



VICTORIA POLICE

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Dear Mr Turnbull

Victoria Police submission on the Green Paper: *Because mental health matters*

Firstly, I would like to congratulate you and your team on such a comprehensive discussion paper that recognises the many and complex issues surrounding mental health. I am aware that the paper is the product of considerable consultation with partner agencies and I believe that this effort is evident in the welcome attention you have given to policing requirements and contributions in relation to mental health outcomes.

As you would be aware, police see the effects of mental disorders on individuals and communities every day. We know that they can impact greatly on how safe, supported and included people feel. Accordingly, Victoria Police nominated mental health as one of its priority issues in the *Victoria Police Business Plan 2006/07* and appointed a Corporate Sponsor to oversee the portfolio. To fulfil this commitment, Victoria Police examined current practice, consulted widely and developed a Mental Health Strategy for the organisation.

The *Victoria Police Mental Health Strategy* (April 2007) contains 60 directions for improving policing knowledge and information, internal and external partnerships, and training, which mirror many of the goals outlined in the discussion paper. I am therefore confident that the implementation of our directions will support and benefit from the initiatives progressed in the Victorian Mental Health Strategy, and the Justice Mental Health Strategy.

As part of our commitment to contributing to the development of a whole of government approach, Victoria Police has prepared a submission on the Green Paper. The submission draws on the knowledge and experience of senior managers, specialist areas and frontline members from across Victoria Police to provide answers to the discussion paper questions and additional information on policing interactions. I trust that this information assists the deliberations of the Mental Health Inter-Departmental Committee and Officers' Group, of which Victoria Police remains an active and interested member.

In the meantime, I wish you and your team well in the challenging, but important, work ahead and look forward to following its progress.

Yours sincerely

Christine Nixon APM
Chief Commissioner

FOCUS AREA 1: PREVENTION**Taking prevention seriously – actively promoting mental health and wellbeing****Creating wider opportunities for promoting mental health in local communities**

What are the most promising avenues for further work across families, schools, early childhood settings and workplaces?

Are there other settings that should be considered?

What partnerships should be developed to support a coordinated approach to progress in the above settings?

Victoria Police has a strong interest in activities that promote mental health as police often respond to the consequences of the breakdown of the protective factors for mental health. Accordingly, police have considerable knowledge and experience in working with other agencies to put in place prevention strategies and are keen to do so in the area of mental health promotion.

In addition to the settings outlined in the paper, Victoria Police suggests there needs to be a greater focus at an earlier stage on the impacts of social and economic trends on otherwise resilient local communities and individuals. The drought, mortgage pressures and housing affordability are examples of issues that have emerged to increase steadily the stresses that police encounter as family violence incidents, assaults, thefts, self-harming and suicides.

The environmental scanning and population-based planning proposed in Focus Area 7 should provide the means for identifying a broader range of vulnerable communities and individuals. Acting on the findings of such analysis at an earlier stage would enable provision of a more diverse array of interventions (eg. financial counselling, housing support, care packages) that prevent progressive deterioration in mental health and wellbeing that eventually require clinical, or policing, interventions.

The collective responses that have developed to the drought in a number of local communities provide models of the information, support services, participants and resources that need to be mobilised for such situations. However, there is a clear need to assign responsibility for identifying such situations and mobilising the appropriate partnerships much earlier.

Strengthening social inclusion efforts to protect and reduce inequalities in mental health

What aspects of current work can most effectively be built upon to promote social inclusion and reduce inequalities in mental health outcomes?

Victoria Police has actively participated in place-based initiatives such as Neighbourhood Renewal and run community capacity-building initiatives such as local Reassurance Policing projects (eg. in the Braybrook Maribyrnong Neighbourhood Renewal area) and programs to engage culturally and linguistically diverse communities (eg. youths from the Horn of Africa) and at risk youth (eg. Operation Newstart¹). The strength of these initiatives is that they enable individuals to articulate their priorities that, more often than not, reflect service data such as crime statistics. They also provide the focus and the means for harnessing diverse expertise and resources in the service of common objectives.

Expanding the scope of such initiatives to include mental health promotion activities therefore makes sense, as the risk factors are generally the same. However, the effectiveness of such an expansion will depend on the availability and capacity of appropriate local services to provide the activities that, police experience suggests, are particularly limited for the higher risk groups of rural communities, indigenous Victorians and refugees.

¹ Operation Newstart is a partnership between Victoria Police and the Department of Education & Early Childhood Development, targeting adolescents in the state secondary school system deemed to be at significant educational risk. An evaluation of participants found 70% have externalising problems at clinical levels, 75% exhibit conduct problems, 33% are depressed, 33% have been Children & Adolescent Mental Health Service clients and 20% have been DHS clients.

Reducing the risk factors for poor mental health associated with substance misuse

Who are the priority target groups in the community for providing education and support on the mental health risks of substance misuse?

What are the opportunities for better integration of mental health and substance abuse prevention efforts?

How can relevant service systems be supported to identify and respond at an early stage to mental health risks arising from substance misuse?

The paper lists a number of services where young people and adults first present as important sites for action (p.54). Victoria Police recommends adding 'involvement with police' to this list as police are often the first public agency to detect the substance misuse of many young people and adults when they arrest them for public drunkenness, breach of the peace, assault, or drug use and possession. Police may also encounter these individuals at a family violence incident, or when they are in need of assistance (eg. present welfare concerns), or when they are victims of crime.

Police currently have a number of options available for response, including issuing a caution, issuing a drug diversion, making a formal or informal referral to an appropriate support service, recommending court diversion with treatment conditions, detaining until sober or until they can transfer care, or laying charges. In some cases, police use a combination of these.

However, there are significant limitations to the ability of police to translate their interactions with people at risk of developing poor mental health because of their substance misuse:

- there is no power equivalent to the public drunkenness provisions (s.13 of the *Summary Offences Act 1966*) for police to detain a person affected by licit or illicit drugs until they no longer pose a risk to themselves or to others, or until they can be transferred into the care of another person;
- there is no power for police to refer habitual substance misusers to appropriate health and welfare agencies without consent, even when police believe they may be homeless or have an acquired brain injury;
- there are limited services to which police can refer individuals they have cautioned or given an official warning, particularly if the individual presents with a dual diagnosis; and
- there is no secure medically-supervised facility to which police can lodge individuals affected by, or withdrawing from, drugs and/or alcohol misuse, possibly in combination with mental health issues.

Removing these limitations would enable police to make best use of these inevitable interactions in order to link people with the services they require, at the earliest opportunity, and thereby reduce the likelihood of future harm and repeat involvement with police.

Renewing Victoria's suicide prevention focus through a wider range of government programs

What are the best opportunities to embed suicide prevention activities in universal and specialist services?

What aspects of the current approach to suicide prevention need further improvement?

The paper notes that 444 deaths met the legal standard of suicide in Victoria in 2006 (p.28). As the investigators of these and other reportable deaths on behalf of the Coroner, police are in a unique position to gather information on risk factors, service gaps and prevention strategies. To this end, the *Victoria Police Mental Health Strategy* (April 2007) commits to working with the State Coroner on minimum standards for suicide inquest briefs to ensure that Coroners and the community have consistent and comprehensive information on which to base suicide prevention activities and service improvements. Under development is a template to capture information on the individual's background and any significant trigger events, in a format suitable for data analysis.

Victoria Police also sees a significant opportunity to strengthen the prevention response to individuals who threaten or attempt suicide. Police attend calls for assistance in these situations and have a power under s.10 of the *Mental Health Act 1986* to apprehend the individual in order to arrange for their assessment by a mental health practitioner or examination by a registered medical practitioner. However, if the individual does not meet the criteria for admission under s.8 of the Act, police generally have little option but to release the person. In many cases, the individual subsequently threatens or attempts suicide again, or commits suicide. The toll this takes on the individual, their family and friends, and the attending police, is considerable.

At present, there is no means by which responding agencies can gain, and act on, a complete picture of an individual in distress. An individual may have contact with police, ambulance, hospital, community services, school or workplace counsellors, telephone helplines and their treating practitioner, with no one aware of the full extent of their episodic contacts; a full detailing may only occur when police prepare an inquest brief.

