illness”.148

Entry requirements to the Force Response Unit involve a seven day ‘Basic Skills Course’ which encompasses areas such as navigation, map reading, crowd and riot control, officer safety scenario training, physical training.149

Compounding the brevity of the course is the fact that the actual training provided is inadequate to deal with individuals suffering from a mental illness. The focus of this training is operational and physical rather than behavioural in nature.

It seems unlikely that one could acquire the necessary skills to deal with individuals suffering from a mental illness with the extent of training provided and the timeframe.

6.3 CONCLUSION

Overall, it becomes evident that although some minimal training is provided in regard to working with individuals suffering from a mental illness, its focus is on making police officers conscious that mental illnesses exist in the community, that they are prevalent and that they might encounter them in their duties. However, it does not provide police with any specific training to adequately negotiate with individuals suffering from a mental illness or to assist them by any other behavioural means.

As a result of legal and political changes, and in particular the policy of deinstitutionalisation of consumers of the mental health system, police officers have been given increasing responsibility and power.

This results in additional demands on police officers to, in effect, ‘act as social workers, psychologists, caseworkers, customer service officers as well as law enforcers. According to Professor Thomson of Monash University, “We are asking the police to take on these responsibilities but we are giving them little basis to make that judgment, we are not giving them the opportunity to get the skills to exercise that power.”’150

This statement succinctly expresses the need to improve current police training. According to Professor Thomson, it is crucial for the police to recognise symptoms of mental illness and understand that fear drives the aggression displayed by many people suffering an acute psychotic attack.151

Current police training does not provide police officers with the skill to make this type of assessment. Instead, it seems that all violent offenders are dealt with in a similar manner. That is, police are not discriminating between individuals suffering from a mental illness and non-mentally ill persons, possibly, because they feel that their life is indeed threatened.

This raises serious issues. Individuals suffering from a mental illness may not be aware that their actions may be regarded as criminal and are therefore unknowingly placing themselves in dangerous and violent situations, simply because of their illness.

It is therefore submitted that this approach should not continue, as clearly, those suffering from mental illness require specialised treatment. Arguably, the individuals suffering from mental illness in those situations may not possess the same element of criminality as a person unaffected by mental illness.

While excessive use of force against any citizen, whether suffering from mental illness or not, is unacceptable, it must be recognised that more specific measures need to be implemented in order to diffuse situations, with minimal use of force, involving individuals suffering from mental illness.

143 Training Instructor, Victorian Police Training Academy in Glen Waverley, 21 June 2004
145 Training Instructor, Victorian Police Training Academy in Glen Waverley, 21 June 2004
146 Ibid
149 “To Recruits, The Force Should Be in the Mind as Well as the Muscle”, The Age, 21 May 1994
150 Ibid
7. NATIONAL AND INTERNATIONAL DEVELOPMENTS

7.1 NATIONAL DEVELOPMENTS

7.1.1 Federal Level
Following a spate of police shootings of individuals suffering from mental illness in 1994, a Crisis Intervention Ad Hoc Advisory Group was established by the government to provide expert advice to Australian police and Health Ministers on the need to develop better practices for managing crisis situations involving those suffering from mental illness.151

7.1.2 Whiteford Report
In 1998, Dr Harvey Whiteford, the Director of Mental Health (Commonwealth) produced the “Final Report of the Mental Health Crisis Intervention Ad Hoc Advisory Group”.152 The report attempted to provide guidelines as to future best practice regarding police handling of crisis situations involving individuals suffering from mental illness. In doing this, the underlying theme of the report was to highlight ways in which physical risk to both police officers and those suffering from mental illness could be reduced.

