NSW Police Force

Summary Internal Review of the NSW Police Force response to mental health incidents in the community

NSW Police Force

April 2024

NSW GOVERNMENT

Purpose of the review

The NSW Police Force (NSWPF) has conducted a review of the NSW Police Force role, responsibility and response to mental health incidents in the community. This report is a summary of that review. It is not intended to represent NSW Government policy.

The purpose of the review was to:

- Examine the demand on the NSWPF in responding to mental health incidents in the community;
- Review training across the organisation relating to mental health;
- Define the role of police in response to mental health related incidents in the community;
- Review current deployment operations; and
- Review potential options for alternate models through engagement with national and international law enforcement partners.

Executive summary

The prevalence of mental ill-health continues to increase within the NSW community and the demands on health services and community supports are stretched. This demand has seen an increased dependence on police as the call of both first and last resort and an over reliance on police as the primary responders to emotional distress and mental health crises.

The key recommendation of this review is that the NSWPF work with NSW Health to explore models for responding to mental health incidents in NSW consistent with the principles of the 'Right Care, Right Person' model. This will require further consultation with stakeholders including NSW Health and Ambulance NSW, as well as consumers, peers, carers, and non-government organisations involved in mental health service provision.

The ‘Right Care, Right Person’ model is centered on a trauma informed response to people suffering emotional distress and mental health crises. It ensures that the agency who can help the most is the agency to respond, and allows police to reinvest in focusing on core policing functions.

Context

Between 2013 and 2019, the number of people reporting psychological distress in NSW increased from 9.8% to 17.7%[1]. The Australian Bureau of Statistics reports the extent of the impact of mental health in NSW in 2020 – 2022 as 40.5% of people aged 16–85 years having a lifetime mental disorder.[2] More broadly across the Australian community in 2020–2022:

- 42.9% of people aged between 16-85 years had experienced a mental disorder at some time in their life;
- 21.5% of people had a 12-month mental disorder with anxiety being the most commonly experienced;
- 38.8% of people aged 16-24 years had a 12-month mental disorder;
- One in six Australians (16.7% or 3.3 million people) aged 16–85 years had experienced suicidal thoughts or behaviours in their life; and
- 3.3% (644,600 people) had experienced suicidal thoughts or behaviours in the previous 12 months.[3]

Police are called to respond to people threatening harm to themselves or others. Police may exercise a power of detention under section 22 of the *Mental Health Act 2007* (NSW) if the person has recently attempted suicide or if the police believe the person is likely to cause serious physical harm to themselves or others.

The increasing demand on the NSWPF to respond to mental health issues in the community is not occurring in isolation – other States and Territories in Australia and other countries around the world have experienced similar trends. Both national and international law enforcement agencies are looking to health-led initiatives to better address mental health issues in the community and reduce the growing impact on frontline police.

NSW Health is the lead agency in NSW in responding to mental health related incidents.

Mobile crisis services are provided in NSW through each local health district's Acute Care Team.[4]

NSW Health and NSWPF have collaborated to develop a Memorandum of Understanding (MOU), which provides the overarching framework to guide how staff work together when responding to situations involving people with mental health problems to best meet the clinical and safety needs of the person and staff.

However, where ambulance and mental health services are not available, police are relied upon to attend a mental health emergency.[5] This is especially the case in rural and regional NSW.

As a result, the demand on frontline police has increased and engagement with mental health consumers now forms a significant component of everyday policing in NSW. The increasing demand on frontline police, resources and training requirements presents a significant challenge for NSWPF.

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[1] Mental Health Commission of New South Wales, Living Well in Focus 2020-2024: A strategic plan for community recovery, wellbeing and mental health in NSW.

