A RESOURCE FOR FUTURE INITIATIVES

Police apprehension as a response to mental distress

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PURPOSE OF THE RESOURCE // WHO IS BEHIND IT // THE METHODOLOGY

A lived-experience led resource for mental distress response

> "I was having an anxiety attack and they pepper sprayed me"

This resource builds on the project 'Experiences of police apprehension for psychosocial disability; a codesigned investigation', funded by the National Disability Research Partnership. Through an exploration of police apprehension in mental health contexts, it presents the research findings, the principles, and reform agendas that must be at the forefront in commissioning appropriate and dignifying responses to mental distress.

The term 'mental distress' speaks to situations where police have responded and perceived a person's distress as 'mental illness', as defined under state and territory mental health legislation. For example, the s351 of the Mental Health Act (2014) (Vic).

> *Section 351 states that a police officer, or a protective services officer on duty, may apprehend a person if they are satisfied that the person appears to have mental illness, and because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person (s351(1)).*

> *In undertaking the apprehension, neither a police officer nor a protective services officer is required to exercise any clinical judgement as to whether the person has mental illness (s351(2)).*

Traditionally, training and resources for responding to people in distress have been informed by models which do not consider the needs of people that it impacts. The knowledge of people with lived experience continues to be dismissed and de-prioritised by the service systems which are intended to serve them.

'Police Apprehension as a Response to Mental Distress' centres on the expertise of people who have experienced police apprehension as a response to their distress. Based on the findings from one of the first research projects co-designed with survivors of police apprehension in a mental health crisis, this resource exists as an authoritative guide to inform future thinkers, decision makers, and program designers, and to influence in-service training currently in place.

A co-designed and co-led research project

This resource is the result of a co-produced project conceived of by lived experience academics, and led by a lived experience group, over a 10-month period in 2021-2022.

Semi-structured interviews were conducted with 20 eligible participants with experience of mental health-related police intervention in Australia.

Interviewees were eligible for participation if they were over 18 years of age, had no related ongoing legal disputes regarding the police engagement and were not currently in an inpatient setting.

Interviews were guided by a co-developed interview schedule containing key questions relating to the research question. All interviews were co-delivered with at least one interviewer who had experience of police apprehension.

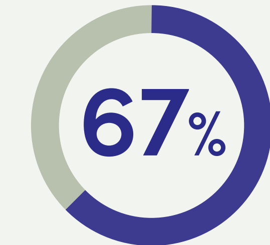
In total, a number of 27 instances of being apprehended by police was disclosed. Interview transcripts were thematically analysed, coded, and integrated into a framework, resulting in a distilled data set to present the findings and priority points.

The contents of this resource are informed by the voices, experiences and first-hand conversations with survivors of police apprehension for mental health distress.

IN VICTORIA

police respond to a mental health call out every

12 minutes[1]



of people who are taken to mental health services are taken for

SUICIDAL INTENT

not for

RISK OF HARM TO OTHERS.[2]

1. Glenn Weir, Witness statement no. WIT.0003.0002.0001 to the Royal Commission into Victoria's Mental Health System, Royal Commission into Victoria's Mental Health System, 5 July 2019, 11.
2. Ward, Beth, Jason Kollios, Fiona Smith, Sharon Klim, Ainslie Senz, and Anne-Maree Kelly. 2021. "Characteristics and Outcome of Patients Transported by Police to Emergency Departments under Section 351 of the Mental Health Act 2014 (Vic)." Emergency Medicine Australasia. https://doi.org/10.1111/1742-6723.13879.

THE FINDINGS

Key Insights from the Research Findings

Participants in our study were more often than not, harmed by police and health responses to psycho-social disability. The most common responses experienced by participants were intimidation, threat and physical restraint. Many had been handcuffed and transported in a divvy van, capsicum sprayed at close range, hit with batons, or tasered.

1. The pre-police apprehension context

1.1. Participants faced intersecting oppressions prior to police contact

Almost universally, participants experienced social and economic disadvantage and exclusion prior to experiencing mental health-related police apprehension. This included family violence, histories of child sexual assault and abuse, homelessness, housing precarity, and discrimination based on psychiatric diagnoses.

1.2. Service systems interact together in unhelpful ways

Participants reported the absence of preventative support, leading them to self-present at emergency departments. Others shared that their access to mental health services were solely through police interventions during crisis events.

