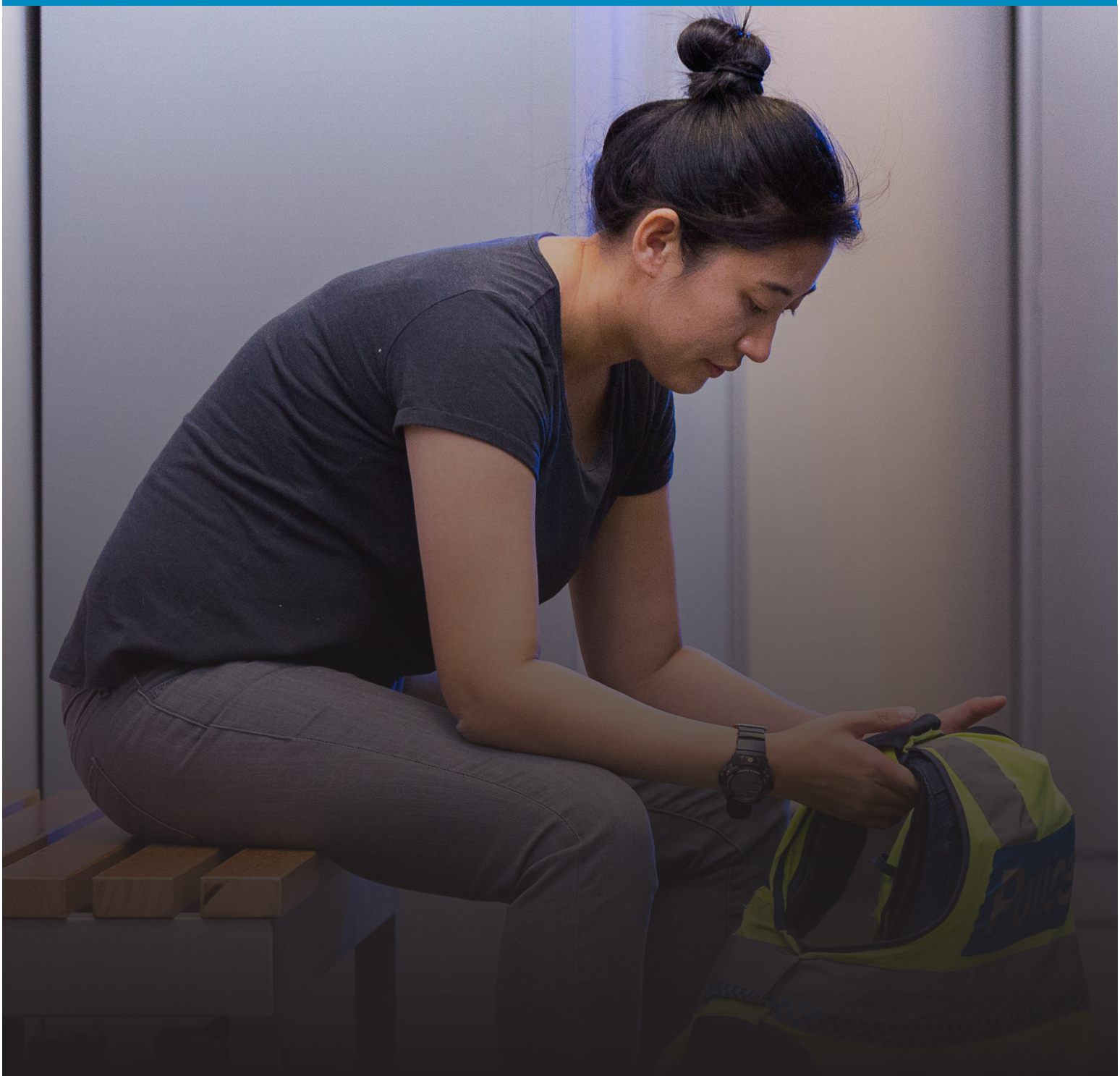

Submission to

ROYAL COMMISSION INTO MENTAL HEALTH

July 2019

Protect > Represent > Support

The Police Association Victoria

The Police Association Victoria is an organisation that exists to advance and represent the industrial, legal, professional and welfare interests of its members. The Police Association's membership of approximately 17,000 is drawn exclusively from sworn Police Officers at any rank, Protective Services Officers, Police Reservists and Police Recruits who serve in the Victorian Police. Membership of the Association is voluntary. By virtue of its constitution, the Association is not affiliated with any political party.

The Submission

This submission utilises a range of literature to establish the high prevalence of occupation-based, poor mental health amongst police. We examine current initiatives targeted at our members, highlighting numerous examples of how these strategies fall short. Specifically, we address the impact poor organisational response, culture and stigma has on our members' mental health and identify systemic failings in the WorkCover system. A lack of support for members post-service is further established. Our mission is to provide an accurate representation of the experiences of our members and the challenges they face in relation to their mental health and in the context of their role as police in dealing with mental health in the community.

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Executive Summary

In this submission The Police Association of Victoria (the Association) provides a series of clear and achievable recommendations to the Royal Commission into Mental Health based on our members' experience with, and deep understanding of, the current mental health system in Victoria. Parts 1 to 4 of this submission are focussed on enhancing the mental health outcomes for our 17,000 Police and Protective Service Officer (PSO) members. We advocate for adequate mental health care and responses for our present and past officers, given their unique occupation-based experiences. We build on previous advocacy concerning prevention, early intervention, improvements to the WorkCover process, and the needs of police veterans. Parts 5 and 6 of this submission focus on those encounters which require police to co-ordinate with other agencies in a heavily under-resourced mental health system. The frontline responses of police to people in mental health crisis need to be more formally acknowledged and creative solutions need to be sought with health and welfare services, to better meet the needs of those who are falling between the cracks of community mental health services.

Police and PSOs are particularly vulnerable to the effects of occupation-based mental health issues.

While all workers are prone to work-related stress, police, as first responders, are especially vulnerable to poor mental health and wellbeing outcomes arising from their work. The relative prevalence of mental health amongst Police and Protective Service Officers (PSOs) is directly related to the nature and context of the work they perform. Further, the occupational context of modern policing takes a significant toll on the mental health of police. Shift work, high workload, increasing role expectations, and a high-pressure working environment also make police especially vulnerable to poor mental health outcomes. The culture of policing creates further barriers to help seeking.

Police and PSOs require a unique and tailored mental health strategy, overseen by an external body.

Research has highlighted the importance of the workplace in the prevention, support and management of mental health issues amongst police. In recognition of this both Victoria Police and the Association have endeavoured to prioritise mental health in discussion and strategy in recent years, resulting in a number of successful initiatives. However, to date these initiatives have not resulted in a comprehensive prevention and early intervention program. Going forward, the cultivation of mentally healthy workplaces needs to be a priority in order to promote positive mental health amongst Victorian police from the starting point. The unique structure of policing workplaces must be factored into mental health initiatives. Collaborative initiatives focussed on mental health involving both the union and employer are highly beneficial for all involved.

There must be ongoing investment in early intervention state-wide.

As it stands there is too much reliance on services at the low-level end of mental health suffering. There is little to no treatment options between this stage and the point in time

where an officer requires a high-level of treatment, such as hospitalisation. A more uniform treatment model is needed that provides early access to treatment to address this gap. Injury Management Consultants employed by Victoria Police are severely under resourced. Despite an increase in the availability of services relating to mental health, a lack of effective investment in clinical and associated personnel has meant that officers are not adequately supported. Further, and in an effort to address the shortcomings that exist in reliance on underfunded internal service provision, the BlueHub model requires adequate state funding. This model provides a best-practice clinical assessment framework and functions at a dedicated site for police officers. The clinical assessment function includes a recommended treatment plan and referral recommendations to specific trained practitioners and services.

The systemic failings of the WorkCover Process must be addressed.

Police make workers' compensation claims relating to psychological injury at an especially high rate. The WorkCover process is regarded as extremely stressful and emotionally exhausting by many officers who have come into contact with it. Poor practices identified by the Victorian Ombudsman in 2016 continue to permeate the system and shape officers' experiences at a time when they are at their most vulnerable. Specifically, inadequate injury investigative practices that fail to consider the entirety of evidence continues to result in unfair dismissal of claims. A lack of transparency has meant that insurers drive decision making in many instances. Additionally, there are many examples in which the time officers spend waiting for their claim to be approved is unacceptably drawn out. The WorkCover system must change so as to enable officers to return to good health, receive fair compensation and return to work when they are ready and able.

Veteran Police and PSOs require a comprehensive support system post service.

Many officers become unable to remain at work due to mental health issues. Currently, services for these veterans are limited and underfunded. Police and police veterans need a well-resourced scheme to service their needs. Additionally, it must be noted that officers deserve superannuation entitlements that recognise the heightened risk that extended length of service poses to mental health. Subsequently, officers who have left policing require a range of supports to ensure that occupation based mental health issues continue to be addressed. The system should offer practical assistance to facilitate post-service mental health.

Investment in successful co-response models in the community is essential.

Police and PSOs play a small yet crucial role in Victoria's mental health system; a system which continues to be heavily under-resourced and often lacking in cohesion and collaboration. In a context of finite resources to respond to people who appear to be experiencing a mental health crisis, innovative service delivery is required to ensure that responses are effective and efficient. Research has found that both mental health-based response models and co-responding police-mental health programs have strong linkages with community services and reduce pressure on the justice system. Psychiatric triage, streamlining police involvement, and facilitating timely access to mental health services is also important in reducing the risk of violent interactions. However, given the limits of investment to date, officers suggest that programs and initiatives are often ad hoc and restricted in geography and scope. Both CATTs

and PACERs require adequate resourcing so that first responses to community members in need are primarily health -based.

