APS Australian Psychological Society

Policing Services With Mentally Ill People: Developing Greater Understanding and Best Practice

James RP Ogloff,[1] Stuart DM Thomas,[1] Stefan Luebbers,[1] Gennady Baksheev,[1] Irina Elliott,[1] Joel Godfredson,[1] Dragana Kesic,[1] Tamsin Short,[1] Trish Martin,[1] Lisa Warren,[1] Jonathan Clough,[1] Paul E Mullen,[1] Catherine Wilkins,[2] Ashley Dickinson,[2] Leanne Sargent,[2] Eva Perez,[2] David Ballek,[2] and Emma Moore[2]

[1]Centre for Forensic Behavioural Science, Monash University and Victorian Institute of Forensic Behavioural Science (Forensicare), and [2]Victoria Police

Although it is now well known that there is a disproportionate number of people with mental illnesses in the criminal justice system, surprising little attention has been paid to the challenges faced by policing people with mental illnesses in the community. This article provides an overview of some of the key findings from a programme of research undertaken in Victoria to further understand and develop a best practice model at this interface. The areas covered will include the prevalence of psychiatric symptoms and mental illnesses among police cell detainees; the existing knowledge base and attitudes of police towards mentally ill people; the relationship between mental illness and offending; the frequency and nature of police apprehensions of mentally ill people under the Mental Health Act; the association among mental disorder, police shootings, and other injuries to people as a result of these encounters; and police interactions with victims of crime. The work highlights the need for ongoing improvements in policing people with mental illnesses, and particularly the need for improved inter-agency practices for dealing with them.

Key words: jail inmates; mental illness; offenders; policing; use-of-force; victims.

What is already known on this topic	What this paper adds
1 There is a high prevalence of mental illness among those who come into contact with the criminal justice system.	1 People with mental illnesses are vastly overrepresented among those who police take into custody, with more than half of all people having had contact with the public mental health service.
2 Working with people with serious mental illnesses present challenges to the police.	2 On average, police apprehend one person every 2 hr; they struggle to obtain appropriate mental health services for these people.
3 There is a modest relationship between mental illness and offending.	3 The vast majority of people with serious mental illnesses do not offend; however, as a group, people with mental illnesses have a much greater risk for offending and violence than others in the community.

I've only been here for 2 years but in that time I've seen a massive array of how people display their mental illness. The longer I'm in this job the quicker I am able to make an assessment. The more variance of displaying symptoms that I can see the more often I can pick them quickly. Sometimes it's almost impossible to tell.[1]

In the past two decades, considerable attention has been paid to mentally ill and disordered people in the criminal justice system. Systematic studies show unequivocally that both men and women with mental illnesses, including serious mental illnesses (i.e., psychotic and major mood disorders), are significantly overrepresented in prisons (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001; Brugha et al., 2005; Fazel & Danesh, 2002; Ogloff & Tye, 2007). Research shows further that those people with major mental illnesses have a disproportionately high offence and violence offence rate when compared with the general community (Douglas, Guy, & Hart, 2009; T. Short, S. D. Thomas, P. E. Mullen, & J. R. P. Ogloff, in prep.). With relatively few exceptions, most of the work that has been published has considered the so-called back end of the criminal justice system (i.e., prisons and psychiatric services). Very little work focuses on the point at which people are apprehended by the police and taken to hospital or into custody.

With pressured and resource-starved public mental health services, much of the burden of dealing with people with major mental illnesses falls to the panoply of community service providers, including the police and other emergency services.

In 2010–2011, Victoria Police responded to a total of 780,000 events (Victoria Police, 2011). These events included emergencies, serious incidents, criminal offending, and antisocial behaviour, and routine response calls for non-emergencies. The vast majority of calls to police do not result in arrest but lead to other outcomes.

Previous research and popular anecdote suggests that during the course of their duties and calls for assistance, the police commonly come into contact with mentally disordered people (Wylie & Wilson, 1990). That being said, very little is actually known about specific contact rates, or the precursors, processes, interventions, and outcomes of these encounters. What we do know is that at the extreme end of the spectrum, people with mental disorders are overrepresented in critical incidents that result in police shootings (e.g., Dalton, 1998). For example, the 2005 investigation into police shootings in Victoria by the Office of Police Integrity (2005) found that three out of six people fatally shot by the police were found to be mentally ill by the coronial reviews, and an additional two were also believed to have been mentally ill. Ongoing concerns have been expressed about police fatalities as evidenced by media interest in coronial inquests into police shootings, despite police often being exonerated (e.g., Inquest into the Death of Tyler Cassidy, Victorian Coroner's Court Case 554208).

A number of concerns have been identified regarding the nature and outcomes of police contact with mentally disordered people; one of the most pressing concerns has been levelled at the lack of specialist skill training that police receive in relation to dealing with people who are in acute mental distress (e.g., Vermette, Pinals, & Appelbaum, 2005). Very little is known, however, about how police view mental illness and how frequently they believe they come into contact with people who are mentally ill. Similarly, almost no research exists regarding police officers' use of their emergency powers under mental health acts, which typically permit them to apprehend people at imminent risk of harm to themselves or others, and take them to hospital for further assessment.

The relationship between criminal behaviour and mental illness continues to receive considerable attention. Wallace, Mullen, and Burgess (2004) undertook a data linkage study to examine the patterns of offending in a large cohort of patients with schizophrenia admitted to psychiatric services in Victoria. The criminal records of 2,861 patients with a first admission for schizophrenia recorded on the Victorian Psychiatric Case Register in 1975, 1980, 1985, 1990, and 1995 were compared with a matched community comparison group. Results showed that people with schizophrenia were three times more likely than those without mental illness to commit an offence, and five times more likely to commit a violent offence. A similar, but significantly larger, study by Jablensky, Morgan, Morgan, Valuri, and Ferrante (2004), which linked 219,052 cases on the Western Australia psychiatric register with 388,370 individuals on the criminal offender's database, found differences in the rate of contact with police across diagnostic categories. Just under half (48.5%) of individuals with substance misuse diagnoses, 39.1% of individuals with personality disorders, and a third (32.5%) of individuals with schizophrenia had been in contact with the justice system, with the majority of offenders having been arrested prior to any contact with psychiatric services. There is a need to update these studies to determine if and how patterns of offending have changed over the last decade, and whether any such changes impact on the revision of best practice community policing initiatives.

Beginning in the 2006–2007 fiscal year, Victoria Police selected mental health as one of its priority areas, and enhancing policing responses to people with mental illnesses as a strategic service delivery commitment. Since that time, Victoria Police has developed a comprehensive and sophisticated mental health strategy, and has undertaken significant changes in how police officers are trained and how people with mental illnesses are treated. Part of the early strategy was to engage with Monash University and the Victorian Institute of Forensic Mental Health (Forensicare) to undertake a program of research, which will be highlighted later.