The report suggested a number of strategies to reduce the risks inherent in crisis situations involving individuals suffering from a mental illness, such as:

- an increased focus on safety,
- systematic arrangements facilitating agency co-operation;
- information sharing between agencies;
- development of crisis response teams;
- an appropriately effective legislative regime (both on a state and federal level) to promote these strategies.153

7.1.3 Wooldridge Report
Following the release of the Whiteford Report, the then Minister for Health and Aged Care, Dr Michael Wooldridge produced a further report which, in part, discussed the issue of police handling of those suffering from mental illness.154

Wanting to advance the progress made in preceding years, the report focused on the importance of information sharing between police, mental health workers and agencies. The report stressed that effective management of crisis situations involving the individuals suffering from a mental illness requires that police obtain as much relevant information as possible, before attending the incident, and where possible, obtain advice from mental health workers. In his report Dr Wooldridge stated that:

“Many incidents attended by police involve problems for which they have little or no skills. For example, people with mental disorders, psychologically disturbed people or people with intellectual disabilities present special problems to police who are best addressed by those who are properly trained in these fields, who possibly know the person and their history and can offer direct assistance or advice. Each jurisdiction should endeavour to establish formal arrangements with the Mental Health Authorities to ensure that appropriately skilled people are available to police twenty-four hours a day.”155

Furthermore, the report highlighted the need for the police to introduce standard procedures for dealing with those suffering from mental illness, as well as for strengthening partnerships between the police and mental health services.

We submit that Dr. Wooldridge’s interpretation of best practice is accurate in its general essence, but flawed in its specificity.

Dr. Wooldridge’s interpretation of the issue suggesting that the capacity to have mental health workers available for police to access, across Australia, 24 hours a day, seven days a week is hard to fault. However, such an interpretation is wholly idealistic and one that has little regard for administrative and economic limitations. The failure to recognize that the economic costs involved with supporting such a system is a significant oversight. The current issues facing the NSW system are evidence of this.

7.1.4 Aftermath of the Whiteford and Wooldridge Reports
As a result of both the Whiteford and Wooldridge Reports, state and federal police ministers adopted a series of national police guidelines for incident management. As a result, all jurisdictions ensure that police training provides an appreciation of the psychology related to incidents involving individuals suffering from a mental illness.156

7.2 VICTORIA
The issue seems to be rather dormant in Victoria, with neither the Victorian Government, nor the Victorian Police bringing the topic into the spotlight of public debate in the last 10-20 years. Despite a string of police shootings in Victoria over the last decade, many involving those suffering from mental illness, it seems that the issue of police handling of individuals suffering from mental illness has attracted little attention in this state.

However, it is relevant to note that associated issues relating to individuals suffering from a mental illness who had been found guilty of a criminal offence and the criminal justice system in Victoria were examined in a Justice Statement released by the Department of Justice in May 2004 titled ‘New Directions for the Victorian Justice System 2004-2014’.

7.2.1 ‘New Directions for the Victorian Justice System 2004-2014’
A major challenge facing the criminal justice system in Victoria is the continuing over-representation of individuals suffering from a mental illness who have been charged with an offence relative to the incidence of mental illness in the general community.

It is estimated that the number of individuals suffering from a mental illness in the corrections system is between three and five times higher than those in the general community.157 The government acknowledges that the traditional sentencing approach taken by the courts does little to prevent offenders suffering from a mental illness from re-offending, as it fails to address the underlying causes of these offenders’ behaviour.

Therefore, it is recommended that reforms to the justice system in Victoria incorporate the health and social service systems.158 This Justice Statement proposes a range of specific initiatives aimed at addressing the over-representation of offenders suffering from a mental illness and reducing re-offending. It proposes that the government further develop problem-solving approaches for courts to employ and adopt a co-operative approach with other service providers.159

7.3 NEW SOUTH WALES
Police handling of individuals suffering from a mental illness was discussed by the NSW Government in its recent review of state mental health services. In December 2002, the NSF Legislative Council Select Committee on Mental Health provided their final report in relation to an inquiry into mental health services in NSW.160

The NSW Government has endeavoured to build a collaborative framework in the form of a “Memorandum of Understanding” operating between relevant agencies such as NSW Police and NSW Health.

As both the NSW and Victorian organisational infrastructure design to tackle violent situations involving the individuals suffering from a mental illness are very similar (i.e. the use of a separate crisis intervention team and similar police jurisdiction), recent debate concerning the situation in NSW is very relevant in discussing potential advancements for the Victorian system.