Given that there is sufficient evidence to show that once an individual has attempted suicide they are far more likely than the general population to make further attempts or to commit suicide, Victoria Police believes there is a strong case for:

- determining how information on an individual at risk of suicide can be shared with appropriate response agencies, without deterring the individual from seeking help;
- providing more assertive outreach to individuals at risk of suicide; and
- aggregating data on contacts with individuals at risk of suicide to provide a clearer picture of the magnitude and characteristics of the problem and to inform service planning.

FOCUS AREA 2: EARLY INTERVENTION

Intervening earlier—achieving better outcomes for children, young people and families

While the focus on children, young people and families is critical, Victoria Police believes that 'early intervention' and 'early identification' is broader than age. It must also include **early in onset** and **early in episode** as these present particular challenges:

- the signs and symptoms may be misunderstood, misinterpreted or masked;
- all age groups are affected;
- the mental health problem may be a contributor to, or caused by, other problems;
- authority to intervene to refer individuals to care and treatment services is limited; and
- the capacity of care and treatment services to respond to early signs and symptoms, much less multiple problems, is limited.

However, improving the collective capacity to respond early in onset and early in episode is essential for preventing individuals from developing prolonged, persistent or deteriorating mental health problems. Early identification of mental health problems would also enable services to deliver targeted responses and make best use of their finite resources. Victoria Police believes that investment and support in the following areas would enable police to link individuals in need to the appropriate care and minimise their involvement (and repeat involvement) with the criminal justice system:

Clinical assessments

An increased capacity for police to arrange for timely psychiatric assessments of individuals in custody would better inform how to manage individuals with complex needs, determine what treatment and support they should receive and how their matter should be progressed through the criminal justice system. More formal diagnostic understanding of an individual's mental health problems and needs would also assist the decision-making and efficiency of other justice and support services in providing appropriate interventions.

At present, Custodial Nurses visit most of the larger police stations and offer routine physical and mental health screening of prisoners. Some of the personnel have specialist psychiatric nursing qualifications, other have specialist training in drug and alcohol nursing. All of the nurses can identify individuals in need of some form of psychiatric attention and a mental health assessment is always part of the current health assessment. The current assessment is often limited by the lack of an appropriate clinical space in which confidential assessment can occur and the tensions created by having police provide security at the expense of other work. The current service is relatively superficial and aimed at effective risk management in liaison with community and criminal justice resources.

Victoria Police believes there is a value in:

- extending the Custodial Nursing network to cover all the police gaols;
- providing more appropriate clinical spaces within police stations; and
- providing sufficient security personnel to allow for assessments that are more extensive; and
- extending the service in liaison with forensic mental health practitioners to allow timely preliminary reports to assist the courts in making appropriate dispositions.

A network of Custodial Medical Officers supports the current nursing service. These doctors are mostly local general practitioners who assist with meeting the acute medical and mental health needs. One or more doctors are available at every location in the state that holds prisoners.

Victoria Police is currently undertaking a five-year project with Monash University (Project PRIMeD) to examine the interface between policing and mental health. This project has trialled the application of the Brief Psychiatric Rating Scale by the Custodial Nurses as a screening tool to identify the mental health issues and needs of individuals in police cells. Early data (see Focus Area 5) suggest that this screening tool is effective in identifying a range of mental health problems and is suitable for application by the Custodial Nurses.

Victoria Police therefore sees the need for developing greater clinical capacity to screen all individuals in police cells in order to assist in managing this generally unwell and unstable population safely and appropriately. Additional nursing resources would ensure that clinically relevant information is recorded in the E*Justice system to ensure that appropriate care is offered throughout the criminal justice system. Enhanced clinical capacity would allow the clinicians to assist routinely in the assessment of individuals not detained in police cells but whom police believe require assistance. Reporting of such pre-court assessments could inform bail deliberations and help distinguish those who need mental health interventions and for whom for diversion is an option.

Forensic assessments

Victoria Police has a pressing need for access to timely forensic psychiatric assessments. At present, police can call out a Forensic Medical Officer (contracted from the Victorian Institute of Forensic Medicine) to assess an individual's fitness to be interviewed, but not their mental capacity at the time of the offence or at the time of their court hearing. This has a number of implications:

- police have ongoing issues in dealing with defendants in the Magistrates' Court who raise the defence of mental impairment, under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. If the defence is successful, the legislation confines the magistrate hearing the matter to a single disposition of unconditional release, without the ability to mandate assessment, treatment, or support. Police may also have costs awarded against them. By contrast, if the defendant is found not guilty by reason of mental impairment in the County or Supreme Courts, they are sentenced to a period of forensic care. With the ability to arrange for a forensic psychiatric assessment at the point of charging, police would be in a better position to decide whether to proceed with the matter or to support the defendant's timely transfer into appropriate care. This also has the added potential to resolve matters and provide therapeutic interventions more quickly;

- police have limited ability to obtain independent forensic advice on a defendant's proposed defence of mental impairment;
- there is no capacity for timely forensic psychiatric assessments of victims to support the special hearing provisions which were introduced in December 2007 to spare child victims and those with a cognitive impairment (subject to indictable offences only) from having to give evidence and be cross-examined in court. However, there have a number of challenges by defence barristers at committal hearings recently in relation to the victim's cognitive impairment which has resulted in hearings being adjourned while police arrange for an assessment of the victim's cognitive impairment and hence, their eligibility for the special hearing provisions. Such delays and unnecessary distress to the victim undermine the intent of the provisions. A timely forensic report to the court on the victim's cognitive impairment at the time of the committal hearing and subsequent capacity to give evidence by other means would address this issue. In order to achieve this, Victoria Police requires access to a pool of forensic practitioners, recognised by the Court for their expertise in assessing victims for cognitive impairment;
- if found guilty, or not guilty by reason of mental impairment in the higher courts, the court has to order a pre-sentence report on the defendant, which further delays resolution of the matter. A forensic assessment performed at the point of charging could provide the court with expert advice on the defendant's mental capacity at the time of offending (and much closer to the time of offending) and treatment needs, in the event that the defendant is to be sentenced. This would save police, court, corrections and forensic psychiatric time and resources.

Victim support services

Victims of crime are at significant risk of developing or exacerbating mental health problems, both from the offence and the stress of having their matter go to court. At present, the Victims Assistance Counselling Program provides a range of practical and therapeutic support to victims of crime. Victoria Police considers there is a need to better equip their staff to work with victims with existing, emerging or potential mental health problems, through specialised training (eg. Mental Health First Aid), and through greater access to mental health practitioners (eg. by contract, through brokerage funds or by referral arrangements with community-based mental health services).

There is sufficient research to indicate that individuals with a mental disorder are at heightened vulnerability of victimisation. For example, they are:

- 59-times more likely than the general population to be a victim of theft;
- 4 to 14-times more likely to be a victim of violent crime;
- 10-times more likely to be a victim of sexual assault; and
- 6 to 7-times more likely to be a victim of homicide.²

Increasing the support provided to victims is important for their mental health and wellbeing, and to minimising their risk of re-victimisation.

² Teplin, Linda A.; McClelland, Gary M.; Abram, Karen M. & Weiner, Dana A. (2005) 'Crime victimisation in adults with severe mental illness.' *Archives of General Psychiatry*, Vol 62(8), Aug, 911-921
 Cuvelier, Monique (2002) 'Victim not Villain: The mentally ill are six to seven times more likely to be murdered.' *Psychology Today*, May-June
 Victoria Law Reform Commission (2004) 'Improving the system for complainants who have a cognitive impairment' In *Sexual Offences: Law and procedure, Final Report*. Melbourne: Victoria Law Reform Commission
 Hiroeh, Urara; Appleby, Lousi; Mortensen, Preben B & Dunn, Graham (2001) 'Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study.' *The Lancet*, Vol 358, Dec 22-29, 2110-2112.

Multidisciplinary teams

The concept of 'no wrong door' is particularly pertinent in the area of early intervention as police typically encounter individuals with multiple and complex needs, some of which may be undiagnosed, untreated or only just emerging. Under existing access criteria and service capacity, police can spend considerable time trying to identify the appropriate mental health, disability support, drug and alcohol or other service and negotiating referral of the individual in their custody. Where the individual presents with more than one issue, is not yet in crisis, has difficulty in communicating, has no fixed abode, or is encountered after hours, access can be extremely difficult, time-consuming, frustrating and inappropriate for the individual in need.