This article provides an overview of some of the key findings from a programme of research undertaken in Victoria to further understand and develop a best practice model at this interface. While the research findings are from Victoria, the major themes are consistent with jurisdictions in Australia and internationally. The areas covered in this article will include the prevalence of psychiatric symptoms and mental illnesses among police cell detainees; the existing knowledge base and attitudes of police towards mentally ill people; the relationship between mental illness and offending; the frequency and nature of police apprehensions of mentally ill people under the Mental Health Act; the association among mental disorder, police shootings, and other injuries to people as a result of these encounters; and police interactions with victims of crime.

Project PRIMeD (Police Responses to the Interface of Mental Disorder)

As noted, to assist with understanding the challenges and enhancing the capacity of police to work with mentally ill people, a joint research project was undertaken among Victoria Police, Monash University, and Forensicare. The project, "PRIMeD," was funded for 5 years (2007–2011) by an Australian Research Council Linkage Grant (LP0774829). The project was overseen by a steering committee and an expert advisory committee, and resulted in more than 15 studies, including five doctoral theses, being completed. There were four phases of the project: Phase 1—scoping and formulation (including prevalence of mental illness among police detainees, police officers' attitudes and knowledge about mental illness, in-depth interviews with police officers, and focus groups involving interagency partners, including health and other emergency service agencies); Phase 2—police apprehension of people suspected to be mentally ill (monitoring police apprehension of people under the Mental Health Act); Phase 3—police use of force (exploration of the relationship between mental illness and police use of force, including fatalities); and Phase 4—schizophrenia and offending/victimisation (an exploration of the relationship between schizophrenia and offending/victimisation). The work is culminating in the development of a best practice model of policing people with mental illness.

Prevalence of Symptoms of Mental Illness and Diagnoses Among Police Cell Detainees

To determine the prevalence of symptoms of mental illness and psychiatric disorders that are present among police cell detainees, two studies were undertaken. Linkages were made with the police contacts database to gather offence-related information, and with the public mental health database to obtain detainees' histories of mental health care. In addition, collateral information was sought—where available—from detainees' community-based general practitioners.

In the first study (Ogloff, Warren, Tye, Blaher, & Thomas, 2010), a representative sample of 614 people (561 males; 53 females) detained around Victoria (average age: 31 years) was screened for symptoms of mental illnesses using the Brief Psychiatric Rating Scale, which the custodial nurses administered. Results showed that one third of detainees reported current psychiatric symptoms at the time of detention—the most commonly reported symptoms being anxiety and depression.

More than half of the sample had some prior contact with the public mental health system, and almost one third of detainees (32%) were receiving psychiatric treatment in the community at the time of being arrested. Of these people, half (17%) were treated by a public mental health agency, and the remainder by private psychiatrists and general medical practitioners. The psychiatric disorders being treated included mood disorders (usually depression)—11%; anxiety disorders (including posttraumatic stress disorder)—8%; and psychotic disorders (primarily schizophrenia)—5%. Substance abuse emerged as a pervasive problem, with 70% of detainees reporting current use, usually of multiple substances. Medical management of acute withdrawal symptoms was required for 21% of detainees.

Unsurprisingly, pre-existing mental health problems were associated with a greater number of psychiatric symptoms being experienced while in police cells, and the most severe psychiatric symptoms were present among those who had previously been hospitalised in a psychiatric service (a proxy indication of the severity of their mental disorders). Of note, no differences were found for the types of offences for which people were charged, regardless of their mental health histories or symptomatology; most had been charged with non-violent offences.

In the second study (Baksheev, Thomas, & Ogloff, 2010), 150 people (136 males; 14 females) detained in police cells (average age: 30 years) were assessed using the Structured Clinical Interview for DSM-IV-TR (SCID-IV) to identify current (past month) and lifetime mental illness. Three quarters (75%) of detainees met diagnostic criteria for at least one mental disorder at the time they were in police custody. Substance dependence disorders were the most common diagnoses; however, even when these were excluded, one in two detainees still met criteria for a mental disorder. Moreover, 32% of detainees had a diagnosis of both a substance use and mental disorder (i.e., dual diagnosis).

Figure 1 shows a comparison of the lifetime prevalence of psychiatric samples compared with a sample of 5,000 non-offending people in Victoria (Short, Thomas, Luebbers, Ogloff, & Mullen, 2010). As Figure 1 reveals, the odds of meeting diagnostic criteria for a psychotic disorder were 15 times higher in detainees than in the general population.
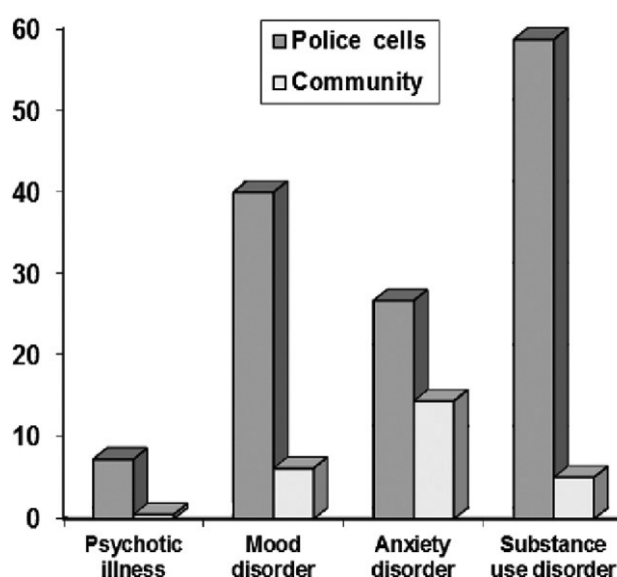

Figure 1 Comparison of lifetime rates of primary mental disorders in police cells and the community.

As with the sample in the first study, the majority of detainees (70%) had committed non-violent offences leading to their arrest (e.g., theft, obtain property by deception, and fail to answer bail). Over half had a history of contact with the public mental health system, with considerable variation in the intensity of services having been provided; one in four detainees had been admitted to a psychiatric hospital on at least one occasion.

In addition to determining diagnoses, Baksheev, Ogloff, and Thomas (2012) also administered two mental health screening tools to the sample to compare their results with the SCID-IV: the Brief Jail Mental Health Screen (BJMHS; Steadman, Scott, Osher, Agnese, & Robbins, 2005) and the Jail Screening Assessment Tool (JSAT; Nicholls, Roesch, Olley, Ogloff, & Hemphill, 2005). Using existing police practices for identifying mental illness, which are generally informal and unsystematic, fewer than half (47%) of the detainees were correctly classified as needing mental health care while in police cells (Baksheev et al., 2012). Alternatively, the BJMHS correctly classified two thirds of those experiencing a serious mental illness, and correctly identified 73% of detainees experiencing any mental disorder. Performing even better, the JSAT correctly classified three quarters of those experiencing a serious mental illness, and correctly identified 82% of detainees experiencing a mental disorder.