2. During police apprehension

2.1. Police officers escalated the situation and mental distress

Participants spoke of being observed by police officers and emergency service workers while being apprehended as highly intimidating. The presence of large numbers of police officers, and use of force, often escalated and amplified experiences of mental distress.

Participants recalled that no matter their presentation, police officers had a predetermined plan of how they would respond to a mental health call out, with little discretion available to officers, such as a personalised response to the individual subject to apprehension.

I had the knife for protection. In my head, it was, this knife is going to protect me. It wasn't even about killing myself anymore... I was shocked, just seeing a sea of cops, it seemed to me at the time, and just two paramedics, and I started saying, the first things that came out of my mouth was like, police, you go over there. You intimidate me.

POLICE APPREHENSION AS A RESPONSE TO MENTAL DISTRESS

2.2. Police use of force is common and distressing

Participants frequently experienced intimidation, threats, and the use of excessive and disproportionate force or physical restraint by police. **This was experienced as:**

- **Excessive numbers of police in attendance**
- **Use of pepper spray at close range**
- **Rough handling**
- **Being thrown in divisional vans**
- **Tasering**
- **Use of police dogs**
- **Being hit with police batons**
- **Handcuffing**
- **Being mechanically restrained in divisional vans or on stretchers**
- **Being misinformed that they were 'being arrested'**

They expressed feelings of shame, humiliation, criminalisation and dehumanisation, and experienced fear of potential harm, injury, or death by police.

I was having an anxiety attack and they pepper sprayed me. I had bruises all over my hands from the handcuffs they put on really roughly, even though I wasn't under arrest and then they took me to hospital.

I was thrown into a stretcher, undressed forcefully, exposed, almost undressed. Because they were trying to remove my top, in front of the house. Paramedics kept pulling at my clothes, exposing me, exposing my upper, top of the body, and I said, 'Could you not undress me' and the policeman didn't even remove his eyes.

I'm cowering on the nature strip, going 'Please don't kill me' because I thought they were going to take me back to the police station and bash me ... My birth father was Aboriginal, so the idea of going to a police station at all was scary anyway.

[Police assume] you're a mental health patient, therefore you're going to attack, so [they're] just going to grab you straightaway and start dragging you towards the divvy van and not really bother to have a conversation ... They just assume that you're going to do the wrong thing, assume that you want to hurt them, assume that you want to hurt everyone.

The United Nations Convention on Rights of Persons with Disabilities (UNCRPD) states that forced treatment, such as being forcibly transported to hospital, can be considered a breach of the right to liberty and security of person.

2.3. Police use of force mirrors experiences of coercion in mental health services

As a direct result of police apprehension, some participants faced forced hospital admissions and further distress from coercive mental health measures such as involuntary assessments, sedation, seclusion, and physical and mechanical restraint by hospital staff or security guards. This experience profoundly shaped their attitude towards mental health services, and their perception of how these services engaged with them.

On that first night in, I was in isolation, but that first night there was a bed provided in a room, and I was lying on the bed, and then all of a sudden, the light goes on, in bursts six doctors and nurses, they physically held me down and then chemically restrained me after that. That was my introduction to the public mental health system.

I collapsed on the ground and said, "Can you help me?" No-one was helping me. Then they got police or security guards, I think it was both, dragged me and shackled me to the bed. For about three quarters of an hour, I was crying and yelling "Can you let me go."

Post-police apprehension

3.1. Participants were exposed to material vulnerability

As a result of being apprehended by police and involuntary detained in hospital without access to their phone, participants experienced significant material consequences, including loss of employment, career reputational damage, property damage and theft, and strained relationships within the neighbourhood and community.

They sacked me because I wasn't at work [when detained at the hospital]. I wasn't allowed to contact them to say where I was, anything like that. They [the hospital] didn't care.

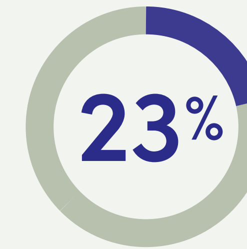
I was in [hospital] for a while, and [when I] came back to my home the whole place was ransacked.

3.2. Changes in identity and distrust of services

Participants conveyed that the shame, humiliation, and diminished self-worth stemming from police apprehension had altered their self-perception and sense of identity. Some expressed that as result of their apprehension experiences, they now avoid contact with the police due to their fear and mistrust. Beyond fear, participants spoke about the feeling of being criminalised by a system response supposedly designed to support them.