Victoria Police therefore strongly advocates for much closer integration between the treatment and support services, extending to include General Practitioners, other private providers, and Commonwealth-funded initiatives such as the Personal Helpers and Mentors program. This would enable police to link individuals with varying levels and types of needs to services quickly and before they experience or cause further harm. Intervention at the earliest presentation of problems would likely avoid the need for more specialised services later, including further involvement with police.

In addition to more integrated services, Victoria Police supports the rollout of models of multidisciplinary teams that can identify and respond to an individual's range of needs. Examples of effective models exist in a number of areas, including the Integrated Family Violence Strategy and the Dual Diagnosis initiative. However, the police/health interface has developed in an ad hoc manner, which has generated a plethora of referral criteria and burgeoning referral pathways. Multidisciplinary teams offer a simplified, streamlined referral pathway for police and for individuals with various needs.

Local multidisciplinary teams already exist in some areas. The Northern Assessment and Referral Team (NARTT) established in May 2003 receives referrals from three 24-hour police stations in the Darebin and Whittlesea Police Service Areas. Operated from Plenty Valley Community Health, the NARTT comprises alcohol and drug, family violence, child and family, and mental health services. The Team contacts the individual within 24 hours of the police referral and police may refer victims, offenders and persons in need of assistance either by faxing or emailing the consent form, or by a Team member collecting it from the station. The Team subsequently notifies the referring police member by email of whether the individual has engaged with the Team. The Team also provides police with monthly statistics and short case studies, for feedback and education.

The NARTT averages 80-100 referrals per month and since starting has received over 2,100 referrals from more than 286 individual police officers. NARTT has on-referred individuals who require further assistance to 93 individual agencies. The range of presenting issues include family violence, substance misuse, anger management, mental health, violence, financial, housing, gambling, sex offending and unemployment. An evaluation of 53 offenders referred to NARTT in a six-month period showed those who did not take up a referral had more than double the re-involvement rate with police within six months of referral (ie. 18 of the 27 who engaged had no further contact, while only 7 of the 26 who did not engage had no further involvement). Echuca Regional Health Services and Goulburn Valley Community Health Service have since launched local versions of the model, and currently average 200 and 25 referrals per month respectively.

Multidisciplinary teams such as these provide a clear referral pathway for individuals with mental health, and other issues, that do not reach the threshold for apprehension under s.10 of the *Mental Health Act 1986*. They also provide a means of linking people with services that is not dependent on their matter proceeding through the criminal justice system (eg. the brief is not authorised).

Power to intervene before crisis point

Early intervention relies on the ability to link individuals with the services they require at the first opportunity. The police powers to do so are limited to situations of:

- crisis response (eg. s.10 of the *Mental Health Act 1986*);
- enforcement of mandated interventions (eg. revocation of a Community Treatment Order);
- application of offending-related conditions (eg. treatment conditions attached to a recommendation for court diversion under the *Magistrates' Court Act 1989*); or
- where the individual consents to a police referral to another agency.

While these powers are appropriate, they do not cover individuals whose level of need has not yet reached crisis point, who are incapable of providing informed consent, or who are not involved in a criminal matter. These individuals are likely to come to police notice for creating a nuisance or disturbance, to have chronic problems that render them cognitively impaired, to be a low-level offender, or to be a victim. Moreover, a number of them come to police attention repeatedly. Two recent local inter-agency trials demonstrate the prevalence of such mental health problems and the accuracy of police behavioural assessments.

From 1 January to 31 March 2006, Western Health, the Metropolitan Ambulance Service, the Werribee-Mercy Hospital and Region 2 Division 1 police³ trialled a standardised police referral process for people presented to the Emergency Department under s.10 of the *Mental Health Act 1986*. The data from the trial indicated that police transferred approximately 80% of the mental health patients in the Emergency Department, and that 77% of patients referred received some form of psychiatric treatment (39% were admitted and 38% were discharged with psychiatric follow-up).

From 9 September to 8 December 2007, Southern Health, the Metropolitan Ambulance Service and Region 1 Division 3 police⁴ trialled a secondary response unit to police divisional vans and the ambulance (PACER), staffed by a CAT Team clinician and a police member. Around 75% of the individuals that PACER assisted were previous clients of at least one of the services, 94% involved a diagnosis (with around one-third involving drug and alcohol issues), around 25% required admission, while others were referred or were supported by development of a treatment plan. Around two-thirds of jobs were at a residential address, thereby avoiding the need to transport the individual to the Emergency Department.

From these examples alone it is apparent that police are adept at identifying mental health and other problems and that not all of these problems require admission. The capacity to refer individuals who present with welfare concerns or the early onset of a mental health problem would avoid situations and harms from escalating and would likely reduce demand on the specialist mental health services.

Better access to information on shared clients

Many inquest briefs describe individuals who had multiple contacts with multiple agencies, typically in isolation. No single agency had a complete picture of the individual's needs and presentations, limiting the capacity for an integrated and planned approach. Alternatively, numerous briefs show individuals existing in an unhealthy or unstable environment, whether as a child in an abusive home, or a young person with substance abuse problems or of no fixed abode.

When responding to individuals in a broad range of circumstances, adequate information on typical behaviours, effective communication strategies and appropriate contact persons is vital for a planned police response that maintains the safety and wellbeing of all involved. Too often, confirming an individual's identity and needs is a time-consuming and/or futile exercise, leaving police to manage and make decisions about an individual who may be

³ The police stations involved were Footscray, Williamstown, Altona North, Laverton, Sunshine, Keilor Downs, Melton and Werribee.

⁴ The police stations involved were Moorabbin, Sandringham, Brighton, Caulfield, Cheltenham, Mordialloc and Chelsea.

distressed, violent, or at risk of harming themselves or others, based on limited or no background information, and ad hoc expert advice.

Victoria Police therefore strongly urges inter-agency collaboration to agree the circumstances in which information sharing is necessary, the information that can be shared lawfully, the means for providing it swiftly, and the mechanisms for auditing information exchanges for accountability. Frontline workers then need scenario-based guidelines on the permissible information sharing in order to expedite requests for information, particularly after hours when there are fewer supervisory staff available to approve requests.

Personality disorders and acquired brain injury

Victoria Police advocates an improved service response to individuals with personality disorders. While the diagnosis and treatment of such disorders are still subject to debate, they nonetheless present considerable challenges for frontline services, such as police. Individuals with personality disorders are often frequent presenters to police as offenders, nuisance or disturbance calls, and welfare concerns. While their behaviour may sometimes be misunderstood or undiagnosed, police experience significant difficulty in referring them to mental health, disability or other support services as they do not fit within the respective service criteria and there appears to be few mechanisms available for providing the ongoing support that many such individuals require. Adopting the 'no wrong door' concept, Victoria Police therefore seeks urgent attention to providing an adequate service response to individuals with a personality disorder. The alternative is that they continue to come to police notice, with all the social and economic costs that that entails.

Likewise, Victoria Police sees a need for a particular focus on acquired brain injury. Police encounter individuals with varying degrees of brain injury that they have acquired through an accident, violence or prolonged substance misuse. They present in all forms of police callouts, whether as victims, offenders or persons in need of assistance and pose considerable challenges in terms of managing their safety and wellbeing, and in investigating and deciding whether to proceed with a criminal matter. As with personality disorders, the appropriate referral pathway is not always apparent or available to police. In anticipation of the prevalence of acquired brain injuries increasing, Victoria Police believes that effective service responses are essential.

Strengthening capacity for early identification and intervention through universal services, including early childhood services and schools

Providing earlier and age-appropriate treatment and support to children and young people with emerging or existing mental health problems and their families

What should be the respective roles of universal, secondary and specialist mental health services in a system of care focused on early identification and intervention? Why?

Should a stronger problem identification capacity be developed? If so, what should be its key features?

What are the appropriate and viable options for structuring services for adolescents and young adults:

- * Are there distinct groups, defined by age or type of mental health problem that need different interventions?
- * What service arrangements should deliver these interventions?
- * What would be the key features of accessible and effective service models?
- * How should such services be located in the broader service system?

