Discussion Paper 4
March 2005

Preserving life and dignity in distress

Responding to critical mental health incidents

Office of the Public Advocate—Queensland

Office of the Public Advocate

Postal address: GPO Box 149
BRISBANE QLD 4001

Telephone: (07) 3224 7424

Fax: (07) 3224 7364

Email: public.advocate@justice.qld.gov.au

Website: http://www.justice.qld.gov.au/guardian/pa.htm

Public Advocate's overview

We are all vulnerable to crises in life. Crisis may be relatively mild and short-lived, such as the upheaval we feel during times of transition. Or crisis may be more serious and enduring, precipitated by any number of misfortunes—ill health, the loss of a job, or the death of a loved one. During such times, our capacity to weather the crisis depends on our ability to marshal inner resources of strength and resilience, our ability to seek help, the love of our family and friends, and the access we have to formal sources of support.

However, for many Queenslanders who live with a mental illness or psychiatric disability, the experience of crisis is very different. Crisis is more likely to be a recurring feature in their life and to have enduring and far-reaching consequences. Not only can severe mental illness itself trigger complex crisis situations, but the reality of life for many people predisposes them to crisis—a reality that all too frequently includes homelessness, poverty, substance use, discrimination, social isolation and unemployment.

During times of crisis, people with a mental illness face greater risks than others. They may experience crisis more severely, be less likely to seek help from formal or informal supports, and lack the insight to understand that they are in crisis. The crisis might be accompanied by active psychosis, delusions, paranoia, hallucinations, or the effects of substance use.

It therefore follows that people in mental health crisis are more likely than others to come into contact with police. In fact, it has been said that police officers have become the de facto front-line workers of our mental health system. In most cases the interactions that police have with people with a mental illness will be resolved safely and without incident. However in a small number of cases the interaction will result in a so-called 'critical incident'.

Such critical incidents are invariably complex. The person with a mental illness will most likely be highly distressed and fearful for their own safety, may be experiencing paranoia or delusions involving police, and may have a history of contact with law enforcement. Combined with this is the response of the police officer—an officer who may have received only cursory mental health training, who may be fearful for their own safety and that of others on the scene, and who is acutely aware of the potential for violence that exists in dealing with situations of behavioural disturbance.

Historically, the outcomes of critical mental health incidents involving police have been varied. In my interactions with community mental health representatives, I have noted that the Queensland Police Service is widely admired for the professional response that its officers have frequently demonstrated in sometimes difficult circumstances.

However, it is also true that mental health crisis situations have, on a number of occasions, led to a lethal outcome involving the death of a distressed person. In fact, I am aware that as many as four people with a mental illness have been fatally shot by police in Queensland in the past three years.

These incidents, while relatively uncommon, can have devastating and long-term consequences—not only for the person's family and loved ones, but also for the police officer involved, and for community attitudes and perceptions. Strong negative community reactions to adverse incidents involving mental illness can put at risk years of substantive systems reform, as evidenced by the events of several years ago with respect to the forensic mental health service in this State. Such highly publicised incidents also threaten the credibility and reputation of police.

It is these incidents, and the determination to find a better set of responses to people in mental health crisis situations involving police, that serve as the impetus for this Discussion Paper.

A number of the essential ingredients to improving police response to such incidents are already in place. In the *Mental Health Act 2000*, Queensland has the legislative basis for a humane response to people with a mental illness, one that provides for their diversion from the criminal justice system and into mental health care. Within government, a significant partnership agreement is now in place between Queensland Health and the Queensland Police Service, and a number of local agreements between district police and mental health services are in effect.

What is missing is a concerted focus by government on the safe and humane resolution of crisis situations, one in which both psychiatric and emergency service responses are truly integrated.

Far from following a traditional law enforcement approach, the solution lies in addressing broad systems change in both the police and mental health systems for crisis care within the whole community. To this end, the Discussion Paper proposes a specific path of action for the Queensland Government, based on evidence of what is known to work well in other jurisdictions. Queensland is uniquely placed to take advantage of this knowledge and experience, because of the strong legislative and administrative basis already in place.

The solutions proposed in this Discussion Paper do not represent a panacea for all mental health crises. Furthermore, while the Paper proposes an enhanced critical response capacity by police, the success of this initiative depends in good measure on the continued reform of mental health services and the responsiveness of other community infrastructure.

Crisis response in mental health is critical. Equally important is crisis *prevention*. This highlights the need for a greater focus on psychosocial rehabilitation, to more effectively assist vulnerable citizens with a mental illness on their journey of recovery. By facilitating a return to an optimal level of independent functioning in the community, psychosocial rehabilitation services can assist people to live satisfying, hopeful and contributing lives—even within the limitations imposed by mental illness. The development of such inner resources will, in turn, strengthen individuals' natural coping abilities and help them avoid situations of crisis.

What is clear is that the comprehensive address of mental health crises requires two things: community-based psychosocial rehabilitation, and a responsive critical incident capability by police and mental health services. It is in this context that I commend the Discussion Paper to the reader.

IAN BOARDMAN
Public Advocate—Queensland

Table of contents

Summary of recommendations

Recommendation one: **Adoption of CIT**

It is recommended that the Queensland Government, through the Queensland Police Service and Queensland Health, develops and implements a Crisis Intervention Team program for responding to critical mental health incidents in Queensland, based on the 12 principles contained in this discussion paper (section 7.0).

It is recommended that this program be developed from a position that upholds the rights and dignity of people with a mental illness, and recognises that working with this cohort is a valid and valuable part of operational policing. It is recommended that the CIT program receive a level of support from both departments commensurate with the high level of need for this program.

Recommendation two: **High-level taskforce**

It is recommended that a high-level, multi-agency taskforce, with relevant Ministerial support, be commissioned to oversee the development and implementation of the CIT program. Following international best-practice it is recommended that this taskforce be constituted to include relevant consumer advocate bodies to provide practical and positive advice on its implementation.

Recommendation three: **CIT coordination**

It is recommended that, in implementing the CIT program, additional coordinator positions/teams be established within both the Queensland Police Service and Queensland Health. For effective administration of the CIT program, additional capacity may be required at both the corporate and district levels of both departments.

Recommendation four: **Non-lethal weapons**

It is recommended that the Queensland Police Service provides ready access for CIT officers to non-lethal weapons, for the safe and humane resolution of critical mental health incidents.

Recommendation five: **Mental health input into crisis situations**

It is recommended that Queensland Health establishes protocols across the State for the provision of specialised mental health advice to police for the safe and humane resolution of critical mental health incidents.

Recommendation six: **Substance-use disorders**

It is recommended that Queensland Health investigates the possibility of co-locating substance abuse and mental health services, or finds another equally potent mechanism to ensure equitable access to treatment for clients with dual psychiatric and substance use disorders.

Recommendation seven: Crisis prevention

It is recommended that the Queensland Government, via Queensland Health, applies greater funding to non-emergency crisis response teams (via public community mental health services) to respond to mental health crisis situations that do not require police involvement.

It is also recommended that the Queensland Government, via Queensland Health and Disability Services Queensland, applies greater funding towards a range of psychosocial rehabilitation services, based in the non-government sector, to assist the return of vulnerable citizens with a mental illness to an optimal level of independent functioning and to strengthen their natural coping abilities and social networks, so as to better help them prevent situations of crisis.

Recommendation eight: Follow-up and community linking

It is recommended that, for clients who do not qualify for psychiatric treatment, the police-based CIT program be augmented with a commitment by Queensland Health to link them to services and supports in the community, and to provide sufficient follow-up subsequent to the referral. These tasks may require additional capacity within Queensland mental health services.

Recommendation nine: Enhancing capacity

It is recommended that the Queensland Government examines the funding of mental health services, to ensure sufficient capacity in clinical services to meet the increased referral demands from the CIT program.

It is also recommended that the Queensland Government examines the funding of community-based human services, to ensure sufficient capacity in the areas of counselling, non-clinical case management, peer support, housing support, and substance abuse, in order to ensure sufficient capacity to meet the increased referral demands from the CIT program.

Recommendation ten: Dedicated and private reception

It is recommended that, in implementing the CIT program, Queensland Health provides a dedicated and private space within health services for the reception, triage and assessment of people in mental health crisis. It is recommended that consideration be given to locating this function within mental health services, rather than in hospital emergency departments.

Recommendation eleven: Partnership with ambulance service

It is recommended that a partnership be forged with the Queensland Ambulance Service as part of the CIT program, because of the imperative to transport people with a mental illness to hospital in the least restrictive manner possible.

Recommendation twelve: Mental illness in prison

Because of the reported high incidence of mental illness among prisoners and arrestees, it is recommended that the Queensland Government, through the Queensland Police and Department of Corrective Services, undertakes a formal audit of prisoners and those on remand to determine more precisely the rate of mental disorders among this population, in order to assess whether current service responses are adequate.