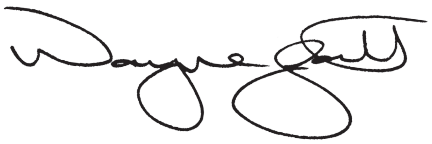
The state must prioritise adequate resourcing and staffing of mental health services, and legislate protocols for police/clinician transfer of patients.

While many police interactions with people who appear to be mentally ill require no further police action, police regularly have contact with mentally ill persons who are experiencing psychiatric crisis and require some form of mental health transfer. Officers are only too aware of the limited number of psychiatric places available across the state, in addition to the stringent submission criteria at appropriate facilities. An additional issue is that there are not clear or mandated protocols for hospitals and treating institutions to accept members of the public brought in by police. The myriad of Memorandums of Understanding, understood and enforced to varying degrees, result in inconsistencies of practice with respect to police-initiated transfers. There is a clear need to develop shared principles and rules of engagement that clarify roles and stipulate how best to enlist resources in a range of circumstances.

Protective Service Officers must be upskilled to perform hospital security duties and take carriage of transfers.

Excessive policing resources are used to perform hospital security duties. Further innovation is required to improve the delivery of services to mentally ill persons. The requirement for police to step in as security guards in some scenarios could also be avoided if PSOs were able to assist with appropriate training and authority. The duties performed during hospital security duties involves little more than PSOs are already trained for. It is acknowledged that additional training would be needed for PSOs in that environment. Upskilling to enable PSOs to perform hospital guard duties would ease the current stress on resources. Further PSOs have the potential to undertake multiple roles at a hospital, including the provision of a general security presence.

For consideration by the Commission,



Wayne Gatt

Secretary
The Police Association of Victoria

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Part One: The high prevalence of poor mental health amongst police and Emergency Services Workers

While all workers are prone to work-related stress, police, as first responders, are especially vulnerable to poor mental health and wellbeing outcomes arising from their work.[1] Beyond Blue's 2018 national study involving over 21,000 participants, examined the mental health and wellbeing of emergency service workers including police, ambulance, fire and rescue and state emergency services (SES) personnel (ESWs).[2] Police were the largest agency involved, as 8,088 participants were police employees and 141 were former police employees.[3] Beyond Blue's research reveals a concerning high prevalence of poor mental health amongst ESWs.[4] This research found that one in three ESWs experience high or very high levels of psychological distress, far exceeding that of the general population and other industries including the Australian Defence Force (ADF).[5] ESWs also experience suicidal thoughts at twice the rate of the general population and are three times as likely to have a suicide plan.[6]

1.1 Occupational stress amongst Emergency Services Workers

The relative prevalence of mental health amongst ESWs is directly related to the nature and context of the work they perform. ESWs have been found to be subject to occupation-based and psychosocial risks. While psychosocial risks are to do with the internal working environment of the individual, occupation-based risks refer to those that ESWs are exposed to because of the type of work they are involved in. Examples of occupation-based risks include traumatic and/or violent incidents and accidents,[7] of which ESWs, especially police, are consistently exposed to.[8] Further, work in the emergency services sector is often highly emotional.[9] Over half of ESWs report that they have experienced a traumatic event through their work which has significantly affected them.[10] The nature of the work ESWs are engaged in means that exposure to trauma will be ongoing, rather than localised to a specific event or incident.[11] Research has shown that exposure to traumatic, stressful events is linked to higher rates of poor mental health, as occupational burnout, stress, anxiety and depression manifest.[12] Research of police populations in particular has also demonstrated that occupational stress increases the risk of conditions including heart disease and sleep disorders.[13]

Research has shown that exposure to trauma, including violence, is linked to cognitive dysfunction as well as high stress levels.[14] Excessive stress can cause people to experience physical conditions such as high blood pressure and can negatively impact on work/life balance and personal relationships.[15] The likelihood of a person experiencing mental health conditions such as anxiety and depression also increases alongside excessive stress. Such conditions may be symptomatic of occupational burnout.[16] Abuse of alcohol is another negative outcome that can arise from work-induced stress.[17] Many persons suffering from trauma self-medicate to cope with their symptoms, which often leads to social isolation and delay in help-seeking. Beyond Blue's research concluded that 50% of ESWs report excessive alcohol use at a rate that poses short and long-term harm.[18] ESWs who experience mental health issues including anxiety, depression and PTSD are also at a higher risk of engaging in illicit drug use.[19] Further, persons experiencing mental health issues are more likely to engage in problematic gambling.[20] Research has indicated that this behaviour can present itself in varying degrees over time.[21]

Beyond Blue's research found that more than 40% of ESWs have been diagnosed with a mental health condition of some kind in their life time, in comparison to 20% of adults in the general population in Australia.[22] Extensive research has found that ESWs are more likely to be diagnosed with a mental health condition, such as Post-Traumatic Stress Disorder (PTSD), compared to the general population.[23] Research indicates that 10% of current ESWs are suffering from PTSD.[24] In a recent survey, 23% of former ESWs were recognised as suffering from probable PTSD, in comparison to 4% of Australian adults in the general population.[25] PTSD is a serious mental health disorder that arises from exposure to trauma.[26] While symptoms of PTSD can arise following specific critical and traumatic incidents, PTSD can also be the result of ongoing, cumulative exposure to trauma over a period of time.[27] Depression and substance abuse are also common amongst persons suffering from PTSD.[28] Considering these factors, there is no doubt that the high prevalence of poor mental health amongst ESWs is tied to the nature of the work involved.

1.2 Mental health and Policing: Occupation and Context

Police experience mental health issues at an alarming rate. Beyond Blue's research found that 10% of police experience very high levels of psychological distress, indicating severe mental health issues. Comparatively, 8% of ambulance, fire and rescue and state ESWs are found to have very high levels of psychological distress.[29] Further, the research found that 11% of police had probable PTSD compared with 9% of fire and rescue workers, 8% of ambulance workers, 6% of SES workers, 8% of adults in the ADF and 4% of adults in the general population.[30] Amongst Victorian police specifically, 20% of those surveyed reported receiving a diagnosis of depression at some stage in their lives, while 9% indicated that they currently suffer from depression. These figures are significantly higher than the general population in Australia. Further, 77% of those Victorian police who reported attempting suicide also reported suffering from depression.[31]

The increasing incidence of police experiencing poor mental health is echoed in international

jurisdictions. In the UK as at 2017, the number of police who took sick leave due to mental health reasons relating to stress, depression, anxiety, psychological disorder, PTSD, insomnia, post-natal depression or trauma doubled in comparison to the six years prior.[32] A subsequent survey involving more than 18,000 police in this jurisdiction in 2018 found that police had lower life satisfaction compared to both the defence force and the general population. Nearly 80% of survey participants indicated that they had experienced stress, anxiety, low mood, or other mental health issues within the 12 months prior. A further 95% of police indicated that these experiences either came about or were made worse, because of work.[33]

In Canada, a survey of two police departments found that 88% of participants reported moderate to severe anxiety and 87% indicated that they experienced moderate to severe depression. Engagement in suicidal behaviours (such as suicidal thoughts and planning) amongst Canadian police is also higher than the general population.[34] In the US, research has found that almost one in four police will experience suicidal thoughts at some stage throughout their lifetime. Suicide rates amongst American police are also four times higher than firefighters. In comparison to the general population in the US, American police suffer from higher rates of PTSD, occupational burnout, depression and anxiety amongst other mental health conditions.[35] Consequently, the occupational basis of stress and mental health issues for police is clear.

"The occupational context of modern policing takes a significant toll on the mental health of police. Shift work, high workload, increasing role expectations, and a high-pressure working environment also make police especially vulnerable to poor mental health outcomes."

Being more likely to suffer from mental health conditions including PTSD, police experience excessive levels of distress as a result of consistent exposure to low level stresses in their place of work.[36] The 2016 Victoria Police Mental Health Review (the Review) found that depression, anxiety and substance abuse amongst Victorian police was just as, if not more common than prevalence of PTSD. Police have a heightened susceptibility to developing PTSD due to being threatened with weapons and violence, including death, in the course of their work. Levels of stress and anxiety are also exacerbated as a result of these threats occurring.[37] Beyond Blue's research indicates that 28% of police report being verbally harassed or assaulted often or very often and 25% of police report being physically assaulted or attacked sometimes, often or very often. The research concluded that these experiences resulted in higher levels of psychological distress amongst police.[38]

Further, the occupational context of modern policing takes a significant toll on the mental health of police. Shift work, high workload, increasing role expectations, and a high-pressure working environment also make police especially vulnerable to poor mental health outcomes.[39] Further examples of organisational sources of stress include poor leadership

and promotion processes, insufficient staffing and resources as well as poor workplace culture.[40] Organisational stress increases a person's likelihood of experiencing depression and anxiety.[41] Police in remote communities may face additional stresses including lengthy travel times, social and geographic isolation, limited access to back up and inadequate access to health, social and welfare services.[42] The impact these stresses have on the mental health of police cannot be underestimated.