How could family-centred practice be better embedded in models of care?

Victoria Police has no additional comments.

Delivering appropriate mental health support for particular groups of vulnerable young people

What would be the important key features and functions of a service offering dedicated mental health support to vulnerable young people?

Victoria Police has a strong interest in the mental health support provided to vulnerable young people and the integration of multiple forms of support. As the paper and the *Vulnerable Youth Framework Discussion Paper* note, police encounter children and young people in a range of contexts and presenting various challenging behaviours or vulnerabilities (eg. police processed 30,000 young people under 18 years in 2006/07). Police therefore require support as one of the universal services involved in early identification and intervention.

In addition to the work proposed under the Vulnerable Youth Framework, Victoria Police suggests the need to examine the impacts of the varying service definitions of children and young people on inter-agency collaboration. The upper age limit ranges from 18 years for police, to 25 years for the Children & Adolescent Mental Health Service, and a dual track for youth justice clients aged between 18 and 20 years into either the youth or adult system. While these definitional differences reflect statutory and professional specifications, they can complicate referrals and data analysis (eg. transitions from youth to adult services).

From a policing perspective, the service system for providing mental health support to young people also needs a forensic mental health component, whereby children and young people with serious or emerging mental health problems can receive treatment and support while in custody. Victoria Police suggests that such a service would cater for those on remand, those unfit to stand trial, those given a custodial sentence and those found not guilty by reason of mental impairment. As discussed in Focus Area 4, individuals placed in this service require linkages to community-based support upon their release.

Building stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem

What supports should be in place for young people who are carers of parents with mental health problems, or with combined mental health and drug problems?
What models would be most effective?

The aforementioned information sharing between frontline services would aid effective and appropriate referrals. As the paper and the *Vulnerable Youth Framework Discussion Paper* indicate, the issues experienced by children and young people can vary according to their age and can compound in number and effect. They may also be impacted by the child or young person's environment, as the 'Families where a parent has a mental illness' Strategy recognises.

If police were therefore able to make enquiries with other frontline services about involvements of individuals providing care to a child or young person, they could perform a more comprehensive risk assessment (eg. identify welfare concerns). The ability to check whether adult family members (who may have no previous police involvement) are receiving mental health, drug and alcohol, or disability support services, would enable police to determine what additional supports, if any, the young person and their family may require.

FOCUS AREA 3: ACCESS**Providing the right service at the right place – streamlining access and emergency responses****Providing access to 'right time, right place' mental health care by making it easier for people to obtain mental health information, referral and advice****Improving the efficiency and effectiveness of psychiatric triage in specialist mental health services**

How do we enhance access points to the specialist mental health system and what critical issues should be considered? What role should GPs and other primary care providers play in this?

What reforms are required for the mental health triage functions in AMHS?

As discussed earlier, it is police experience that they could refer a significant proportion of the individuals they apprehend under s.10 of the *Mental Health Act 1986* for psychiatric assessment or examination earlier in the onset of their illness or the particular episode. However, the limited service capacity to support individuals with low acuity presentations and the limited authority for police to link individuals with such services means that police become involved either as a last resort or because the individual's behaviour has escalated to a level that poses risks to themselves or others. Building the early intervention component of the service system should therefore increase the role that primary care providers play.

Related to this, the specialist mental health system would benefit from stronger linkages to other community-based services, including primary care providers. This would enable hospital-based mental health practitioners to refer individuals brought in by police under s.10 but who do not meet the criteria for admission to other appropriate services. At present, a common police experience is for practitioners to advise police to release the individual, with no follow-up service arranged. The frustration for police, family and friends, and many individuals themselves, is that this can result in a revolving door of apprehension, assessment and release. This appears to be a particular predicament in the cases of individuals apprehended under s.10 because they have threatened or attempted suicide or self-harm, but who may present coherently and rationally when brought before a mental health practitioner for assessment or a registered medical practitioner for examination.

For police therefore, the critical features of the mental health triage function are that it:

- is available 24-hours a day, across the state;
- is staffed by clinicians who can provide expert advice on response strategies, can refer to appropriate sub-acute Area Mental Health Services and other services (eg. local GPs), and can access the RAPID database;
- can perform timely face-to-face assessments, preferably onsite in the community, for individuals police apprehend under s.10; and
- can provide timely responses to individuals presenting with dual diagnosis (including personality disorders) or dual disability (including acquired brain injuries).

Creating an integrated emergency service system that can respond effectively to people experiencing a psychiatric crisis

What reforms to mental health CAT services are needed?

Is it appropriate for CAT services to be both the gatekeepers to acute inpatient services and providers of acute care in community settings?

What reforms are required to support police and ambulance services' capacity to respond efficiently and effectively to people experiencing a psychiatric crisis?

Is it time for a concerted approach similar to that used with cardiac conditions, leading to possible initiatives such as focused staff training and designated mental health experts within the ambulance system?

Victoria Police has no position on the entity that provides face-to-face assessments, expert advice for crisis and non-crisis situations, and referral to appropriate services. Provided these functions are available in a timely and consistent manner, across the state and after hours, it does not matter to police whether the provider is the CAT team or another entity.

Moreover, Victoria Police understands that there are two broad functions encapsulated within the CAT team model – crisis assessment and community-based casework. The crisis assessment function is of direct relevance and importance to Victoria Police as it is an essential component of police applying the s.10 apprehension power. The casework function is of indirect benefit to police as ongoing outreach support reduces the likelihood that individuals living in the community will reach crisis point and potentially come to police notice.

The main service reform required to both of these functions, from a policing perspective, is a significant increase in capacity. With greater capacity across the state and after hours, mental health practitioners would be able to assess an individual onsite in the community soon after their apprehension under s.10. As the PACER trial (mentioned earlier) demonstrates, this has numerous benefits:

- minimises the time that an individual is detained by police for health reasons, consistent with the objectives of the *Mental Health Act 1986* that intervention is provided in the least restrictive and least intrusive manner;
- improves the outcomes for the individual as they are either admitted or referred to appropriate sub-acute care;
- avoids unnecessary transportation by the ambulance or by police (typically via a divisional van);
- avoids unnecessary presentations at Emergency Departments; and
- avoids long waits in Emergency Departments for the individual and police; as the paper notes, mental health patients tend to have the longest wait in Emergency Departments.

Both the PACER trial and the trial based around the Western Health highlight that police primarily need timely access to face-to-face assessment (ie. screening and diagnosis), face-to-face and telephone clinical advice, and referral functions. These functions may align effectively with the triage service, with an injection of personnel.

Greater capacity in the casework function would also assist policing duties. It would provide support for individuals with mental health issues living in the community to comply with their treatment plan, vary that plan as needed, and put in place any other support required. From police experience, this would significantly reduce the likelihood that such individuals cease treatment or become disengaged from services without anyone realising until they reach crisis point or otherwise come to police notice.

Police would support the increased capacity for community-based casework by contributing to the development and implementation of inter-agency response plans for shared clients, as already occurs at the local level. Police would also *accompany* clinicians on welfare checks or to revoke a Community Treatment Order, where the clinician has justified safety concerns.

To assist with identifying the areas where demand consistently outstrips capacity, and the amount of additional capacity required, Victoria Police is introducing a Mental Health Transfer Form. This one-page sensitised form, developed in consultation with operational members, clinical representatives, and DHS Mental Health and Disability Services counterparts, will capture information on type of police involvement (eg. s.10, apprehension of an involuntary patient, referral for welfare concerns), response times from other services, and outcomes of police involvement (eg. individual admitted, referred, released). Victoria Police will share this data with the mental health, disability support and ambulance services in order to ensure there is sufficient capacity to respond to the needs apparent within local communities. This supports the population-based planning proposed in Focus Area 7.

The other main area of reform required to better support police referrals is to strengthen the response to individuals presenting with dual diagnosis or dual disability, as proposed in more detail in Focus Area 5. As the data from the PACER trial indicate, a significant proportion of the individuals who presented as having mental health issues had concurrent or solely substance use issues. Project PRIMeD data indicate that at least 70% of individuals in police cells have substance abuse/dependency issues and 22% were withdrawing while in the cells.