It is important to note that neither sample of detainees included people identified by police as needing immediate psychiatric care, since those people were taken by police to hospital in accordance with the police powers under the Mental Health Act (1986). Taken together, these studies substantiate the high rate of mental health symptoms and psychiatric diagnoses among police cell detainees. Importantly, many detainees with a mental illness were not being identified using current police screening practices. The way that detainees with a mental illness are identified and treated has significant implications for their safety and well-being in police custody.

Police Officers' Knowledge, Attitudes, and Experiences Working With Mentally Ill People

Given the prevalence of mental illness among those with whom the police have contact, it is important to learn about police officers' experiences and attitudes regarding this population. Over the years, factors such as deinstitutionalisation, increasingly restrictive involuntary commitment criteria, and a limited availability of community-based mental health services have increased the involvement of the police in dealing with individuals who have a mental illness. In this context, a survey of a representative sample of 3,534 Victorian (77.8% males; 23.2% females) police officers' experiences and knowledge of mental illness was undertaken (Godfredson, Thomas, Ogloff, & Luebbers, 2011). Respondents estimated that in an average week, they regularly come into contact with mentally ill people, with 50% reporting at least one to two such encounters a week, and more than one third reporting between three and ten encounters. These encounters occur in a wide range of contexts, including calls for assistance by mental health services, during patrol duties, and doing welfare checks on regulars who "drop-in" to police station front desks. Many contacts occur during times of crisis.

The most commonly reported sources of information used by police members to determine if someone is mentally ill were (in order of what members use most) person-based information (consisting of previous knowledge of the person and the person's behaviour observed at the scene, such as speech content, behaviour, appearance, aggression, and violence); police sources (information recorded in the police database and information provided by dispatch); and health information (information provided by health/mental health services). Responses indicated that officers' understanding of mental illness was more likely to be based on their on-the-job training and/or experience of mentally ill people in their private life, rather than information gained from more formalised courses provided by Victoria Police or other external agencies. They reported that they generally learned how to deal with mentally ill people via an apprenticeship-style approach, with junior officers learning from their superiors, again reinforcing the notion of an accumulated experience-based practice approach to learning.

Police reported a number of challenges to resolving situations with people experiencing mental illness, with the five ranked most frequently identified themes being the following: gaining support from mental health services; communicating with the mentally ill; avoiding violence/aggression in the encounters; cooperation and compliance of the person experiencing mental illness; and effectively identifying and understanding mental illness.

In a related study, a subset of 304 police officers, who completed the survey in the study earlier, also watched one of three videos depicting a police encounter designed to elicit maximum opportunities for police members to exercise their discretionary powers (Godfredson, Ogloff, Thomas, & Luebbers, 2010). Each one of the videos was identical, except that the mental state and behaviour of the individual subject were varied. The subject was portrayed as being either mentally ill, not mentally ill, or with an ambiguous mental state, and the situation depicted included a minor offence (drinking in a park), no injuries, no bystanders, and an anonymous complainant who had left the scene. Each scenario ended prior to the encounter being resolved. Members were then asked how they would *actually* (i.e., in their actual job) and *ideally* (i.e., given ideal resources/circumstances) resolve the encounter using the following options: (1) walk away from the situation; (2) handle the matter informally (e.g., referral to a welfare or community mental health service); (3) call for assistance from the mental health Crisis Assessment and Treatment Team (CATT); (4) apprehend and take under Section 10 of the *Mental Health Act* (1986); or (5) arrest.

The results are presented in Figure 2, and show that in the scenario where the individual was not mentally ill, most of the police members (almost 70%) would have both likely and ideally handled the situation informally. Approximately 20% would have arrested the individual, 5% would have walked away, and very few police would have sought any involvement of mental health services.

The greatest discrepancy between what officers ideally like to do and what they would actually do occurred when the subject's mental state was portrayed as being possibly mentally ill or obviously mentally ill. In the ambiguous scenario, the preferred option (40%) was to call a CATT, yet in reality the majority of officers would try to handle the matter themselves informally (60%). In the mentally ill scenario, the majority of officers preferred to have the assistance of a CATT (55%), yet again in reality members would use their powers to apprehend the person under Section 10 of the *Mental Health Act*. The discrepancies between *actual* and *ideal* responses in scenarios where the individual was possibly or almost certainly mentally ill suggest that officers face considerable obstacles when resolving encounters with people experiencing mental illness. The research from the broader project confirmed that officers often have difficulty getting the help they perceive they need, and finding an appropriate placement or mental health services for the mentally ill people with whom they come into contact.

The findings demonstrate that police officers have frequent contact with mentally ill people, and these encounters are associated with considerable practical difficulties, both in terms of knowing how to deal with people experiencing mental illness and how best to find appropriate supports for them. While officers were generally using appropriate behavioural signs to identify mental illness, their knowledge about mental illness primarily came from idiosyncratic experiences on the job and/or in their private lives. Variation in officers' understanding of mental illness accounts for some of the variation in the options that members use to resolve encounters with the mentally ill. The scenario study showed further that while officers were adept at selecting outcomes appropriate to the mental health needs with which an individual presents, there was a large discrepancy between what members would ideally like to do and what they ultimately choose to do when trying to resolve encounters with mentally ill people. It appears that police generally feel unsupported by mental health services, and try to handle matters themselves either informally or using apprehension powers (i.e., arrest or Section 10).

