

Mental Health and Policing Interactions in NSW

LAW ENFORCEMENT CONDUCT COMMISSION

Submission of the Community Restorative Centre (CRC)

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1. ACKNOWLEDGEMENT OF COUNTRY

CRC acknowledges the Traditional Custodians of the land on which we work and live. We recognise their continuing connection to land, water, and community. The offices of CRC stand on the lands of the Gadigal, Wangal, Bidjigal, Wiljkali, Baarkintji, Darug, Wiradjuri, Dharawal, Awabakal, and Worimi peoples. We pay respects to Elders, past and present.

The overrepresentation of First Nations peoples in the criminal legal system¹ across this continent is a national shame. We recognise the harm caused by these systems and the tireless advocacy of Indigenous peoples to reduce the criminalisation of their communities. Ultimately, incarceration is not part of First Nations cultures, and First Nations peoples have had, and continue to have, systems of accountability outside of the colonial carceral system.

2. ABOUT COMMUNITY RESTORATIVE CENTRE

Community Restorative Centre (CRC) is a lead NGO in New South Wales (NSW) providing specialist support to people affected by the criminal legal system, with a particular emphasis on the provision of post-release and reintegration programs for people with multiple and intersecting needs. Recognising First Nations communities are overrepresented in the prison system, CRC supports a large number of First Nations community members in our everyday work.

CRC has over 70 years of specialist experience supporting people involved with prison systems. All CRC programs aim to reduce recidivism, break entrenched cycles of criminal legal system involvement, and build pathways out of the criminal legal system. CRC works holistically to do this, addressing issues such as homelessness, drug and alcohol use, social isolation, physical and mental health, disability, employment, education, family relationships, financial hardship, and histories of trauma.

¹ We use the term 'criminal legal system', as opposed to 'criminal justice system' to reflect that the 'justice system' in Australia has been imposed on First Nations communities without their consent through settler colonialism. The term 'criminal legal system' also highlights the way the system-including police, courts and prisons- frequently fail to deliver justice. These failures are part of a broader, ongoing problem. This is evident in the fact that First Nations people in Australia have the highest imprisonment rate in the world, are racially targeted by police, and experience a lack of accountability from the 'justice system' when First Nations people die in custody.



3. INTRODUCTION

Thank you for the opportunity to submit to the Law Enforcement Conduct Commission (LECC) request for submissions to inform improvements to mental health and policing interactions in NSW. CRC's work with people impacted by incarceration means we work daily alongside people transitioning from custody who face complex, entrenched cycles of disadvantage, with histories of trauma, homelessness, substance use and mental health needs. For many of the people we support, their contact with the criminal legal system was catalysed, or significantly worsened, by unmet mental health and social support needs. Their experience of police contact has often been the beginning of a cycle of harm.

A note on alternative first responders being regarded as out of scope

We acknowledge that the call for submissions specifies that LECC cannot make comments or recommendations about whether agencies other than police should be first responders in NSW. While we note this limitation, alternative first responders are the elephant in the room. Alternative first responders are not a matter of political imagination; they have been occurring in Australia for many years, including initiatives led by First Nations and LGBTQIASB+ communities. Supporting alternative first responder models is a matter of political will and readiness, for which we encourage government support.

We highlight that in June 2026, the NSW Legislative Council debated a motion on mental health emergency responses, which asserted that police attendance at mental health crises can result in harm and fatal consequences (New South Wales Parliament, 2026). The motion recognised broad consensus that police should not be the primary responders to such incidents. NSW Minister for Mental Health Rose Jackson stated that “police are not the right people to respond” when a person is experiencing a mental health crisis and does not pose a danger to themselves or others, acknowledging that such individuals require “care from experts in health-led responses” rather than police intervention (New South Wales Parliament, 2026). Members noted repeated government commitments to develop an alternative responder model and criticised the lack of implementation despite substantial evidence supporting reform.

Notably, the motion also called for full funding of critical mental health services, investment in community-based supports and step-up/step-down services, and public planning to



address identified service gaps, recognising that health-led crisis responses can only function effectively when supported by adequately funded mental health infrastructure (New South Wales Parliament, 2026).

It is CRC's position that responses that do not centre police will contribute to reductions in people being inappropriately funnelled into the criminal legal system based on unmet mental health and related social support needs. Non-police responses will also reduce instances of physical, material and social harm and violence experienced during police interactions, as well as through the judicial and correctional systems that are known to create and exacerbate many forms of disadvantage associated with criminalisation and incarceration, including forms of mental ill-health and psychosocial disability.