Police often have trouble in arranging for an assessment of an individual who presents with mental health and a co-occurring issue as these individuals appear to fall between the criteria of each of the relevant services. As a result, police are variously advised to detain the individual until they are no longer drug or alcohol-affected or to seek assistance from the other relevant service. Both responses are unacceptable as detention in a police cell, there is no legislative power for police to detain someone who is drug-affected for their welfare or assessment, and police are unable to respond to other calls for assistance while they are negotiating access to a receptive service.

Victoria Police therefore offers two approaches to addressing concurrent issues:

- train and resource multi-disciplinary service providers, particularly in the assessment, advisory and referral functions. Work is already underway in this area (eg. the Dual Diagnosis initiative) and should remain a priority for development; and
- establish emergency protective custody facilities where police and paramedics can lodge individuals with serious co-morbidity presentations so that they can be stabilised and assessed in a secure medical environment. This would avoid using police cells or divisional vans and Emergency Departments as holding areas and would ensure that the complex and high risk needs of these individuals are monitored and managed by clinical (rather than custodial) personnel.

Reducing the level of preventable crisis by providing a robust system of community-based primary and specialist mental health care

What models of care and new processes should be considered in EDs to improve outcomes for people with mental health problems and other complex needs presenting in this service setting?

How can we reduce the number of non-urgent presentations to hospital emergency departments and the 'flow' of patients from EDs?

As outlined earlier, investment in early intervention models such as multidisciplinary teams and onsite community psychiatric assessments would significantly reduce the number of individuals that police bring to Emergency Departments, which otherwise continues to increase (eg. from 3,260 in 2004/05 to 4,217 in 2006/07⁵). Such a reduction would have consequent savings in terms of police time and resources, and ambulance demand. Clearly, it would also reduce the distress and improve the timeliness and appropriateness of the response provided to the individual.

⁵ Victorian Emergency Minimum Dataset (2007), Department of Human Services.

FOCUS AREA 4: SPECIALIST CARE**Meeting the needs of people with severe mental health problems – building responsive specialist public mental health services****Building a more proactive system of specialist community-based mental health care that is geared to early intervention, relapse prevention and recovery**

How can we achieve a more integrated clinical and psychosocial rehabilitation response?

How can we strengthen the interface between GPs and the specialist mental health service system, particularly in the areas of shared care, assessment and referral?

What are the characteristics of our current community-based service system which promotes the use of Community Treatment Orders? If we envisage a more consumer-focused, voluntary treatment system, what would need to change?

The current community-based service system places the onus for seeking and maintaining treatment on individuals, their family and friends, and when problems arise, frontline services such as police and paramedics. From a policing perspective, without sufficient capacity to provide assertive outreach services, this creates a greater risk that problems will not be detected until they reach crisis point and require a more intensive response from police and mental health services. By definition, an individual in this situation is less capable of making reasoned and voluntary decisions about their treatment and care. To prevent further harms from occurring to the individual or to others, involuntary treatment appears to be the main means of stabilising the individual until other less intensive responses are feasible. Preventing individuals from reaching crisis point and from isolation from the social supports that would detect emerging needs would contribute to more individuals being in a position to make informed and voluntary decisions about their treatment.

Victoria Police is endeavouring to assist individuals with mental health issues to express their preferences while they are in a position to do so by introducing a capacity to volunteer information for inclusion in a Person Warning Flag on the central LEAP database. Prompted by queries from a number of individuals, carers, and advocacy groups, and similar in concept to advance directives, the initiative allows authorised persons (ie. the individual, their parent or legal guardian) to volunteer information. The information relates to typical behaviours, effective communication strategies and appropriate contact persons, and must still meet the existing criteria for a Person Warning Flag (eg. the person is likely to come to police notice in the future). This information will then be available to frontline police and call dispatchers (ie. '000' operators) and will inform operational responses. Accurate information, based on the individual's behaviours (rather than diagnosis) will minimise the risk of misinterpreting actions or situations escalating. Anyone who volunteers information can request a copy of the record of the information and can request the removal of the information at any time, provided there has been no subsequent police involvement.

Addressing service gaps - eating disorders

What reforms are required to improve the early identification and treatment and continuity of care of people of all ages with eating disorders?

How should we consider the respective roles of local, regional and statewide services in this area?

Victoria Police has no additional comments.

Accessing a wider range of bed-based care options that are well integrated with both clinical and social supports

What reforms are required to improve the efficiency and effectiveness of Victoria's specialist adult and aged mental health bed-based service system?

What are the characteristics of our current service system which results in recourse to practices such as seclusion? If we want a more consumer-focused, voluntary treatment system where the consumer is regarded as a partner in their recovery, what would need to change?

Should we consider reconfiguring the boundaries between CCU and PDRSS residential rehabilitation services?

Victoria Police strongly supports investment in the suite of acute, sub-acute and rehabilitation services needed to provide the right support to individuals, for as long as required. The capacity to do so is likely to reduce the risk that they will come to police notice.

Victoria Police also notes the paper's reference to the "marked reduction" (p.82) in the use of seclusion and mechanical restraint and recognises that this is in keeping with the objectives of the *Mental Health Act 1986* of providing treatment and care in the least restrictive and intrusive manner. Victoria Police would, however, wish to be assured that part of this reduction is not attributable to individuals being held in police custody (eg. while waiting in the Emergency Department, or in the back of a divisional van, or in handcuffs) or police facilities (eg. police cells) instead. None of these should be the preferred option for an individual with mental health issues, unless they present safety risks that require police authority.

Improving consumer and carer experiences, making sure that expectations with regard to access, rights, equity and respect are met

What key policy directions should be considered over the next 5-10 years to achieve improved consumer empowerment and self-determination?

What strategies/mechanisms are required to better support the active involvement of consumers in their treatment and care?

What are the best models for supporting a carer sensitive approach in the mental health system?

What carer support models are most appropriate for Indigenous people and their families and CALD communities?

How can we best promote culturally sensitive practice within mental health services and in broader social support services?

Victoria Police has no additional comments.

Tailoring services for clients with particular needs, especially forensic clients, including both bed and community-based support

What reforms are required to improve the efficiency and effectiveness of the community and bed-based forensic service system? How can AMHS and PDRSS better support and provide treatment and care for clients with a forensic mental health history?

Victoria Police strongly supports proposals to invest in the capacity within Thomas Embling Hospital and the prison-based mental health services, in recognition that making the most of the opportunity to address the needs of individuals while they are in state care reduces the likelihood that they will return to state care via the criminal justice system.

Further to this, Victoria Police agrees with the need to supplement these secure bed-based services with adequate post-release linkages to community-based services so that individuals continue to receive the treatment and support provided in prison or in Thomas Embling Hospital. Ensuring these linkages will involve increasing the capacity of the forensic mental health and justice system to identify and access local community-based services (ie. through awareness of and partnerships with the services available). It will also involve increasing the capability and willingness of community-based services to treat individuals referred from the forensic mental health and justice systems (ie. through education in the specific needs of individuals referred from these systems and the impact of their problem behaviour).

As stated earlier, Victoria Police is keen for this reform process to close service gaps that are evident to police, namely:

- to provide a specialist youth forensic mental health response for young people on remand, unfit to plead/stand trial, found not guilty by reason of mental impairment, or sentenced, in order to provide therapeutic interventions at the acknowledged age of onset and before a cycle of offending and disadvantage is established; and
- a capacity to respond to individuals with personality disorders or an acquired brain injury, especially those whose level of presentation or level of offending are not so serious as to warrant intensive interventions (eg. sentencing to Thomas Embling Hospital) but who nonetheless repeatedly come to police attention.

FOCUS AREA 5: COMPLEX CLIENTS

Responding better to vulnerable people – improving care and support in the community

Promoting a more coordinated and tailored approach to people who require support from multiple services

What key system reforms are needed to support the effective coordination of care across multiple service systems?

How could existing service platforms be used to support local partnerships and linkages in the delivery of age-appropriate coordinated care?

How can family or carer supports be most effectively incorporated into integrated care planning?

What statewide guidance and support is required to support any new model of care coordination?