Recommendation thirteen: SCAN model for people with mental illness

It is recommended that the Queensland Government, through the Queensland Police Service and Queensland Health, considers the establishment of a SCAN-type model for people with a mental illness.

Recommendation fourteen: CIT response to other vulnerable groups

It is recommended that the Queensland Police Service and Queensland Health considers expanding the proposed CIT program to include responses to other vulnerable groups with decision-making disabilities, particularly people with an intellectual disability or an acquired brain injury.

The Office of the Public Advocate's interest

The interest of the Office of the Public Advocate in this issue was first articulated in the Public Advocate's 2002–03 Annual Report to the Queensland Parliament, in which he acknowledged the emerging partnership between the Queensland Police Service and Queensland Health to ensure a 'coordinated system of care' for people with a mental illness.[1]

In his 2003–04 Annual Report to the Queensland Parliament, the Public Advocate recommended that

> *...the Queensland Government, through Queensland Health and the Queensland Police Service, funds the development and implementation of Crisis Intervention Teams that respond to crisis situations involving police and people with a mental illness.*[2]

Established under the *Guardianship and Administration Act 2000*, it is the role of the Public Advocate to provide systems advocacy on behalf of vulnerable Queenslanders with a decision-making disability. The functions of the Public Advocate are to:

- promote and protect the rights of adults with impaired decision-making
- promote the protection of the adults from neglect, exploitation or abuse
- encourage the development of programs to help the adults to reach the greatest practicable degree of autonomy
- promote the provision of services and facilities for the adults
- monitor and review the delivery of services and facilities to the adults.

The Public Advocate has a responsibility to advocate on behalf of adult Queenslanders who have an active mental illness or psychiatric disability, an intellectual disability, an acquired brain injury or a dementia.

In publishing this discussion paper, it is the intention of the Public Advocate to examine the systemic responses that are currently made to vulnerable Queenslanders who experience a psychiatric crisis, and to propose a course of action for government that will better meet the needs of people experiencing such crisis situations. In examining these issues, the Public Advocate acknowledges several important sets of guiding principles.

First, the general principles under the *Guardianship and Administration Act 2000* particularly:

- all individuals have the same basic human rights regardless of their capacity (no. 2)
- the fundamental human worth and dignity of all individuals must be recognised (no. 3)

- all individuals have a right to participate, to the greatest extent practicable, in decisions affecting the their life. Any decisions made for people must be done in a way that is least restrictive of their rights (no. 7)
- all individuals have a right to confidentiality of personal information (no. 11).[3]

Second, this discussion paper acknowledges the importance of the principles embedded in the *Mental Health Act 2000*, particularly:

- all individuals have the same basic human rights regardless of whether they have a mental illness
- the fundamental human worth and dignity of all individuals must be recognised
- to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting their life, especially decisions about treatment
- to the greatest extent practicable, a person is to be helped to achieve maximum physical, social, psychological and emotional potential, quality of life and self-reliance
- the importance of a person's continued participation in community life and maintaining existing supportive relationships are to be taken into account.

Third, this discussion paper acknowledges the National Mental Health Statement of Rights and Responsibilities, particularly:

- the right to respect for individual human worth, dignity and privacy
- the right to timely and high quality treatment
- the right to expect that educators, police and other non-health professionals will receive sufficient education to enable them to recognise and refer people who may have a mental health problem or mental disorder
- the right to expect that mental health services will be integrated with general health services so as to provide comprehensive health care, including access to specialist medical services
- the right to be treated in the most facilitative environment with the least restrictive or intrusive treatment.[4]

Fourth, this discussion paper acknowledges the intentions of the National Mental Health Plan 2003–08, particularly Outcome 8: Improved Access to Acute Care. Key Direction 8.3 commits all governments to:

> *Improve linkages between acute inpatient units, crisis assessment teams and emergency departments, and between these services and other relevant providers, which may include general practitioners, private psychiatrists, private hospitals, ambulance services and the police.*

Part 1 Mental health crisis situations

1.0 The experience of crisis

In any crisis situation, even a healthy person may experience a temporary breakdown in their coping skills. The experience of crisis is likely to affect their perception, decision-making capacity and problem-solving ability.[5] In dealing with a personal crisis, most people are likely to seek help from others to help them manage the situation. As Rosen states,

> *Most crises are part of the normal range of life experiences that most people can expect, and most people will recover from crisis without professional intervention. However, there are crises outside the bounds of a person's everyday experience or coping resources which may require expert help to achieve recovery.*[6]

Rosen (1997) goes on to describe three main types of crises:

- developmental crises, such as those related to stress arising from transitions between normal life-stages
- situational crises, such as those related to specific situations such as the loss of a job or the death of a loved one
- complex crises, such as those associated with severe trauma or severe mental illness.[7]

Severe mental disorders affect some three per cent of the Australian population.[8] This includes people who live with schizophrenia, bipolar disorder and other forms of psychosis, some forms of depression, and anxiety disorders such as panic disorder and obsessive compulsive disorder. For many people with a serious mental illness, the experience of crisis may be very different than for 'healthy' people.

- Due to the episodic nature of many mental illnesses, people with a psychiatric disability are likely to experience crisis more frequently than others.
- Relative to other people, a person with a mental illness may experience the symptoms that accompany crisis more severely.[9]
- Relative to other people, a person with a mental illness may be less likely to seek help, and may in fact not understand that they are in crisis.[10]
- There is a reciprocal relationship between crisis and mental illness. That is, severe mental illness can trigger complex crises for a person; alternatively, the stress of life crises can precipitate episodes of mental illness.
- The reality of life for many people with a mental illness predisposes them towards crisis. For many people, this reality is characterised by the experience of homelessness, poverty, substance use, discrimination, social isolation and unemployment.

During times of psychiatric crisis, a person will experience thoughts, feelings and/or behaviours which cause severe distress to themselves or those around them. These may include difficulty organising thoughts, hallucinations, delusional thoughts, severe mood swings, and disturbed behaviour.[11] They may require immediate support, or even a formal service response, to alleviate this distress.

2.0 Crisis response

The nature and timing of crisis response is critical for people with a mental illness. While an in-depth examination of psychiatric crisis response lies outside the scope of this paper, the literature reports the following factors as fundamental to effective mental health crisis response.[12]

- Multidisciplinary teams are most effective in responding to crisis. In addition to a community mental health team this might include general practitioners, community workers and emergency services. Crisis services should be part of a whole-of-system approach and should forge good relationships with other services and sectors.
- Family and other informal, culturally-appropriate sources of support should be involved in responding to crises.
- Collaboration with the individual in crisis is paramount, in order to facilitate their 'ownership' of the situation and its resolution, and for the person to learn new coping skills (doing 'with' people rather than 'to' them). People affected by severe mental illnesses are much more likely to cooperate when they feel listened to and are consulted, and when they are offered choices regarding types of proposed interventions. They are also more likely to cooperate with interventions which are tailored to their individual needs.
- Crisis responses should promote a person's recovery process.
- There should be clear processes in place for transition arrangements, including the transfer of information between service areas and organisations (e.g. between police and mental health services).
- Within defined parameters of safety, crisis responses are most effective in natural, non-clinical environments. That is, crisis response should be *mobile*.
- Service responses that are flexible and available 24 hours a day are most effective.
- There is widespread acknowledgement of the need for greater services, structure, support and social networks in the lives of vulnerable people, in order to facilitate their natural coping mechanisms and help them to prevent crisis.

- Appropriate and timely crisis responses to people with mental illness may avoid critical incident situations (i.e. more serious mental health crises in which the need for police and other emergency services arises).

3.0 The thin blue line of mental health

It is widely acknowledged that police frequently represent the first line of response to people with a mental illness, particularly in times of crisis. This is in part a result of deinstitutionalisation, which has seen the movement of people with a mental illness from long-term psychiatric facilities into the community, but without the promised funding for community services.[13] The under-funding of community infrastructure, particularly psychosocial rehabilitation services, has left many Australians who have a mental illness without proper care and support, and without the means to manage their illness and avoid situations of crisis.

The frequent interaction that police have with people who have a mental illness is also a reflection of the under-funding of public mental health services across the country. Australia spends some 6.4% of its health budget on specialised mental health services.[14] This is significantly lower than a number of other developed countries, which report spending 10–14% on mental health.[15]

Historic under-funding of mental health services in Australia has seen services struggle to meet increasing demands. It is conceivable that this pressure would particularly be felt in Queensland, which has the lowest spending (per capita) on mental health, and the fewest number (per capita) of clinical mental health staff, of any state in Australia.[16]

That police frequently represent the front-line response of the mental health system is demonstrated by evidence from a variety of sources.