A series of 25 in-depth interviews with police officers was also conducted. The semi-structured interviews were completed on site at five different police stations. The interview lasted from 40 to 90 min and involved officers with a range of experience: 5 had just over 2 years of experience, and 7 had over 20 years of experience. The work revealed that officers come into contact
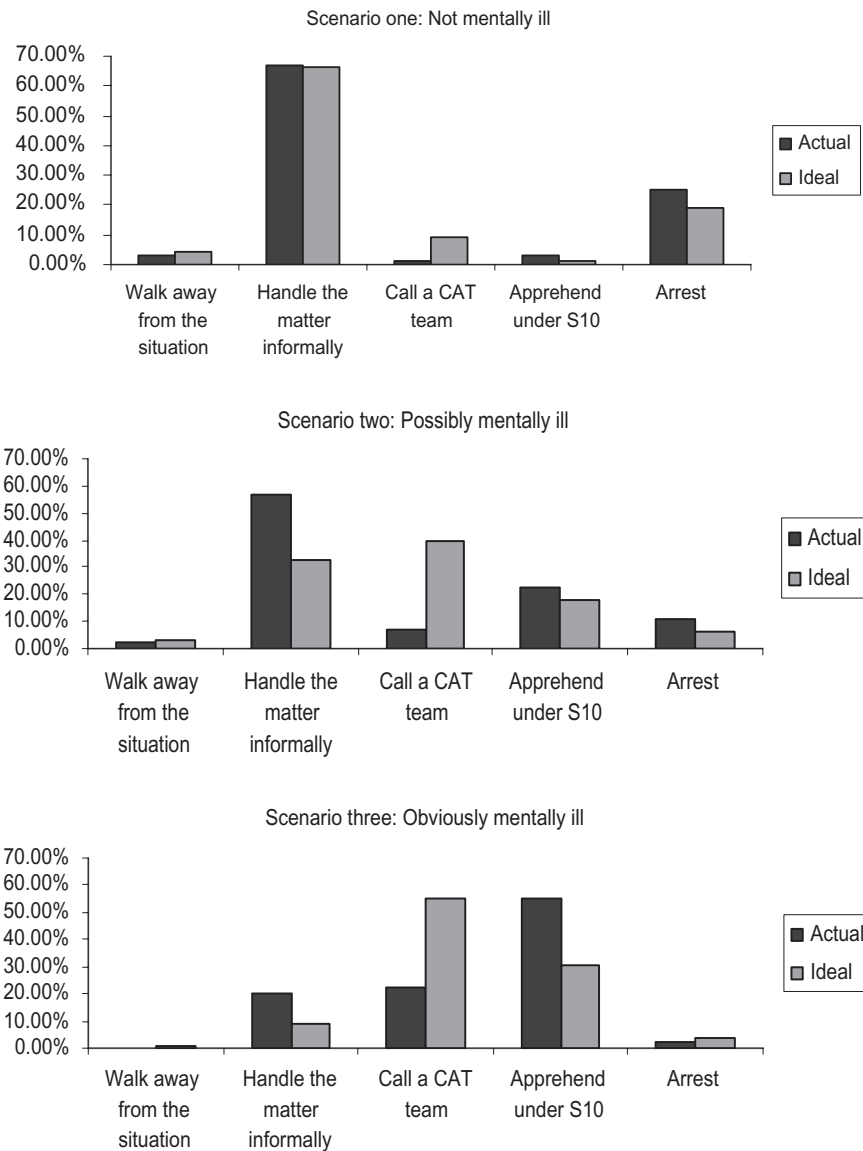
Scenario one: Not mentally ill

Scenario two: Possibly mentally ill

Scenario three: Obviously mentally ill

Figure 2 Police officers' actual and ideal approaches to resolving a situation when the mental state of the subject was varied. CAT = Crisis Assessment and Treatment; S10 = section 10, Mental Health Act, Victoria.

with many people who appear to be mentally ill, as the following quotations make clear:

> There's a lot of psychiatric patients coming through the police station. More than ever.

> I was not aware of how many people have a mental illness until working [here] and making contact with them.

> We have a lot of dealings with them, every day, taking up lots and lots of man hours.

> It's a bloody massive problem.

Police officers also noted that they developed individual strategies for dealing with them, based upon their own common sense and experiences, as follows:

> I don't know I think it's after 22 years I get a pretty good idea of whether someone's off their . . . basically mentally incapacitated or not. I don't know I would probably go on a gut feeling more than anything else.

> Obviously I'm not a psychiatric person but I deal with a lot of odd or mentally ill people presenting different. You can tell usually if someone's just drunk or. I don't know you just get a vibe for it.

> I don't have the sort of training to say whether someone is mentally ill or not . . . You're thinking purely from your experience in life.

The interviews with police officers showed a significant degree of compassion as the following quotation exemplifies:

> My dealings with any of the mental health people is [usually] not the result of them being charged with something, it's a welfare issue, thinking

we can't leave this guy out in the street. He's accusing me of killing his grandmother, what's he going to say to the next person that walks past and, if they take offence to that, what are they then going to do? Are they going to belt this bloke? Are we then going to be coming back here for an assault? So it's primarily as a welfare issue for that person and to some extent for the community as well. He's a bit disturbed but he's not going to harm anyone so you err on the side of caution, do what you think is the right thing and try and get him some help.

Finally, the most unexpected finding of the interviews was reports from officers about "regulars." These are people with mental disorder that have a regular form of support from a particular officer:

I've gone out of my way to visit her to see how she's going. She needs to be somewhere where people can look after her. People take advantage of her because of her good heart. You know sexual favours and money. And when she gets her pension it goes on alcohol, smokes. And she's always ringing up here at night. She gets jabs in the arse for something. I went and saw the case workers because she had to move away from these people next door cause they took advantage of her. I said "when they come and see you—you come and see me." I haven't seen her for a while but I've been too busy. I should go around and see her cause I feel bad she'll think I've abandoned her. But she knows where I am. Some of them won't deal with anyone else and they get attached to you. I like to help people. This is a job where you deal with the shit of the world all the time and if you can do something nice for somebody, she might come around. A bit of good karma doesn't hurt you every now and then. It's always nice to think you've done something nice at the end of the day. You don't get it every day. So if I can go home and say A's having a better day cause I went and said hello. I don't have to go there and save the world. It's just something little you can help somebody do cause they just needed a bit of advice "Don't give all your money away to dick head. I want to see that money here tomorrow." And I go around tomorrow and it's still there. I'm happy with that. That's one more day she's got some cash.

Sometimes you think if I am really, really friendly and sound really, really helpful then they will just go away and the catch is they're thinking "oh great" and then they will ring you all the time. I've got a lady who rings me every two weeks—she always thinks people are after her. It's just paranoia, she always thinks there's people watching her or whatever . . . and it's just somebody walking past her house. So I'll just say little things to keep her happy like "oh yeah I've been patrolling around your house more often," and then straightaway she will say, "oh yes I've noticed there's been no problems," so she's happy, we're happy. It's the easiest way to do it but then it means you get phoned every two weeks.

Some police here have good relationships with some of the mentally ill. D would often ring up Officer C, and C would spend an hour on the phone with him, just down tools. C's now retired. I've had that contact with him when C hasn't been available, where I was aware at the time that C was keeping him, so it was easy enough for me to do the same sort of thing. I just put him on speaker phone and keep doing what I'm doing.

While anecdotal, the in-depth interviews provided considerable information and added important context to the more quantitative research findings. It is noteworthy that following each presentation of this information to audiences that include police officers, we are regaled with additional anecdotes that confirm the information provided.

The Frequency and Outcome of Police Apprehensions Under the Mental Health Act

As indicated earlier, one of the options available to the Victorian police under the Mental Health Act is the power to apprehend people whom they believe are mentally ill, and transport them to a facility to provide mental health services. 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 between December 2009 and November 2010. The people who were the subjects of the transfers were then linked to police and public mental health databases to examine history of police contact and history of mental health care. In addition, thematic analysis of the police members' descriptions of incidents was conducted to identify the common scenarios resulting in police involvement and mental health transfers.

Nearly all (90.7%) police mental health transfers originated in the context of psychiatric crises. Of all the encounters, only 2.4% were the result of a planned interaction between police and the person who was ultimately transferred. The vast majority 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. Finally, it was family members who had most commonly contacted the police for assistance. The analyses further revealed that police went to considerable efforts to try and engage supports/services for the person being transferred (e.g., driving to multiple hospitals/services).

