Mental Health and Policing

Mental Health Coordinating Council

Submission to the Law Enforcement Conduct Commission LECC

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INTRODUCTION

WHO WE ARE

Mental Health Coordinating Council (MHCC) is the peak body predominately for community-managed mental health organisations (CMOs) in NSW and is a Registered Training Organisation (RTO). We mostly represent community-based, non-government organisations that support people living with mental health challenges. MHCC's 150 plus members assist people to live well in the community by delivering mental health and psychosocial supports including social inclusion, rehabilitation, and clinical services. Our purpose is to promote a strong and sustainable community-managed mental health sector with the investment, resources, and workforce it needs to provide effective psychosocial, health and wellbeing programs and services to the people of NSW.

MHCC provides policy leadership, promotes legislative reform and systemic change, and develops resources to assist community-based organisations build their capacity to deliver quality services informed by a human rights-based, trauma-informed, recovery-oriented practice approach. MHCC works closely with Mental Health Australia on matters of national interest to the sector, including cross-governmental collaboration, bilateral agreements, and the NDIS. We also collaborate with other peak bodies across a diversity of human service contexts, and are members of the Mental Health Alliance, a partnership of state-based peak bodies and professional associations, on matters of mutual interest in NSW.

The RTO delivers accredited and non-accredited programs, that support organisations and individuals to deliver high quality mental health and related psychosocial and rehabilitation services. We also deliver training and professional development more broadly across human service sectors including housing and homelessness, alcohol and other drugs and disability.

MHCC thanks LECC for this opportunity to contribute to public discussions concerning Mental Health and Policing - an area requiring urgent reform. We are hopeful that this consultation will lead to meaningful improvements for people with lived and living experience of mental health challenges, their families, carers and kin as well as the broader community.

BACKGROUND

Data has shown that in the five years to July 2023, at least 52 people experiencing mental health crises were killed by NSW Police. The state's Law Enforcement Conduct Commission (LECC), noted in its own five-year review published in 2023: *that nearly sixty-eight out of one hundred and fifty-seven critical incidents - involved a person in a mental health crisis and resulted in death or serious injury* (p.41)[1].

The NSW Government has long been aware of this issue, which has been repeatedly raised in the media and examined through multiple inquiries, including the *NSW Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales*. In the Joint Parliamentary Committee's Report to Government, it said: *that police are too often drawn into responding to mental health crises because the health system is under-resourced and overly crisis driven.*

The report noted concerns about the suitability of police and emergency departments as default responses for people in acute distress and pointed to the need for: *improved crisis alternatives and stronger community-based mental health care to reduce unnecessary police contact*.[2] The report also urged police to improve mandatory mental health training for officers and *"explore"* becoming second responders. It was suggested that health workers be the first people called to mental health incidents. However, in the absence of adequately funded and widely available crisis and outreach services, police too often remain the default responders.

In May 2026, Yasmin Catley, Minister for Police and Counterterrorism in NSW, announced that the police and the health department were expected to sign a new agreement on how to deal with mental health incidents, as the police union demands officers no longer be the *"default response for every crisis"*. The Minister went on to say that the government is considering an approach akin to the UK's *"right person, right care"* model, which sees health workers rather than police attend mental health callouts, if no crime is being committed and there is no risk to life. An internal review conducted by NSW police released in September 2024 recommended following the UK approach. Police admitted in the review that when they attended mental health incidents, they were often *"an escalating factor"*, and it would be better if experts were deployed instead.

Police and the government had been under pressure to enact reforms after the deaths of Clare Nowland, Steve Pampalian, Jesse Deacon and Krista Kach in 2023 while experiencing mental health distress. The pressure grew again after public housing resident Collin Burling died last year after he begged for help while restrained by police.

Premier Minns said at the time:

"I'm conscious of the challenges you are facing every day, with a broad mission, with more responsibilities, with a desperate need for more officers in the field."

MHCC understand that a Memorandum of Understanding is due to be signed between NSW Health and NSW Police. We urge government to ensure that responses are appropriately aligned with circumstances and need, rather than utilise a sledgehammer approach to all events which often ends in escalation and exacerbated trauma.

Reform from a community-managed mental health sector perspective

MHCC have consulted members about this review and particularly thank Mind Australia, who provided direct input into this submission. The sector strongly supports moving away from police-led responses toward health-led, trauma-informed, least restrictive crisis models, with police involvement reserved for serious risk situations. We want to see evidence-based models that embed health expertise and include community follow-up[3].

We have long called for alternatives to police for emergency responses for people experiencing acute mental distress, including: psychosis, delirium, dementia or the co-existing impacts of substance use in the community, but not limited to Police, Ambulance, Crisis Mental Health Outreach for early intervention and PACER (e.g., Mental Health Acute Assessment team (MHAAT); Mental Health, Ambulance and Police Project (MHAAP); Mental Health First Responder (MHFR) Program, and Suicide Prevention Outreach Teams (SPOT)[4].