A note on policing and settler-colonialism

Policing cannot be understood separately from its historical foundations in settler-colonialism. The core function of colonial policing was the defence of the colony and the maintenance of a social order that protected the interests of a privileged few while enabling the exploitation and dispossession of many.

In settler-colonial contexts, policing developed not as a neutral institution of public safety, but as a mechanism for enforcing colonisation, controlling and enslaving marginalised populations, and maintaining racial, social and economic hierarchies (Cunneen, 2023; Ritchie, 2017). From this perspective, racism, ableism, sexism and classism are not unintended by-products of policing but are embedded within its historical and contemporary functions (Deivanayagam et al., 2021).

These dynamics are particularly evident in police interactions with racialised people experiencing mental health crises, where institutional priorities centred on control, compliance and the use of force often result in escalation rather than de-escalation (Rowe & Dowse, 2023). Harm is compounded for First Nations peoples who experience disproportionate levels of police harm and are overrepresented among those seriously injured or killed in police encounters.

Longstanding features of colonial policing, including the exercise of wide-ranging discretionary powers without accountability, continue to shape contemporary policing cultures (Cunneen, 2023). This contributes to a pattern in which violence is routinely



justified based on police not knowing the person was experiencing a mental health crisis, or that the use of force was ‘proportionate’ due to the perception that the person appeared aggressive or violent (Vitale, 2017).

Recognition of the colonially constituted nature of contemporary Australian policing necessitates we move beyond accounts that locate solutions solely in police training or operational practices, and toward alternative first responders for people experiencing mental health crisis, particularly those in First Nations communities.

How we developed this submission

To develop this submission, we have drawn on research, our own organisational knowledge, and CRC case studies. CRC also consulted with the Aboriginal Legal Service (NSW/ACT), and has regard to the [National Justice Project’s Alternative First Responders Position Paper](#) (National Justice Project, 2025), which informs and aligns with many of the positions advanced in this submission.

4. SUMMARY OF RECOMMENDATIONS

Recommendation 1: That the LECC formally recognise and communicate, through its reporting and advisory functions, the evidence supporting alternative first responder models for mental health crisis response, including community-led and lived-experience-informed approaches that reduce reliance on police intervention.

Recommendation 2: That the NSW Government recognise harmful policing practices toward people with mental illness as a public health issue.

Recommendation 3: That the NSW Police Force undertake a comprehensive review of policies, practices and Standard Operating Procedures (SOPs) to prioritise the reduction of unnecessary police involvement in mental health crisis responses.

Recommendation 4: That the LECC call for and support a Royal Commission or equivalent independent public inquiry into police responses to people with mental illness.

Recommendation 5: That the NSW Police Force strengthen the implementation of existing mental health response, diversion and health-led initiatives.

Recommendation 6: That the NSW Police Force commit to a comprehensive independent review and audit of NSW Police Force mental health training.



Recommendation 7: That the NSW Police Force commit to the incremental reallocation of the portion of their budget currently being utilised for unnecessary and inappropriate police responses to mental health crises, in line with a justice reinvestment approach.

Recommendation 8: That the NSW Police Force and partner agencies, in the design, expansion and implementation of co-responder and alternative first responder models, adopt a holistic and multidisciplinary approach that recognises mental health crises are often shaped by intersecting social, economic and health factors.

Recommendation 9: That the NSW Government ensure that Aboriginal Community Controlled Organisations are adequately resourced and prioritised to provide culturally safe alternatives to police responses for Aboriginal and Torres Strait Islander peoples.

Recommendation 10: That the NSW Police Force undertake a comprehensive review of recommendations from previous Commissions, inquiries and reviews relevant to policing and mental health, and publicly report on their implementation status, ongoing relevance and any reasons for non-implementation.

5. MENTAL ILLNESS AND DISTRESS

It is important to establish the way we conceptualise mental health as related to its intersection with policing. Mental illness refers to a wide range of conditions affecting a person's thinking, mood, behaviour and capacity to engage with daily life. Not everyone with a mental health condition experiences psychosocial disability, but where they do, that disability refers not to a diagnosis but to the barriers and consequences that arise from the interaction between an individual's mental health condition and the structures, attitudes and systems within society that restrict participation and inclusion. These can include barriers to housing, employment, relationships and participation in community life (Mental Health Coordinating Council, 2021).