...and I felt like, that's it, I'm out of society. That's it, I'm a bad person now. I just felt so debased, like I wasn't a person, like I didn't belong to society anymore.

I don't deal with them. I don't call them. I don't have anything to do with them. I avoid them. I see a police officer on the street, I turn my head, I try and walk around them.



of people taken by police to mental health services are admitted to hospital.

MOST ARE JUST SENT HOME[3]

People who use mental health services are

6 times

MORE LIKELY TO BE FATALLY SHOT BY POLICE[4]

3. Ward, Beth, Jason Kollios, Fiona Smith, Sharon Klim, Ainslie Senz, and Anne-Maree Kelly. 2021. "Characteristics and Outcome of Patients Transported by Police to Emergency Departments under Section 351 of the Mental Health Act 2014 (Vic)." Emergency Medicine Australasia. https://doi.org/10.1111/1742-6723.13879.
4. Dragana Kesic, Stuart Thomas and James Ogloff, 'Mental Illness among Police Fatalities in Victoria 1982–2007: Case Linkage Study' (2010) 44(5) Australian & New Zealand Journal of Psychiatry 463

3.3. Connection with others and community helps

No participant reported only positive experiences with police or ambulance services. A small number of experiences recounted genuine care and consideration shown by police. However, these were almost always described in contrast to other exceedingly harmful experiences. Such responses seemed to be based in human-to-human acts of kindness from individual officers and not attributable to police processes or attitudes.

To me, the policeman, even though he knew I wasn't mentally well, still didn't hesitate to try and get me connected to the cricket club. He was trying to help me out, so he could identify that it would be a benefit for me to be linked in with the cricket club, even though I was really quite acutely unwell.

The traumatic experiences of apprehension stayed with people, for life.

Police apprehension in a perceived mental health crisis is a significant and often traumatic event in people's lives, which can amplify their disadvantages in all domains of life.

Intense fearfulness, and specifically fear of police, were persistent themes across interviews. The response of police during a perceived mental health crisis was overwhelmingly seen by participants as inappropriate and excessive, resulting in painful, wide-ranging, and long-lasting personal consequences for the individuals involved.

Participants expressed a unanimous preference that police are not involved in responses to mental health. If police are to remain involved in mental health responses, changes to the current practice and law are necessary.

THE PRINCIPLES

Principles for Improving Responses to People in Distress

> "Because we are in mental distress does not preclude us from having a humane response from those proposing to help us"

Participants identified that responses should be characterised by humanity, respect, understanding, empathy, and a focus on de-escalating situation of distress.

Upholding human rights

Responses to mental health crisis can entail significant human rights violations, such as through the excessive use of force, i.e., handcuffing, tasering or pepper spraying. Some instances of excessive use of force have fatally injured people.

Embedding a human rights-focused approach must be an essential part of changing how we respond to people experiencing psycho-social distress, particularly by upholding the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which acknowledges our right to equal recognition before the law, access to justice and recognition of liberty and security of the person.

Some states, including Victoria, have human rights legislation. Victoria has the Charter of Human Rights and Responsibilities, enacted in 2006, which aligns with UNCRPD's rights in sections 9,10, 21 and 22.

Restoring dignity to people in distress

Responses to distress must preserve the distressed person's dignity. First responders should come with an understanding of trauma, understanding mental health distress presentations, and the practical knowledge to de-escalate heightened situations.

This understanding would prevent first responders from feeling threatened by the person in distress, instead engender understanding of what the person might be going through and offer insights into how to communicate with compassion. Responders need to reframe their role, recognising the opportunity they have in supporting someone during one of the most vulnerable periods of their life.

"The best response is when I've been treated with kindness. It makes me feel connected and valued, at a time when everything feels disconnected and hopeless."

Providing comfort, safety and support

When feeling upset, most humans seek basic comfort and a safe environment in which to recover. It follows that providing comfort, safety and support should be the starting point in any response to distress.

Currently, responses often include transfer into further environments where harm commonly occurs such as public mental health inpatient units, causing further physical and/or emotional harm.

Realising this principle requires broad reforms across many aspects of community and service systems. However, implementing the basics of comfort and safety in guiding small scale interactions in responding to distress will make a significant difference to an individual's experience. This can be achieved through actions such as warmth, being offered a snack, a listening ear, and the absence of disdain, aggression, and violence.