As the prevalence data on p.89 of the paper indicate, many individuals with mental health issues have other concurrent issues, including involvement with police, as a victim, offender or person in need of assistance. Victoria Police therefore supports the proposed progress towards a lead agency model for coordinated case management and believes that this requires the information sharing and intervention powers outlined in Focus Area 2.

In addition, Victoria Police believes the boundaries between service systems need to align, in order to facilitate timely referrals. While most services, including police, operate under Local Government Area boundaries, the Area Mental Health Services do not. Moreover, different catchment areas apply to the Child & Adolescent, Adult and Aged mental health services. This presents significant difficulties for police when trying to refer an individual whom they encounter outside of their area of residence or with no fixed abode. Police can also be redirected from the nearest mental health service to one some distance away, all the while detaining the individual in police custody. In regional areas, this can involve considerable time and travel, typically with the individual in the back of a divisional van. As alluded to elsewhere in the paper, such a response is not acceptable for someone experiencing a physical health problem, such as a cardiac arrest or broken leg, and is contrary to the intent and provisions of the Human Rights Charter.

Improving access to stable and affordable housing, together with appropriate and scaled support to reduce homelessness and sustain tenancies

What are the key reforms required to improve access to social housing and private rental for people with mental health problems?

What role could or should Housing Associations and other areas, such as local government, play in the provision of social housing for various age groups with mental health problems?

How can we more effectively support people of all ages with mental health problems and/or psychiatric disability who are at risk of or are homeless?

What reforms can be implemented to improve responses to young people who are homeless and who require treatment and support from mental health services?

Victoria Police recognises that stable accommodation is central to maintaining mental health and wellbeing, and therefore welcomes initiatives aimed at providing more supported and supportive housing options, particularly when these link with community-based mental health services.

However, Victoria Police urges that all affected agencies be involved in planning decisions about the establishment of additional housing options. Given the affordability of metropolitan housing stock, Victoria Police would be concerned with a trend to settle groups of individuals with mental health and other needs in regional areas that do not currently have the staff or resources to meet such an increase in the number and complexity of individuals. Police already find it challenging to access after hours or culturally appropriate mental health services in some regional locations that have concentrations of acknowledged higher risk populations, such as recent humanitarian migrants or Indigenous Victorians. Accordingly, the allocation of housing resources needs to be in step with other supporting infrastructure.

In addition, notifying emergency services of where supported or supportive houses are located would enable these personnel to prioritise and plan responses to calls for assistance, and to involve any other services that are already in place. As suggested earlier, the better the information on which police can base their decisions, the more tailored and timely the response they can provide to the person in need.

Focusing on the needs of people from particular vulnerable and disadvantaged groups

Responding effectively to people with a dual diagnosis

How can we better respond to the needs of people with mental health problems and co-occurring substance misuse across the continuum of need? What are the areas for priority action and why?

If we were to develop a more integrated response to the needs of people with a dual diagnosis what would this response look like and who should it target?

How can we respond more effectively to the needs of Indigenous people at risk of or with a dual diagnosis?

Victoria Police agrees that the priority areas for consideration are individuals with dual diagnosis in police custody, Indigenous persons, young people, individuals involved in family violence incidents, and prisoners due for release. The unique needs of these groups of individuals compound the existing challenges of accessing services to meet needs that span at least two disciplines. As indicated earlier, Victoria Police is keen for this whole of government reform process to advance the concept of 'no wrong door' so that frontline workers such as police can make the most of the interactions that will inevitably occur by referring them to the appropriate services quickly, safely and effectively.

Victoria Police also suggests the development of targeted awareness campaigns to communicate the signs and symptoms of mental health problems, and to remove the stigma of seeking help (eg. the recent Mind Matters campaign). If individuals are not comfortable or confident in seeking help at an early stage, it undermines the potential of initiatives such as the proposed 24-hour telephone advice line and increases the likelihood that they will reach a point where they come to police notice or are subject to involuntary treatment.

Adults and young people with serious mental health problems engaged in the criminal justice system

How can we reduce the risk of offending behaviour by, and victimisation of, people with a serious mental illness (including those with a co-existing substance misuse, disability or other complex problems) and their engagement with the criminal justice system?

How can we most effectively support people with serious mental health problems at each transition point in the criminal justice system to reduce the risk of them re-offending or being re-victimised?

Individuals with mental health issues are common in calls for police assistance. For example, around 50% of individuals reported missing have mental health issues and around 20% of individuals are reported missing from mental health services.⁶ At least 14% of all family violence incidents involve one or more mental health risk factors.⁷ The heightened vulnerability of individuals with mental health issues to victimisation and to suicide and self-harm have been illustrated earlier.

Likewise, the Project PRIMeD study of the prevalence of mental illness in police cells found a significant over-representation of all the major mental disorders, including that:

- 25% of individuals reported a psychiatric history;
 - 6.2% had a documented psychosis;
 - many needed prescription psychotropics, including antipsychotics (2.4%), antidepressants (5.4%) and benzodiazepines (11.9%);
- 70% had some form of substance abuse/dependency;
 - 21% were in withdrawal;
 - 23.2% were taking opiate substitutes;
- 48.1% were registered on the RAPID public mental health database;
 - 17% were in treatment at the time they were in the cells; and
 - 15% began treatment as a child.

Hence, it is clear that mental health issues are a significant and common contributor to offending, victimisation and vulnerability, and that addressing this contributor would prevent considerable harms and demands on policing services. Victoria Police is already working with others on initiatives to improve its ability to link individuals with the appropriate interventions, including:

- Collaborating with representatives of the Magistrates' Court and Police Prosecutions on increasing the police recommendation of court diversion for defendants with mental health issues, including the suggestion of treatment and support conditions where it is apparent that this may prevent further offending;
- Evaluating current cautioning and diversion policy and practice to determine how they may more consistently and effectively direct individuals from the criminal justice to therapeutic alternatives; and
- Evaluating current Independent Person programs for young people in police custody and Independent Third Persons for adults with a cognitive impairment in police custody to determine patterns of usage, linkages with treatment and support services, and outcomes of involvement.

However, improvements to outcomes of these programs are dependant on the availability and responsiveness of community-based treatment and support services. As discussed earlier, the powers for police to link individuals to therapeutic services are limited, therefore what few opportunities exist must be maximised.

At the same time, Victoria Police urges consideration of removing unintended outcomes. For example, the automatic dismissal of matters in the Magistrates' Court where the defence of mental impairment is successful compels police to weigh considerations of a reasonable prospect of a conviction, the risk of costs awarded against police and the public interest in

⁶ LEAP data, Victoria Police.

⁷ LEAP data, Victoria Police.

bringing the matter to court. Typically, this weighing must occur in the absence of an independent forensic assessment (mentioned earlier). As a result, police may withdraw or alter the charges, or proceed and have the case dismissed, without police or the Magistrate being able to refer the defendant to any form of care or treatment service, despite the defendant having proven that they have mental health issues of a level to cause impairment and contribute to offending. The inability to provide a therapeutic intervention risks the defendant progressing to further or more serious offending which may then be dealt with in the higher courts, where a broader range of dispositions exist.

Furthermore, in light of the evidence of the level, complexity and instability of individuals in police cells, Victoria Police is keen to outsource its custody management role to more appropriate and qualified personnel. The assessment, management, medication and monitoring of an overwhelming majority of individuals with mental health, substance abuse and self-harming issues is not best performed by police. As the outsourcing of the operation of the Custody Centre demonstrates, a combination of custodial and clinical staffing provides effective and efficient prisoner management, releases police to perform operational duties and generates significant cost savings.

Proposals for increasing victim support services and establishing emergency protective custody facilities are outlined earlier in the submission.

What we want to achieve for Indigenous people and communities
 What specific actions are required to improve the social, spiritual and emotional wellbeing of Indigenous people, their families and communities?
 How can we support the specialist public mental health service system to better respond to the needs of Indigenous people experiencing poor social, spiritual and emotional wellbeing and their families?
 What is the role of government in supporting Indigenous communities to draw on their own social and cultural resources to find and implement local solutions to the social, spiritual and emotional wellbeing needs of their community members?

Victoria Police supports the comments and proposed areas for concentration in the paper.