7.3.1 NSW Select Committee on Mental Health - Final Report
In contrast to the negative view of the Victorian Police’s handling of individuals suffering from mental illness, an overall positive sentiment has been shown in regards to the NSW police handling of individuals suffering from mental illness.

Evidence submitted to a 2001 NSW Legislative Council Inquiry into Mental Health Services in NSW, stated that “individuals and organisations expressed a high regard for police in their conduct when dealing with people with a mental illness.”161

It could be argued that this contrast could be attributed to the lower number of fatalities arising from high profile incidents between police and individuals suffering from a mental illness in NSW, as compared with Victoria. During a seven year period between 1 January 1990 to 30 June 1997 three individuals suffering from a mental illness were shot dead by NSW police, in contrast with seven shot dead by Victoria Police.162
7.3.2 Obstacles to Effective Policing and Individuals Suffering from Mental Illness

Police reluctance to adopt a more active role in dealing with individuals suffering from mental illness

Evidence submitted to the 2001 NSW Inquiry indicated reluctance from members of the police in having to adopt a more active role when dealing with individuals suffering from mental illness.

In fact, representatives of the NSW Police "expressed concern that some mental health workers view the police as de-facto mental health workers". 163 Despite accepting their role as being the first port of call in an emergency situation, they supported the segregation of the policing and mental health aspects of situations involving individuals suffering from mental illness.

In effect, they were content with managing the policing aspects of the situation, and waiting for the CATT team to address the mental health aspects. This mindset may also exist in Victoria and might represent an obstacle in the implementation of alternative models for police handling of individuals suffering from mental illness.

Plurality of procedures

Another obstacle preventing effective police handling of individuals suffering from a mental illness identified in NSW is the plurality of local procedures between police and mental health workers.

This issue could also exist in Victoria.

Though this issue could be overcome by developing a standard procedure for dealing with such situations, it is submitted that a shift to a statewide procedure, despite solving many existing problems, may indeed bring about many new problems, i.e. the inability of a statewide protocol to be considerate of local intricacies. Furthermore, such a shift would incorporate a possibly lengthy transition period.

The adoption of alternate models such as the "Memphis Model", despite its heavy reliance on partnerships between health bodies and policing bodies, would reduce such issues, because the police act as a unilateral body geared to deal with crisis situations involving individuals suffering from a mental illness.

Lack of ready access to mental health workers

During the inquiry, NSW Police stated that ready access to mental health workers represents the biggest disability in dealing with individuals suffering from a mental illness. With reference to recent crisis situations involving Victoria Police, it could be seen that this issue is a significant obstacle also facing Victoria Police.

In relation to this particular issue, NSW Police complained that NSW mental health workers were:
• reluctant to work outside of business hours;
• would not attend scenes where the person’s behaviour is violent;
• were unable to attend because of other commitments;
• would not be called out on overtime;

• would not attend if it is suspected that the person has some other condition; e.g., personality disorder, drug induced psychosis, etc and;
• unable to replace members when they go on leave due to financial restrictions.

These defects stemming from the current NSW system renders the CATT team approach partially useless, a far cry from the desired system expounded in the Wooldridge Report for 24 hour a day, seven day a week statewide access to mental health workers.

These problems are not symptomatic of alternate models, such as the Memphis Model. This is because members of the police are already available 24 hours a day, seven days a week and are readily available to deal with a crisis situation involving individuals suffering from a mental illness.

The adoption of such a model would have clear advantages over the current system in place in both NSW and more importantly Victoria.

During the inquiry, the NSW Police stressed that significantly more resources needed to be invested in enabling mental health workers to be ready 24 hours a day, and in any location. 165 It is highly likely that the same issues exist in Victoria.

The amount of resources (both financial and human) required to address the issues inherent in the CATT team system would be immense. Having mental health workers available 24 hours a day, seven days a week in all regions (including rural areas) of the state would be an extremely costly endeavour. As stated earlier, it is submitted that the investment from either state and/or federal governments required to make the CATT team approach used in NSW and Victoria fully effective, would render the approach financially unviable.