- In 2003, Queensland police responded to some 17,000 callouts across the State relating to people with a mental illness, a 17% increase from 2001. Some 11% of these callouts resulted in a mental health crisis situation.
- In a 2002 study of Sydney police, it was found that more than 10% of police time is spent dealing with mentally disturbed people. Further, 74% of police had dealt with a least one person with mental health problems in the past month.[17]
- Under the *Mental Health Act 2000*, Emergency Examination Orders (EEOs) can be made in emergency situations by police, ambulance or psychiatrists if they believe a person has a mental illness and there is imminent risk of significant physical harm to self or others.[18] In 2003–04, almost 3500 EEOs were taken out across Queensland. This figure represents a 39% increase in the number of EEOs from the previous year.[19] It is conceivable that police officers would have taken out the majority of these orders.

- Police in other jurisdictions have also recognised the significant impact that mental health is having on their work. For example, in late 2004 police in New South Wales joined with mental health workers, doctors and community services workers to form the Mental Health Workers Alliance. The Alliance exists to draw public attention to the resource deficits in mental health services in NSW, which it maintains are impacting on the work of a number of professions. According to a 2004 survey by the Alliance, some 93% of police report that caring for people with a mental illness is affecting their ability to do 'core work responsibilities', while only 14% feel they are adequately trained for this work.[20]

4.0 Police involvement

Given the frequent interaction that police have with people with a mental illness, the nature of this contact warrants further investigation. A variety of themes emerge from the literature on this issue.

4.1 A 'problem' for police

Interactions with people who have a mental illness are frequently viewed as problematic for police. In fact, there is even some disagreement within police ranks as to the desirability of engaging with this cohort, given the traditional view of policing as concerned with maintaining order and imposing control.[21] Police may view the interactions they have with people with a mental illness as problematic for a variety of reasons.[22]

- Police may be unclear about their role in relation to issues of 'social support'. The boundary between law enforcement and social work may be unclear.
- Officers may not have the interpersonal skills and expertise for effective crisis resolution in cases of mental health crisis.
- Police may not understand mental illness, and may hold negative attitudes towards people who live with a mental illness.
- Responding to people with a mental illness may be viewed as detracting from their 'real' work of law enforcement.
- Perceived barriers within the mental health system may also impact on the response police provide to people with a mental illness. Such barriers most commonly relate to police frustration with the responsiveness of the mental health system, the time-consuming attempts by police to provide people with access to professional assistance, and a lack of understanding of how the mental health system works (e.g. confusion over whether a person in crisis taken by police to a mental health service will be accepted for treatment).
- Police may see people with a mental disorder as unpredictable or dangerous, and feel unprepared for their dealings with them.

- Police may be concerned about the potential for violence that exists in dealing with incidents of behavioural disturbance, particularly when there is a mental illness and co-existing substance use disorder.

4.2 Identification and response

Perhaps the most important issue with respect to police contact is that mental illness should be correctly and promptly identified by police in their dealings with members of the community. While police should not be expected to undertake clinical diagnostic assessments, it is imperative that they are familiar with, and learn to recognise, the likely symptoms and behaviours of a person who is experiencing acute mental illness. Failure to appropriately identify existing mental illness can have serious consequences for the individual, as highlighted in the recent, highly publicised Rau case in Australia.

Studies in several jurisdictions have revealed that a significant number of offenders with a mental disorder pass through the criminal justice system without being correctly identified and receiving proper health care and social support.[23] A recent study in the Brisbane watch house explored the substance use and psychological distress of 288 arrestees using the General Health Questionnaire, an established, well-validated and reliable measure of psychological health. The study found that 82% of male and 94% of female arrestees exhibited 'significant psychological distress'. Further, some 86% had at least one substance-use disorder. These findings raise serious questions about the mental health status of people arrested by police.[24]

Following appropriate identification, the particular response initiated by police can significantly determine long-term life outcomes for the individual. In a traditional law enforcement approach, police are likely to see bizarre or threatening behaviour as dangerous and in need of control, and to apply an enforcement approach. In contrast, a mental health approach will view the same behaviour as symptoms of illness and distress requiring support, empathy and intervention.

4.3 Interpersonal skills

Research shows that it is often the interpersonal skills of police officers that are critical in influencing the outcomes of their interactions with people who have a mental illness, and which may largely determine the quality of the experience for highly distressed people. As Fitzsimmons argues, good interpersonal skills on the part of police can 'act as a buffer to limit the trauma and humiliation' of the experience of a mental health crisis involving police.[25] Some of the specific skills required include passion (for working with people with a mental illness), kindness, sincerity, understanding, active listening skills, and good personal communication.[26]

People with a mental illness continue to face significant discrimination and stigma in many areas of life. Stigma can have a substantial impact on mental health outcomes and on people's capacity to participate effectively in society.[27] The nature of the interaction that people with a mental illness have with police has a significant potential to either diminish or exacerbate their experience of stigma. In fact, police interactions may affect a broad range of factors in people's lives (for example, their relationships with neighbours, in situations where police respond to a mental health crisis at the person's home).

4.4 Development of expertise

Despite the role that police play in mental health, they generally have inadequate training to understand and respond appropriately to situations involving mental illness.[28] It is universally acknowledged that police officers need specialised training in mental health, beyond the cursory information they receive during their initial police training.[29] Such training should focus on the development of expertise, rather than 'training for training's sake'. It should canvass at a minimum the following:

- mental illness and substance use disorders
- psychotropic medication and treatment modalities
- patient rights and mental health legislation
- how to interact with people with a mental illness
- active listening skills and empathy training
- crisis intervention and de-escalation skills
- role-playing scenarios
- community mental health resources available for referral.[30]

Training is best provided by a combination of mental health providers, family and 'consumer' advocates, and people who have a lived experience of mental illness. Cross-training between police officers and mental health professionals is also advantageous, and will assist bridge-building between the two sets of professionals.

4.5 Co-existing substance use

Substance use disorders frequently accompany mental illness; this is known as dual diagnosis or co-morbidity. In fact, as many as 64% of psychiatric inpatients in Australia may have an active or prior drug problem; correspondingly three-quarters of people with drug problems may also have a mental illness.[31] Substance use may exacerbate the symptoms of schizophrenia, contribute to disruptive behaviour, and impact on a person's adherence to medication.[32] Co-existing substance use also has a number of implications for police interaction.

- People with dual diagnosis may be more difficult to engage and more unpredictable. The presence of substance use may raise the potential for violent behaviour.
- Substance use may mask the presence of mental illness; alternatively substance use might be mistaken for mental illness.
- In interacting with the health system and transferring clients in crisis, police need to have a single point of access to both the mental health and substance abuse systems, so they are not required to distinguish between mental illness and psychoactive substance use.

4.6 Diversion from the criminal justice system

A recurrent theme in the literature is the importance of diversion for people with a mental illness from the criminal justice system into mental health care and other community supports. A legislative basis is required for this diversion to take place. In the M*ental Health Act 2000*, Queensland has the basis for the diversion of people with a mental illness from the criminal justice system to mental health care. Under the Act, the Mental Health Court determines issues such as criminal responsibility and fitness for trial, and by its decisions may remove an offender with a mental illness from the criminal justice system into the mental health system. Where a person is charged with an offence, the Court decides whether, when the offence was allegedly committed, a person was of unsound mind, of diminished responsibility (where the charge is murder) and, if the person was not of unsound mind, whether they are fit for trial.

It is clear that diversion will only be effective if early detection of mental illness occurs by police or corrective services, and if the police can facilitate access to services for treatment and support of the person.

4.7 Lethal events

It is also recognised in the literature that, from time to time, lethal events occur when police interact with people who have a mental illness. A 1998 study of police shootings in Australia from 1990-97 found that in more than one-third of police shootings, the deceased person was reported to have been either depressed or to have had some form of psychiatric history requiring treatment. That is, a significant number of people shot by police were either affected by mental illness or were psychologically disturbed at the time of the incident.[33]

5.0 Critical mental health incidents

Critical mental health incidents are distinguished from other interactions people with a mental illness have with police by virtue of a number of elements, such as the presence of or potential for violence or self-harm, the presence of firearms or other weapons, and the degree of distress

experienced by the individual. Under the Memorandum of Understanding between the Queensland Police Service and Queensland Health, the Interdepartmental Steering Committee has defined a mental health crisis situation as:

> *an event, or circumstance in which a person appears to be mentally disturbed, impaired in judgement and exhibiting highly disordered behaviour. It is a situation which may involve serious risk to the life or health or safety of the person or of another person.*

A mental health crisis situation requires coordination and communication between police and mental health services. Immediate assessment is needed to ascertain the need for treatment, to prevent further deterioration in the person's mental or physical health, or to prevent harm to the safety and health of the person or the public in general.[30]

In examining police response to critical mental health incidents, a number of issues emerge from the literature.