[2] Australian Bureau of Statistics (2020-2022), *National Study of Mental Health and Wellbeing*, ABS Website

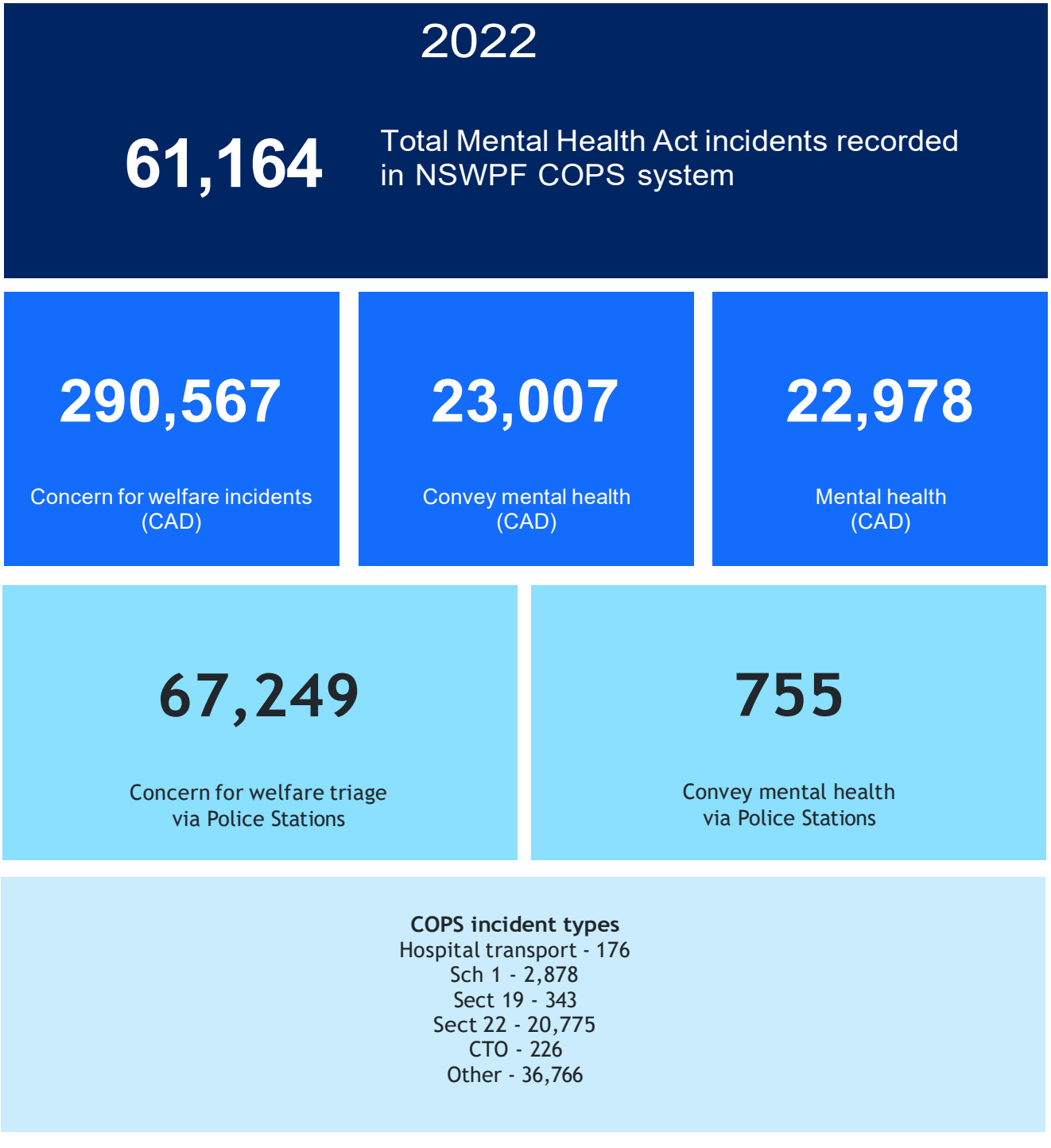
[3] Australian Bureau of Statistics (2020-2022), *National Study of Mental Health and Wellbeing*, ABS Website

[4] https://www.healthdirect.gov.au/crisis-management

[5] Assaults on members of the NSW Police Force / Legislative Assembly, Committee on Law and Safety [Sydney, N.S.W.]: the Committee, 2020. 1 online resource [55] pages. (Report no. 1/57 Committee on Law and Safety), p16

Demand

On average a mental health incident is attended/recorded by NSWPF every 9 minutes. In 2022, NSWPF recorded 61,164 incidents in its COPS system in relation to people experiencing a mental health emergency or incident where there was not an associated criminal offence. This is an increase from around 43,000 incidents in 2018 (41.6%) - approximately 10% per annum.