1.3 A culture that stigmatises mental illness

The culture of policing creates further barriers to help seeking. Policing culture favours traits including toughness, resilience, and the ability to 'suck it up'.[43] Consequently, this culture stigmatises mental illness, which is often viewed as a form of weakness in the policing environment.[44] In Beyond Blue's survey, 61% of ESWs reported that they felt they ought to be able to 'pull themselves together' in reference to their mental health condition.[45] ESWs with probable PTSD who delayed seeking help or did not access support services also indicated that they did not want to be seen as weak and feared they would be treated differently at work.[46] Additionally, 33% of ESWs reported feelings of shame relating to their mental health condition while a further 36% indicated that they felt embarrassed seeking professional help.[47]

Beyond Blue's survey further found that 61% of ESWs surveyed reported that they avoided telling others about their mental health condition.[48] 72% of police surveyed also indicated that they believe their colleagues would be resistant to discussing their mental health condition within the organisation. This finding is higher in comparison to ambulance, fire and rescue, and SES sectors.[49] The police as an organisation has the highest number of workers who report being subject to stigma from their colleagues. Research consistently shows tahat fear of being treated differently by peers as a result of mental health issues persists amongst ESWs and ADF personnel.[50] Research conducted by The Police Association further supports these findings, as members reflected that admitting a mental health issue exists and seeking help were among the most difficult decisions they had had to make as police officers.[51]

A resistance to seek help at the onset of symptoms presenting is commonplace amongst police. The 2016 Victoria Police Mental Health Review found that police delayed seeking help for mental health issues. This was attributed to a lack of recognition of the early signs of deteriorating mental health, and to a fear that help seeking will negatively impact career progression.[52] This finding is supported by other research, which indicates that police fear their career will be negatively impacted and they will face negative social consequences if they seek help relating to mental health issues.[53] Most recently, Beyond Blue's research found that 28% of ESWs with high levels of psychological distress and 18% of ESWs with very high levels of psychological distress were able to recognise that they had some type of issue relating to their mental health but did not feel compelled to seek treatment or support. This view was also held amongst 17% of ESWs with probable PTSD.[54]

1.4 Organisational response: The importance of a mentally healthy workplace

Research has demonstrated that the way an organisation responds and treats employees with mental health concerns greatly affects the impact on the individual.[55] Research has also shown

that organisations with a proactive, positive approach to mental health have improved rates of morale, engagement and lower rates of absenteeism, conflict and other issues.[56] In Beyond Blue's survey 44% of police indicated that their organisation is not committed to promoting mental health amongst officers. This figure exceeds all other emergency services sectors.[57] Reducing stigma relating to mental illness and improving workplace culture is intrinsic to address the issue of poor mental health amongst police.[58] Poor organisational culture not only negatively impacts police officers' ability to recognise symptoms of deteriorating mental health in themselves and their peers, but also affects a person's likelihood of taking action to address issues.[59] Delay in help seeking and lack of early intervention detrimentally affects police, as mental health conditions are more likely to be exacerbated.

Alongside trauma, workplace culture can have a significant impact on the manifestation of a person's mental health issue. Research has highlighted the importance of the workplace in the prevention, support and management of mental health issues amongst police.[60] Providing support to others can serve as an important protective factor for promoting wellbeing and mentally healthy workplaces. When ESWs experience mental health issues themselves, their ability to provide support to others is impeded. Beyond Blue's research indicates that ESWs who receive minimal social support experience probable PTSD and high and very high psychological distress at a substantially higher rate in comparison to ESWs who receive high levels of social support.[61] As such, the importance of peer-to-peer support within the workplace cannot be underestimated.

The cultivation of mentally healthy workplaces needs to be a priority in order to promote positive mental health amongst Victorian police from the starting point. The unique structure of policing workplaces must be factored into mental health initiatives. Policing organisations consist of a highly diverse range of roles, including highly specialised areas where the nature of these roles is notably different. As such, mental health strategies must be modified to adapt to each distinct workplace. Too much focus on a 'one size fits all' approach in decision making has led to a lack of consideration for these differences that exist within different workplaces. Further, a greater understanding of the diverse cultures and personalities that exist within different workplaces needs to be contextualised and considered in mental health initiatives and strategies. Measures developed with input by officers at a local level to protect against poor mental health need to be applied to individual workplaces within Victoria Police.

RECOMMENDATION 1

That in collaboration with an external workplace consultant, every workplace within Victoria Police develops a unique mental health strategy, which is distinct to each individual workplace.

Part Two: Organisational Initiatives: Prevention and Early Intervention

Considering that police are vulnerable to occupation-based mental health issues, policing organisations require comprehensive strategies and initiatives focused on prevention and early intervention. Prevention refers to interventions that take place before the onset of an issue, subsequently preventing the issue from developing.[62] Policies and initiatives focused on prevention have been shown to reduce prevalence of mental health conditions and as such must be a core focus of mental health strategies.[63] Further, prevention strategies are cost-effective.[64] Preventative approaches intend to reduce the incidence and recurrence of mental health issues and mental illness, including reducing symptoms.[65] Selective prevention strategies focus on a particular at-risk group[66] and are therefore a suitable approach in the context of mental health issues relating to ESWs. Importantly, prevention strategies strengthen protective factors and reduce risk factors, subsequently lessening the likelihood of mental health issues presenting.[67] Further, early intervention strategies intend to mitigate the level of harm experienced by the worker in relation to their mental health. Subsequently, early intervention can have a profound impact on the worker and their condition.

Consequently, effective strategies that better prevent and support police and Protective Services Officers (PSO's) who suffer from mental health issues are required. Collaborative initiatives focussed on mental health involving both the union and employer are highly beneficial for all involved. The Mental Health Steering Committee and the Head to Head fundraiser walk in 2018 are examples of highly successful initiatives through which The Association and Victoria Police have collaborated and engaged with one another. With contribution from health professionals and officers, The Association and Victoria Police also co-developed 'equipt'. 'equipt' is a free wellbeing app and is designed for currently serving police, former police, PSO's, police employees and their families. The app supports physical, social and emotional wellbeing and provides a platform where internal and external support services are easily accessible.[68] The Association have also provided a number of other prevention initiatives and services to support officers' mental health, including LifeWorks, which provides officers and their families with 24-hour, comprehensive access to counselling.[69]

2.1 Attempts at prevention and support by Victoria Police

In an attempt to address the findings of the 2016 Victoria Police Mental Health Review,[70] which revealed a series of concerns relating to police officers' mental health, Victoria Police launched their Mental Health Strategy and Wellbeing Action Plan 2017-2020 (Strategy) in 2017.[71] The Strategy outlines a number of initiatives focused on six objectives, including leadership, preparedness, support, organisational systems, services and transition. Initiatives include targeted leadership programs and a mental health literacy plan which incorporates suicide prevention initiatives. The strategy also indicates that from the recruit stage, greater focus on the psychological preparation of officers, including unsworn employees of Victoria Police and the families of officers, is needed. Further, the strategy includes plans for the development of specific programs to support officers who are in roles that especially expose them to ongoing traumatic events, such as SOCIT (Sexual Offences and Child Abuse Investigation Teams).[72]

Victoria Police have endeavoured to prioritise mental health in discussion and strategy in recent years, resulting in a number of successful initiatives. However, members report that there is a lack of action in translating the Review into practice overall. As an example, there is a lack of action within Victoria Police to promote improvement in management style in relation to mental health issues. A culture that stigmatises mental health issues continues to pervade Victoria Police as an organisation despite genuine attempts to eliminate it. For some members, mental health initiatives are seen as tokenistic against a seemingly ever-present backdrop of trauma and workplace stress that confronts officers. Overall, a lack of program oversight and analysis has made it difficult to determine which initiatives are effective and which are ineffective in practice. Previous Royal Commissions, including The Royal Commission into Family Violence[73], have had success in the appointment of internal and external agencies, who monitor and ensure that recommendations are implemented, and properly evaluated. Legislation by way of The Family Violence Reform Implementation Monitor Act 2016 ensures that these changes are carried through.

RECOMMENDATION 2

That an external body is established and legislated to oversee the implementation of the recommendations that come out of the Royal Commission with regard to police and emergency services agencies.

2.2 The importance of early intervention

It is important to note that symptoms of distress may arise gradually over a period of time, rather than immediately after a specific event.[75] Recovering from traumatic incidents can also take a number of months and is often linked with conditions including anxiety and depression. Further, recovery may be impacted and the chances of PTSD developing exacerbated with repeated exposure to cumulative traumatic events.[76] Research shows that accessing treatment upon receiving a diagnosis of PTSD is critical in reducing the impact of co-morbid conditions such as depression and anxiety on workers. Delaying such treatment decreases a person's likelihood of returning to work and seriously impedes their recovery.[77] It is therefore crucial that police and PSO's, have the resources and necessary support to access treatment relating to mental health from the onset of symptoms presenting, as early intervention can have a significant impact on a person's condition.[78]

As it stands there is too much reliance on services at the low-level end of mental health suffering, such as the Employee Assistance Program (EAP). There is little to no treatment options between this stage and the point in time where a officer requires a high-level of treatment, such as hospitalisation. A more uniform treatment model is needed that provides early access to treatment to address this gap. Additionally, Injury Management

Symptoms of distress may arise gradually over a period of time, rather than immediately after a specific event. Recovering from traumatic incidents can also take a number of months and is often linked with conditions including anxiety and depression."