5.1 Creating the right culture

The single most important systems element pertains to police culture. Appropriate and innovative responses to mental health crises are only possible from within a community policing framework, rather than a traditional policing approach. Traditional views of policing involve enforcement, investigation and control of bizarre or threatening behaviour. Community policing approaches are characterised by a problem-solving approach to operational police problems and the use of community partnerships to accomplish operational objectives.[34]

In applying a community policing approach to the resolution of critical mental health incidents, the following are paramount:

- a police culture that values and respects the job of working with people who have a mental illness as a valid and valuable part of operational policing
- a recognition of the person as distressed and in need of support, rather than as a potential offender
- a willingness to take some responsibility for the distressed person
- a commitment to the safe and humane resolution of the incident – one which upholds the dignity and rights of the individual, and shows concern for their well-being
- a focus on problem-solving and an effort to prevent the incident from escalating
- an understanding of the broader psychiatric and community-based service context which exists to provide support for the person

- a commitment to consultation and partnership with other government and non-government stakeholders, including those places where people with a mental illness gather (e.g. boarding houses, drop-in centres and homeless services)
- a recognition that vulnerable people with a mental illness are frequently victimised in our community (e.g. through active discrimination, stigma or as a victim of crime) and that the experience of victimisation is likely to have an impact on their behaviour and their reactions towards police.[36]

5.2 Police and mental health collaboration

It is clear that critical mental health incidents cannot be adequately resolved by police or mental health services in isolation; a truly collaborative and integrated approach is needed.[37]

- Written agreements and procedures between police and mental health services should be in place at both the corporate and local levels, and be complemented by regular face-to-face meetings. The partnership should be based on a mutual understanding of, and respect for, the respective roles and responsibilities of each party. Equal ownership of, and leadership on, the issues by both police and mental health services is required.
- Such partnerships should focus on forging a coordinated system of care between mental health and police services, and provide a single point of entry for people into the mental health system.[38] Agreements should clearly delineate the lines of responsibility (i.e. at what point does the mental health service assume responsibility for the person?).
- The creation of a shared language concerning mental health incidents between police and mental health services will facilitate more collaborative assessment and response.
- Cross-training of police officers and mental health staff will facilitate greater collaboration.
- Consultation with mental health staff at the scene of a crisis situation can help bring about a successful resolution.
- In a number of jurisdictions, partnerships with non-government peak bodies and consumer advocacy groups have greatly assisted the development of effective crisis response mechanisms.[39]
- Through jointly analysing their service data, police and mental health services can identify people who have repeat contacts with police, in order to work with them to develop long-term solutions to avoiding crisis situations.

- Joint protocols should be developed for voluntary referrals by police officers to mental health services, and by either police or mental health services to other community-based services. Voluntary referrals should be made when a person does not meet the criteria for involuntary treatment.[40]

5.3 De-escalation

The priority of police officers engaged in critical mental health incidents should be the safe and humane de-escalation of the situation by engaging directly with the distressed person. Successful de-escalation requires exceptional interpersonal, active listening and negotiation skills, in addition to a sound understanding of the experience of having a mental health crisis. While a detailed examination of negotiation skills is beyond the scope of this paper, a police officer effectively using de-escalation techniques will:

- remain calm and avoid overreacting
- indicate a willingness to understand, empathise and help
- speak simply, using short sentences
- understand that a rational discussion might not be possible at that point in time
- recognise that the person might be overwhelmed by sensations, thoughts and voices
- be aware that the sight of a uniform or firearm might provoke fear
- reassure the person that no harm is intended
- allow the person in distress to participate in decisions about the situation's resolution
- acknowledge that a person's delusional or hallucinatory experience is real for them.[41]

5.4 Dual emphasis on safety and care

It has already been acknowledged that the traditional policing and mental health perspectives on mental health crisis situations are likely to differ. One is likely to view the person as an offender, the other as a vulnerable, distressed person. One might view the behaviour as threatening and dangerous, the other as a distress call for help. In responding to the person, the traditional police perspective will focus on the need for safety and control of the situation; the mental health perspective will focus on the need for specialised psychiatric care.

A dual focus is needed in critical mental health incidents, one which seeks to both maintain the safety of the situation *and* to secure specialised care for a vulnerable person. Both elements are intertwined.[42] Clearly, it is the task of police to uphold the safety of all people on the scene, while the mental health team should work to maintain a person's

mental health needs, and to preserve their rights and dignity.[43] While police have prime responsibility for maintaining safety in the situation, it is incumbent on police to consult closely with mental health professionals in their decision-making so that, as much as possible, the resolution of the situation does not diminish a vulnerable person's rights, dignity or well-being.

5.5 Use of force and restraint

In resolving critical mental health incidents, it is imperative that police officers have ready access to non-lethal weapons as an alternative to their firearms.[44] Traditionally in Queensland, non-lethal weapons have only been carried by members of the police special response team, which is called upon in crisis situations such as hostage negotiations. The use of force exists on a continuum, and officers responding to mental health crisis situations should employ other strategies than the use of lethal force. Use of weapons should always be a last resort. While some forms of non-lethal weapons may be inappropriate in certain situations, a range of technologies exist and is widely used in other jurisdictions.[45]

Similarly, in taking a person into custody and transporting them to the mental health service, police, ambulance and mental health staff should use the least amount of sedation and restraint possible.[46] This is consistent with the National Standards for Mental Health Services.[47] The use of restrictive measures in transporting people to hospital can have a significant impact on their experience of victimisation and stigma. Front-line services should provide care with as much dignity as the situation allows. Thus the use of ambulance transport is preferable for transporting a person to hospital; a police vehicle should be the last resort. It is also necessary for police and ambulance services to liaise closely over the transportation of a person to hospital.

5.6 Contribution of mental health services

In addition to the participation of mental health professionals on the scene of a critical incident to support and advise police, the literature recommends a range of initiatives by mental health services, to complement the critical incident response capability of police. These include:

- a single point of entry for police into the mental health system[48]
- a streamlined intake process available 24 hours a day, so that police can drop people off at the health service and promptly return to operational duties[49]
- a separate entry for police officers to the mental health facility, equipped with an office and telephone[50]

- a dedicated and private space for the reception of people with a mental illness in the health service who are transported to hospital
- a dedicated position or team within the health service responsible for coordinating mental health triage and assessment, to give appropriate priority to psychiatric emergencies that require an urgent response
- a dedicated position or team in the health service responsible for coordinating follow-up support and referrals to other community-based services
- the active involvement of consumers and advocates in the design and delivery of the crisis response service[51]
- the co-location of mental health and substance use services to respond to the high incidence of dual disorders, or an enhanced capacity of the service to work with both disorders[52]
- equal access to services for people with a mental illness and co-existing acquired brain injury, intellectual disability or personality disorder (axis II disorder)[53]
- a process for the ongoing assistance, support and referral of people who need mental health support but who do not qualify for psychiatric treatment or who do not satisfy the stringent clinical diagnosis for mental illness[54]
- service infrastructure to help prevent psychiatric crises: a mobile mental health crisis service for non-emergency situations which do not require police involvement, and the provision of psychosocial rehabilitation services to strengthen people's coping skills and assist them to stay well in the community and avoid crisis
- the involvement of ambulance services in the crisis response partnership.

5.7 Community linking and follow-up

Not every person taken by ambulance or police to a mental health service will be accepted for treatment. Of the 3500 Emergency Examination Orders taken out by police, ambulance officers or psychiatrists in 2003–04, over half (56%) did not result in assessment documents being made.[55] Thus over half the people brought by a professional to an authorised mental health service in an emergency situation were determined by the service to not satisfy the stringent criteria for a diagnosable mental illness and/or to not require formal assessment or treatment.

The reasons for these refusals are complex and varied, and a full examination lies beyond the scope of the present discussion. While

contemporary mental health legislation may have effectively raised the threshold for inpatient admission, this issue cannot be explored without reference to the historic and ongoing funding crisis of mental health services across Australia, and the resulting struggle of services to meet demand. Queensland's mental health funding per capita was the lowest of any Australian State when the National Mental Health Strategy commenced in 1992. It remains so today, despite significant increases in funding.[56]

Whatever the reasons, a reinvigorated police response capability to critical mental health incidents will not succeed unless there are mental health and related services (inpatient, outpatient and community-based) to respond following police intervention. In cases when a person does not qualify for treatment, it is clear that additional service elements are still needed—a refusal of service from a hospital does not diminish the situation of crisis for an individual. The mental health service should:

- take responsibility for sourcing services and support for the person, either community-based or those operated by Queensland Health
- play an active role in referring people to such services
- play an active role in following-up people who have been referred to other services.

It follows that the police crisis response capability will be successful if there is sufficient community-based infrastructure in place to meet a broad range of needs for people in crisis. A range of services are needed including:

- non-clinical case management
- psychosocial rehabilitation
- counselling
- housing assistance and homelessness service
- substance abuse treatments
- peer support services and drop-in centres
- crisis telephone lines skilled in providing mental health assistance.