Police often requested support from multiple services when dealing with these incidents, primarily from CATT and/or Ambulance Victoria. In one out of six requests for support from a CATT, no response was available. When support was provided, it was generally available within 1 hr; however, over a quarter of response times were between 2 and 5 hr. Similarly in one out of ten requests for ambulance support, none was available. When they did respond, however, the majority of ambulance support responded within 30 min (over a quarter of response times were between 1 and 5 hr later). In close to 80% of incidents, police transferred the community member to a hospital emergency department, with the remainder being transferred to a police station or directly to a psychiatric facility.

The results show 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. However, 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. Further examination of this group showed that while they were not found to meet the criteria for involuntary admission to hospital, they were still needy: high rates of personality disorder, substance use disorders, intellectual disability, and acquired or traumatic brain injury.

They also had a lower level criminal offending (e.g., nuisance offences) than the other people apprehended and transferred to hospital.

In general, police spent 2 hr resolving these incidents (a quarter take 3.5–6.5 hr). This is approximately eight times longer than the average police "job" and represents a considerable drain on police resources.

The mental health histories were accessed for the police transfers and revealed that almost all (94%) had a diagnosed mental illness. Compared with a random sample of mental health service users (Short et al., 2010), those transferred by police were two to three times more likely to have an illness characterised by psychosis (i.e., schizophrenia spectrum or affective psychosis). They were also more likely to have a co-occurring substance use disorder or personality disorder. They also had more intensive involvement with the mental health service system in the past. Finally, they were generally younger when they were first admitted to hospital, had more periods of hospitalisation, and a greater length of stay when hospitalised.

A significant proportion (51%) of those transferred by police had been charged with a criminal offence during their lifetime, and just under half had been the perpetrator of family violence. The rates of offending for this group are 10 times greater than those in the general population. Their rates of family violence were 20 times greater than people in the general population.

These findings suggest that police are regularly performing mental health transfers, approximately one every 2 hr across the state. The people being transferred present as a group with multiple and complex needs (i.e., high rates of psychosis, co-occurring substance use, and personality disorder, combined with elevated propensities towards criminal behaviour). Importantly, police are engaging these people when they are in crisis with limited support—a context that represents a highly challenging scenario.

The Relationship Between Police Use of Force and Mental Illness

The Victoria Police philosophy regarding the contact with the public espouses the use of minimum force in resolution of an incident; however, under some circumstances, the police are of course legally sanctioned to use lethal force to protect themselves or others. This study investigated the prevalence and nature of mental illnesses present among those against whom the police have used fatal force. This study investigated all 48 incidents of fatal police force that occurred in Victoria between 1980 and 2008 to examine the mental health and associated criminal histories of the people fatally killed by police (Kesic, Thomas, & Ogloff, 2010, 2012a). The situational characteristics of the fatal use of force cases were also examined (i.e., the context in which these incidents occurred, decedents' behaviours and mental state, the presence and characteristics of suicide by police, and the associated police response).

Of particular note, the majority of the decedents were previously known in some capacity to either the criminal justice system or the mental health system. Most had been convicted of or charged with criminal offences, and nearly a quarter had been victims of crime. More than half had a diagnosed mental disorder, and more than a third of these had multiple psychiatric

diagnoses. All of the major psychiatric disorders were significantly overrepresented as compared with prevalence rates in the general community (Short et al., 2010), with severe mental disorders, such as psychosis and schizophrenia, more than 12 times more likely to be found in the sample of fatalities compared with estimated rates in the general population. More than half were affected by substances, and this likely contributed to their aggressive behaviour during the incident.

The majority of the incidents were unplanned police operations, initiated by the decedent, and dealt with by general duties officers. Most incidents escalated quickly and were over in less than 10 min, although some lasted for a number of hours. The vast majority of decedents were noted as behaving aggressively during the incident (e.g., having weapons, threatening officers, refusing to disarm, and resisting arrest). Police were found to have applied prescribed risk assessment and management protocols in over half of the incidents. The use of non-lethal tactics, including communication and negotiation, was attempted in a number of incidents in an attempt to safely resolve the situation.

The examination of fatalities suggests that not only are mental disorders, including the more severe mental disorders, common and overrepresented in these incidents, but there is also a high degree of associated criminal offending. Additionally, mental disorders were more likely to be found in a subgroup of the fatalities that were found to fit the criteria for "suicide by police" (15 of 45 fatalities). This research suggests that provoked shootings (so-called suicide by cop) are common among the fatality cases; they also seemed to differ from the rest of the fatalities on a number of other indicators, including duration of the incidents, their behaviour during the incident, and the police response.

Using a similar methodology to the study earlier, a second study examined the individual and situational characteristics of people involved in non-fatal use of force incidents with the police (Kesic, Thomas, & Ogloff, 2012b, 2012c). A random sample of 10% of the 4,267 use of force cases from 1996 to 2008 were linked with the police and public mental health databases.

The findings are presented in two main areas. Investigations were conducted for two "mentally disordered" groups where (1) the police believed and recorded that, from their perspective, the person was experiencing a mental disorder; and (2) the person had a diagnosed mental disorder as recorded on the public mental health system database. Seven per cent of non-fatal use of force cases were perceived and recorded by the police as being mentally disordered at the time of the incident. More than half of these cases involved mental health-related calls (e.g., preventing suicide/self-harm, assisting an agency or family with a mentally disturbed person).

Compared with the rest of the sample, those considered mentally disordered by the police were more likely to be deemed irrational/unstable, but they were less likely to appear alcohol-affected and to avoid police apprehension. More than half of those deemed to be mentally disordered by police behaved violently (primarily weaponless contact or property damage), and almost a third used violent/abusive language. Although only a quarter of those perceived as mentally disordered used or threatened to use weapons on the police, they were two times more likely to actually use this force type on the police than the rest of the sample.

The police were significantly more likely to use or threaten to use weapons (Oleoresin Capsicum "OC" spray specifically) on those who appeared mentally disordered, regardless of the subject's behaviour. Almost one half of the subjects received minor injuries during the incident, and one in seven also injured the police. However, they were no more likely to injure police, or to be injured by the police, than subjects who did not appear to have a mental illness.

The second set of analyses compared the police officers' use of force on people who had a record of a psychiatric illness on the public mental health database with those with no such illness. Overall, almost half of the use of force sample had been the clients of the public mental health system, and more than a third had a diagnosed mental disorder. All of the major mental disorders were significantly overrepresented in the use of force sample as compared with their prevalence in the community. In the main, these findings are similar to those for all accused with whom the police come into contact.

Incidents involving those with a history of diagnosed mental disorders were likely to be related to offending: street arrests/checks, subduing suspects/offenders, and domestic disputes. People with a history of mental disorder were significantly more likely to have been convicted of violent and sexual offences than other subjects.