Consultants employed by Victoria Police are severely under resourced. Despite an increase in the availability of services relating to mental health, a lack of effective investment in clinical and associated personnel has meant that officers are not adequately supported.
In an effort to address the shortcomings that exist in reliance on underfunded internal service

RECOMMENDATION 3

That funding be allocated to Victoria Police to expand the provision of internal services accessed by officers beyond the Employee Assistance Program, including the appointment of additional Injury Management Consultants.

provision, the BlueHub pilot Project was initiated. In consultation with The Association, St John of God Pinelodge Clinic is currently in the midst of a pilot trial of the model in Dandenong, Victoria. The BlueHub model consists of a centralised support centre 'the BlueHub', with satellite sites operating state-wide to support it and provide coverage across Victoria. The model aims to provide a best-practice tailored clinical assessment framework and functions at a dedicated site for officers to access. The clinical assessment function includes a recommended treatment plan and referral recommendations to specially trained practitioners and services across the state in the BlueHub network. The intention is for the facility to develop and implement a quality assurance framework to ensure that all mental health practitioners aligned to the BlueHub program receive the appropriate ongoing training and support to provide evidence-based treatment to officers. It is noted that a centralised assessment facility developed specifically for police and ESW's would provide officers with the anonymity and privacy that is often lacking in public clinical settings. The BlueHub model is an important addition to the array of existing mental health services accessible to officers. The model addresses some key shortfalls of the current system, which is reliant on internal service provision that does not go far enough to support officers experiencing mental health issues.[79] Subsequently, State Government funding would be well spent on the BlueHub Project already funded for limited pilot in Victoria. Further, the expansion of the model to include police veterans would be an appropriate and worthwhile development going forward.

RECOMMENDATION 4

That State Government funding be allocated to expand the provision of external services through the Blue Hub model. Following on from the pilot trial, it is recommended that State Government provide additional and ongoing investment to sustain the project and ensure it remains a viable support.

2.3 Centralisation of resources is a detriment to regional and rural areas

There has long been concern relating to the short-term and long-term needs of people with mental health issues in regional and rural areas.[80] Research suggests that ESWs in regional and rural areas have an elevated risk of experiencing mental health issues. A study investigating

mental health amongst rural paramedics found this cohort to be at a higher risk of experiencing depression.[81] Inadequate resourcing compounds these issues, posing a serious disadvantage to officers in regional and remote communities. Concern relating to a lack of clinical services and support in regional areas has been widely regarded as a pressing issue on a national level.[82] Particularly, crucial aspects of community-based treatment, low-level care and intensive support are lacking in these locations.[83]

Following on from the Review, the 2017 Victoria Police Mental Health and Wellbeing study found that police from regional areas were 26% more likely to experience anxiety compared to police from metro locations.[84] Victoria Police have previously identified that officers who work in regional and rural areas have insufficient access to timely treatment in the form of clinical services relating to mental health. Victoria Police have also noted that there are locations in Victoria where psychological and psychiatric services are near impossible to access.[85] In an attempt to address these service gaps, Victoria Police previously recommended that alternative methods of delivery of services be made available to regional and rural officers. Arising from the 2017 Victoria Police Mental Health and Wellbeing Study, e-treatment, which is a form of psychological support provided through phone or skype, has been integrated into the new EAP. Despite this initiative, substantial gaps continue to bar regional officers from accessing timely and effective treatment. The centralisation of primary resources within Victoria Police in metropolitan Melbourne continues to disadvantage regional Victoria, impeding early intervention, strategies and resources from servicing these areas. A tailored outreach approach would provide our regional officers with a far more accessible range of services relating to prevention, treatment and aftercare. Officers who work at non-24-hour stations are especially in need of a strategy tailored to their unique needs. The prioritisation of quality outreach services relating to mental health for officers in regional and remote areas would significantly help to address this gap.

RECOMMENDATION 5

That funding and infrastructure for clinical services within Victoria Police in regional areas is increased and made adequate in order to migrate from a metro-centric model to one that services officers equally across the state. Additionally, that a tailored outreach approach is developed, consisting of preventative measures and treatment services relating to mental health. This approach should especially target officers who work at non-24-hour stations in regional and remote locations.

Part Three: Industrial Response

ESWs make workers compensation claims relating to mental health or psychological injury at ten times the rate of the general population in the workforce in Australia. As at 2017, Victoria Police reported that mental health injuries make up 31% of all WorkCover claims amongst police specifically.[86] Beyond Blue's study concluded that police make the highest number of claims within the emergency services sector.[87] Their research found that 11% of police had made a workers compensation claim for mental health related factors associated with their work at one point in their careers, and 5% had made a claim more than once.[88] This finding is supported by Safe Work Australia, who identify police officers as one of the occupations with the highest number of workers compensation claims relating to mental health, as measured over a five-year period.[89] Those who work in an frontline role have been found to be most likely to make a claim either once or more than once, further demonstrating the tie between occupational trauma and poor mental health outcomes.[90] In recent years the rate of claims has continued to rise. Advice from the Convener of Medical Panels has confirmed an unexpected increase in the number of referrals relating to psychological injuries within the past year.[91]

"Beyond Blue's research finds that 61% of ESWs indicate that their recovery was negatively impacted as a result of the workers compensation process. This figure increases to include 75% of workers with probable PTSD."

Many officers who come into contact with the WorkCover system find the process to be highly stressful and emotionally taxing, which often impedes their recovery.[92] The WorkCover process is regarded as daunting, highly stressful and difficult to understand by many police who have come into contact with it. Police have identified that treatment is difficult to access in a timely manner, delaying early intervention, treatment and consequently recovery. Further, the process has been described as stigmatising and guilt ridden, exacerbating the challenges police already face in seeking help.[93] 68% of participants in Beyond Blue's survey reported that they found the process to be moderately to extremely stressful. A further 76% did not believe they were treated especially fairly.[94] Police and ambulance workers who consulted with the Association highlighted the impact such a stressful WorkCover process had not only on their working lives, but also their social lives and their humanity.[95] A survey conducted by the Association also found that many members identified numerous barriers when reporting prevalence of PTSD. Many members regarded the process of putting in claims, seeking time off work and contacting welfare services as extremely tough.[96]

Unsurprisingly, Beyond Blue's research finds that 61% of ESWs indicate that their recovery was negatively impacted as a result of the workers compensation process. This figure increases to include 75% of workers with probable PTSD.[97] The research also found that three in four ESW's consider the current workers compensation process to be damaging to their recovery.[98] This finding is echoed by research conducted by the Association in which the majority of police and ambulance personnel describe the WorkCover process as on par or more detrimental

than dealing with the effects of PTSD itself.[99] Data in the 2016 Victoria Police Mental Health Review further supports these findings, as interviews with family members of police veterans and officers on WorkCover highlighted how trying and difficult the process is for officers and their families.[100]

The Victorian WorkCover system is indeed flawed. However, the introduction in 2019 of provisional payments pilot for mental health claims to Victorian ESW's, including police and PSO's, has been a significant amendment and improvement to the system.[101] The introduction of this legislation by the State Government does not however address the ongoing issues that persist in relation to the investigation of claims, specifically relating to psychological injury.

3.1 Systemic failings: Uncovering of poor practice in the Victorian WorkCover system

Claims relating to psychological injury are rejected at a far higher frequency compared to claims relating to physical injury.[102] Historically, a culture which questions the legitimacy of psychological injury and PTSD has permeated the WorkCover system and society more broadly.[103]

In 2016 the Victorian Ombudsman uncovered a range of deeply concerning findings relating to complex workers compensation claims. The investigation found poor decision making amongst insurance agents, including frequent instances where evidence was utilised selectively to reject or terminate claims.[104] Further findings by the Ombudsman of wrongdoing amongst agents included the utilisation of leading questions to independent medical examiners (IME's) and 'doctor shopping' to find a medical examiner who would support an opinion ultimately resulting in the rejection or termination of entitlements. Instances of agents failing to provide background information to medical examiners was also identified in the research.[105] Additionally, a culture of poor decision-making at conciliation was revealed. The Ombudsman concluded that the majority of decisions in these instances were ultimately altered or overturned, not without significant, detrimental impact on the worker and their recovery.[106] Consultation with employers' resulting in agents being influenced by employers', poor internal review protocols and a focus on financially incentivising the rejection and termination of claims were also recognised as actions of wrongdoing in the investigation.[107] An ongoing disjunction between policy and practice detrimentally impacts officers' with mental health issues who come into contact with the WorkCover system.

3.2 The inadequacy of investigative practices

A lack of proper examination of evidence resulting in the dismissal of circumstantial evidence by insurers continues to occur. Despite Recommendation Three of the Ombudsman's previous Review,[108] agents in their investigations continue to disregard reports by the IME and ignore

Case Study One

Senior Constable X had a PTSD claim rejected on the basis of management action. A substantive IME report diagnosed Senior Constable X with PTSD, noting symptoms were first experienced in 1999, and that reliving this period was particularly overwhelming for

the member. There was no attempt by the circumstantial investigator to obtain statements from any of the three Victoria Police officers mentioned in the manager's WorkCover report. A statement was also not taken from one of Senior Constable X's supervisors who was able to corroborate Senior Constable X's statement regarding first notifying his employer about his symptoms. At the time of the conference, the insurer withheld two documents supporting the acceptance of liability (the manager's WorkCover report and the IME supplementary report) from the conciliator and Senior Constable X.

Case Study Two

The Association recently assisted Sergeant Y who is suffering from PTSD as a result of his work. Prior to his diagnosis of PTSD, Sergeant Y was operating in a seconded position for an extended period. After requesting an extension on his secondment, which was rejected, Sergeant Y prepared to return to his gazetted position. Due to undertaking significantly taxing work during this time, Sergeant Y had previously expressed concern to a fellow employee about his mental health. Sergeant Y saw his general practitioner and was subsequently diagnosed with PTSD. Prior to returning to his gazetted position, Sergeant Y lodged a WorkCover claim. The corroborating witness who could verify Sergeant Y having expressed concern about his mental health prior to his imminent return to his gazetted position, was not spoken to. Instead, the investigator spoke to the supervisor at the station who affirmed that Sergeant Y lodged his claim soon after being told that he would be returning to his gazetted position. The case was ultimately rejected based on reasonable management action. The corroborating witness was not mentioned by the independent agent in their final report to Gallagher Basset.

nominated witnesses, who would otherwise provide critical evidence to support a officers' claim. As a result, Section 40 of the Workplace Injury Rehabilitation and Compensation (WIRC) Act 2013[109] is not being properly applied. The below case studies provide examples of some of the many instances in which evidence has not been sufficiently examined, or has been dismissed, to support the rejection of a psychological injury claim.