NSW Select Committee’s assessment of the current CATT system approach

After assessing submissions, the NSW Select Committee concluded in agreement with the NSW Police that "it is detrimental to mentally ill persons and to the community for mental health services to rely so heavily on the use of police resources". 166 From this it can be concluded that the NSW Government are content on a segregated system in dealing with individuals suffering from a mental illness, and on improving its effectiveness by investing more resources in making mental health workers more accessible.

In stating this, it must be noted that alternate models, such as the Memphis Model (refer to Chapter 6 for details) would be a radical departure from the current NSW system approach and the "Memphis Model", despite not creating a specialist response branch of the Queensland Police, as is the case of the Memphis Model, the strategy does incorporate training of police to deal and better communicate with individuals suffering from a mental illness and the development of a network with local mental health agencies.

In relation to the latter aspect of the plan, emphasis has been placed on creating a “formalised procedural system that enables the transfer of information between agencies as well as providing ready access to skilled professionals”.

7.4 QUEENSLAND

In partial contrast to NSW and Victoria, there have been greater shifts towards a more collaborative approach in relation to crisis situations involving individuals suffering from a mental illness, especially in areas where there is a higher proportion of individuals suffering from a mental illness residing, for instance the Logan district.

7.4.1 Queensland Health - Logan District Strategy

In particular, the Queensland Health – Logan District Strategy adopted some of the principles established in overseas models such as the "Memphis Model". Despite not creating a specialist response branch of the Queensland Police, as is the case of the Memphis Model, the strategy does incorporate training of police to deal and better communicate with individuals suffering from a mental illness and the development of a network with local mental health agencies.

7.4.2 Best Practice Conference 2003 – Policing & Mental Illness

On 10-11 November 2003, a “Policing & Mental Illness” conference was held at Conrad
8. THE MEMPHIS MODEL - UNITED STATES

7.5 INTERNATIONAL DEVELOPMENTS

The issues facing the police and mental health workers in dealing with crisis situations involving individuals suffering from a mental illness are universal. Our research has uncovered several initiatives and practices that have been adopted overseas such as New Zealand and the United States in response to these issues.

7.5.1 New Zealand

7.5.1.1 Current Initiatives

In 2002, the Wellington branch of the New Zealand Police commenced a program of formalized police training in order to improve their handling of individuals suffering from a mental illness and to remove stereotypes and negative perceptions held by police officers that were imposing barriers in dealing with individuals suffering from a mental illness.163

The training was supervised by mental health workers who had significant experience in dealing one-on-one with individuals suffering from a mental illness and consisted of an intensive three-hour training session that was undertaken by 165 New Zealand police officers over a five-week period.163

Subsequent evaluation of this training program identified existing attitudes; reinforced by police culture represented a significant influence on police perceptions and their handling of individuals suffering from a mental illness.17 In addition, the evaluation also pointed out that there was a “strong correlation between how interested people were in the training and how confident they felt in applying what they had learnt in training”.17

7.5.1.2 Proposed Initiatives

A recent NZ report suggested that education and training in relation to individuals suffering from a mental illness should be conducted at many stages of a police officer’s career and should be developed in consultation with mental health groups.173

7.5.2 United States

Another interesting development is the Memphis Model developed by the Memphis Police Department in Tennessee due to its success in dealing with individuals suffering from a mental illness.169 Old Joseph Robertson, who suffered from a mental illness, was the victim of the fatal police shooting of 27 year old Joseph Robertson, who suffered from mental illness.179

The police, when called to assist in situations involving individuals suffering from a mental illness, did not know how to deal with them. The training did not teach them how to control and de-escalate a situation but only how to “take down” someone at risk of harming themselves or others forcibly.171 This made family members of individuals suffering from mental illness distrust the police and often they would only be called after the situation had escalated beyond control.

Due to the invention of better drugs for the treatment of mental illnesses and the negative image of mental asylums in the public and political eye, it became common practice to ‘de-institutionalise’ mentally ill patients in the 1960s.181

The subsequent cut in funding for mental care and public housing in the following decades caused many individuals suffering from a mental illness to have nowhere to live or go for help. Many found themselves with little choice but to live on the streets, often becoming addicted to alcohol or mind-altering substances to help curb the side effects of their medications.181 Lack of resources and training for the police in dealing with these cases resulted in re-institutionalisation of many individuals suffering from mental illness, although unfortunately not in mental health clinics where they should have been but in prisons because the police did not know what else to do with them.