This report acknowledges the limitations of data analysis in quantifying the mental health response within the NSWPF. Data capture and analysis has been found throughout numerous national and international reviews both by law enforcement and health service agencies as an issue requiring further enhancement to accurately measure the impact of mental health on policing and health services within the community. The data contained within this review is limited to police response to mental health where there is no associated criminal offence involved (mental health non-crime).

Police training

Commencing at recruitment and continuing throughout their career, NSWPF officers undertake various training programs and mandatory continuing policing education. Multiple facets of this training are translatable to vulnerable people in the community including people with mental health related issues.

The NSWPF regularly reviews training to ensure best practice and to equip frontline police officers to respond to the safety and welfare of the community.

The Mental Health Intervention Team (MHIT) in the NSWPF Crime Prevention Command is a full-time unit that provides specialist training, advice and guidance to police officers on issues relating to mental health.

Since 2009, 2,229 police officers have completed a four-day MHIT education package designed to provide frontline police officers with a practical skill set to assist with managing people experiencing a mental health crisis event or who have suicidal ideation. The package educates police to identify behaviours in the field indicative of mental illness and provides tools such as communication strategies, risk assessment, de-escalation, and crisis intervention techniques. It also allows for an understanding of the *Mental Health Act* 2007 and the accompanying MOU between the NSWPF, Ambulance Service and Ministry of Health. The package was based upon the Memphis Model of Crisis Intervention Team.

In 2020 the training package underwent a review and the curriculum was revised and condensed into a two-day training package.

In 2022 a revised co-delivered training model was developed to ensure that all NSWPF personnel receive mental health training every year and additional mental health training is also provided based on an officer's experience levels within the organisation. Training is a combination of face to face, online, scenario based and experiential learning.

Challenges with the current approach to police deployment in mental health matters

Consumer and lived experience sentiment highlights that police may not be the most appropriate agency to provide the primary response to the majority of mental health crisis and emotional distress incidents in the community. In a majority of instances where police are deployed, a criminal offence has not been committed and there is no threat of violence or weapon involved. While police are best equipped to respond to incidents involving criminality and public order, other health professionals are able to provide more appropriate care for people experiencing mental health crises.[6]

Using police officers as the primary response to mental health crisis increases the risk of adverse outcomes for mental health consumers, limits appropriate service engagement and treatment, and increases missed opportunities to address consumer mental ill health. In these cases, the involvement of law enforcement is often perceived as a threat, an authoritarian response and an escalating factor. The mere presence of the police uniform, firearms, lights, and sirens can potentially escalate the situation, intimidate mental health consumers, and increase the potential of adverse outcomes. Over-reliance on police responding to mental health related incidents can cause distress and increase the risk of injury for both individuals experiencing mental health concerns and police officers.[7]

The high volume of police deployment to mental health related matters can also have flow on impacts to other community safety issues, limiting resources of police to respond to other matters.

Section 6 of the *Police Act 1990* (NSW) defines that the role of police in NSW is to reduce violence, crime, and fear, prevent and detect crime, protect persons from injury or death, and protect property from damage along with providing essential services in emergencies. Police training and capability is focussed on these primary core responsibilities and police are trained to assess and respond to perceived threats. The police response to a mental health crisis may lead to adverse outcomes which may have been more appropriately managed by an agency with the skills, expertise, and training to engage as the first line of response to mental health related matters.

Section 22 of the *Mental Health Act 2007* highlights the threshold at which police involvement is justified. This is where the officer believes on reasonable grounds that the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person.