People with mental health problems and co-existing disability
 How can we support both the specialist disability and mental health service sectors to better identify, treat and support people with mental health problems and co-existing disability?
 What housing and support models would best support this group? What features would these models have?
 Should a more centralised approach be considered for people with more severe mental health problems and co-existing disability? What would such a service response look like and who should it target?

Victoria Police agrees with the requirements listed in the paper (p.106) for improving the outcomes for individuals with a dual disability. As with efforts to refer individuals with a dual diagnosis, police are often frustrated and delayed by the amount of negotiation that can be required to link an individual to either one of the services; this is exacerbated in the area of disability support services as there is currently no after hours intake service. This is another area where making the 'no wrong door' concept a reality will make a significant difference in police response times and outcomes.

In expanding the dual response capabilities of the mental health and disability support services, Victoria Police also recommends that these services also incorporate either strong links with, or staff qualified in, drug and alcohol, personality disorder and acquired brain injury responses.

Victoria Police is currently working with the Mental Health & Drugs Division, and Disability Services, within the Department of Human Services on Protocols outlining respective roles, responsibilities and responses, with a view to adopting a more integrated approach at both the statewide and the local level.

As suggested earlier, accurate assessments undertaken at an individual's earliest encounter with the criminal justice system would form the basis for future decision making within the justice and other support systems.

Refugees with mental health problems

How can we more effectively support refugees, including children and young people, who have, or are at risk of, mental health problems?

The challenges outlined in the paper in recognising and responding to the unique mental health issues of refugees reflects the experiences of police who work with local refugee communities. The challenges increase when these communities exist in regional areas where access to mental health and other support services is already limited and covers a large geographical area. Planning and increasing service capacity is, however, complicated where refugee populations are transient (ie. they follow the job opportunities).

Victoria Police also supports the proposals to increase the culturally appropriate services available to this population, by both expanding dedicated services such as the Victorian Foundation for Survivors of Torture and improving the cultural competency of the public mental health services.

However, in addition to education about the mental health problems within refugee communities, Victoria Police suggests a need to provide awareness campaigns aimed at overcoming the stigma and reluctance to seek help, especially before problems become extreme or individuals come to police notice.

Overcoming stigma and reluctance to seek help also relates to reducing the social isolation and pre-existing trauma that many refugees experience. Victoria Police recognises its role in assisting refugees to integrate within their local communities by running a range of activities with refugee youth (eg. sporting events) and community groups (eg. social gatherings), as well as sending local police on fact finding tours to better understand the environment from which these refugees have come.

Maximising the individual's potential for recovery by supporting their social and economic participation in community life

How can Victoria better support people with a mental health problem to become job ready and secure meaningful employment?

What role should the specialist mental health service system play in this regard?

What role could local and regional partnerships play in achieving this outcome?

Victoria Police has no additional comments.

FOCUS AREA 6: WORKFORCE

Developing our people – building a high quality and sustainable workforce

Building a knowledgeable, skilled and sustainable specialist mental health workforce with an ensured supply

What other means could be used to grow the Victorian mental health workforce, both in the short and long term?

How can we encourage more workers to practice in rural areas?

What incentives do we need to attract experienced and trained staff back to mental health services?

How can public mental health services work better with private providers to improve client care and enhance workforce development?

Victoria Police has no additional comments.

Embedding a culture of service quality, responsive to evidence-based practice and client need

How can we facilitate adoption of best practice in client care by mental health workers?
 What could we do to strengthen direct care governance in mental health services?
 How can we facilitate continuous quality improvement in mental health service provision?

Victoria Police has no additional comments.

Systematically improving the capability of the broader health and community services workforces through education and training

How can we support workers in other health and community services to better respond to mental health problems and achieve better recovery for people affected by mental illness?

Victoria Police strongly agrees that it is critical for police to receive the training and education required to recognise, understand and respond to the range of mental health issues that present, including when they present in concert with other issues. It is also important for police to understand the service systems and their access criteria so that they know whom to refer and how.

To this end, the *Victoria Police Mental Health Strategy* has a major focus on updating the approach to, and delivery of, mental health-specific training and information. At present, training in the area of mental health comprises:

- o foundational, promotional and refresher courses, such as the recruit Diploma of Public Safety (Policing) and the Operational Safety & Tactics Training undertaken by all frontline police every six months;
- o specialist training, such as the qualification course for negotiators, detectives and sexual offences and child abuse investigators;
- o competency-based modules within a range of courses, such as communication skills and critical incident management;
- o awareness training commissioned to meet specific needs, such as the Mental Illness Fellowship course, Psychological First Aid, and Mental Health First Aid;
- o joint training and information sessions organised at a local level by police, ambulance and hospital personnel on roles, responsibilities and responses; and
- o training among support functions, such as Police Communications, that impact on the way in which Victoria Police interacts with people with a mental disorder.

Nonetheless, this training is under review to make it:

- o practice oriented (eg. scenario based and interactive);
- o phased according to the specific roles and levels of police members;
- o supported by reference material (eg. legislation, practice guides, case studies) on the Mental Health Knowledge Bank on the intranet;
- o partly delivered by external experts (eg. service providers, individuals with the lived experience);
- o inclusive of the breadth of mental health issues and interactions that police have (eg. including intellectual disability, personality disorders, acquired brain injury);
- o reflective of expectations and obligations under the Human Rights Charter;
- o reviewed annually to reflect changing priorities, new information and feedback from police members and external partners; and
- o relevant to the mental health and wellbeing needs of Victoria Police personnel, in recognition of the demanding nature of operational duties and the organisation's broader OH&S obligations.

The *Victoria Police Mental Health Strategy* recognises the need for a multi-pronged approach to equipping police with the required knowledge and skills, and therefore proposes that:

- o the corporate courses (eg. recruit training, Operational Safety & Tactics Training, detective training etc.) provide the core knowledge and skills expected of police;

- on-demand courses supplement the knowledge and skills of police with particular responsibilities or interest in mental health issues. In keeping with the recommendation of the Commonwealth Senate Select Committee on Mental Health report (April 2006), Victoria Police has accredited six police as trainers, customised the program, and is rolling out the two-day Mental Health First Aid program across the state. Since October 2006, around 270 police have volunteered to undertake this program, with a further 420 enrolled for the remainder of 2008⁸;
- targeted training be available on specific issues (eg. suicide prevention) and/or in specific areas (eg. in drought affected areas); and
- local interagency training and information be supported to share respective knowledge and skills, and build relationships between police, clinicians, disability support workers and others.

This approach to police training reflects the findings of a recent Project PRIMeD study of police awareness of and attitudes towards current training. Of the 1,265 police surveyed, researchers found:

- a confidence among police in their ability to respond to individuals with mental health issues, but a widespread interest in knowing more;
- a preference for practice based training, rather than 'lectures';
- a preference for role-specific training (eg. provide supervisors with training for their duties);
- support to provide both mandatory and supplementary training; and
- a desire for the training to communicate clearly the expectations of police (eg. when they should use an informal response and when they should intervene).

In addition to updating its own suite of training, Victoria Police is also actively involved in the development of new police-specific training resources, such as the national Dementia Training Project by the Australia and New Zealand Policing Advisory Agency. In collaboration with each Australian policing organisation, the Agency is developing a range of training products to assist police to recognise and respond to the policing needs of individuals with dementia, a population that is likely to continue to increase.

However, this commitment to training police to recognise and respond to mental health issues remains in relation to the conduct of operational duties, including the transfer of care from police to treatment and support services. Increasing police competence in this area cannot, and should not, be an alternative to filling service gaps within the health and disability support service systems. Neither should it expand policing roles and involvement to include functions that are the responsibilities of other service sectors.

Strengthening leadership within the mental health service system and across the broader health and community services system

Are there other ways that we can strengthen leadership within mental health services and across the broader health and community services system?

There are 21 Emergency Services Liaison Committees across the state⁹, comprising local police, ambulance, Emergency Department and mental health service representatives. These Committees meet regularly to discuss service issues and improvements, run joint training sessions (eg. information days, workshops, inductions and ridealongs) and develop coordinated responses for shared clients. Victoria Police has noticed a correlation between effective Committees and productive working relationships.

⁸ By the end of 2008, Victoria Police will have exceeded the 5% target of frontline workers trained recommended in the Select Committee report. Victoria Police will continue to offer the program in 2009.