The police, when called to assist in situations involving individuals suffering from a mental illness, did not know how to deal with them when in highly agitated states due to intoxication or mental instability. Their training did not teach them how to control and de-escalate a situation but only how to “take down” someone at risk of harming themselves or others forcibly.171 This made family members of individuals suffering from mental illness distrust the police and often they would only be called after the situation had escalated beyond control.

The result was that police response often ended in arrest and injury.171 It became evident that there had to be a better way to deal with individuals suffering from a mental illness instead of simply dealing with them within the confines of the Criminal Justice system.

Unfortunately, it is usually only after tragedy that police departments look for change. The Memphis Model was implemented by the Memphis Police Department in response to the community outrage following the fatal police shooting of 27 year old Joseph Robertson, who suffered from mental illness.179

The primary aim of the Memphis Model is to promote teamwork and enhance communication amongst law-enforcement officers, mental health professionals, consumers (of the mental health system) and family members, in order to provide comprehensive care to this growing population.177

Underpinning the initiative is a community partnership comprising of national and state bodies such as the Memphis Chapter of the Alliance for the Mentally Ill (AMI), mental health providers, two local universities (the University of Memphis and the University of Tennessee) and the Memphis Police Department.178

The establishment of this unique and creative alliance was for the purpose of developing a more intelligent, understandable, and safe approach to mental health crisis events. This community effort was the genesis of the Memphis Police Department’s Crisis Intervention Team and reflected a significant shift to the public perception of mental illness, as beginning to recognise it as an illness, and not a crime.

Formed in 1988, The Memphis Crisis Intervention Team (CIT) consists of volunteer police officers who, in addition to performing their day-to-day duties as patrol officers also respond to calls that have been identified as being in relation to mental illness.178

8.2.1 Police Training Under the Memphis Model

The selected officers undergo a specialised 40-hour training program provided by personnel from a range of backgrounds; such as mental health providers, legal experts, family advocates and mental health consumer groups.

The training exposes CIT officers to widespread interaction with the consumers, with a particular

Jupiters on the Gold Coast, Queensland.169 Over 200 people from Australia and overseas attended the conference, including members of the police force, criminology academics, government representatives, mental health workers, mental illness advocacy groups, individuals suffering from a mental illness and their families.

The conference provided a forum for the police and mental health workers to raise common issues concerning policing and mental illness, discuss current perspectives and approaches taken and establish future directions for policy development.

The keynote speakers at the conference were Major Sam Cochran, Coordinator of the Memphis Police Department’s Crisis Intervention Team and Dr. Randolph Dupont, Associate Professor of the University of Memphis (Department of Criminology and Criminal Justice). Major Cochran and Dr. Dupont showcased the Memphis CIT program they helped pioneer as a best practice model for policing and mental health crisis situations.

8.1 HISTORY

The police, when called to assist in situations involving individuals suffering from a mental illness, did not know how to deal with them when in highly agitated states due to intoxication or mental instability. Their training did not teach them how to control and de-escalate a situation but only how to “take down” someone at risk of harming themselves or others forcibly.171 This made family members of individuals suffering from mental illness distrust the police and often they would only be called after the situation had escalated beyond control.

The result was that police response often ended in arrest and injury.171 It became evident that there had to be a better way to deal with individuals suffering from a mental illness instead of simply dealing with them within the confines of the Criminal Justice system.

Unfortunately, it is usually only after tragedy that police departments look for change. The Memphis Model was implemented by the Memphis Police Department in response to the community outrage following the fatal police shooting of 27 year old Joseph Robertson, who suffered from mental illness.179

The primary aim of the Memphis Model is to promote teamwork and enhance communication amongst law-enforcement officers, mental health professionals, consumers (of the mental health system) and family members, in order to provide comprehensive care to this growing population.177

Underpinning the initiative is a community partnership comprising of national and state bodies such as the Memphis Chapter of the Alliance for the Mentally Ill (AMI), mental health providers, two local universities (the University of Memphis and the University of Tennessee) and the Memphis Police Department.178

The establishment of this unique and creative alliance was for the purpose of developing a more intelligent, understandable, and safe approach to mental health crisis events. This community effort was the genesis of the Memphis Police Department’s Crisis Intervention Team and reflected a significant shift to the public perception of mental illness, as beginning to recognise it as an illness, and not a crime.