This reflects the legislative intention that police involvement should relate to the core functions of police, that is to detect crime and protect life.

Sections 19 and 20 of the *Mental Health Act 2007* confer broader powers on NSW Ambulance, medical practitioners, and mental health clinicians (accredited persons) based on their greater knowledge, understanding, expertise and experience in identifying mental health concerns, and the circumstances in which they come into contact with consumers in their role as the first response in mental and medical emergency matters.

Even significantly increasing mental health training for police officers will still not meet the level of knowledge and expertise held by NSW Health practitioners and NSW Ambulance whose primary core functions are the physical and mental health of the community. Police are not qualified or trained mental health professionals, nor should they be expected to be. Prioritising police training to address de-escalation and threat in circumstances where police attendance is requested is unlikely to adequately address the needs and risk to people experiencing mental health conditions in the community.

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[6] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, February 2021, Volume 1 p558-560;

[7] Assaults on members of the NSW Police Force / Legislative Assembly, Committee on Law and Safety [Sydney, N.S.W.]: the Committee, 2020. 1 online resource [55] pages. (Report no. 1/57 Committee on Law and Safety) p16

Issues raised by independent reviews

Independent reviews have highlighted the challenges and significant risks associated with the current deployment model.

For example, in 2021, the Royal Commission into Victoria's Mental Health System acknowledged that a lack of mental health services in Victoria was contributing to an increased reliance on the police to respond to people experiencing mental illness or psychological distress. [8]

The Royal Commission noted that, given that most people experiencing a mental health crisis haven't done anything illegal, the involvement of police can be humiliating and traumatic. Many consumers, carers, and service providers—including Victoria Police itself—expressed dismay about the growing involvement of police in situations where people are experiencing a mental health crisis.[9]

The Royal Commission recommended that the Victorian Government:

1. Ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.
2. Support Ambulance Victoria, Victoria Police, and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe, Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police, and responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required). [10]

In 2020, the Productivity Commission's *Mental Health Inquiry Report* noted the Police Federation of Australia's view that policing services often respond to people experiencing a mental health problem, that they are one of the only services readily available on a 24/7 basis and are often the first and quite often the only responders particularly in regional and remote locations.[11] The Productivity Commission stated that police are typically not mental health clinicians and so cannot adequately 'triage' people to appropriate mental healthcare.[12] The Commission further stated that "ideally police should only respond to mental health-related incidents when there is a threat to public safety or when there is an imminent risk to staff involved".[13]

In the 2021 inquest of Jack Kakoua, the NSW Coroner recommended developing criteria to determine whether a situation requiring police attendance indicates a person of interest with known or suspected mental health problems, where those problems may exacerbate the situation requiring police attendance or may require particular skills to deescalate the situation.[14]

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[8] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, February 2021, Volume 1 p 514

[9] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, February 2021, Volume 1 p 514-515

[10] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, February 2021 Recommendation 10

[11] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra, p 1025

[12] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra, p 1026

[13] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra, p 1032

[14] State Coroner, Magistrate Teresa O'Sullivan (12 May 2021). Inquest into the death of Jack Kokaua (File no. 2018/54392)

Potential options for alternative deployment models

The increasing demand for mental health services is not unique to NSW and different models have been explored nationally and internationally to develop better processes to manage the increased policing response to mental health incidents.

These include street triage, co-deployment models, Police Ambulance and Clinical Early Response, mental health clinicians in radio communication areas, multiagency hubs, and mental health help lines. Options for alternative deployment models are set out below. It's important to note these models are not mutually exclusive and the optimum response may involve a combination of models.

Police, Ambulance and Clinical Early Response Program (PACER)

The PACER program is a partnership initiative between NSW Health and the NSWPF. The program is owned, funded, and administered by NSW Health. Commencing in 2020, PACER embeds mental health clinicians in 16 out of 57 Police Area Commands (PAC) and Police Districts (PD) to support police when responding to mental health emergencies.