Those with a diagnosed mental disorder were more likely to be deemed irrational/unstable and more likely to appear drug-affected. By contrast, they were less likely to appear alcohol-affected and less likely to avoid police apprehension. More than half of those with a diagnosed mental disorder were deemed by police to have behaved violently, and around half used violent language. The most common used force against police was weaponless contact, followed by verbal force. One in seven used or threatened to use weapons, and were more likely to use this force on the police compared with the rest of the sample.

There was no significant difference in the likelihood that police used more severe force types between those with a history of mental disorder and the rest of the sample; however, there was a trend for the police to use or threaten to use weapons on those with a history of psychotic disorder diagnosis. Almost a half of those with a diagnosed mental disorder were injured by the police, and almost a sixth also injured the police. However, those with a history of mental disorder were no more likely to injure the police, or to be injured by the police, than the rest of the sample, and the injuries received were minor in most cases.

These findings suggest that diagnosed mental disorders and associated criminal offending are common in non-fatal use of force incidents between the Victoria Police and the public. While a person was deemed to be exhibiting signs of mental disorder in only 7% of cases of non-fatal force, almost half had a history with public mental health services and one third had a diagnosed mental illness.

Although only a minority of those with mental illnesses possessed weapons, they were more likely to use or threaten to use these weapons on the police. Finally, while the police were no more likely to use or threaten to use weapons on those with a history of mental disorder diagnosis, they were more likely to use OC spray on those individuals who appeared mentally ill during the encounter regardless of their behaviour at the time.

The Relationship Between Schizophrenia and Offending/Victimisation

As noted in the introduction, studies have found a modest but significant relationship between severe mental illness and violence. In the context of community policing, it is important to more fully understand the nature of the relationship among mental illness, offending, and victimisation. Therefore, the next study examined the association among psychotic disorders (such as schizophrenia), criminal behaviour, and crime victimisation (T. Short et al., in prep.). Given that it is family members, rather than strangers, who typically fall victim to violent actions by mentally ill people, the study also examined family violence incidents and the use of intervention orders. The degree to which comorbid substance abuse increases the risk of criminality or victimisation was examined.

Rates of family violence, criminal offending, and victimisation were compared between schizophrenia patients and a randomly selected community control group. The schizophrenia sample was taken from the state-wide mental health register, and included all persons aged between 18 and 65 who had been diagnosed with a psychotic disorder between 1975 and 2005. In total, 4,168 patients and 4,641 random community members were included. For the purposes of this study, "violent offences" were defined as any physical acts involving force or causing harm to the victim (such as assault, armed robbery, and homicide); this included all contact sex offences (such as rape or indecent assault). All other offences, including theft, stalking, driving, and drug-related offences, were considered "non-violent."

One quarter (24.6%) of psychotic patients had been charged with a criminal offence during their lifetime, and 10% had been found guilty of a violent offence. Rates of offending among psychotic patients were 3.5 times higher than in the community sample. The psychotic patients were 4.5 times more likely than the general community sample to have committed a violent offence. People with psychosis were also significantly more likely to have had contact with police as a result of intervention order applications and officer attendance at family violence incidents.

Comorbid substance use disorders significantly increased the risk of offending and violence. Almost half of all patients with a comorbid psychotic illness and as substance use disorder had committed an offence, and 20% had committed a violent offence. When compared with the general community, however, even those *without* concurrent substance abuse were more than twice as likely as the general community to have committed a violent crime.

A significant proportion of patients who offended violently had committed offences while on an involuntary community treatment order under the Mental Health Act. That is, despite increased levels of supervision in the community, patients on these compulsory orders were still at increased risk for violence.

In addition to offending histories, the Victoria Police database includes all police contacts with victims of offences. This enabled an examination of the victimisation rates and characteristics of mentally ill versus non-mentally ill people. Overall, rates of victimisation were *lower* in people with psychosis compared with people without; however, schizophrenia patients were shown to have a significantly *higher* number of violent and sexual victimisation incidents than others. Patients with

psychosis and an offending history were also significantly more likely to have a record of victimisation than patients without an offending history. Although the exact reasons for the relationship between schizophrenia and victimisation are unclear, it may be that the general degree of dysfunction and disenfranchisement so common among people with chronic schizophrenia not only increases the likelihood that some of them will offend, but also that they will be criminally victimised.

Of note, those with comorbid substance misuse were the most vulnerable to victimisation—being nearly four times more likely than the general community to become the victim of a violent crime, and almost half of them had some record of crime victimisation. One in five dual diagnosis patients had been a victim of a violent crime.

Overall, the vast majority (90%) of schizophrenia patients do not commit violent crime. Only one in four patients has a criminal record, and one in ten has a violent conviction. However, the rates of offending and violence in this group are significantly higher than in people without a diagnosis of psychosis. Drug abuse significantly increases the likelihood of violence in both psychosis patients and the general community, but this study demonstrated that even patients with no history of substance use disorders have a statistically elevated risk of offending. Offenders and victims are not mutually exclusive groups. Patients with a history of offending were also more likely to have a history of victimisation—thus, it is likely that these individuals are in frequent contact with police in some capacity. Although most patients with schizophrenia disorders do not have a victimisation record, they are between two and three times more likely to have a record of violent victimisation compared with people who have not been diagnosed with a schizophrenic illness. As with offending, drug abuse significantly increases the risk of being victimised.

Police Officers' Interactions With Victims

While the focus of most of the research undertaken in Project PRIMeD has been on policing offenders with mental illnesses, a study was conducted to investigate the impact of the police–victim interaction on victims, as well as approaches that might improve victims' experiences with police (Elliott, Thomas, & Ogloff, 2011; in press). Previous research has shown that the process by which people are dealt with by the law is as important, or even more important, than the outcome they experience. This is known as procedural justice (Thibaut & Walker, 1975), and an aim of the present study was to explore the importance of the police treating victims in what could be defined as a procedurally just manner.

In-depth interviews were conducted with 110 people who had reported a crime (personal or property) to the police in the previous year. The interviews covered victims' perceptions of their treatment by the police and its impact on their well-being. Ratings of procedural justice, legitimacy, satisfaction, fair outcome, and well-being as a result of the interaction with the police were also obtained.

Consistent with previous research, higher perceived procedural justice was associated with higher perceived legitimacy, outcome fairness, and satisfaction with the interaction. Victims who received a desired outcome as a result of the interaction

with the police had higher scores on fair outcome and satisfaction, but not legitimacy, than the other participants. Procedural justice had a greater impact on outcome fairness and satisfaction than the realisation of a desired outcome.

Not only was higher procedural justice associated with a better outcome for victims, but it was also associated with greater psychological well-being as a result of the interaction with the police. Victims who received a desired outcome had higher scores on well-being and lower scores on powerlessness after their interaction with the police. Procedural justice had a greater impact on victims' well-being than the realisation of a desired outcome.

Validation of their experiences of victimisation and showing that taking actions to solve the crimes were essential in addressing the negative psychological consequences of the crime—feeling violated, experiencing helplessness, and not feeling safe anymore—as a means of giving victims a sense of closure, empowerment, and making them feel safer.