Formed in 1988, The Memphis Crisis Intervention Team (CIT) consists of volunteer police officers who, in addition to performing their day-to-day duties as patrol officers also respond to calls that have been identified as being in relation to mental illness.178

8.2 THE MEMPHIS MODEL

The selected officers undergo a specialised 40-hour training program provided by personnel from a range of backgrounds; such as mental health providers, legal experts, family advocates and mental health consumer groups.

The training exposes CIT officers to widespread interaction with the consumers, with a particular
focus on communication. Officers are trained to diagnose different mental illnesses; the medications commonly prescribed to each illness and are taught role-playing techniques and verbalisation skills to defuse crisis episodes.

The training program is a "two way street", in that training personnel often accompany police officers on patrol to assess the types of situations that police are confronted with, in order to ensure that current and future training remain relevant. Such a progressive training regime promotes a mutual respect between police officers and mental health workers with regard to one another’s roles, as well as an awareness of the risks and difficulties with which each other are faced.

The structure of the training program is a clear example of how the financial and administrative viability of the program is heavily reliant on the strong and willing partnerships between mental health groups, other interested bodies and the Memphis Police.

8.2.2 The Memphis Model in Action

A trained dispatcher answers a 911 call, asking relevant questions and taking down information in order to detect if the situation may involve an individual suffering from mental illness. If it is found to be the case, the dispatcher locates the nearest CIT officer via computer.

CIT officers may be dispatched anywhere within the city. This is why it is important that the volunteers are part of the normal patrol units as it must be ensured that there is an even spread. Once CIT officers and other regular officers have been assigned to an incident, they will often meet up and travel to the scene together, the CIT officer becoming the one in charge to oversee the crisis.

When police arrive at the scene, the consumers are often hard to control, intoxicated or under the influence of drugs. Rather than forcibly controlling the situation, officers have been trained to talk to the consumer, calming and de-escalating the crisis. Calling the consumer by name, being polite and using hand actions, speaking slowly and calmly while keeping their attention on themselves, CIT officers use techniques that have been designed to handle the situation without the need to resort to violence to contain the situation. Each officer keeps notes of the details of each consumer that they have had contact with, with special attention on their illness, what medication they are on and any other relevant details. Often the relationship between the CIT officer and consumers becomes so developed that family members or the consumers themselves request the presence of certain CIT officers to come whenever they are needed.

When the situation has been controlled, consumers are not taken to prisons but to a hospital or rehabilitation centre where they can receive the help they need. This process ensures that consumers are not unnecessarily sent to prisons but receive the treatment and help that they need while maintaining their dignity.

It is also important to have full community support for the project, because a fundamental aspect of the whole process is the availability of community resources such as hospitals and rehabilitation centres that can deliver the special attention required for these unique cases on a 24 hour basis.

8.2.3 Benefits of the Memphis Model

Since the CIT program began in Memphis both the citizens and criminal justice system of Memphis have experienced significant benefits of the program. Some of the benefits of the program are listed below:

- Crisis response is immediate
- Arrests and use of force has decreased
- Under-served consumers are identified by officers and provided with care
- Patient violence and use of restraints in the ER has decreased
- Officers are better trained and educated in verbal de-escalation techniques
- Officer's injuries during crisis events have declined
- Officer recognition and appreciation by the community has increased
- Reduced stigma and perception of danger attached to mental illness
- Less "victimless" crime arrests
- Decrease in liability for health care issues in the prison
- Relief to overburdened criminal justice system
- Cost savings

Graph 1 shows a decrease in the number of officer injuries during crisis situations involving individuals suffering from mental illness since the introduction of the Memphis CIT program in 1988.