For over a decade, across its submissions and related consultation material, MHCC has consistently argued for:

- a health-led, trauma-informed, least restrictive response to mental health crisis rather than routine police-led intervention[5]
- stronger community-based psychosocial supports and better integration between crisis response, outpatient/community mental health, and non-government supports[6]
- limiting police involvement to situations involving serious and imminent risk, with care responses led by health professionals wherever possible[7].
- investment in specialist police training to support safer de-escalation when police involvement is unavoidable, and to enable a successful transition to a health-led crisis model.

We have consistently supported a model informed by reviews of other crisis-response programs, including co-response approaches[8], where:

- NSW Ambulance paramedics are appropriately trained to support and de-escalate mental health crises and take the primary role in responding to mental health emergencies
- NSW Police Force only attends where there is a serious risk of harm or an immediate threat to life and safety.

Research that supports our position

In the article *Police Use of Force in Mental Health Crises: An Analysis of Coronial Inquest Findings from Australia* (Dodd S, Morgan M, Weir B & Bowyer J) published in the *International Journal for Crime, Justice and Social Democracy* in 2025[9], the authors examine coronial inquest findings on fatal police use of force against people experiencing mental illness in one Australian jurisdiction, with a focus on the lead-up to incidents, the individuals' mental health histories, and the tactical approaches used by police.

Analysing these findings adds to concerns about police-led responses to mental health crises. Dodd and colleagues found that police are frequently the first responders to incidents involving people experiencing a mental illness, and that these interactions may escalate to the use of force, including fatal force. This evidence supports the need to reduce reliance on police as the default crisis responder and to invest in health-led, trauma-informed alternatives.

This paper supports our argument that a police-led default response is unsafe and inappropriate for many mental health crises. It also suggests that police intervene in crisis situations can materially shape whether events escalate. The article situates these incidents within broader Australian data showing a significant share of police fatal shootings and custody-related deaths involve people with mental illness. The problem is not anecdotal — but it is part of a broader systemic pattern.

This reinforces the need for health-led, least restrictive crisis responses rather than routine police attendance. The research also supports concern that the use of police as default responders can shift mental health crisis into a law-enforcement frame, increasing the risk that distress is managed through control, coercion and force rather than care and support.

When police need to be involved

Where police involvement is necessary because there is a serious and imminent risk to life or safety, their role should still be governed by evidence-based mental health best practice standards rather than command-and-control policing.

The evidence suggests that safer interactions are more likely when officers receive specialised, scenario-based training in mental health crisis response, with a strong focus on verbal and non-verbal communication, empathy and de-escalation. In high-risk situations, the objective should not simply be rapid control of the person in distress, but the safest possible resolution of the incident through calm engagement, careful assessment and the least restrictive response available[10].

Research also suggests that one-off mental health awareness training is not enough to improve police responses in these circumstances. If police are to remain involved in a limited range of high-risk crisis events, training must be ongoing, informed by evidence-based best practice, and reinforced through supervision, operational guidance and evaluation of behavioural outcomes. This means measuring whether police interactions reduce escalation, fear, injury and use of force — not merely whether officers report increased confidence or improved attitudes.

Taken together, the evidence supports a limited and specialist role for police in mental health crises: one that is reserved for situations of immediate safety risk and shaped by de-escalatory, trauma-informed and culturally safe practice. Training should be delivered by an accredited Registered Training Organisation with extensive experience in mental health education and should be co-designed and delivered with both health and lived experience expertise.

Australian evidence suggests that specialised police mental health training can improve some aspects of crisis response where police involvement is unavoidable. In an evaluation of the NSW Police Force Mental Health Intervention Team, Herrington and Pope (2014) found that enhanced training was associated with increased police confidence in responding to mental health-related events, reduced police involvement in transporting people experiencing mental health distress, and improved handover to mental health services. These findings support the value of specialised training, clear protocols and stronger service pathways where police are required to attend high-risk incidents[11].

However, the same study also found that training alone did not resolve persistent problems in interagency collaboration. The authors concluded that these difficulties reflected deeper organisational and accountability differences between police and health services, suggesting that improved training, while necessary, is not sufficient on its own. This reinforces the need for broader system reform in which health services, not police, are the primary responders to mental health crises wherever possible, with police involvement limited to situations involving serious and imminent risk[12].

Recent qualitative research also suggests that improving police responses to people experiencing mental health crisis is not only a matter of better training, but of addressing the underlying character of the response itself. Drawing on health care workers' perspectives, Morgan (2024) found that even where police use procedurally fair techniques, responses may still be experienced as dehumanising, criminalising, and shaped by a system-to-human rather than human-to-human interaction.

This is particularly important in mental health crises, where people are especially sensitive to how they are treated and where the quality of engagement can influence whether distress is reduced or escalated. The study reinforces the need for stronger formal and informal collaboration between police and health care workers and informs MHCC's position that where police involvement is unavoidable, it should occur within a genuinely health-informed, person-centred and least restrictive model of crisis response[13].