5.8 Information sharing

In order to safely resolve critical mental health incidents, police may need access to health-related information about the person involved. It is imperative that agreements are in place between police and mental health services for the necessary sharing of personal information, while upholding the privacy and confidentiality of the individual as much as possible. As articulated in the National Approach for Information Sharing in Mental Health Crisis Situations, 'effective management of crisis

situations requires provision for information sharing that is underpinned by legislation to provide a formal basis for information sharing across agencies'.[57]

The information needed by police might include:

- relevant aspect's of the person's illness, treatment or personal history
- information about any history of violent or irrational behaviour, and any history of substance use
- warning signs that would point to a deterioration in the person's mental health
- 'triggers' to avoid when interacting with the person
- what might help calm the person and de-escalate the crisis.

Clearly, personal health information should be shared only when it is likely to lessen the threat to the safety and health of persons involved in a crisis.

Part 2 Case study: The crisis intervention team, Memphis

6.0 Types of response mechanisms

There are three basic models of mental health crisis response mechanisms.[58]

6.1 Specialised mental health response based within the police team

In these models, mental health professionals are employed (as un-sworn officers) by the police service. They offer on-site and telephone consultation to sworn police officers who are undertaking mental health crisis response. In such models there are usually no formal partnerships enacted between police and mental health services; after taking a person into custody and transporting them to the mental health service, there are no special provisions for their reception.

6.2 Specialised mental health response based with the mental health team

This represents the traditional crisis response model. Here, partnerships are developed between mental health staff and police officers, however the mobile crisis mental health teams (which are part of the health service) operate independently of the police and provide their own response to critical incidents. Not only is this model unable to provide as rapid a response to critical incidents as police-based models, but as it is operated by the health service it cannot respond to highly critical incidents (e.g. those involving violence and firearms).

6.3 Specialised police response based within the police team

The third model actively involves sworn police officers who, having received specialised training in mental health, act as the front-line response to critical mental health incidents in the community. These officers, who are called from general duties in the event of a mental health crisis, act as liaisons to the formal health system. Further, there are special arrangements established within the health service for the reception and assessment of people who are brought in by police following a mental health crisis situation.

7.0 Memphis CIT project

The Memphis Crisis Intervention Team (CIT) program is the most widely known example of the third model, a specialised police-based response to critical mental health incidents.

The Memphis CIT project commenced in 1988, when a public scandal followed the police shooting death of an individual in crisis with a history of mental illness and substance use. A high-level cross-community taskforce was established to promote better responses to individuals in mental health crisis situations. This work saw the birth of the CIT project, which has been replicated across the United States of America in several jurisdictions.

In the CIT model, a number of general duties police are recruited for the project and receive special mental health training. In the event of a critical mental health incident, these officers respond immediately to the scene, oversee police operations, liaise with mental health services, and intervene to de-escalate and resolve the crisis. The person is transported to a mental health service, in which arrangements have been made for their reception. Police hand over the individual to the mental health service, and are able to quickly resume operational duties. The mental health service responds with appropriate triage and assessment. Mental health staff and protocols are in place for the referral and follow-up of individuals who do not quality for inpatient psychiatric treatment but who need other forms of support and assistance.

Examining the CIT model in more detail, it can be seen that there are 12 key principles which have been fundamental to the success of this model.

7.1 Leadership and profile

In the case of the Memphis CIT project, the Mayor personally commissioned the establishment of a taskforce with the heads of police, health services and high-profile consumer advocate body, NAMI (National Alliance for the Mentally Ill).[59] Given the mandate for systemic reform, the taskforce was afforded sufficient powers to leverage the necessary systems changes in order to bring about a better set of responses to critical mental health incidents. Thus from the outset, a significant and high-level political impetus created the climate for reform.

Since its establishment, the CIT project has developed a momentum and profile of its own. The project's status, forged over a period of time, is based on its reputation as a professional and highly responsive unit that has delivered tangible benefits to the community, to the police service and to people with a mental illness. A certain status surrounds the CIT project and its officers. Working with people who have a mental illness has come to be regarded as a valid and vital part of operational police work. Relevant officers wear CIT badges to identify them as CIT officers to the broader community.[60] Thus the CIT program has become a highly visible and well-regarded feature of the Memphis police service.

7.2 The place of partnerships

Partnerships are at the heart of the CIT model. The police and mental health systems have developed extensive partnerships concerning crisis response, sharing of information, determining a person's need for mental health treatment, drop-off arrangements at the health service, and referral processes for people who do not qualify for psychiatric treatment. Formal partnerships are reinforced by close collaborative working relationships and regular meetings at corporate and local levels. This partnership

encourages joint accountability for critical mental health incidents, and clearly outlines the areas of responsibility for each party.

Partnerships with the broader community are also paramount in the Memphis CIT model, and have been highlighted in the literature.[61] The nation's principal mental health consumer advocate lobby, NAMI, was engaged as a participant in the development of the project, and has been highly supportive of the role of CIT in the lives of people with a mental illness.[62] By working in a practical and positive way with government agencies, mental health advocacy and peak bodies can deliver a number of tangible benefits to the project:

- they serve to articulate the voice of people with a mental illness, to ensure that their rights and needs are not lost in the ensuing discussions between the police and mental health services
- they can help shape an innovative and comprehensive training package for CIT officers, bringing to bear the lived experiences of people with a mental illness
- they have the capacity to leverage broader community support for the crisis response initiative
- they can help broker the involvement of other community services which are necessary for crisis referral and follow-up.

7.3 The development of expertise

The training given to police officers is one of the central platforms of the CIT project. This training is viewed differently than other police recruitment or in-service training and is characterised by the following.

- Rather than 'training for the sake of training', the focus is on the development of expertise in mental health within the police service.
- Initial CIT training runs for some 40 hours; there is also regular follow-up training.
- Training is delivered by a range of experts including mental health services, family members and consumer advocate groups.
- There is substantial involvement of people who live with a mental illness – as much as eight hours of police-'consumer' interaction.
- There is cross-training of police officers and mental health staff, to facilitate mutual understanding and collaboration.
- Training involves case scenarios and role-playing.
- Training includes recognising the signs and symptoms of mental illness, mental health treatments and medication, responding to people with a mental illness, substance abuse, de-escalation techniques, legislation and patient rights, and available community resources.

7.4 A 24/7 response

The CIT program has the capacity for immediate response, 24 hours a day. To achieve this outcome, the program has been successful in attracting a significant number of general duties police officers to its ranks—as much as 10% of the police service are CIT officers.[63] With such a significant contingent of CIT officers, critical incident response times of five to ten minutes have been reported.[64] Immediate response is critical in mental health crisis situations, in order to prevent escalation of the crisis. Delayed or ineffectual responses may result in the need for greater levels of force in order to resolve the situation.

7.5 Effective coordination at state and local levels

Effective coordination of the CIT program requires dedicated positions within both the police and mental health systems for its oversight. The coordination role within the police system serves to:

- establish and develop partnerships with other agencies
- organise and assist with training
- facilitate the recruitment of officers to the CIT program
- track and review critical mental health incidents
- provide support to CIT officers
- brief other police on mental health crisis response strategies
- promote the CIT program within the police system.[65]

The coordination role within the health system serves to:

- establish and develop partnerships with other agencies
- provide support, education and training to health staff in the emergency department about mental health and crisis response
- coordinate the mental health triage and assessment processes
- promote the CIT program within the health system
- coordinate the referral and follow-up process for people who are not accepted for psychiatric treatment.

7.6 Choosing the right officer

It is clear that working with people in mental health crisis situations may represent a significant departure for some officers from their traditional law enforcement duties. Selecting the right officer for the job is integral to the success of the CIT program. Appropriate screening processes should be in place, in order to identify those police who are best suited to work with this highly vulnerable population. The CIT program rests on having police officers who have distinct qualities. These include:

- passion for working with people who have a mental illness
- kindness, sincerity, compassion and understanding
- capacity for active listening and high-level communication

- capacity to understand the experiences of a person in mental health crisis
- a commitment to involving a vulnerable person in decision-making during a crisis situation
- demonstrated concern for the well-being of vulnerable people
- demonstrated commitment to upholding the rights of vulnerable people.

7.7 No-refusal by mental health services

Appropriate interventions by police in critical mental health incidents will only succeed if the mental health system is sufficiently responsive, accepting the referrals that police bring in. A key feature of the Memphis CIT model is the no-refusal policy by mental health services. That is, all persons brought into the health system by CIT officers are accepted for triage by mental health staff – no one is turned away.

While not every person brought into a mental health service will meet the stringent criteria for assessment and treatment, under the CIT program the mental health service still takes responsibility for their care. A professional staff member or team sources alternative community services or informal support for the person, and provides case management follow-up subsequent to a referral being made.

Not only is there a no-refusal policy in place within the mental health system, but there is appropriate priority given by emergency departments to situations of mental health crisis. It has been reported that psychiatric crises are often viewed as a lower priority than other illness in emergency departments.[66] This raises questions about the applicability of the triage prioritisation process to psychiatric disorders.