The immediacy of the crisis response for the Memphis CIT further supports the program’s effectiveness. Deane et al. examined the response times for three different models of crisis intervention using a random sample of 100 mental health crisis events:
- 1. Mobile Crisis Unit (MCU)
- 2. Community Service Officer (CSO)
- 3. Memphis Crisis Intervention Team (CIT)

In 94 percent of cases, a CIT officer arrived on the scene within 10 minutes. In comparison, a community service officer responded within 10 minutes in 28 percent of cases and a mobile crisis unit in 8 percent of cases.


between the maximum response times for the three different models that the Memphis CIT model has the fastest response time.¹³⁴

Advocate groups for individuals suffering from mental illness and the Memphis Police Department also agree that an "immediate response" is preferable to that of specialised mental health workers on call or a mobile crisis van response.¹³⁶

This is based on the premise that an immediate response by CIT officers acting in an informed and calm manner reduces the risk of physical injury for all involved.

8.3 Conclusion:

¹³⁶ Memphis Police, “Program Outline - Memphis Police Crisis Intervention Team” Date Unknown, p.4
Traditional hard line tactics employed by police against violent individuals suffering from mental illness as well as a lack of basic awareness of mental health issues is reflected in the weak public confidence of the police when working with individuals suffering from mental illness. Parallels can be seen between pre-CIT Memphis and present day Victoria as it can be said that the pre-CIT Memphis view is maintained in Victoria. The implementation of the Memphis Model helped to alter this perception of Memphis Police.

Prior to the implementation of the Memphis CIT program, the police were not prepared to deal with individual suffering from mental illness, family members of individuals suffering from mental illness distrusted the police, the criminal justice and mental health systems were adversaries and the police response often resulted in arrest and injury.  

The Memphis Model changed this, as it is a very complete and effective way of dealing with individuals who suffer from mental illness in a way assists them, adhering to the needs of these people rather than disrespecting them by criminalizing their behaviour by placing them into correctional facilities with no regard to their needs or circumstances. Individuals suffering mental illness are a burgeoning unique population - consisting of young people - that deserve special care, treatment, and service.

By offering an immediate humane and calm approach, CIT officers reduce the likelihood of physical confrontations and enhance better patient care. As such, the CIT program is a beginning for the necessary adjustment that law enforcement must make from traditional police responses to a more humane treatment of individuals with mental illness.

It is submitted that police training for mental health issues should incorporate a two-pronged approach:
1. Basic training for all police officers.
2. The establishment of a special taskforce designed to provide immediate response to crisis situations involving individuals suffering from a mental illness. It is recommended that the training requirements for all officers be based upon the Memphis Model.

9. RECOMMENDATIONS

9.1 BASIC TRAINING FOR ALL POLICE OFFICERS

It is necessary that all police officers undergo a mandatory amount of basic training.

This training should be undertaken at the recruit level. In addition, ongoing training should be provided to ensure that officers' skills remain current and relevant. The training should provide all officers with:
- a general awareness of mental health issues that are prevalent in society;
- a basic appreciation of common mental illnesses and their systems;
- an ability to deal with and communicate with individuals suffering from a mental illness, and
- an understanding and support of the Memphis Model.

The training should be provided by mental health workers given that they have significant experience with and exposure to individuals suffering from a mental illness. Previous programs have found mental health workers to be effective teachers of mental health issues. Also, relevant academics and experienced police psychiatric staff should have input into the delivery of information and content.

9.2 ADOPTION OF THE MEMPHIS MODEL

The implementation of a CIT program into Victoria would be a logical step and one which would minimise miscommunication and would reduce violence between police officers and individuals suffering from a mental illness. Successful implementation of such a model requires that the key factors are addressed.

The foundation of the Memphis Model is the huge community support and strong communication and collaboration between all the parties involved. Therefore it is extremely important for any city or state considering the implementation of such a model to obtain the support of all the local Police, Ambulance and Mental Health Services.

It must be stressed that the CIT program is not just a separate, isolated group of individuals who happen to deal with individuals suffering from mental illness but it is a group effort with a common goal working together to achieve an objective. Parties must understand that without communication and teamwork, any CIT program attempted will not be successful.