Some suggested strategies may be drawn from the research that the police may use to validate the victim's experiences, improve their outcomes, and reduce some of the sequelae that come with being victims. First, police need to ensure that they treat the victim as a person—not a case or statistic. At the same time, though, police should acknowledge that the wrong happened and should emphasise the unacceptance of the crime. In their interactions with victims, they need to ensure that they do not display attitudes that the victims might perceive as being blamed for their victimisation. They also need to employ empathic listening skills in their work with victims.

Summary and Conclusions

As the information provided in the summary of the findings earlier shows, police face considerable challenges when working with mentally ill people. The prevalence of mental illness among the people police bring into custody is significantly greater than what one would expect in the community. Moreover, mentally ill detainees present with a number of needs that often exceed the resources afforded to deal with them. Very often, the police are 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.

While police have generally positive attitudes towards mentally ill people, and they accept this part of their work as necessary in community policing, they struggle to obtain much needed resources and options for people with mental illnesses. The findings show that the police can accurately identify those people who are exhibiting positive signs of psychotic illnesses. Perhaps surprisingly, the primary challenges police noted in resolving situations with people experiencing mental illness is gaining support from mental health services. More predictably, the remaining significant concerns focus on the individuals with mental illnesses, including the need to communicate with them and seeking their cooperation, employing successful mechanisms/strategies to help ensure they do not become violent, and of course effectively identifying and understanding mental illness.

Among the starkest findings obtained from Project PRIMeD was the realisation that, on average, police officers apprehended

and transported one person every 2 hr to psychiatric services. This represents almost 5,000 episodes per annum, which is significantly greater than the annual number of admissions in any individual mental health service in the state. Almost all 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.

The prevalence of severe mental illnesses among those against whom the police use force, including fatal force, was greater than it was even for those whom the police take into custody. Indeed, the prevalence of psychosis among those whom police killed was 12 times greater than the general community. This presents a significant challenge for the police since the analysis of episodes where force, including fatal force, was used shows that many of the subjects of force have complex difficulties, and initiate then escalate the threat against the police. Moreover, the strategies police use to reduce violence may not be as effective for people who are thinking irrationally as a result of psychiatric crisis. Ongoing research is needed to explore the use of force phenomenon, including the tragic situations where subjects apparently engage the police in a quest for "suicide by police"—which was found to be approximately one third of all cases where fatal force was used in this sample, and up to half of fatal shootings in other jurisdictions.

It is significant that while mentally ill people are overrepresented among those with whom the police come into contact, those detained are no more likely to have a history of violent offending than others. It is the case, however, that while most people with mental illnesses do not offend, they are at greater risk for engaging in offending and violent offending than others in the community. Moreover, this risk elevates when the mentally ill person also has a co-occurring substance use disorder. The relationship between mental illness and offending/violence is important since it highlights the need for mental health services, and often times, the police to manage mentally ill people appropriately when they are at risk for violence.

Contemporary police work involves much more than arresting and detaining people. The results showed that people with major mental illnesses are at an elevated risk for violent victimisation. Thus, approaches to engaging with victims need to take into account the unique needs/complexities brought on by those victims with a mental illness. As the research on approaches to victims of crime shows, the process by which police engage victims is as important as the outcome they ultimately receive in the criminal justice system. Approaches police use can and do affect the victims' experiences in the criminal justice system, and the strategies noted earlier can help ensure positive victim–police interactions in dealing with crime.

The results have significant implications for policy reform, service development, and integration. Overall, it is apparent that a whole of government response is required and that any development of training or services by the police alone will not be enough to address the plethora of concerns and issues identified through the programme of research summarised in this article. A political willingness is required to address the issues arising to enable ministries to work together. Ultimately, it is important that diversion from justice is available to people with mental illnesses who do not pose a risk of significant violence

and who have not committed a serious offence. Only with a coordinated systematic focus on the problems that affect people with mental illnesses coming into contact with the police can meaningful advances be made. While a thorough analysis of the advances that are necessary to rectify the complexities involving policing people with mental illnesses is beyond the scope of this article, we would like to conclude by noting some developments that would be helpful in addressing some of the matters arising from the research.

There certainly is a need for ongoing training of all police officers and other relevant emergency service personnel (i.e., ambulance drivers/paramedics) to (1) understand the signs and symptoms of major mental illnesses, and even more importantly (2) how to work with and manage people with mental illnesses in crisis, whose thinking and behaviour are irrational and impulsive. Similarly, training for mental health professionals regarding risk of violence/offending among people with mental illnesses is required. Virtually all contacts with police and mentally ill people arise out of crisis situations, and many of the individuals in question are patients of mental health services. Therefore, some proportion of crises could likely be averted if those who care for people with mental illnesses have a better understanding of their risk factors and the necessary elements of management.

While necessary, training alone is not sufficient. Service systems are required to address the needs of mentally ill people who come into contact with the police and to assist the police in linking these people to services. Given the diversity of geography, needs, and services, however, there is no one model that will best suit all locations. Rather, a number of specialist models are needed to suit the needs of particular regions or circumstances. In regions with smaller populations and fewer available services, crisis intervention teams may be most effective. Such teams would include select police officers with advanced training and experience working with mental illnesses who would work alongside mental health professionals to provide an outreach service to people with mental illnesses when a police presence is required. These teams would work on an on-call, as need, basis as required.

In areas with mental health services (i.e., inpatient beds and community mental health services), and frequent episodes of contact between mentally ill people and police, mobile police/mental health services make some sense. In practice, these services typically have a police car that is jointly staffed by a police officer experienced in working with mentally ill people and a mental health professional who is experienced in working with mentally ill people in crisis. Such services exist in several jurisdictions internally, and have been trialled in Victoria with success. These services work best to assist police in managing people with mental illness who are known to the mental health service and can reconnect them to mental health services. The limitation of these services, however, is that they do not provide solutions for complex cases nor do they provide accommodation for those who require it beyond mainstream mental health services.

Consistent with the approach earlier, among its recommendations, the Senate Select Committee on Mental Health (2006) recommended "[t]hat mobile intensive teams or crisis assessment teams be adequately resourced to provide mental health

crisis responses 24 hr a day, 7 days a week, minimising the need for police and ambulance attendance and in many cases, avoiding inpatient admission." These teams differ from the jointly staffed police/mental health professional cars insofar as they are solely staffed by mental health professionals. The limitation of such services is that they cannot reasonably assist where the target of the crisis presents a risk of violence.