When PACER is available and police are called to a mental health emergency, the clinician may attend with police to assess the person's mental health needs and organise appropriate care. This can lead to better outcomes and experience for consumers, increased understanding, and awareness by first responders, and diversion of mental health consumers from emergency departments.

However, there are some challenges with PACER including a lack of availability state-wide, lack of 24/7 service provision, and inconsistent data recording, processes, and responses. Less than one third of PACs and PDs have access to PACER and only two of the locations are in regional NSW. In practice, even where PACER is available, access varies widely. No PAC or PD has 24/7 access to the program.

Dedicated police units and co-deployment models

The premise of this model is based on specially trained and dedicated police officers providing first line response to mental health crises and acting as liaisons to the mental health system. They establish strong partnerships with local advocacy groups and health providers.

Over the years, national and international law enforcement have trialled and implemented similar models, which are often a blend of police, ambulance, and clinicians, in dedicated unmarked vehicles and in plain clothes. Recently, some agencies have moved towards a Mental Health Ambulance model, which sees a mental health clinician co-located with the ambulance crew and attending mental health incidents. Police provide support where the risk threshold requires restraint, use of force, or the person is armed or violent. Whilst this model is a positive initiative, the ability to meet demand requires significant commitment and investment in dedicated officer, training, transport, and clinical resources. The initial proposal for the NSWPF MHIT was for those trained officers to be the preferred primary response, however due to limited numbers of trained officers and increased calls for service for mental health incidents, dedicated deployment was unachievable.

Embedded Mental Health Clinicians in Communications Centres (MHCC)

There are several different versions of this concept however it generally involves embedding mental health clinicians in police communications centres. Their expertise is then available to front line police statewide. They provide a similar response to those clinicians involved in PACER without being on scene in person. Using virtual communications platforms, clinicians can triage and assess consumers in the field whilst police are on scene. The clinicians are also able to access records, make referrals to community mental health services and other social services, as well as provide police with guidance and advice around options and de-escalation strategies.

Like PACER, the model is aimed at minimising presentations at hospital emergency departments, assisting police to assess and manage mental health incidents in the community, access relevant records and triage, and refer people for follow up.

A limitation within NSW is the lack of a central database within NSW Health which limits the ability to easily access information about presenting people. The MHCC initiatives require significant investment to manage demand - an issue similar to PACER that often means the resources are not available 24/7 or have limited capability and rely heavily on initial police attendance at the scene.

Mental Health Telephone Services (Mental Health Line)

Mental Health Telephone Services are dedicated telephone services funded by state and federal government that provide advice and assistance to consumers, families, carers and first responders. One of the most significant enhanced initiatives aligned with the 'Right Care, Right Person' model discussed below, and also implemented in other international health authorities, is a dedicated behavioural health emergency triple digit number. The United Kingdom National Health Service (NHS) have NHS '111' for mental health and emotional distress. NHS '111' service allows consumers to check if they need urgent mental health help, obtain urgent mental health support immediately, and obtain general information, advice and treatment, 24 hours a day, 7 days a week.

The NSW Mental Health Line is staffed by trained mental health professionals who offer mental health advice, complete a brief assessment, and make recommendations for appropriate care, including referral to NSW mental health services. It is unclear how well utilised this service is in the community.

Street and Community Triage

Street and community triage are versions of the MHCC and PACER programs delivered by Local Health Services remotely. Police who are dealing with a person in mental health crisis and/or distress are afforded direct access to mental health practitioners, who can assess the person via video platforms and ensure they receive the appropriate support. As well as the provision of enhanced support for the individual, effective community triage ensures that the emotional and time demand placed on police officers is significantly reduced. As with MHCC and PACER, this is likely to require significant investment to manage demand, with issues likely to include availability of services state-wide and 24/7. Variations in approach by different Local Health Services may lead to inconsistencies in responses across the State, presenting challenges for both consumers and operational police.