These case studies demonstrate the impact that inadequate investigation and consideration of evidence by agents poses to officers seeking compensation for psychological injury. It is clear that a tighter process to ensure agents take into account the entirety of evidence in investigations is necessary. This view is consistent with the views expressed by the courts (see Pulling v Yarra Ranges Shire Council [2018] VSC 248). A determination based on Section 40(1)(a) requires an assessment 'whether management action is the predominant cause of the injury where multiple causes are in issue depends upon an evaluation of the proportionate contribution made to the injury by management action on the one hand and the other cause or causes on the other.'[111]

RECOMMENDATION 6

The Workplace Injury Rehabilitation and Compensation Act 2013 must be properly applied in every circumstance. In order for a claim to be rejected on the basis of Section 40(1) of the Act, agents must take all reasonable steps to ensure the entirety of evidence is considered in decision making.

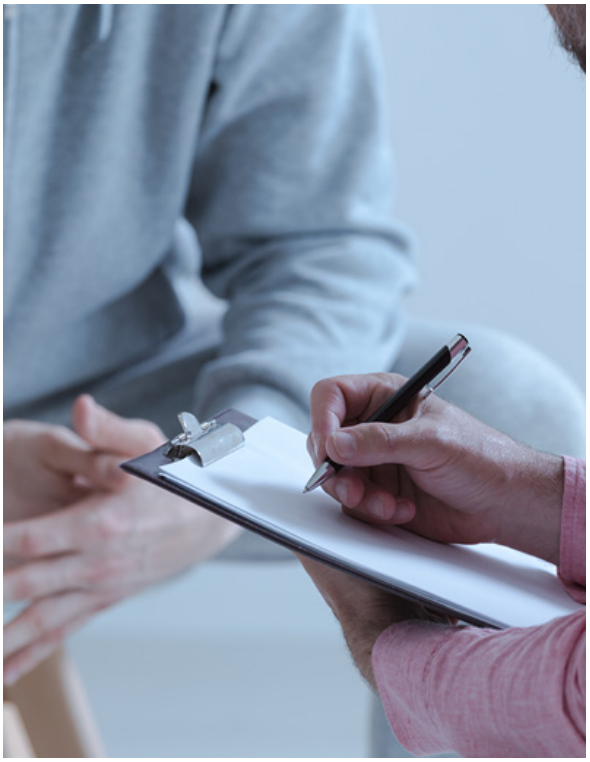
Additionally, there is a persistent lack of transparency by insurers in a system through which the employer still drives decision-making in many instances. When agents obtain evidence that is contrary to the insurers position, it is often disregarded in preference for the narrative of the employer or the manager. If conflicting versions of an incident are reported by employer and employee during an investigation, the case is routinely rejected, regardless of available evidence to support the employee. A lack of proper oversight of the practice of agents and insurers means that there is inconsistency and unreasonable decision-making in the investigation and handling of claims.

RECOMMENDATION 7

That the focus through which Worksafe promote compliance is shifted to focussing on overseeing the regulation of insurers, as opposed to focussing on claims management.

3.3 Prolonging the trauma

A common reason psychological injury claims are rejected relates to counterclaims by the insurer that the injury in the claim is 'wholly or predominantly' caused by reasonable management action, as defined in Section 40 of the WIRC Act 2013.[112] In such instances, all other evidence relating to the psychological injury is discounted. Considering that the copious stress and exposure to trauma police endure through their work significantly increases their likelihood of experiencing mental health issues, the WIRC Act is grossly misapplied in such instances. Practice by insurers that considers all other contributing factors relating to a psychological injury as insignificant is a detriment to officers seeking fair compensation. Inevitably these cases proceed to conciliation where they are then accepted, unnecessarily prolonging the process for officers.



There are many instances in which the aforementioned poor investigation of claims by insurers unnecessarily require claims to proceed to

court. In such examples a three-and-a-half-month-long process can extend to nine months. Often these cases are accepted in favour of the officer, exemplifying missed opportunity to avoid the court process entirely and lessen the emotional toll such an extensive timeframe has on the worker and their condition. The lengthy process invariably worsens the workers' injury considerably and is further exacerbated by financial stress and social isolation. The likelihood of receiving effective treatment for a psychological injury declines as the chronicity and severity of symptoms increases.[113] For many officers, these delays reduce the prospect of returning to work, or even normal daily life.

There is a perceived reluctance of the Accident Compensation Conciliation Service (ACCS) to issue a direction at conciliation, despite the insurer rarely presenting an 'arguable' case. The threshold for an 'arguable case,' as evaluated by the ACCS, is seemingly very low. This lack of direction on the part of the ACCS leads to lengthy and ultimately unnecessary delays for officers, as claims inevitably resolve prior to a court hearing.[114] Police suffering from psychological injury are therefore spending an increased length of time in the system, without access to treatment. The calamitous impact of delay in this process on officers' mental condition, as well as the financial and emotional impact, cannot be underestimated.

RECOMMENDATION 8

That consistent with Recommendation 2 of the 2016 Victorian Ombudsman review, the Workplace Injury Rehabilitation and Compensation Act 2013 be amended to provide the Accident Compensation Conciliation Service with the power to issue a direction to an agent where a decision has not considered all of the causative factors and applied the wholly and predominantly test consistent with the views of the Supreme Court.

3.4 Back to Basics: Reaffirming the Aims of the WorkCover process

The workers compensation scheme in Victoria intends to provide support, rehabilitation and compensation to workers' suffering from sickness or injury relating to their work. Compensation is designed to ensure that workers suffering a workplace injury are not financially disadvantaged. Compensation is a right, not an option, for workers who have been rendered unable to work through injury received at their employment. Aside from adding to the financial security of an individual, these payments can provide personal validation, afford help seeking and treatment and act as a 'symbolic acknowledgement' of the harm incurred.

Importantly, the scheme also seeks to aid workers to enable their return to work.[115] Research has shown that once in good health, timely return to work can be hugely beneficial for workers health and wellbeing.[116] Returning to work benefits the worker, their family, the employer and society more broadly.[117] Research has shown that workers can experience psychological harm when they are absent from the workplace for an extended period of time. Research by Safe Work Australia in 2018 found that workers who return to work are twice as likely to consider their general health to be 'very good' or 'excellent' compared to those who are not working. Further, those participants who had returned to work experienced significantly

less financial stress compared to those who remained absent from the workforce.[118] These findings demonstrate the significant impact returning to work can have on workers who have experienced psychological injury. As such, the system in practice must ensure that workers are returned to good health first and foremost. The system must strive to ensure that workers receive fair compensation and are adequately supported to return to work in a timely manner. The WorkCover system must fulfil its original purpose and prioritise the health and wellbeing

RECOMMENDATION 9

The goal of the WorkCover system must be to return people to good health as the first priority. If they are willing and able, the system must then strive to return workers to work in a timely and therapeutic manner. The system must be fair and provide just compensation for workers.

of the worker as the utmost priority.

Many police become unable to continue working as a result of psychological injury, resulting in ill-health retirement.[119] Due to the nature through which ill-health retirement can and does eventuate, the extent to which officers definitively retire due to ill-health is difficult to ascertain. It is likely that there are numerous officers who retire in large part due to mental health issues tied to the nature of their work. The 2016 Victoria Police Mental Health Review found that a considerable number of police veterans overall experience mental health issues associated with their work as police. The Review found that police veterans who had left Victoria Police ten or more years ago were still dealing with mental health issues relating to their previous employment as police.[120] These issues included depression, substance abuse, conflict with family and relationships and social isolation.[121] Beyond Blue's research further supports these findings, indicating that 11% of police veterans surveyed had severe probable PTSD, while 5% had moderate and 9% had mild levels of probable PTSD.[122]

It is clear that officers experience mental health issues beyond their time in the job, as these issues continue to permeate the lives of officers as they transition into retirement."

4.1 Post-service support

As part of its set of recommendations, the Review indicated that all retiring officers should be subject to a mental health screening, coinciding with the development of a treatment plan funded by Victoria Police to address and treat any mental health issues identified. The Review also recommended that the Retired Peer Support Officer Program should to receive more funding and expand accordingly in order to be equipped to best serve police veterans.[123] The Program is made up of police veterans who provide free support on a voluntary basis to other veterans who have resigned or retired from Victoria Police. The Program predominantly offers support relating to mental health conditions including stress, depression and PTSD.[124] In 2018 The Association embarked on a joint venture with Victoria Police by way of the Head to Head walk. To date, the initiative has raised over $659,000 for the Program.[125]

Various non-for profit, volunteer-run organisations who support police officers with psychological injury or mental health issues resulting from their work operate internationally. These organisations also assist in the provision of prevention initiatives. Such examples include Police Care UK[126] and Badge of Life in Canada[127]. The Royal Canadian Mounted Police have a Support for Operational Stress Injury Program, which provides veterans as well as current employees with peer support to assist them with coping with and managing their psychological injury.[128]

It is clear that officers experience mental health issues beyond their time in the job, as these issues continue to permeate the lives of officers as they transition into retirement. Considering these findings, there must be tailored, ongoing mental health support services made readily

available to retiring and police veterans.