In metropolitan areas with high rates of police contact with mentally ill people in crisis, as we found to be the case in Melbourne, solutions, such as those presented earlier, are likely to have only limited utility. Indeed, Steadman et al. (2001) found that a specialised crisis response unit was a critical factor in surmounting many problems that have been encountered in police–mental health interactions. Such units, which are not new and have been described in the literature for at least two decades (Ogloff, Finkelman, Otto, & Bulling, 1990), provide a safe form of short-term accommodation for those in crisis. The units are staffed by a multidisciplinary team of health professionals. Over a short period (e.g., 72 hr), the detainees can be stabilised, triaged, and linked to mental health services. Steadman et al. (2001) found that among the advantages of such units, outcomes included having one-third fewer arrests for police services with access to specialised response services as compared with those without the services.

Beyond the specific models that could be developed to integrate police and mental health, better linkages are required between police and area mental health services. The research showed that the lack of knowledge and understanding of mental health services presented additional difficulties for police. Finally, it is important to have integrated mental health services within justice agencies, including police and corrections (prisons and community corrections). There can be little doubt that the plight of the mentally ill in the criminal justice system, and the frustration faced by both police and mental health services, can be improved by building on the findings of the research presented and the policy and service system recommendations outlined.

Acknowledgements

Note

1. These are the comments of a young police officer who participated in interviews as part of the research presented in this article.

References

Baksheev, G. N., Ogloff, J. R. P., & Thomas, S. D. (2012). Identification of mental illness in police cells: A comparison of police processes, the brief jail mental health screen and the jail screening assessment Tool. *Psychology, Crime and Law*, *18*, 529–542.

Baksheev, G. N., Thomas, S. D., & Ogloff, J. R. P. (2010). Psychiatric disorders and unmet needs in Australian police cells. *Australian and New Zealand Journal of Psychiatry*, *44*, 1043–1051.

Brinded, P. M. J., Simpson, A. I. F., Laidlaw, T. M., Fairley, N., & Malcolm, F. (2001). Prevalence of psychiatric disorders in New Zealand prisons: A national study. *Australian and New Zealand Journal of Psychiatry*, *35*, 166–173.

Brugha, T., Singleton, N., Meltzer, H., Bebbington, P., Farrell, M., Jenkins, R., . . . Lewis, G. (2005). Psychosis in the community and in prisons: A report from the British National survey of psychiatric comorbidity. *American Journal of Psychiatry*, *162*, 774–780.

Dalton, V. (1998). *Police shootings 1990–97* (Australian Institute of Criminology Trends and Issues in Crime and Criminal Justice). Canberra: Australian Institute of Criminology.

Douglas, K. S., Guy, L., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. *Psychological Bulletin*, *135*, 679–706.

Elliott, I., Thomas, S., & Ogloff, J. R. P. (2011). Procedural justice in contacts with the police: Testing a relational model of authority in a mixed methods study. *Psychology, Public Policy, and Law*, *17*(4), 592–610.

Elliott, I., Thomas, S. D. M., & Ogloff, J. R. P. (in press). Procedural justice in victim-police interactions and victims' recovery from victimisation experience: A grounded theory study. *Policing and Society*.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys. *Lancet*, *359*, 545–550.

Godfredson, J. W., Ogloff, J. R. P., Thomas, S. D., & Luebbers, S. (2010). Police discretion and encounters with people experiencing mental illness: The significant factors. *Criminal Justice and Behavior*, *37*, 1392–1405. doi: 10.1177/0093854810383662

Godfredson, J. W., Thomas, S. D., Ogloff, J. R. P., & Luebbers, S. (2011). Police perceptions of their encounters with individuals experiencing mental illness: A Victorian survey. *Australian and New Zealand Journal of Criminology*, *44*, 180–195. doi: 10.1177/0004865811405138

Jablensky, A., Morgan, F., Morgan, V., Valuri, G., & Ferrante, A. (2004). Psychosis, crime and first onset of schizophrenia: A population-based study. *Schizophrenia Research*, *67*(1 Suppl. 1), 9.

Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2010). Mental illness among police fatalities in Victoria 1982–2007: A case linkage study. *Australian and New Zealand Journal of Psychiatry*, *44*, 463–468.

Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2012a). Time, space and suicide by police: Coronial reports analysis of fatal police shootings. *Criminal Justice and Behavior*, *39*(8), 1107–1125.

Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2012b). Estimated rates of mental disorders in, and characteristics of, incidents of nonfatal use of force by police. *Social Psychiatry & Psychiatric Epidemiology*. doi: 10.1007/s00127-012-0543-4.

Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2012c). Use of nonfatal force on and by persons with apparent mental disorder in encounters with police. *Criminal Justice and Behavior*, in press.

Nicholls, T. L., Roesch, R., Olley, M. C., Ogloff, J. R. P., & Hemphill, J. F. (2005). *Jail Screening Assessment Tool (JSAT): Guidelines for mental health screening in jails*. Burnaby, BC: Simon Fraser University.

Office of Police Integrity. (2005). *Review of fatal shootings by Victoria police*. Melbourne, Vic.: OPI.

Ogloff, J. R. P., Finkelman, D., Otto, R. K., & Bulling, D. (1990). Preventing the detention of non-criminal mentally ill people in jails: The need for training and research. *Nebraska Law Review*, *69*, 434–471.

Ogloff, J. R. P., & Tye, C. (2007). Responding to mental health needs of women offenders. In R. Sheehan, G. McIvor, & C. Trotter (Eds.),

What works with women offenders (pp. 142–181). Devon: Willan Publishing.

Ogloff, J. R. P., Warren, L. J., Tye, C., Blaher, F., & Thomas, S. D. M. (2010). Psychiatric symptoms and histories among people detained in police cells. *Social Psychiatry and Psychiatric Epidemiology*, *46*(9), 871–880.

Senate Select Committee on Mental Health. (2006). *Select committee on mental health: A national approach to mental health—from crisis to community*. Canberra: Commonwealth of Australia.

Short, T., Thomas, S. D., Luebbers, S., Ogloff, J. R. P., & Mullen, P. (2010). Utilization of public mental health services in a random community sample. *Australian and New Zealand Journal of Psychiatry*, *44*, 475–481.

Steadman, H. J., Scott, J. E., Osher, F., Agnese, T. K., & Robbins, P. C. (2005). Validation of the brief jail mental health screen. *Psychiatric Services*, *56*, 816–822.

Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialised crisis response site as a core element of police-based diversion programs. *Psychiatric Services*, *52*, 219–222.

Thibaut, J., & Walker, L. (1975). *Procedural justice*. Hillsdale, NJ: Erlbaum.

Vermette, H. S., Pinals, D. A., & Appelbaum, P. S. (2005). Mental health training for law enforcement officers. *Journal of the American Academy of Psychiatry & Law*, *33*, 42–46.

Victoria Police. (2011). *Annual report 2004/2005*. Melbourne: Victoria Police Centre.

Wallace, C., Mullen, P. E., & Burgess, P. (2004). Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. *American Journal of Psychiatry*, *161*(4), 716–727.

Wylie, J. R., & Wilson, C. (1990). *Deinstitutionalisation of the mentally disabled and its impact on police services* (Report Series No. 93). Brisbane: Australasian Centre for Policing Research.