Alternate Referral Pathways (ARP)

Alternative Referral Pathways provides frontline police with the ability to refer consumers who do not meet criteria for detention under the *Mental Health Act 2007* but may require support and intervention with a referral to an NGO or health service that will follow up with the person. ARP requires police to engage with health services and NGOs to establish procedures and referral processes. This initiative provides police officers with an alternate outcome that mitigates risk through non-action. One of the limitations of ARP relates to the issue of informed consent and the legalities of providing the mental health consumer details to a third party. Furthermore, the Productivity Commission noted that police officers are typically not mental health clinicians so cannot adequately 'triage' people to appropriate mental healthcare.[15]

'Right Care, Right Person' model

The 'Right Care, Right Person' (RCRP) model was initiated by Humberside Police in the United Kingdom. In 2023 the UK Home Office and relevant agencies supported the national implementation of the RCRP initiative across policing.

The RCRP model is designed to make sure that people of all ages who have health and/or social care needs are responded to by the right person, with the right skills, training, and experience to best meet their needs. It is focused on the interface between policing and mental health services.

Before the introduction of RCRP, Humberside Police identified they were deployed to an average of 1,566 incidents per month about concerns for welfare, mental health incidents or missing persons.

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[15] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra, 1026

Humberside Police were concerned that by attending these incidents, they were not providing the most suitable intervention to vulnerable members of the public who required specialist support. This was putting both the public and their officers at risk. It also meant that police officers were not responding to the public in the most effective manner. The high level of deployments was also impacting on the force's ability to attend calls for service that required a policing response, for example, where a crime had occurred or where there was a risk to life.[16]

Humberside Police made the conscious decision to concentrate on the core policing duties set out by Sir Robert Peel. These still form the basis of policing in the UK today. The core duties under common law are preventing and detecting crime, keeping the King's peace, and protecting life and property. Following this decision, Humberside Police sought legal advice to understand where duty of care responsibilities lie and where other agencies would be more appropriate to attend calls for service. This advice was used as a basis to support the development of the RCRP model.

The RCRP model establishes a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents relating to people with mental health needs. The adopted threshold for a police response to a mental health-related incident is:

- To investigate a crime that has occurred or is occurring; or
- To protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.[17]

The RCRP threshold is used to determine whether the police are the appropriate agency to respond when the public or other professionals report a mental health-related incident including to police. While the decision to attend an incident is determined by assessing that the incident meets the RCRP threshold, the decision to use powers is made by an officer at the scene of an incident.[18]

The RCRP threshold is intended to be used in a way that is responsive to dynamic situations and involves a continuous risk assessment approach.[19]

In 2023 the UK Home Office and relevant agencies supported the national implementation of the RCRP initiative across policing. In July 2023 the UK Government published a collective national commitment from the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to work to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs.[20]

The Metropolitan Police commenced implementation of RCRP in November 2023.

Advantages of the RCRP model include that it is a consumer centric and trauma informed approach. It provides for engagement by appropriately skilled and trained experts with the knowledge to assess and treat affected persons appropriately. It reduces stigma associated with a uniformed police response, and reduces the need for use of force and restraint by police officers. It allows re-investment in core police functions and crime prevention and police training to focus on appropriate risk deployments (e.g., high risk situations).

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[16] Information contained in this section of the report has been provided by Humberside Police16 and the College of Policing

[17] National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk)

[18] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement- right-care-right-person-rcrp

[19] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement- right-care-right-person-rcrp

[20] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp

Recommendation

The increased demand on policing capabilities responding to mental health and health crises in the community has seen both national and international law enforcement agencies undertake significant review and analysis of the role and function of policing in mental health. These reviews have seen the development of collaborative partnership initiatives, co-deployment models, mental health clinician triage and guidance, 24/7 mental health phone lines, and mental health ambulances to name a few. Whilst these initiatives are a significant step towards enhancing mental health consumer experience in crises, ensuring the right service and treatment is received, and timeliness of response is afforded to the consumer, the ability to meet demand falls short. It is this shortfall that has seen a reliance on police response as the first contact and primary deployment option in the community.

The NSWPF recommends that the NSWPF work with NSW Health to explore models for responding to mental health incidents in NSW consistent with the principles of RCRP.