RECOMMENDATION 10

That all officers who retire have access to the BlueHub program, or a similar scheme that enables them access to timely, quality mental health treatment and support services. Further, that this initiative be properly funded by government to ensure that veterans sustaining injury at work receive sustainable support in retirements.

4.2 The Australian Defence Force: A model adaptable to policing

Like police, Australian Defence Force (ADF) veterans are vulnerable to poor mental health outcomes as a result of the nature of their work. A recent study found that nearly half of veterans who departed from the ADF within a five-year period had some form of mental disorder. The process of accessing support through the Department of Veterans' Affairs (DVA) has been regarded as complex and difficult to navigate.[129] As a result of a push for change, in 2018 the Veterans' Affairs Legislation Amendment Bill passed the senate. This bill enables veterans' access to a means-tested payment to assist them with dealing with mental health issues while they wait for DVA to evaluate their claim. Training and counselling, including financial counselling is provided to veterans alongside the payment, which is also provided to families whose family member died of suicide within the previous two years.[130]

Veterans and their families, as well as serving officers have access to a widespread range of online resources and services relating to mental health through an online portal titled At Ease, which is set up through DVA. Information relates to issues including resilience, stress management (including management of alcohol), as well as suicide prevention and awareness. Further, the site provides tools for general practitioners and other health professionals to assist them with veteran-specific patient treatment and assessment.[131]

DVA also provide free counselling to all veterans who have completed at least one full day of service, and their families. This service known as Open Arms is available for life. DVA also have available a number of mobile apps, including High Res, Operation Life – Keep Calm, Stay Safe and The Right Mix, which aim to support the mental health and wellbeing of serving officers, veterans and their families. Additionally, DVA funds group treatment programs for veterans, as well as currently serving officers, for treating PTSD in hospitals.[132] In 2017 the National Mental Health Commission conducted a review into suicide and self-harm prevention services available to currently serving and former ADF personnel. The review found that personnel and their families who had accessed services recently, reported highly positive experiences. There were however many reports of experiences by personnel that led to feelings of frustration and distrust in the system.[133] The review clearly illustrates that ADF personnel are at risk of suicide and mental illness post-service.[134] The military and policing are unique occupations through which personnel are exposed to cumulative trauma that makes them susceptible to poor mental health outcomes. Like defence personnel, many police experience ongoing mental health issues post-service and require adequately funded continuous care. Considering these factors, lifelong counselling should be an essential component of mental health services made

available to officers.

RECOMMENDATION 11

That a Veterans specific program akin to what exists in the Australian Defence Force be established that provides police and their families access to lifelong, free counselling, mirroring the Open Arms service that exists within the Australian Defence Force.

4.3 Access for police veterans inter-state

Police veterans who relocate to a different jurisdiction have reported difficulties accessing workers compensation funded treatment services, as a result of residing in a different jurisdiction. Currently, ADF personnel who possess a Veteran's Health Card issued through DVA, are able to access treatment paid for by DVA, regardless of their location. Research has indicated that 90% of ADF veterans using health cards to access support services report positive experiences.[135] The introduction of a 'Blue Card' for police veterans, mirroring these entitlements is both appropriate and necessary.[136]

RECOMMENDATION 12

That police veterans have access to a scheme mirroring that set up by Department of Veterans Affairs, gaining access to a 'Blue Card' to gain access to treatment (funded by Victoria Police) regardless of the jurisdiction.

4.4 Access to Superannuation

The Association has called upon the Government to implement change with regard to increasing the projected age for disability benefits to age 60 in superannuation entitlements. Disability benefits are currently only available to officers under the age of 55 and the value of the benefit is determined by assuming the officer would have worked to 55 and not beyond. This may have been valid when the scheme was designed, and the average police recruit was 19.5 years of age and officers could access their accrued benefits from age 50. However, the average police recruit is now 29.5 years of age and the majority of officers cannot access a superannuation retirement benefit until age 60. Officers joining after age 25 have reduced benefits under the Emergency Services Superannuation Scheme (ESSSuper), should they be unable to work. General community expectation and the superannuation preservation rules underpin an assumption that normal working life now extends to age 60.[137]

RECOMMENDATION 13

That the State Government endeavor to reform ESSSuper to ensure the projected age for disability benefits is changed to age 60. This means the majority will receive disability benefits in line with the intent of the schemes design, aligning disability with the expected working life, that is, presently to age 60.

Additionally, research recognises that the possibility of experiencing mental health issues increases with length of service. Beyond Blue's research found that police and ESWs who had performed longer lengths of service, (ten or more years) experienced higher levels of suicidal thoughts, probable PTSD and psychological distress. Further, longer serving police and ESWs experienced lower levels of wellbeing, in comparison to those who had served for two years or less.[138] Considering that extended length of service increases the chance of mental health issues including PTSD developing, officers should be treated differently with regard to superannuation enabling them to retire with health and dignity.

RECOMMENDATION 14

The Federal Government should review the superannuation preservation age regime and consider a lowered preservation age for police and emergency services workers.

Many officers become unable to remain at work due to mental health issues. Many also suffer from mental health issues associated with their work in policing later as police veterans. Victoria Police have identified a number of initiatives, including the Peer Support Officer Program (the Program), that function to support officers post-service. Organisations such as these play a vital role in supporting officers and their mental health after they cease working in policing. They bridge a gap left by governments in care arrangements for police veterans. However, services are limited unfunded and supported only by the recent fundraising efforts of agencies like Victoria Police and the Association. Veteran police need a well-resourced and fully funded scheme to service their needs. Police would benefit from comprehensive lifelong counselling and Health Cards which could be used to pay for treatment regardless of location within Australia, similar to the scheme applicable to the ADF. Additionally, it must be noted that officers deserve superannuation entitlements that recognise the heightened risk that extended length of service poses to mental health. Subsequently, officers who have left policing require a range of supports to ensure that occupation based mental health issues continue to be addressed.

Part Five: Mental Health in the Community

Statistically, those suffering mental health issues are more likely to be victims than perpetrators of crime.[139] Further, most encounters between police and persons with mental illness do not involve major crimes or violence, nor do they rise to the level of emergency apprehension.[140] The remainder of this submission focusses on those encounters which require police co-ordinate, to varying degrees, with other agencies in a heavily under-resourced system. The frontline responses of police to people in mental health crisis need to be more formally acknowledged. Creative solutions need to be sought with health and welfare services to better meet the needs of those who are falling between the cracks of community mental health care services.[141]

5.1 At the frontline of an under-resourced system: Police involvement with mental health in the community

The process of deinstitutionalisation in Victoria has not occurred in tandem with adequate provision of community based mental health services. This reality is not unique to Victoria. Research internationally identifies inadequate planning and service provision following deinstitutionalisation and a lack of foresight by policy makers regarding the impact of these changes upon police services.[142] One unintended consequence of this under-resourcing is a continued increase in the frequency of police encounters with those who have a mental illness. Research suggests that these encounters occur multiple times per week for most general duties police.[143] There exists anecdotal evidence that the number of encounters has been steadily increasing over recent years.[144] Additionally, the prevalence of mental illness among the people police bring into custody is significantly greater than what one would expect in the broader community.[145] A 2010 Victorian study found that three-quarters of detainees met the diagnostic criteria for at least one mental disorder at the time they were in custody, with one quarter having had a prior admission to a psychiatric hospital.[146] Comparable to international jurisdiction, one Victorian study found that police reported around one in five potential offenders they encountered appeared to have a mental illness.[147]

A range of risks are associated with encounters between police and people who have a mental illness. Most assaults against police occur when a member of the community is under the influence of drugs or alcohol, experiencing an acute mental health episode, or presents with a combination of

these risk factors.[148] Whilst in the minority, these encounters can be physically dangerous for both police and the person with a mental illness.[149] Research in Victoria in the time period 1995-2008 suggests that psychoses and schizophrenia are dramatically overrepresented in cases where police are required to resort to using force.[150] Numerous inquiries have given rise to a number of strategies to address the use of force in police interactions with those experiencing a mental health crisis, including enhanced training, an increased commitment to the development of services, and governmental mental health strategies to address the underlying issues. However, officers report that a gap remains. Options available to police to resolve incidents the better the outcomes for people interacting violently with police are limited. It is imperative that police have every less than lethal tool available to them when confronted with members of the community who are a threat to themselves, others or indeed police themselves.

RECOMMENDATION 15

That the Government explores whether all frontline police are provided with all of the available less than lethal equipment to resolve situations that requires use of force.