Mental health exists on a continuum and is shaped by the interaction of individual, social, economic and environmental factors. Social determinants such as poverty, trauma, housing instability, racism, discrimination and social exclusion can increase the risk of mental ill-health and impede recovery (Australian Institute of Health and Welfare, 2024; World Health Organization & Calouste Gulbenkian Foundation, 2014). They are also the factors most likely to bring someone into contact with the criminal legal system (McCausland & Baldry, 2023).



Indeed, a 2023 NSW Bureau of Crime Statistics and Research (BOCSAR) study found that people identified with psychosocial disability represented the disability group most likely to experience criminal legal contact and imprisonment, particularly for people who have both psychosocial and cognitive disabilities (BOCSAR, 2023).

People who come to the attention of police as a result of mental health concerns are not a homogenous group. Public health, mental health and alternative first responder organisations commonly distinguish between the following presentations:

- **Mental health crisis:** A situation in which a person experiences acute psychological, emotional or behavioural distress that substantially impairs their ability to cope, function safely or care for themselves, and may place them at risk of harm. Mental health crises can include psychosis, severe anxiety, suicidal ideation and self-harm, among other presentations. A mental health crisis is a health event and does not in itself involve criminal offending (Substance Abuse and Mental Health Services Administration (SAMHSA), 2020, 2025). In NSW, these presentations account for the majority of police mental health callouts (NSW Government, 2024).
- **Behavioural health crisis:** A broader category that encompasses both mental health and substance use crises, including situations in which a person's behaviour is affected by a combination of psychiatric, alcohol and other drug, social and environmental factors (SAMHSA, 2020, 2025). Critically, substance use can produce presentations that are clinically indistinguishable from primary psychiatric episodes, including agitation, disorientation, paranoia and perceptual disturbance (Miles-Johnson & Morgan, 2022). The overlap creates significant diagnostic complexity even for trained clinicians.
- **Situational crisis:** Acute distress arising from a life event or circumstance such as domestic violence, homelessness, bereavement or financial crisis rather than an underlying mental health condition. A person in situational crisis may display significant emotional dysregulation without meeting any clinical threshold for mental illness (SAMHSA, 2020).

Significantly, these presentations may intersect, and people experiencing acute or severe mental distress may have a reduced capacity to communicate clearly, understand, or comply with police directions. In practice, behaviours associated with distress may be



interpreted through the lens of officers' implicit biases, prior patterns of police contact, or communication and cultural differences, increasing the likelihood that distress is perceived as non-compliance or aggression. This can lead to criminalisation rather than diversion and care, with vulnerability to police use of force further compounded where mental distress intersects with marginalised or minoritised social groups across race, gender, age, sexuality, disability, socioeconomic disadvantage or cultural and linguistic diversity (CALD).

Case Study: 'Sandy'

'Sandy' is a middle-aged Aboriginal woman living with diagnoses of schizophrenia and intellectual disability. For most of her life, she lived with her mother, who was her primary source of support. Her mother played a vital role in maintaining Sandy's stability, ensuring she took her medication consistently and had secure accommodation.

During a period of significant mental health deterioration, Sandy stopped taking her medication and experienced a psychotic episode. During an argument with her mother, Sandy allegedly threatened her with a pair of scissors.

Recognising that her daughter was unwell and in need of treatment, Sandy's mother contacted emergency services and requested an ambulance. Instead, police attended the home and Sandy was arrested.

Following the incident, police applied a no-contact Apprehended Violence Order (AVO), preventing Sandy from having any contact with her mother. She was charged with a number of offences, including stalk/intimidate, and was remanded in custody for approximately three months before being granted bail.

The consequences of the AVO were profound. Because Sandy had always lived with her mother and relied on her for accommodation, daily support and assistance with medication, the order immediately left her homeless. With no meaningful support network beyond CRC, she began sleeping rough, often staying in parks and train stations.

Sandy's psychosis and lack of access to consistent treatment made it difficult for mainstream services to engage with her effectively. At the same time, she was required to comply with strict bail conditions, including reporting to a police station each day while homeless and unwell.



Over the following two years, CRC provided intensive support and advocacy. This included assisting Sandy to navigate the criminal legal system, attending multiple court appearances, and advocating for the variation of the AVO. Throughout this period, Sandy's mother consistently stated that she did not want the AVO to remain in place. Her intention had been to obtain medical help for her daughter, not to initiate a criminal justice response or prolonged separation.