Kyprianides and Bradford's (2024) review of 92 studies found consistent evidence that police encounters are associated with negative mental health impacts[14]. The review suggests that the harms of police contact are not limited to the use of force or extreme incidents - but can also arise through experiences of policing perceived as unjust, coercive or criminalising. This strengthens the case for reducing reliance on police as default responders to mental health crises and for ensuring that, where police involvement is unavoidable, responses are trauma-informed, least restrictive and grounded in dignity and procedural fairness.

Lived experience leadership central to model design

A further important perspective comes from lived experience research on police apprehension in mental health contexts. The lived-experience-led resource *Responding to Mental Distress: A resource for future initiatives*,[15] argues that many people experience police apprehension during mental distress as stigmatising, harmful and traumatic, and that response systems have too often been designed without adequately centring the needs and knowledge of those most affected. This strengthens the case that reform should not be limited to improving police technique alone. Even where police involvement is considered necessary because of serious and imminent risk, responses must still be guided by dignity, humanity, trauma-informed practice and lived experience leadership[16],[17].

Lived experience research also shows that police apprehension during mental distress can itself be traumatic and stigmatising, reinforcing the need for crisis responses that are not only lawful, but humane, dignified and shaped by the expertise of people with lived experience[18].

MHCC have provided our recommendations in full in Appendix 1. We are keen to follow the development of the LECC Mental Health and Policing review and express our willingness to be contacted.

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Appendix 1: RECOMMENDATIONS

Recommendation 1: Establish health-led crisis responses as the default

- Make health-led crisis response models the default response to mental health crises where no crime is being committed.
- Reserve police involvement for situations where there is a serious and imminent threat to life or safety.
- Prioritise referral to community-based alternatives, such as Safe Havens, where people in distress can be assessed and supported outside emergency departments and the criminal justice system.

Recommendation 2: Limit police involvement to serious and imminent threat to life and safety

- Limit police involvement in mental health crises to situations involving serious and imminent threat to life and safety.
- Define police as a secondary or support responder wherever possible.

Recommendation 3: Strengthen scrutiny of force used in mental health-related incidents

- Subject the use of force and other coercive or harmful police practices in mental health-related interactions to stronger independent scrutiny, public reporting and continuous review.
- Use findings and observations from this oversight to reduce responses that escalate distress, trauma or perceived injustice.

Recommendation 4: Require specialised, ongoing police training for high-risk incidents

- Provide NSW Police with specialised, ongoing and scenario-based training for mental health crisis response.
- Focus training on de-escalation, communication, trauma-informed practice, and recognising key presentations (such as psychosis, delirium, cognitive impairment, dementia and substance-related distress).
- Embed specialised training in mental health crisis response, de-escalation and suicide prevention as a core component of police cadet education.

Recommendation 5: Embed trauma-informed, person-centred and culturally safe practice

- Guide all crisis response reforms by trauma-informed, person-centred and least restrictive principles, with particular attention to dignity, cultural safety, diversity and communication needs, and the experiences of groups at heightened risk of harmful police contact.
- Where police involvement is unavoidable, minimise practices that are unjust, coercive or criminalising.

Recommendation 6: Embed training in supervision, practice and evaluation

- Embed police mental health training in ongoing professional development, operational guidance, supervision and evaluation of outcomes.
- Measure success by reductions in escalation, injury, fear, use of force and unnecessary apprehension.

Recommendation 7: Strengthen interagency protocols and safe handover pathways

- Develop clear interagency protocols between NSW Health, NSW Ambulance and NSW Police.
- Define and agree roles, thresholds for police attendance, information-sharing, and safe referral pathways to health and community-based services.
- Government to review and amend s81 of the Mental Health Act 2007 (NSW) to ensure transport provisions align with health-led, least restrictive crisis response reforms.

Recommendation 8: Centre lived experience in reform design and evaluation

- Centre people with lived experience of mental distress, including police apprehension, in the design, implementation and evaluation of crisis response policy, police training and service reform.

Recommendation 9: Expand and fund community-based crisis alternatives

- Expand and adequately fund community-based crisis alternatives.
- Include ambulance-led responses, mobile mental health outreach, first responder models, suicide prevention outreach teams, and follow-up support to reduce unnecessary police contact.

Recommendation 10: Invest in community mental health and psychosocial supports

- Invest in stronger community mental health and psychosocial supports, including step-up/step-down, aftercare and non-government supports, to reduce crisis escalation and reliance on emergency services.

Recommendation 11: Establish a formal evaluation process after two years, with ongoing review every five years

- Evaluate the model after two years implementation, and every five years thereafter, to assess effectiveness, safety and outcomes.
- Ensure that the evaluation is independently led, government-commissioned, and overseen by a cross-sector governance group including NSW Health, NSW Police, LECC, the NSW Mental Health Commission, lived experience representatives, carers and the community-managed mental health sector.

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