Although the majority of police encounters with those suffering from mental health issues are routine in nature, police involvement with members of the community suffering mental illness is multifaceted. Police perform largely a welfare role with respect to acute mental health episodes in the community. Indeed, police have been referred to as '*streetcorner psychiatrists*', '*psychiatric medics*', '*forensic gatekeepers*' and '*amateur social workers*'.[151] While the rights of people with mental illness to not be subject to involuntary treatment has been progressively recognised, police face difficult decisions when responding to instances of antisocial behaviour where it is a manifestation of mental illness.[152] In these instances, police are required to use their judgement to respond to such persons in the most appropriate way. All of these encounters are typically time consuming and complex for officers. One of the most detailed studies of these interactions in Victoria was conducted under the title Project PRIMeD. This study investigated the frequency, circumstances, and outcomes of such contacts. Information was obtained for all 4,798 occasions in which the police apprehended a mentally ill person and transferred them to hospital or psychiatric facility between December 2009 and November 2010.[153] This study found that police spent 2 hours resolving these incidents, with a quarter taking 3.5–6.5 hours. This is approximately eight times longer than the average police "job" and represents a considerable drain on police resources.[154] A number of factors have seen this average increase in recent years.[155]

Police and PSOs continue to serve on the frontline as mental health interventionists, and as such have been subject to a wave of "first generation" reform designed to enhance their crisis response capabilities. Yet, this focus on crisis intervention has not answered recent calls to move "upstream" and bolster early intervention in the name of long-term recovery.[156] The Association advocates for a focus on primary prevention and early intervention, in order to reduce prevalence and contact with the criminal justice process. Indeed, it is too simplistic to

consider the issues associated with police encounters with the mentally ill as a problem on the part of policing organisations alone. Other agencies, legal frameworks and mental health service providers all contribute to the frequency and outcomes of these encounters.[157] Police are but a small part of the system. Ideally, future reform would see the police role in intervention reduced further. Going forward, emphasis on moving upstream and strengthen interventions along a continuum of engagement is required to properly delineate the role of police and other practitioners in the mental health system.[158]

"Research has found that both mental health based response models and co-responding police-mental health programs have strong linkages with community services and reduce pressure on the justice system."

Indeed, community members suffering mental health issues present to police with a number of needs that often exceed the resources provided to police to deal with them. Police are frequently forced to employ creative ad hoc options to resolve encounters with mentally ill people that they would not use if mental health resources were more forthcoming.[159] The primary challenge police note in resolving situations with people experiencing mental illness is gaining support from mental health services.[160] Despite decades of reform at the frontline of policing, and continued improvement of police training, difficulties in interagency cooperation remain. These difficulties arise in part from differences in organisational and accountability structures.[161] The successful shift of organisational culture towards collaborative policing across public health issues requires the cross institutional alignment of strategic, managerial, structural, technological, political, and human capital.[162] Experience demonstrates that the best responses to people experiencing a mental health crisis in the community require multi-agency cooperation and collaboration at a local, regional and state level.[163] Only with a coordinated systematic focus on the problems that affect people with mental illnesses who come into contact with police can meaningful advances be made.[164] The recommendations made in the remainder of this submission speak to the effectiveness of collaborative and properly coordinated responses to community members suffering mental health issues.

5.2 Investing in collaborative approaches

In a context of finite resources to respond to people who appear to be experiencing a mental health crisis, innovative service delivery is required to ensure that responses are effective and efficient.[165] Research has found that both mental health based response models and co-responding police-mental health programs have strong linkages with community services and reduce pressure on the justice system.[166] Psychiatric triage, streamlining or reducing police involvement, and facilitating timely access to mental health services is also important in reducing the risk of violent interactions.[167] However, given the limits of investment to date, officers suggest that programs and initiatives are often ad hoc and restricted in geography and scope.

Currently, the Crisis Assessment and Treatment Teams (CATTs) in Victoria are the primary mental health-based response to mental health crisis incidents. In theory CATTs operate

24-hours however the reality stands in stark contrast to this. Inefficiencies and lack of availability mark police perceptions of CATTs. Police can experience long delays in waiting for their arrival. Additionally, since their inception, CATTs have suffered from the same shortage of mental health services available to the Victorian community. This has mirrored the issues with mental health based responses internationally.[168] An additional issue with the current operation of CATTs is the general lack of consultation and collaboration between police and mental health services.[169] Given that mental health crises often constitute either public nuisances, threats to the safety of individuals, or disturbances, officers will continue to attend incidents alongside CATTs. For this reason, promotion of interagency cooperation and collaboration must continue to occur.

A prime example of the co-responder model of this is the current PACER (Police, Ambulance and Clinical Early Response) program. The PACER model encompasses a multi-disciplinary, collaborative approach in a very tangible sense. Police are able to access mental health records, while the mental health professional can access criminal justice data about, for example, arrest records, warrants, prior police contacts and so on.[170] Reviews of the PACER program have demonstrated significant improvements in response times, as well as enhanced interactions with, and outcomes for members of the community when compared with usual services.[171] Another benefit of a multidisciplinary team was the accessibility of both health and police data. Privacy concerns prevent police from accessing information about a person's health records and mental health practitioners from accessing police information. A team consisting of both a police officer and a clinician is equipped to access timely information and use this to identify and attempt to implement an appropriate disposition in the community member's best interests.[172] PACER has also been shown to enable reductions in presentations to emergency departments by diverting people to more appropriate and less restrictive environments, and facilitate direct admission to acute inpatient mental health services when people in crisis were assessed in the community or transported to a police station for assessment.[173] Despite these ongoing successes, currently PACERs are employed on an ad hoc basis, are insufficiently funded, and only operate in certain locations.

The reality in Victoria today, based on a lack of adequate resourcing, is that police are all too often the first, and sometimes only, responders to members of the community experiencing a mental health crisis. Mental health crises are predominantly best addressed by a health-based response. Research demonstrates that clinical only and co-responder models offer the most effective outcomes. Both CATTs and PACERs have been subject to continued positive evaluations. What is required is committed investment to these proven programs.

RECOMMENDATION 16

That Police, Ambulance and Clinical Early Response and Crisis Assessment and Treatment Teams be the primary response to mental health crises, being sufficiently resourced, permanent, known resources that operate state-wide.

Part Six: Reforming the Transfer Process

Police and PSOs offer a unique experience with the impacts of an under-resourced and non-cohesive mental health system. Policing intersections with the Victoria Mental Health System reveal a number of gaps and practices that require clarity. In this Part of the submission, we focus on the process of mental health transfers between police and clinicians. A number of clear recommendations are made toward limiting police involvement with those suffering a mental health crisis and ensuring that assessment and treatment is initiated as quickly as possible.

6.1 Enhancing cooperation between police and clinicians: A uniform handover process

While many police interactions with people who appear to be mentally ill require no further police action, police regularly have contact with mentally ill persons who are experiencing a mental health crisis and require some form of mental health transfer. While protocols between Victoria Police and the Department of Health dictate that Ambulance Victoria has primary responsibility for the transfer of people experiencing mental illness, practice differs from the protocol. Police are commonly required to transport people for mental health assessment.[174] Section 351 of the *Mental Health Act 2014* sets out the powers of a police officer or PSO to apprehend a person who appears to have mental illness where the person needs to be apprehended to prevent serious and imminent harm to the person or any other person.

The exercise of police discretion is particularly relevant in these encounters. One significant factor impacting upon police use of discretion is structural constraints regarding hospitalisation and other alternatives.[175] Officers are only too aware of the limited number of psychiatric places available across the state, in addition to the stringent submission criteria at appropriate facilities. As such, encounters with those that appear to be in mental health crisis is often a fraught and frustrating process. Research demonstrates that arrest may be the only disposition immediately available to police to bring a situation under control. Where a person does not appear to meet the high threshold required for involuntary hospitalisation, but the person's behaviour is too dangerous to be ignored, police are likely to arrest.[176] Indeed, the Review by the Office of Police Integrity found that police were routinely required to take responsibility in spite of the community member's mental health status.[177]

RECOMMENDATION 17

In order to facilitate police transfer to the mental health system and reduce the degree of contact between patient and the police, the number of mental health clinicians and/or facilities needs to substantially increase.

Previous research has identified a number of issues at the police/hospital interface during these transfers. Examples include: difficulty accessing support from the interfacing service, delays in handing over care in hospital emergency departments, and staff occasionally not respecting the professional abilities of staff from interfacing services.[178] However, the more significant issue from a policing perspective is the lack of clear and consistent protocols at the

handover phase, again in the context of an under resourced system.

The PRIMeD study found that police apprehended and transported one person every two hours to a hospital or psychiatric service. This represents almost 5,000 incidents per annum.[179] The majority of these transfers are the result of unplanned calls for assistance. [180] The study found that almost all (91%) of these cases originate in the context of a psychiatric crisis, and all too often police cannot obtain the services or responses necessary to assist the individual.[181] Previous research found that self-harm ideation or intent was the primary reason for police transport to an emergency department under the Mental Health Act in Victoria.[182] The vast majority of transfers in the PRIMeD study occurred because the community member had threatened suicide, attempted suicide, or engaged in self-injurious behaviour. In addition, a significant proportion of incidents required a police response due to aggression and property damage.[183]

The results of the PRIMeD study showed that generally, police identified and transferred appropriate people to services, with just over 75% either being admitted to a psychiatric facility or being assessed by triage as needing review by a psychiatrist.[184] Other research has suggested that the majority are not admitted to a facility. One such study suggesting that 67% of people brought to emergency departments by police in 2009 were deemed safe for discharge upon assessment, and only 26% of those presented being admitted to a psychiatric ward.[185] Further, the PRIMeD study found that one in five community members who the police transferred were assessed and released because they did not meet the criteria for involuntary admission to hospital.[186]

This research echoes anecdotal reports by officers that, in many circumstances, community members transferred by police under Section 351 are subsequently released unsupported back into community. Requests for admission or treatment are often dismissed when police and doctors have differing opinions about the need for admission. A common scenario that plays out in these instances is the pre-emptive release of people from custody, resulting in repeated police attendance.[187] In the worst-case scenario this leads to dismissal/ discharge against police advice. In a recent case, a member of the community was dismissed by the attending doctor, with police returning the individual to their home. The member of community's death by suicide in the hours following is now being

treated as a death in custody. This is not an isolated case. These instances impact the way police understand their own judgments to be perceived by mental health clinicians and have a flow on effect to police mental health and wellbeing. Where police transport mentally ill persons for assessment, premature release from hospital (owing to perceive clinical resource deficiencies) can be regarded as a contradiction against their judgment.[188] In this context police can be discouraged from initiating hospitalisations when appropriate.