Eventually, the court varied the AVO to permit contact between Sandy and her mother. Although the order could not be fully revoked before its expiry, they were able to resume contact.

Sandy's criminal charges were ultimately dismissed after the court properly considered the circumstances of her mental health at the time of the incident.

6. COMMUNITY SAFETY

Safety is relational, not coercive

The ostensible and commonly understood function of policing is to maintain community safety. This submission contends that community safety is a concept that requires more careful definition than is often applied in policy discussions, and that when interrogated properly, it points away from policing as a primary response to mental health distress, and toward the kinds of holistic, relational and health-led supports that evidence shows actually support people and communities in crisis.

Community safety is not fundamentally a law enforcement concept. In a public health context, community safety is the condition in which people are able to live free from harm, fear and instability, and in which individual and collective wellbeing is prioritised in public and social policies and practices, and the systems in which they are embedded (SAMHSA, 2024). This includes responses that proactively address the social determinants that reproduce precarity and vulnerability, such as inadequate housing, poverty, untreated illness, fractured relationships and social exclusion.

Community safety is the social outcome of communities that are supported, connected and resourced. As organisers and scholars Mariame Kaba and Andrea Ritchie have written, “there will be no safety that we don’t make through collective care and the relationships it



requires.....We have to do the work of rejecting the politics of safety, and the carceral and militarized visions of safety, that we have been conditioned to believe are the only path forward” (Kaba and Ritchie, 2022, n.p.). This formulation reflects a conclusion shared by public health researchers and service providers alike: safety is relational, not coercive (American Public Health Association, 2018).

Police responses often disrupt mental wellbeing and community safety

Force and criminalisation rarely, if ever, achieve meaningful and lasting community safety. By its very nature, policing operates under the latent or explicit threat of the use of force, violence and incarceration (Maher, 2021). With respect to mental health crises specifically, ‘welfare checks’ conducted by police officers (Dowse et al., 2021), or the use of arrest for minor or perceived infractions to remove people experiencing distress from public spaces (Strauss et al., 2005) often result in escalation and harm, at times resulting in death of the person in crisis.

Criminal legal techniques are temporary solutions at best, and inherently counterproductive at worst. They frequently exacerbate the severity of the incident, and either do nothing to address the underlying conditions producing the crisis or actively reproduce those conditions. A wholesale police response that is more likely to escalate mental health crises and contribute to protracted forms of distress and harm for individuals and their communities should be understood and acknowledged as antithetical to any conception of community safety.

CRC’s direct experience of working alongside people affected by the criminal legal system makes clear that safety is not achieved through the threat or use of force and violence. It is accomplished when people have stable housing, meaningful connection, access to health care and support systems that treat them as a whole person rather than as a collection of risk factors to be managed.

From this vantage point, criminal legal responses to mental health crises are not merely insufficient, they actively disrupt the conditions that produce safety. They remove people from their communities, create or deepen circumstances that limit stability and connection, and expose people to the well-documented harms of coercion and imprisonment. The NSW Police Force’s own Mental Health Strategic Action Plan 2024 acknowledges the limitations



of police-led responses, recognising the need for enhanced mental health training, de-escalation techniques, interagency collaboration and, significantly, alternatives to traditional enforcement responses (NSW Police Force, 2025). This reflects an increasingly sophisticated institutional position that mental health crises are fundamentally health and welfare matters, and that genuine community safety requires responses calibrated to that reality.

Recommendation 1: That the LECC formally recognise and communicate, through its reporting and advisory functions, the evidence supporting alternative first responder models for mental health crisis response, including community-led and lived-experience-informed approaches that reduce reliance on police intervention.

Recommendation 2: That the NSW Government recognise harmful policing practices toward people with mental illness as a public health issue.

Case Study: 'Alisha'

'Alisha' is a woman who was supported by CRC over several years while navigating complex trauma, domestic and family violence, substance dependence, mental health distress, and significant involvement with both child protection and criminal legal systems. She has been diagnosed with complex post-traumatic stress disorder (C-PTSD) and has a long history of trauma arising from both interpersonal violence and system intervention.

Alisha entered out-of-home care as a teenager after her mother relinquished care. By the age of 15, she was pregnant, living independently in social housing, and attempting to raise her children while experiencing ongoing domestic and family violence perpetrated by her partner. Despite extensive histories of coercive control and video evidence of repeated assaults against her, she was frequently identified by police and other agencies as a perpetrator rather than a victim-survivor.