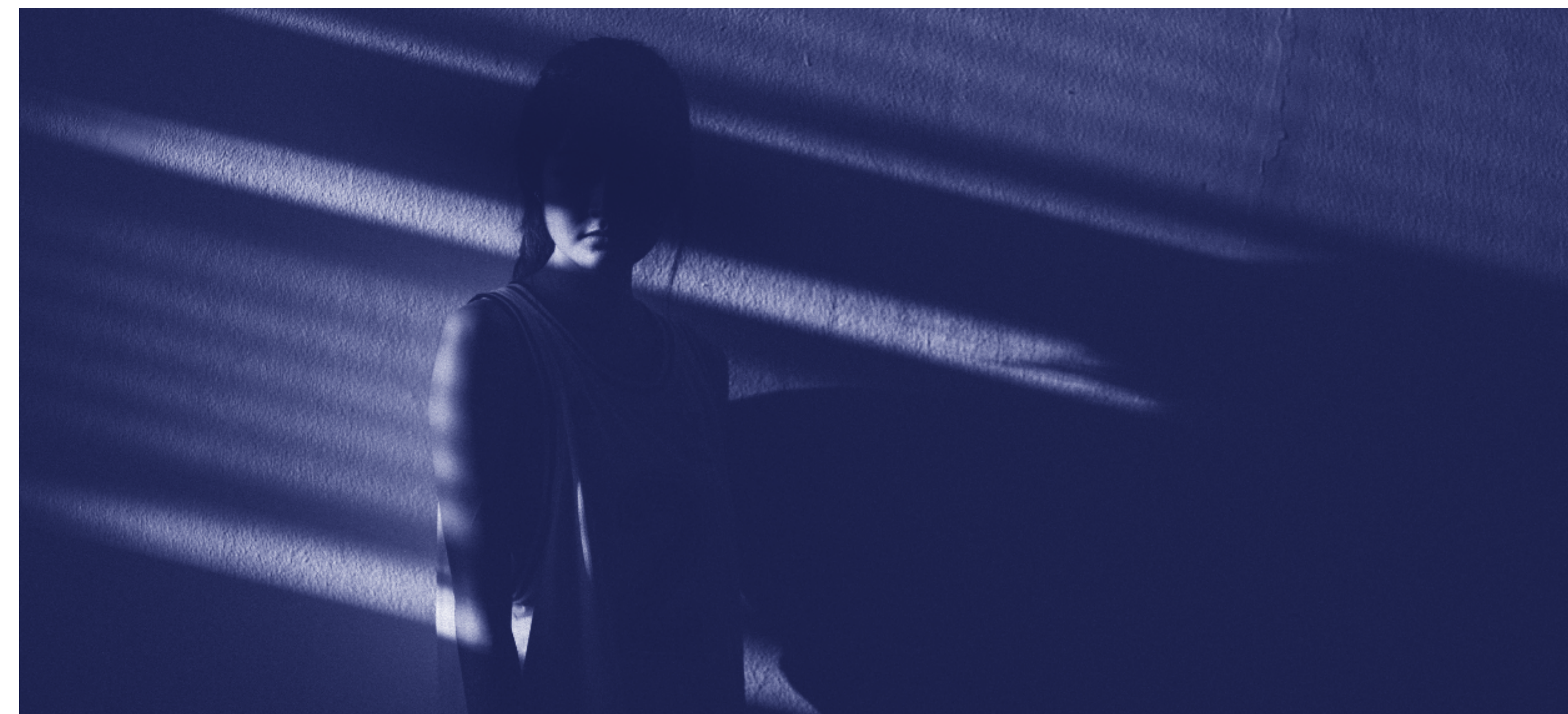
Simply engaging in conversation, asking how the person is, and communicating options would be a better response than the present procedures of restraint and involuntary transport.

A health response

Where a person is framing their experiences of distress as a mental health issue, a biomedically informed response operating from principles of recovery-oriented care is necessary. People should have access to their preferred health and wellbeing professionals in a timely manner before and during crisis events, which is an essential part of reducing the frequency and need of crisis response services.

Given responding to distress is an essential and frequent element of our health system, we must ensure that responses are at the very least, not harmful and ideally compassionate and dignifying. Where health responses do occur in crisis, police co-response should not automatically be triggered for people with any mental health diagnosis.

I'd like to see police have more mental health training than they [do] currently. I don't know why, if there's such a large proportion of people in society with a mental health condition, police aren't given better mental health training.



The 6 Key Emerging Reform Agendas

The following reform agendas have been identified, in order of priority, from the findings of the lived-experience led research.