The twin requirements of no-refusal and appropriate prioritisation by the health service raise questions concerning the adequacy of current funding arrangements for the health and human service systems. The CIT project would therefore likely have implications for:

- the funding of acute inpatient mental health units
- the need to fund specialised mental health teams to manage CIT referrals
- the need to better fund community-based human services, so that sufficient service infrastructure is in place to accept referrals.

7.8 Streamlined intake in mental health services

The Memphis CIT project is also characterised by a streamlined intake process in place within the health services. This involves the rapid handover of the person from police to mental health staff, and allows police to resume their operational duties without lengthy delays. It has been reported that police are able to resume normal duties within 30

minutes of their arrival at the health service.[67] This intake process would be best handled by specialised mental health professionals, or by general nursing staff in close consultation with mental health teams.

Reception by the mental health service also best occurs in a place which is dedicated for people with a mental illness, and which provides some degree of privacy from other patients. This is particularly relevant for regional and rural areas (i.e. small, close-knit communities).

7.9 CIT and the prevention of crisis

In addition to providing an immediate response to critical mental health incidents, the CIT program also serves to play a preventative role with respect to mental health crisis situations.

- CIT officers are encouraged to take an active interest in mental health issues and the broader mental health community. Some have taken on an advocacy role, speaking out on issues affecting people with a mental illness.
- On-going dialogue and liaison takes place between the CIT program and places where people with a mental illness are known to gather (e.g. boarding houses).
- Police and mental health service data is reviewed regularly to identify individuals who experience frequent crises, so that psychosocial rehabilitation support can be provided to help bolster the person's natural coping skills and avoid situations of crisis.
- Over time, CIT officers become known in their community. As a result their contact with people with a mental illness is not limited to full-blown crises. Having specialised skills in recognising mental illness and the early warning signs of crisis, CIT officers can take preventative measures, referring people to the mental health system or encouraging their participation in treatment.
- Health services make referrals for CIT clients to community networks and services, to address a range of psychosocial issues and help them achieve a higher level of independent functioning, improve their social networks, and avoid future crisis situations.

7.10 Non-lethal weapons

As discussed in Section 5.5, ready access to non-lethal weapons is essential for police to safely resolve some critical mental health situations. A key feature of the Memphis CIT program is the deployment of non-lethal weapons to CIT officers.

7.11 Co-location of mental health and substance use services

As already discussed, the incidence of critical mental health situations that involve both mental illness and substance use is very high. In fact, the presence of substance use may make a situation more volatile and make it progress more easily to a critical incident. It has been the experience of the CIT project in the USA, therefore, that services which can respond both to people's mental health and substance use needs will best serve the interests of vulnerable people in distress. It also makes the job of the CIT officers easier, given that they do not have the specialised diagnostic skills for differentiating mental illness from psychoactive substance use. Importantly, mental health services should not be designed as if people are 'pure types', in recognition of the significant number of people who have dual diagnoses (a mental illness and acquired brain injury, intellectual disability and/or personality disorder).

7.12 Community follow-up

The Memphis CIT program actively involves the broader community. People not meeting the stringent criteria for acute psychiatric treatment are referred to community services and supports, and follow-up is managed by the mental health service. This raises a number of pertinent issues.

- There is a need for both formal partnerships and close working relationships between the public mental health and police systems, and the non-government mental health community – at both the corporate and local levels.
- This component of the CIT program relies on there being sufficient capacity within the non-government sector to meet the referrals from the mental health system. The CIT project will not succeed if the widely known 'refusal of service' from inpatient mental health units is simply transferred to the non-government sector.
- There is a need for government to genuinely respect the role of non-government services in mental health service delivery, and to recognise that they represent valid and viable alternatives to clinical service delivery.
- There is a need to fund a wide range of recovery-focussed service types in the community including psychosocial rehabilitation, supportive housing arrangements and peer support services.

8.0 The effectiveness of CIT

Relative to the other two models of crisis intervention, the CIT model has been found to be a more effective approach.[68] This is due to the immediate response by police, the no-refusal policy of mental health services, the rapid and easy drop-off for police, and the centrality of

mental health and community partnerships. The effectiveness of specialised police-based response mechanisms to critical mental health incidents, such as the Memphis CIT program, is confirmed by a growing body of evidence. It would reasonably be expected that, over time, these benefits would see cost savings to government.

- The early intervention of police de-escalation techniques has led to a decrease in lethal events, in the use of restraint and in the need for higher levels of police intervention (e.g. Special Emergency Response Teams).[69] The CIT program enables this to happen by resolving crises earlier in the process.
- The rate of police injuries in critical mental health incidents has decreased fivefold since the commencement of CIT.[70] It could also be expected that injuries to people with a mental illness would also decrease under a CIT model.
- The CIT program rates very favourably according to police officer perceptions.[71]
- People with a mental illness who are under-served by the system are better identified and provided with crisis mental health care.[72]
- Greater dignity and better human service responses are afforded to vulnerable people with a mental illness. Stigma is also decreased with the use of the CIT model.
- An increase in access to health services for vulnerable people in distress brought to hospital by police.
- There has been a decrease in the use of restraints when transporting people to hospital.[73]
- There has been a decrease in the arrest rate of people with a mental illness.[74]
- There has also been an enhancement to the reputation and recognition of police.[75]

There are also benefits for the mental health system from the CIT program.[76]

- Police officers' initial reports of a person's medical history better prepares the mental health team.
- Police spend less time at the health service.
- Patient violence will likely reduce.
- The need for acute hospitalisation will likely reduce.
- Recidivism will likely reduce.

Part 3 Beyond CIT

9.0 Clinical service capacity

As discussed in Section 4.1 above, the research literature reveals that barriers within the mental health system frequently impact on the response that police provide to people with a mental illness. These barriers most commonly relate to police frustration with the perceived lack of responsiveness of the mental health system, and the time-consuming attempts by police to provide people with access to a mental health service.

Adopting a CIT model for responding to critical mental health incidents in Queensland will have implications for mental health services, particularly the requirements for:

- a 24-hour/7-day response, which means that mental health intake staff must be available after hours in all regions
- a no-refusal policy by mental health services, which means that all people transported by police to a mental health service will be accepted by the service, regardless of their diagnosis (although not necessarily all will be accepted for inpatient treatment)
- a streamlined intake procedure, which means that mental health staff will quickly take responsibility for the person, to allow police to promptly return to their operational duties.

It therefore follows that a CIT response to critical mental health incidents in Queensland will be successful if the mental health system can meet the increased demand for services which is likely to result from police referrals.

While a detailed analysis of mental health funding is beyond the scope of this paper, it should be acknowledged that there is considerable scope to increase resources to the mental health sector. For example, the 2004 National Mental Health Report finds that spending on specialised mental health services accounts for 6.4% of all health expenditure in Australia,[77] while other OECD countries are known to spend some 10–14%.[78] Meanwhile, mental illness accounts for almost 30% of Australia's non-fatal burden of disease.[79] The 2004 National Mental Health Report also finds that Queensland has the lowest spending (per capita) on mental health of any Australian State, and the fewest number (per capita) of clinical mental health staff.[80]

10.0 Non-clinical service capacity

In 2003–04, more than half the people brought by police, ambulance or psychiatrists in an emergency situation to a mental health service were not accepted for formal assessment or treatment. Thus they did not meet the stringent criteria set down by the mental health service for a diagnosis of mental illness or for inpatient treatment.

Under a CIT model, Queensland Health will take responsibility for accepting all referrals from the police. In some cases, the mental health service would provide community-based treatment, or would refer the person to other clinical or non-clinical services in the community and provide subsequent follow-up. It could be expected that referrals might be made to community services that provide counselling, relationship support, substance abuse treatment, peer support, housing support or psychosocial rehabilitation.

It therefore follows that a CIT model will be successful in Queensland if there is adequate community-based infrastructure in place. It would therefore be wise to undertake a formal audit of such community-based infrastructure in Queensland, to ensure that sufficient capacity exists to meet the demand of referrals from mental health services.

11.0 Addressing the victimisation of vulnerable people

As discussed in Section 5.1, vulnerable people with a mental illness are frequently victims of crime and violence. For example, almost one-fifth of people with a psychotic illness have been a victim of violence within the past twelve months; 15% do not feel safe in the area where they live.[81] Further, despite the popular stereotype, research shows that people living with a mental illness are more likely to be the victims of violence than its perpetrators.[82] These high rates of victimisation can be readily understood given that the reality of life for many people with a mental illness includes homelessness, poverty, substance use disorders, unemployment, poor access to necessary services, and social isolation.

As Clark argues, these experiences of victimisation—particularly being a victim of crime—have a significant impact on the behaviour of a person with a mental illness, and are likely to impact on their reactions towards police.[83] Clark argues that when these victimising experiences are not resolved for the individual, they may later precipitate critical mental health incidents.