Workers described a recurring pattern in which Alisha's trauma responses, mental distress, previous criminal legal involvement and substance use were interpreted as signs of dangerousness, aggression or non-compliance rather than indicators of victimisation



and vulnerability. As a result, her efforts to seek safety and support often led to further criminalisation.

One particularly concerning incident occurred while Alisha was pregnant and experiencing acute distress associated with C-PTSD. After being issued with a move-on direction at a train station, she and her partner were approached by six police officers. Her partner informed police that Alisha was highly distressed and requested a short period of time to calm her and move her on without escalation.

Officers instead escalated the interaction and used physical force to restrain and remove Alisha. She subsequently attended hospital, where injuries consistent with a serious physical assault were documented. She later attempted to report the incident through appropriate channels and repeatedly requested an event number so the matter could be investigated. Although an event number was eventually provided, she was subsequently informed on multiple occasions that no corresponding event could be located.

On another occasion, Alisha contacted police to report an alleged breach of an Apprehended Violence Order (AVO) after being assaulted by a male partner. When police attended, she was visibly distressed by the incident. Police arrested and charged her, despite Alisha initiating contact as a victim-survivor.

When the matter came before the court, the judge identified inconsistencies in the police facts and questioned why Alisha had been treated as the perpetrator. The charges were subsequently dismissed.

CRC workers also reported repeated instances of the same officers attending future incidents involving Alisha, despite previous interactions where she was not believed and had been misidentified. This reinforced her fear and distrust of police and heightened her distress whenever further police involvement occurred.

7. POLICING MENTAL HEALTH CRISIS AND DISTRESS

Police lack the operational capacity for mental health call-outs

In NSW, police are called to events involving mental health every nine minutes (NSW Police Force, 2024). Often, it is family members or community members concerned about the wellbeing of a loved one who call 000 seeking support. Australian police are required to



provide 24/7 responses to community mental health calls, and police officers mostly respond unassisted by doctors, paramedics, social workers or other health and welfare professionals. Estimates suggest Australian police spend between 10% and 30% of their time managing mental health cases (Karystianis et al., 2026).

As the default responders to many mental health crises, police effectively act as gatekeepers to both the mental health and criminal legal systems, exercising considerable discretion in decisions that can either facilitate access to care or contribute to criminalisation (Thomas & Kesic, 2020). A systematic review found that police are involved in the pathway to care for approximately one in ten people accessing mental health services (Livingston, 2016).

Aboriginal peoples with mental health and cognitive disabilities experience substantially earlier and more frequent police contact than non-Indigenous people because police become the frontline state agency responding to the cumulative effects of colonisation, childhood trauma, out-of-home care, homelessness, poverty, disability, and inadequate health and social supports, such that experiences of social disadvantage become pathways to the criminal legal system (Baldry et al., 2015; McCausland & Baldry, 2023)

Subsequently, people experiencing mental distress may find their access to care, safety and liberty contingent on decisions made within a policing framework rather than a therapeutic one. The result is often the unnecessary criminalisation of the person in crisis, together with avoidable physical, psychological and social harms affecting the individual, their families and support networks, and responding officers (NSW Audit Office, 2025).

The NSW Police Force respond to more than 60,000 mental health incidents each year in NSW, a figure that has grown by approximately 10% annually since 2018. In most cases, no criminal offence has been committed, there is no threat of violence, and no weapon is involved (NSW Police Force, 2024). This means police are attending, at volume and as the default, situations that fall entirely outside their core remit. The NSW Police Force agrees that “over-reliance on police responding to mental health-related incidents can cause distress and increase the risk of injury for both individuals experiencing mental health concerns and police officers”, and “the high volume of police deployment to mental health-related matters can also have flow-on impacts to other community safety issues, limiting resources of police to respond to other matters” (NSW Police Force, 2024, p. 6).



Police lack the skills and disposition for mental health call-outs

Australian research conducted with police recruits found they felt their academy training was too brief, overly theoretical and did not adequately prepare for them for real-world mental health crisis situations. As a result, they tend to learn on the job from senior officers and through trial and error (Morgan & Miles-Johnson, 2022). Additionally, an evaluation of the NSW Police Force's specialised Mental Health Intervention Team (MHIT) found that although MHIT-trained officers reported greater confidence and understanding of mental illness, they were found to use force at rates comparable to non-trained officers (Herrington et al., 2009).