Participants identified that responses should be characterised by humanity, respect, understanding, empathy, and a focus on de-escalating situation of distress.

1. Removing police as responders

Experiencing psycho-social distress should be considered a health issue, not a criminal matter. Wherever possible, police should not be part of a mental health response.

The presence of police appears to be an ill-fitting entry point to the mental health service system. It can make a person who is already heightened or in crisis feel criminalised, stigmatised and intimidated. The mere presence of police can escalate a situation, or lead to unnecessary arrests and misuse of tactical equipment.

The function of police, most associated with responding to criminal offending and public emergencies, is incongruent with the specific and softer skills required to support psychosocial recovery. People who have survived police apprehension envision a supportive, caring and de-escalatory alternative which does not involve police.

[Police have] a really interesting kind of exterior of toughness and unyieldingness. They're not your mate. They're not your friend, and I think that in those situations, you really probably need a friend.

2. Investing in alternative responses

Consumer choice must be central to all clinical decision making. All persons experiencing an episode of psychological distress require individual care tailored to their own needs.

Offering choice is vital, whether in the moment, or planned by the person ahead of time via an Advanced Statement – a document laying out an individual's preferences for treatment. The preferences named in an Advance Statement must be sought out by responders and honoured.

Options may include peer response as a first point of contact, CATT home visits, the opportunity to self-present, co-response by paramedics or police alongside a clinician, a clinical response alongside a peer worker, hospital alternatives, staying home with extra supports or any mix that the person in distress finds most beneficial.

A team like CATT [Crisis Assessment and Treatment Teams] with peer representatives who make assessments related to the need for hospitalisation, a team who provide the transport in a nurturing way and then a separate team supporting people when they leave hospital or at home if they do not need to go. There should be a facility that offers peer support as an alternative to hospital.

3. Developing peer response models

Peer-based models are highly valued by people who have survived police apprehension and are the preferred response to psycho-social distress.

Peer principles of hope, mutuality and empowerment, as well as the embodied knowledge of lived experience, grounds responses to distress in respect and connection. Models of peer response alternatives must be developed, and peer support should be available as part of mental health call-outs. Genuine investment in peer-led initiatives, operating outside of systems set up to respond to criminal matters, offers opportunities for resonant and valued responses to psycho-social distress.

I think peer responses would be a good thing. ... A feeling of equity, a recognition that they're no better than us and an approach that humanises.

4. Focus on prevention

Prevention work needs to take place in hospitals, throughout primary health networks, and in community-based services.

When people are connected with their clinical supports, and those supports are able to identify early warning signs that a person might be going into crisis, steps can be put in place to provide comfort and prevent crisis.

It all started with me trying to go to a GP and saying "I'm losing weight. I've moved to a new job, new area, getting a bit stressed, I need to nip this in the bud now" and they kept saying "Nah, we're busy, we're busy, we're busy" and then, that escalated. From there, it just snowballed.

5. Accountability and reparations when harm is caused by services

There must be oversight mechanisms which acknowledge and provide reparations where services have caused harm, in the context of policing and mental health services.

When harms such as being capsicum sprayed, tasered, restrained, and involuntarily taken to a hospital for non-consensual treatment go unacknowledged, people become fearful of police and stop asking for police support.

Alongside such a mechanism, there must be a commitment to continuous improvement in responses to distress, mitigating and eliminating the likelihood of repeating the harm. Future reforms should focus on strengthening external oversight of police and emergency services so that complaints can be independently investigated and addressed.

6. Training for police in responding to people in distress

Improvements to existing police training must occur, as it is inevitable that some police will be part of the community response to mental distress.

Individual members and the police as a service should improve their responses to mental health in the community, to mitigate the trauma and harm compounded by the current way in which police are used to assist a person in the midst of a mental health crisis.

It is important that police have appropriate training to ensure that the interaction is likely to have the best outcomes for individuals involved. Within the police academy, new recruits and current officers must be encouraged and enabled to attend training facilitated by people with lived experience and peer workers, so that empathy, understanding and shared humanity are fostered. This training should be extensive, reflecting how common these interactions are in police-work.

Education should be linked with community and hospital organisations, creating a shared understanding for responders.

This resource gives a voice to those on the receiving end of police apprehension, and highlights the ongoing impact that these interactions have on people. We hope it provides an important call to action that can influence meaningful system change, reflecting the needs and priorities of mental health service users in the future.

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