⁹ The Committees align with the 21 catchment areas of the adult Area Mental Health Services.

Victoria Police and the Department of Human Services Mental Health & Drugs Division have recently instituted six-monthly reporting by these local Committees to the statewide Inter-Departmental Liaison Committee¹⁰ in order to identify more consistently best practice, system issues requiring attention, and issues requiring clarification.

Based on the evident benefits of the local interagency committees in the mental health arena, Victoria Police is now working with Department of Human Services Disability Services to adopt similar regular interagency interaction between police and the disability support sector.

Victoria Police has also recognised the importance of establishing leadership in mental health issues within the organisation. Accordingly, in 2006 Victoria Police nominated mental health as a priority issue in its Business Plan and appointed a Corporate Sponsor for the mental health portfolio at Department head level. As part of its *Mental Health Strategy*, Victoria Police has also established a network of 120 Mental Health Liaison Officers across the state. These Officers will receive additional information and act as identifiable contact points for colleagues and external stakeholders with queries, suggestions or issues. These Officers also contribute to the development of initiatives designed to assist with operational duties, such as the aforementioned Mental Health Transfer Form, suicide investigation guide and Person Warning Flag amendments.

Victoria Police has therefore found that nominating a pool of individuals and providing them with ongoing support and clear objectives has strengthened leadership on mental health issues within the organisation and partnerships with counterparts.

FOCUS AREA 7: PARTNERSHIPS

Doing things together – strengthening governance, partnerships, knowledge and accountability

Designating local area partnerships to drive population-based service planning and coordination across the continuum of mental health

Which are the most important and useful functions that local mental health partnerships could perform and at what geographic scale?

Who should lead and participate in such structures?

Which existing structures could be built on to better meet mental health needs (taking into account differences between metropolitan and rural areas)?

What kind of statewide guidance and support would such local partnerships require to operate effectively?

As mentioned above, Victoria Police has found that productive partnerships at the local level are essential, as this is generally the point of service delivery to individuals, families and communities, and it allows the shaping of services to the specific demands of an area. However, it would help if the areas and boundaries used by the various service systems align. Most services use the Local Government Areas (or in the case of Police Service Areas, aggregations of these Local Government Areas). One of the notable exceptions is the Area Mental Health Services. This difference in catchment areas impedes referrals, area-based planning and local level collaboration.

Also as previously indicated, Victoria Police has found a benefit in maintaining a statewide (ie. corporate) overview of local partnerships as a means of identifying high performing areas, minimum standards, and systemic issues. A corporate area of responsibility is also useful for liaising with external stakeholders (eg. advocacy groups, academia) and partner agencies (eg. other government departments, statewide service providers), and maintaining a body of knowledge on which Victoria Police can draw when representing policing issues in other forums.

¹⁰ The Inter-Departmental Liaison Committee comprises senior representatives of areas within Victoria Police and the Department of Human Services that contribute to mental health outcomes.

Reconfiguring public mental health service structures to align age-related and PDRSS components, facilitate links with general health structures and allow specialist roles to develop

What should be the priority for governance change in mental health services—alignment of age-related services, clearer alignment with hospital structures or other issues?

Is it better for PDRSS services to be integrated with Area Mental Health Services or with wider primary and community service structures such as community health?

In the shorter term, should we move to identify a single lead or consortium PDRSS provider for each mental health service area?

What benefits would be achieved from broader clustering of mental health services on either a regional or multiregional basis?

What other factors should be considered in rethinking mental health service governance?

Victoria Police has no additional comments.

Embedding accountability for outcomes associated with mental health into funding and reporting systems at all levels, including general health and social support services

What should be the dimensions of a broad outcomes framework for mental health, and at what level should it operate?

What cross-agency governance mechanisms are required to implement such a framework?

What support would local services and programs need to implement the outcomes framework?

What other mechanisms might we use to embed accountability for mental health support across the health and social care system?

Victoria Police strongly agrees that there needs to be better information on the demands for service, responses provided, and ‘what works’, across the public and community service systems. To this end, Victoria Police is introducing its Mental Health Transfer Form to collect, analyse and use information that has not previously been available on interactions between police and individuals with mental health.

However, Victoria Police believes that to be most effective, service information needs to be shared across agencies, both operational information (eg. electronic medical records within the justice system) and performance information (eg. demand data, response data, referrals). Sharing these types of information will drive service planning, improvement and collaboration. It will also provide a more complete and nuanced picture of individual and community needs, as previously discussed in relation to attempted suicides and transitions from youth to adult service systems.

For this reason, Victoria Police prefers that initial outcomes and accountability activity focuses on setting appropriate measures and *integrating* available data, rather than identifying a range of new data for agencies to collect. For Victoria Police, the collection of any new dataset entails significant transaction costs in terms of more paperwork for close to 10,000 operational police; additional data entry for Records Services Branch (whose priority is to enter information onto the LEAP database as soon as possible); changes to IT systems; and additional data extraction, analysis and reporting. While these costs are borne where there is a demonstrated need for the information, Victoria Police suggests that until best use is made of the collective information already available, such a need is difficult to demonstrate.

Likewise, Victoria Police supports the adoption of an outcomes framework, but urges that the outcomes set are specific, measurable, attainable, relevant and timely. For Victoria Police, this means measuring and monitoring only those contributions to mental health outcomes that police can affect. For example, the COAG progress measure “Prevalence of mental health problems amongst people who are remanded or newly sentenced to adult and juvenile correctional facilities” (p.125) is appropriate because prisoner are assessed upon reception to these facilities. However, measures such as “Incidence of criminal and antisocial behaviour linked to mental health problems” (p.24) and “Number of ambulance and police callouts for mental health reasons” (p.25) are not appropriate because:

- they rely on police identifying mental health issues in every situation, despite it being generally accepted that police are not required to exercise clinical judgement;
- mental health issues are not necessarily apparent in every situation;
- mental health issues are not always the primary consideration or relevant;
- mental health issues are often not the reason for police callout, but become apparent when police attend; and
- these measures require not just counting of incidents but establishing a causal link between mental health and an incident.

Victoria Police is keen to work with partner agencies to develop measures that demonstrate the police contribution to mental health issues, based on data collected on key interactions.

Creating an organised statewide research and knowledge management capacity to provide a robust evidence-base on mental health interventions

What should be the scope and priority of a collaborative Centre for Mental Health Intervention?

How should Victoria develop a stronger network of researchers and those involved in program design and service delivery to share information on mental health research findings and generate ideas for projects?

What other strategies for enhancing Victoria's applied mental health research effort would you recommend?

Victoria Police strongly supports collaborative research and is currently working with partners as diverse as Monash University, Forensicare, the Office of the Public Advocate, KPMG and the Australia and New Zealand Policing Advisory Agency on building the knowledge and evidence base on interactions between policing and mental health. Via the *Victoria Police Mental Health Strategy*, the organisation is translating the findings from this research into operational policy and practice.

In terms of research priorities, Victoria Police recommends evaluations of 'what works' in:

- policing responses to the range of interactions involving mental health issues;
- justice interventions that have the greatest impact on reducing re-offending and re-victimisation of individuals with mental health issues; and
- clinical interventions that best enable individuals to live and function within the community, which in turn inform referral practices.

Driving continued strategic policy development, alignment and accountability at the statewide level

What kind of overarching high-level body or bodies should oversee the continuing development and implementation of the Mental Health Reform Strategy? Who should be involved in such a body?

Do you support the concept of a set of partnership groups at statewide level and, if so, what is the best way to divide responsibilities between the groups?

Victoria Police is committed to maintaining the Inter-Departmental Liaison Committee that meets quarterly and comprises senior representatives from across Victoria Police and the Department of Human Services that have an impact on mental health outcomes. This Committee is strengthening its strategic policy development capacity, aided by the reporting from the local liaison committees on service issues and priorities.

Victoria Police is also part of justice-specific committees, such as the Justice Health Joint Management Committee and the Victorian Custody Reference Group. Both committees monitor and develop strategic responses to service issues within the criminal justice system, including responses to individuals with mental health issues.

Victoria Police is therefore keen to contribute to any partnership grouping that advances the collective response to individuals with mental health issues who are likely to, or who have, become involved with the justice system.