The crux of this issue is that there are not clear or mandated protocols for hospitals and treating institutions to accept members of the public brought in by police under Section 351 of the Mental Health Act. The myriad of Memorandums of Understanding (MOUs), understood and enforced to varying degrees, result in inconsistencies of practice with respect to police-initiated transfers under Section 351. There is a clear need to develop shared principles and rules of engagement that clarify roles and stipulate how best to enlist resources in a range of circumstances.[189]

RECOMMENDATION 18

That clear roles and responsibilities between police and medical professionals are developed and 'legislated' on a state-wide level. Cooperation cannot remain informal, by agreement on an individual, location or relationship based dynamic.

6.2 Streamlining the mental health transfers

While the outcomes of the handover phase can present additional issues for police, the fact that police carry responsibility for the transportation and monitoring of members of the community prior to assessment is the primary cause of the issue. Earlier research suggested that the average mental health transfer consumes 2.5 hours of police time.[190] However there is a growing body of anecdotal evidence from police demonstrating increasing wait times, particularly at emergency departments where there is a cultural tendency to see mental health assessments as distinct from and less urgent than other emergency medical responses. This leads to delays in conducting assessments.[191] From a mentally ill person's perspective this does not accord with the dignity and rights to which they are entitled. Additionally, these wait times place significant strain on officers and have detrimental impact on other policing services to the community. Our members with increasing regularity report instances of multiple police units tied up waiting at hospitals, unable to respond to new calls requiring assistance.[192] Depending on the Police Service Area, up to five response units can be off the road at a time. This is particularly true of Police Service Areas containing busy hospitals such as the Royal Melbourne and Alfred Hospitals. Often this leaves police with a very limited emergency response capacity and no proactive capacity whatsoever. While these tensions characterise metropolitan areas, they can be more pronounced in regional and rural areas where mental health clinicians may be on call and located considerable distances from their worksites.[193] This is clearly an issue for the community as it is for police.

To date, Victoria has followed a similar model to other states and territories in which operations

are governed by MOU's with respective Departments of Health (or in WA by the Mental Health Act 2014).

By agreement between police and the hospital staff, police may release the person from custody into the care of hospital staff before the assessment is complete subject to the following considerations:

- **If there are no significant safety concerns** – police can transfer care to hospital staff and the person is released from police custody. If care is transferred, hospital staff will be responsible to arrange for the person to be assessed by a registered medical practitioner or mental health practitioner.
- **If there are significant safety concerns** – police, by agreement with hospital staff should remain until the assessment by a registered medical practitioner or mental health practitioner is complete.

Police have a key responsibility to ensure the safety of people threatening harm to themselves or others. Where the person threatening harm appears to be mentally ill, the focus of any response should be on health and harm minimisation principles. In this context health practitioners have a primary responsibility to respond.[194] Police are theoretically present to act as a support role or as a last resort. However, overwhelmingly the responsibility falls on police to take custody of the person or wait with them for extensive hours, particularly in some hospitals when no security guards are present (for instance in South Australia and Western Australia).

The Association acknowledges the Government's recent $100.5 million investment in six emergency department crisis hubs across the state, to help people with urgent mental health, alcohol and drug issues and alleviate the current strain on emergency departments.[195] However, in addition to geographical limitations, consultation with police in New South Wales, where this model has been drawn from, suggests the potential for persistent issues. In New South Wales, police working in areas closer to these facilities are receiving more jobs and are picking up more people for assessments. Due to issues with capacity at these facilities, police are still required to transport or supervise people for hours at a time. Not only is this problematic with respect to police time and resources, it is also unsafe and traumatic for mentally ill people to be transported in a police vehicle when they should be in an ambulance. The MOU notes that long transport times in police vehicles can potentially increase someone's risk of medical deterioration,[196] again emphasising the need for police vehicles to be used to transport people only as a last resort. The New South Wales experiences suggests that implementation of the crisis hubs cannot be seen as a cure all response. Issues of capacity and continued extensive wait times must be addressed at the state level.

"Police are theoretically present to act as a support role or as a last resort. However, overwhelmingly the responsibility falls on police to take custody of the person or wait with them for extensive hours."

While amendments to the Mental Health Act have tried to alleviate some of the time wasted during handover, these alone have failed to improve the current situation. Police remain committed to assisting in the management of mentally ill people that pose a risk to others in the community during critical events, but this must occur in a sustainable and efficient way. It is clear that excessive and unnecessary policing resources are used to perform hospital security duties. Further innovation is required to improve the delivery of services to mentally ill persons. The requirement for police to step in as security guards in some scenarios could also be avoided if PSOs were able to assist police, provided with appropriate training and authority.[197] The duties performed during hospital security duties involves little more than the role PSOs are already trained for. It is acknowledged that additional operational safety training would be needed for PSOs in that specific environment. Upskilling to enable PSOs to perform hospital guard duties instead of police would ease the current stress on resources. Further, PSOs have the potential to undertake multiple roles at a hospital, including the provision of a general security presence something that could improve other safety related concerns confronting health workers in emergency departments. This would require further amendment to the relevant legislated powers under the Mental Health Act.

RECOMMENDATION 19

That Protective Service Officers be recruited and trained to perform hospital security duties.

Conclusion: A summary of Recommendations

The following table is populated by The Association's substantive recommendations with respect to implementation timeframe. Given the range of recommendations submitted by The Association, it is important to represent a realistic implementation plan.

Table 1. Recommendations by implementation timeframe

	RECOMMENDATION
Within a year of the Royal Commission	Recommendation 2: That an external body is established and legislated to oversee the implementation of the recommendations that come out of the Royal Commission with regard to police and emergency services agencies.
	Recommendation 3: That funding be allocated to Victoria Police to expand the provision of internal services accessed by officers beyond the Employee Assistance Program, including the appointment of additional Injury Management Consultants.
	Recommendation 4: That State Government funding be allocated to expand the provision of external services through the Blue Hub model. Following on from the pilot trial, it is recommended that State Government provide additional and ongoing investment to sustain the project and ensure it remains a viable support.
	Recommendation 6: The Workers Injury Rehabilitation and Compensation Act 2013 must be properly applied in every circumstance. In order for a claim to be rejected on the basis of Section 40(1) of the Act, agents must take all reasonable steps to ensure the entirety of evidence is considered in decision making.
	Recommendation 8: That consistent with Recommendation 2 of the 2016 Victorian Ombudsman review, the Workplace Injury Rehabilitation and Compensation Act 2013 be amended to provide the Accident Compensation Conciliation Service with the power to issue a direction to an agent where a decision has not considered all of the causative factors and applied the wholly and predominantly test consistent with the views of the Supreme Court.
	Recommendation 9: The goal of the WorkCover system must be to return people to good health as the first priority. If they are willing and able, the system must then strive to return workers to work in a timely and therapeutic manner. The system must be fair and provide just compensation for workers.
	Recommendation 10: That all officers who retire have access to the BlueHub program, or a similar scheme that enables them access to timely, quality mental health treatment and support services. Further, that this initiative be properly funded by government to ensure that veterans sustaining injury at work receive sustainable support in retirements.
	Recommendation 13: That the State Government endeavor to reform ESSSuper to ensure the projected age for disability benefits is changed to age 60. This means the majority will receive disability benefits in line with the intent of the schemes design, aligning disability with the expected working life, that is, presently to age 60.
	Recommendation 18: That clear roles and responsibilities between police and medical professionals are developed and 'legislated' on a state-wide level. Cooperation cannot remain informal, by agreement on an individual, location or relationship based dynamic.

In 1 — 3 years following the Royal Commission	Recommendation 1: That in collaboration with an external workplace consultant, every workplace within Victoria Police develops a unique mental health strategy, which is distinct to each individual workplace.
	Recommendation 5: That funding and infrastructure for clinical services within Victoria Police in regional areas is increased and made adequate in order to migrate from a metro-centric model to one that services officers equally across the state. Additionally, that a tailored outreach approach is developed, consisting of preventative measures and treatment services relating to mental health. This approach should especially target officers who work at non-24-hour stations in regional and remote locations.
	Recommendation 7: That the focus through which Worksafe promote compliance is shifted to focussing on overseeing the regulation of insurers, as opposed to focussing on claims management.
	Recommendation 11: That a Veterans specific program akin to what exists in the Australian Defence Force be established that provides police and their families access to lifelong, free counselling, mirroring the Open Arms service that exists within the Australian Defence Force.
	Recommendation 12: That police veterans have access to a scheme mirroring that set up by Department of Veterans Affairs, gaining access to a 'Blue Card' to gain access to treatment (funded by Victoria Police) regardless of the jurisdiction.
	Recommendation 14: The Federal Government should review the superannuation preservation age regime and consider a lowered preservation age for police and emergency services workers.
	Recommendation 15: That the Government explores whether all frontline police are provided with all of the available less than lethal equipment to resolve situations that requires use of force.
More than 3 years following the Royal Commission	Recommendation 16: That Police, Ambulance and Clinical Early Response and Crisis Assessment and Treatment Teams be the primary response to mental health crises, being sufficiently resourced, permanent, known resources that operate state-wide.
	Recommendation 17: In order to facilitate police transfer to the mental health system and reduce the degree of contact between patient and the police, the number of mental health clinicians and/or facilities needs to substantially increase.

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