Another important factor to recognize is that every state is different. A system that works for Memphis may not suit another city and so it is important to not only look at one but to look at a broad range of successfully implemented CIT programs (or related programs) from various cities and then to break each program up into steps, judging which are the more important and relevant steps for Victoria.

Adequate training is essential for all parties involved.

As the individuals suffering from mental illness are a unique group, police will require special skills when entering difficult situations so they can identify mental illness and then communicate this information to other officers. As the program is based on volunteer officers, it is important to distinguish who amongst them has adequate capacity to deal effectively with individuals suffering from mental illness.

Teams must not be only made up of officers who are willing but who are able to handle the tasks at hand. Also, after the police have deescalated the situation, there must be mental health services readily available to take care of the patient after the event. These patients are special cases and will not be treated like normal patients, as often there will be additional safety and security precautions involved. Implementing and managing these precautions in an equitable and humane manner will require additional training.

It is also very important to involve consumers of the mental health system in the program.

A more active role for these consumers (along with family members and professionals) in training police will provide recruits with a more rounded view of mental illness. It may be the first time ever that some of them have heard firsthand from a consumer what it is like to face a state of suicidal depression, mania, or psychosis.
Consumers can talk about how they respond in these states to the words and actions of police sent to assist them. This is why their input into the program is essential as there is no point creating something to attempt to help a particular group if there is no input from the special group itself.

Input from consumers into this type of program is crucial as they can assist in providing advice to the police with regard to communication with individuals suffering from mental illness.

Finally of vital importance to the whole program is the community support and attitude towards consumers. Police are often the first to be called when there is a disturbance of any kind, and so it is important for all to think of consumers as individuals who are unwell – and not criminals.

This attitudinal change is what is needed to create a program to ensure the safety of consumers and those sent to protect them. Without this vital ingredient, the program will be fruitless as the whole point is to help these people and not to outcast them.

9.3 VICTORIA POLICE AND THE DEPARTMENT OF HUMAN SERVICES MENTAL HEALTH BRANCH

It is essential to have clear codified guidelines in place for situations involving the police, individuals suffering from a mental illness and mental health staff. These guidelines are classified into the categories including non-urgent, consultation and urgent contact.

As police are usually first on the scene they should have the knowledge to accurately assess the situation and seek the appropriate assistance where needed. There must be a process to be followed in an urgent situation where workers from mental health services believe police attendance is required because of imminent risk to persons or property.

In high risk situations it is essential that there is co-ordination of trained police negotiators, special operations group members and police psychologists. To ensure people with a mental illness have the best possible care during a crisis situation it may be necessary to change laws and procedures. This is of particular concern where police assist the Crisis Assessment Team in returning individuals to secure custody following the revocation of community treatment orders.

REFERENCES:


Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, Police Shootings 1990-97, No.89, Canberra


Concise Australian Legal Dictionary ‘Community Treatment Order’


Fatal Police Shooting Sparks Stun Gun Debate, The Age, February 11 2004


Memphis Police Department, “Program Outline - Memphis Police Crisis Intervention Team”, Memphis, Tennessee, Date Unknown, accessed from http://www.ptb.state.il.us/publications/Mindex-general.shtml, on Thursday 6 May 2004 at 8:45pm

Mental Health Act 1986 Vic


SANE Fact Sheet: Anxiety Disorder: www.sane.org July 2004

SANE Fact Sheet: Bipolar Disorder: www.sane.org July 2004


SANE Fact Sheet: Drugs and Mental Illness: www.sane.org July 2004

SANE Fact Sheet: Facts and Fiction: www.sane.org January 2005

SANE Fact Sheet: Facts and Figures: www.sane.org January 2005

SANE Fact Sheet: Schizophrenia: www.sane.org July 2004


*Shootings – Police Face Questions*, The Age, January 5 1994


“to Recruits, The Force Should Be in the Mind as Well as the Muscle”, The Age, May 211994


Victoria Police, Project Beacon: A Synopsis, November 1996


“Why Did This Man Have To Die? It Was Police Error, Says Coroner” The Age, June 8 2002