> *The evidence suggests that an individual, without realistic access to social justice, may be expected to respond violently to perceived or actual victimisation. Persons experiencing impaired decision-making are often socially isolated and suffer acts of harassment and exploitation with little access to the criminal justice system or other instruments of legal redress.*[84]

Clearly, a potent service response to the victimisation of people with a mental illness is required, one that:

- recognises their increased vulnerability to experiences of victimisation
- provides an early response to such experiences

- delivers a coordinated service response through several agencies working together
- focuses on the rapid resolution of these incidents so as to prevent the possibility of a critical mental health situation.

With respect to the delivery of a potent, multi-agency response to vulnerable people, the success of the SCAN model (for suspected child abuse and neglect) over a period of many years in Queensland is instructive.[85] Multidisciplinary teams consisting of police, health, and child safety representatives have been established across the State. These teams are activated in cases of child abuse or neglect allegations. They work to ensure the protection of the child and to deliver a coordinated response to child abuse allegations by the agencies involved. This collaborative approach has been very successful and is characterised by

- a victim-centred approach, one which recognises the vulnerability of children and which provides support to the victim and the family
- a robust and multi-lateral decision-making process
- a formalised partnership structure
- a focus on specific individuals and cases
- a mutual respect between agencies of their respective roles and responsibilities
- a partnership with non-government agencies for the protection of vulnerable children
- a focus on case planning and case coordination
- a high degree of professionalism, in which staff from various agencies voice their concerns and hear others' perspectives
- an effective and sensitive sharing of information between agencies
- a regular meeting schedule, one that is not crisis-driven
- a shared sense of responsibility among agencies for the outcome of the response
- a follow-up by individual agencies across disciplines and agencies.[86]

The SCAN system has now been operating successfully in Queensland for over two decades. It represents a viable and proven model for delivering a proactive and coordinated human service response for the protection of vulnerable people. As such, it is likely that the SCAN model, or some variant thereof, could prove effective in responding to the victimisation of people who have a mental illness, and help to decrease the rate of critical mental health incidents.

12.0 Police response to other vulnerable groups

While people with a mental illness require special responses from police and mental health services because of their vulnerability, citizens with other decision-making disabilities are similarly vulnerable and also have high rates of contact with police and the criminal justice system. For example, in New South Wales it is estimated that some 12–13% of the prison population has an intellectual disability.[87] Further, people with an intellectual disability in Australia are almost three times more likely than those without a disability to be victims of physical assault, sexual assault and robbery.[88]

It therefore follows that a Crisis Intervention Team model should also be a priority for other groups of highly vulnerable citizens who have decision-making disabilities, particularly for people with an intellectual disability or acquired brain injury. These groups could also benefit from a Crisis Intervention Team approach, particularly one in which

- police and other human services recognise the vulnerability of these groups of people
- there is specialised training of police and other human services
- there is a coordinated and multi-agency human service response
- a set of referral and follow-up pathways are developed for vulnerable people in distress.

Part 4 Recommendations for future action

Recommendation one: Adoption of CIT

It is recommended that the Queensland Government, through the Queensland Police Service and Queensland Health, develops and implements a Crisis Intervention Team program for responding to critical mental health incidents in Queensland, based on the 12 principles contained in this Discussion Paper (Section 7.0).

It is recommended that this program be developed from a position that upholds the rights and dignity of people with a mental illness, and recognises that working with this cohort is a valid and valuable part of operational policing. It is recommended that the CIT program receive a level of support from both departments commensurate with the high level of need for this program.

Recommendation two: High-level taskforce

It is recommended that a high-level, multi-agency taskforce, with relevant Ministerial support, be commissioned to oversee the development and implementation of the CIT program. Following international best-practice it is recommended that this taskforce be constituted to include relevant consumer advocate bodies to provide practical and positive advice on its implementation.

Recommendation three: CIT coordination

It is recommended that, in implementing the CIT program, additional coordinator positions/teams be established within both the Queensland Police Service and Queensland Health. For effective administration of the CIT program, additional capacity may be required at both the corporate and district levels of both departments.

Recommendation four: Non-lethal weapons

It is recommended that the Queensland Police Service provides ready access for CIT officers to non-lethal weapons, for the safe and humane resolution of critical mental health incidents.

Recommendation five: Mental health input into crisis situations

It is recommended that Queensland Health establishes protocols across the State for the provision of specialised mental health advice to police for the safe and humane resolution of critical mental health incidents.

Recommendation six: Substance-use disorders

It is recommended that Queensland Health investigates the possibility of co-locating substance abuse and mental health services, or finds another equally potent mechanism to ensure equitable access to treatment for clients with dual psychiatric and substance use disorders.

Recommendation seven: Crisis prevention

It is recommended that the Queensland Government, via Queensland Health, applies greater funding to non-emergency crisis response teams (via public community mental health services) to respond to mental health crisis situations that do not require police involvement.

It is also recommended that the Queensland Government, via Queensland Health and Disability Services Queensland, applies greater funding towards a range of psychosocial rehabilitation services, based in the non-government sector, to assist the return of vulnerable citizens with a mental illness to an optimal level of independent functioning and to strengthen their natural coping abilities and social networks, so as to better help them prevent situations of crisis.

Recommendation eight: Follow-up and community linking

It is recommended that, for clients who do not qualify for psychiatric treatment, the police-based CIT program be augmented with a commitment by Queensland Health to link them to services and supports in the community, and to provide sufficient follow-up subsequent to the referral. These tasks may require additional capacity within Queensland mental health services.

Recommendation nine: Enhancing capacity

It is recommended that the Queensland Government examines the funding of mental health services, to ensure sufficient capacity in clinical services to meet the increased referral demands from the CIT program.

It is also recommended that the Queensland Government examines the funding of community-based human services, to ensure sufficient capacity in the areas of counselling, non-clinical case management, peer support, housing support, and substance abuse, in order to ensure sufficient capacity to meet the increased referral demands from the CIT program.

Recommendation ten: Dedicated and private reception

It is recommended that, in implementing the CIT program, Queensland Health provides a dedicated and private space within health services for the reception, triage and assessment of people in mental health crisis. It is recommended that consideration be given to locating this function within mental health services, rather than in hospital emergency departments.

Recommendation eleven: Partnership with ambulance service

It is recommended that a partnership be forged with the Queensland Ambulance Service as part of the CIT program, because of the imperative to transport people with a mental illness to hospital in the least restrictive manner possible.

Recommendation twelve: Mental illness in prison

Because of the reported high incidence of mental illness among prisoners and arrestees, it is recommended that the Queensland Government, through the Queensland Police and Department of Corrective Services, undertakes a formal audit of prisoners and those on remand to determine more precisely the rate of mental disorders among this population, in order to assess whether current service responses are adequate.

Recommendation thirteen: SCAN model for people with mental illness

It is recommended that the Queensland Government, through the Queensland Police Service and Queensland Health, considers the establishment of a SCAN-type model for people with a mental illness.

Recommendation fourteen: CIT response to other vulnerable groups

It is recommended that the Queensland Police Service and Queensland Health considers expanding the proposed CIT program to include responses to other vulnerable groups with decision-making disabilities, particularly people with an intellectual disability or an acquired brain injury.

Endnotes

1 Office of the Public Advocate—Queensland (2003) *Annual Report 2002–03*, p.14.

2 Office of the Public Advocate—Queensland (2004) *Annual Report 2003–04*, p.29.

3 *Guardianship and Administration Act 2000*, Schedule 1, Part 1—General Principles.

4 Australian Health Ministers (1991) *Mental health statement of rights and responsibilities*.

5 Police Executive Research Forum (1997) *The police response to people with mental illness: trainers' guide and model policy*, USA Library of Congress.

6 Rosen, A. (1997) *Crisis management in the community*, Medical Journal of Australia, 167: 633–638.

7 ibid.

8 SANE Australia (2004) *Facts and figures about mental illness*.

9 Rosen, A. (1997) *Crisis management in the community*, Medical Journal of Australia, 167: 633–638.

10 ibid.

11 Victoria Police (2004) *Protocol between Victoria Police and Department of Human Services, Mental Health Branch*.

12 ibid.

13 Human Rights and Equal Opportunity Commission (1993) *Report of the national inquiry into the human rights of people with mental illness*.

14 Department of Health and Ageing (2003) *National mental health report 2004: eighth report—summary of changes in Australia's mental health services under the National Mental Health Strategy 1993–2002*, Commonwealth of Australia, Canberra.

15 World Health Organization (2001) *The world health report, 2001: mental health—new understanding, new hope*. Geneva: World Health Organization.

16 Department of Health and Ageing (2003) *National mental health report 2004: eighth report—summary of changes in Australia's mental health services under the National Mental Health Strategy 1993–2002*, Commonwealth of Australia, Canberra.

17 Fry, A et al (2002) *Social control agents or front-line carers for people with mental health problems: police and mental health services in Sydney, Australia*. Health and Social Care in the Community 10(4), pp.277–286.

18 *Mental Health Act 2000*, Division 3–Emergency Examination Orders (ss.33 and 37).

19 Director of Mental Health (2004) *Annual Report 2003–04*, p.14, Queensland Health.

20 Mental Health Workers Alliance (2004) *Workers Survey*, prepared by Essential Media Communications

21 Fry, A et al (2002) *Social control agents or front-line carers for people with mental health problems: police and mental health services in Sydney, Australia*. Health and Social Care in the Community 10(4), pp.277–286.

22 Police Executive Research Forum (1997) *The police response to people with mental illness: trainers' guide and model policy*, USA Library of Congress.

23 McGilloway, S and Donnelly, M. (2004), *Mental illness in the UK criminal justice system: a police liaison scheme for mentally disordered offenders in Belfast*, Journal of Mental Health, 13(3): 263–275.

24 Heffernan, E. (2003), *Substance-use disorders and psychological distress among police arrestees*, Medical Journal of Australia 179(8): 408–411.

25 Fitzsimmons, P. (2003) *The experiences of people with mental illness when dealing with police*, conference paper, Policing and Mental Illness—Best Practice Conference, Gold Coast.

26 Police Assessment Resource Centre (2003), *Interview with Major Sam Cochran*, PARC Best Practices Review 2(7), pp.9–14.

27 Ozdowski, S. (2004) *Speech to the Mental Health Council of Australia*, Sydney.

28 Borum, R. et al (1998) *Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness*, Behavioural Sciences and the Law 14: 393–405.

29 Hail, J. & Borum, R. (2003) *Police training and specialized approaches to respond to people with mental illness*, Crime and Delinquency 49(1), pp.52–61.

30 Cochran, S. et al (2000) *Improving police response to mentally ill people*, Psychiatric Services 51 (10), p.1315.

31 SANE Australia (2004) *Fact sheet: drugs and mental illness*.

32 Schizophrenia Fellowship of NSW (2005) *Dual Disorders*, fact sheet.

33 Dalton, V. (1998) *Police shootings 1990-97*, Australian Institute of Criminology, paper no. 89.

34 Interdepartmental Steering Committee (2001) *Mental health crisis situation definition for Queensland*, Queensland Government.

35 Borum, R. et al (1998) *Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness*, Behavioural Sciences and the Law 14: 393–405.

36 Clark, M. (2005) V*ulnerable persons, public safety and policing in the 21st century*, unpublished paper.

37 Lamb, R. (2002), *The police and mental health*, Psychiatric Services, 53(10) pp.1266–1271.

38 Bazelon Center for Mental Health Law (2004) *Fact sheet 6: Law enforcement diversion programs*.

39 Council of State Governments (2002) *Criminal Justice/Mental Health Consensus Project*, Kentucky USA.

40 Hopkins, S. (2003) *The voluntary referral protocol—creating more options and better outcomes for mental health consumers*, conference paaper, Policing and Mental Illness—Best Practice Conference, Gold Coast.

41 Council of State Governments (2002) *Criminal Justice/Mental Health Consensus Project*, Kentucky USA.

42 Dupont, R. & Cochran, S. (2000) *Police response to mental health emergencies – barriers to change*, The Journal of the American Academy of Psychiatry and Law, 28: 338–44.

43 National Mental Health Strategy (2000), *Towards a national approach to information sharing in mental health crisis situations*, Commonwealth Government, Canberra.

44 Police Assessment Resource Centre (2003), *Interview with Major Sam Cochran*, PARC Best Practices Review 2(7), pp.9–14.

45 US Department of Justice (2000), *Memphis, Tennessee, police department's crisis intervention team*, Practitioner Perspectives.

46 Council of State Governments (2002) *Criminal Justice/Mental Health Consensus Project*, Kentucky USA.

47 Australian Health Ministers' Advisory Council (1996) *National Standards for Mental Health Services*, Commonwealth Government, Canberra.

48 Bazelon Center for Mental Health Law (2004) *Fact sheet 6: Law enforcement diversion programs*.

49 Steadman, H. et al (2001) *A specialised crisis response site as a core element of police-based diversion programs*, Psychiatric Services, 52: 219–222.

50 ibid.

51 Cochran, S. et al (2000) *Improving police response to mentally ill people*, Psychiatric Services 51 (10), p. 1315.

52 Council of State Governments (2002) *Criminal Justice/Mental Health Consensus Project*, Kentucky USA.

53 Dupont, R. & Cochran, S. (2000) *Police response to mental health emergencies—barriers to change*, The Journal of the American Academy of Psychiatry and Law, 28: 338–44.

54 Council of State Governments (2002) *Criminal Justice/Mental Health Consensus Project*, Kentucky USA.

55 Director of Mental Health (2004) Annual Report 2003–04, p.14, Queensland Health.

56 Department of Health and Ageing (2003) *National mental health report 2004: eighth report—summary of changes in Australia's mental health services under the National Mental Health Strategy 1993–2002*, Commonwealth of Australia, Canberra.

57 National Mental Health Strategy (2000), *Towards a national approach to information sharing in mental health crisis*.

58 Borum, R. et al (1998) *Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness*, Behavioural Sciences and the Law 14: 393–405.

59 US Department of Justice (2000), *Memphis, Tennessee, police department's crisis intervention team*, Practitioner Perspectives.

60 Police Assessment Resource Centre (2003), *Interview with Major Sam Cochran*, PARC Best Practices Review 2(7), pp.9–14.

Endnotes

61 Dupont, R. & Cochran, S. (2000) *Police response to mental health emergencies – barriers to change*, The Journal of the American Academy of Psychiatry and Law, 28: 338-44.

Steadman, H. et al (2001) *A specialised crisis response site as a core element of police-based diversion programs*, Psychiatric Services, 52: 219–222.

62 NAMI (2004) *Crisis intervention training (CIT) on the move across America*, see www.nami.org.

63 Cochran, S. et al (2000) *Improving police response to mentally ill people*, Psychiatric Services 51 (10), p.1315.

64 Dupont, R. & Cochran, S. (2000) *Police response to mental health emergencies—barriers to change*, The Journal of the American Academy of Psychiatry and Law, 28: 338–44.

65 Hill, R. (2004) *The Montgomery Country CIT model: interacting with people with mental illness,* FBI Law Enforcement Bulletin, Washington, 73(7): 18–25.

66 Arey, J. (2002) *The New Orleans Crisis Team*, Law and Order, 50(4):66–69.

67 Steadman, H. et al (2001) *A specialised crisis response site as a core element of police-based diversion programs*, Psychiatric Services, 52: 219–222.

68 Steadman, H. (2000) *Comparing outcomes of major models of police responses to mental health emergencies*, Psychiatric Services 51(5): 645–649.

69 Dupont, R. & Cochran, S. (2000) *Police response to mental health emergencies—barriers to change*, The Journal of the American Academy of Psychiatry and Law, 28: 338–44.

70 ibid.

71 ibid.

72 Memphis Police (2004) *Crisis Intervention Team* see www.memphispolice.org.

73 US Department of Justice (2000), *Memphis, Tennessee, police department's crisis intervention team*, Practitioner Perspectives.

74 ibid.

75 Memphis Police (2004) *Crisis Intervention Team* see www.memphispolice.org.

76 US Department of Justice (2000), *Memphis, Tennessee, police department's crisis intervention team*, Practitioner Perspectives.

77 Department of Health and Ageing (2003) *National mental health report 2004: eighth report—summary of changes in Australia's mental health services under the National Mental Health Strategy 1993–2002*, Commonwealth of Australia, Canberra.

78 World Health Organization (2001) *The world health report, 2001: mental health—new understanding, new hope*. Geneva: World Health Organization.

79 Australian Institute of Health and Welfare (1999) *The burden of disease and injury in Australia*, Commonwealth of Australia.

80 Department of Health and Ageing (2003) *National mental health report 2004: eighth report—summary of changes in Australia's mental health services under the National Mental Health Strategy 1993–2002*, Commonwealth of Australia, Canberra.

81 Better Health Channel (2000) *Mental illness and violence*, Victorian Government. See http://www.betterhealthchannel.com.au.

82 Commonwealth Department of Health and Aged Care (2004) *Reporting suicide and mental illness: a resource for media professionals*, Commonwealth of Australia, Canberra.

83 Clark, M. (2005) V*ulnerable persons, public safety and policing in the 21st century*, unpublished paper.

84 ibid, p.2.

85 ibid.

86 Cameron, P., Roylance, R., Reilly, R. (1999) *Interagency approach to child abuse*, Conference Paper: Children and Crime: victims and offenders conference, Australian Institute of Criminology.

87 Hayes, S C and McIlwain, D (1988) The Prevalence of Intellectual Disability in the New South Wales Prison Population: An Empirical Study, Sydney, Australia.

88 C. Wilson, T. Nettelbeck, R. Potter & C. Perry (1996) *Intellectual Disability and Criminal Victimisation,* Australian Institute of Criminology