The mere presence of uniformed, armed officers can escalate an already heightened situation and frequently results in criminalisation and harm rather than care, with this effect particularly pronounced for people experiencing paranoia, psychosis or acute trauma (Lavoie et al., 2022; Randall et al., 2025). The clinical and situational complexity of mental health crisis presentations demands responders who are trained to distinguish between them, de-escalate compassionately, and connect people to appropriate support. This is not what police training equips officers to do, and it is not what police deployment achieves in practice.

A police response may itself constitute a community safety risk

Police often use coercion and force in their interactions with people with mental illness who may be presenting with 'unusual' behaviour indicative of distress, such as fear, avoidance, agitation or defensiveness (Dowse et al., 2021). Numerous inquiries, media reports, coronial inquests, organisational and individual accounts report extreme forms of harm associated with such responses to people experiencing mental health crisis, including avoidable injury and death.

Australian research conducted with people who have experienced police mental health interventions found that use of force including tasers, chemical weapons such as pepper spray, restraints and police dogs, was common even where no criminal conduct was alleged, and that participants experienced lasting effects including loss of employment, persistent trauma and a reluctance to seek help in future crises (Bradbury et al., 2017; Randall et al., 2025). Even when incidents fall short of physical harm, police responses frequently intensify



rather than alleviate distress, with the chilling effect on help-seeking itself a serious public health consequence (Police Accountability Project, 2019).

In addition to the systemic influence of the militarised structure and crime control mandate of the NSW Police Force itself, a significant ‘canteen culture’ involving the use of power, force and weaponry appears to contribute to violent interactions with vulnerable people (Dowse et al., 2021; Rowe et al., 2022). Publicised recordings from body-worn video and messages between officers reveal disturbing cases where officers have normalised, valourised and collusively reinforced their use of violence against people experiencing mental health distress (Greenbank et al., 2026; MacKenzie, 2026).

A 2025 peer-reviewed study drawing on coronial inquest records from an Australian jurisdiction concluded that the contextual and tactical factors leading to fatal police use of force against people with mental illness point to systemic, rather than individual, failures (Dodd et al., 2025). Indeed, people in mental health crisis are consistently over-represented in serious and fatal police critical incidents:

- The LECC's 2023 report on five years of critical incident monitoring found that of the 157 critical incident declarations made across 2017-2022, 68 (43%) of the incidents involved an interaction with a person in mental health crisis (Law Enforcement Conduct Commission, 2023, p. 41).
- Data from the Australian Institute of Criminology shows that 44 of 105 people (42%) fatally shot by police across Australia between 1989-90 and 2010-11 had an identified mental illness (Australian Institute of Criminology, 2013).
- Data obtained from NSW Police through a Government Information (Public Access) request by then-NSW Greens MP David Shoebridge, and subsequently analysed by ABC, found that of 35 people fatally shot by NSW Police over approximately 20 years to 2018, at least 19 (54%) had a diagnosed mental illness (Wild, Miskelly & Wakatama, 2018).
- In the five years to July 2023, 52 people experiencing mental health crises died during interactions with the NSW Police Force (Byrne, 2026); that's more than 10 people per year.



There is a significant and preventable human cost associated with police responses

The human consequences of systemic failures in mental health crisis responses are longstanding, recurrent and geographically widespread across NSW. Naming those who have died or been seriously harmed during police interactions recognises that these are not merely statistics or policy issues, but people whose lives, families and communities have been profoundly affected. Some of the more widely reported incidents are described below:

Jodi Knott (2023) was brutally assaulted by police officers during a psychotic episode in Emu Plains, NSW after her release from prison. Jodie, who was diagnosed with schizophrenia, was naked in the street when encountered by police. The officers subjected her to violence which has been described as one of the most brutal police assaults ever filmed in Australia. The assault included kicking, stomping, dragging by the hair, and pepper spraying, which were recorded by body-worn camera. Jodi died of cancer 18 months after the attack. Both officers pleaded guilty to assault occasioning actual bodily harm, common assault and using a prohibited weapon without a permit, and were sentenced to terms of imprisonment (Greenbank et al., 2026; Huang, 2026).

Stanley Russell (2021) was a 45-year-old Dunghutti man with a diagnosed intellectual disability and complex mental health needs who was fatally shot by NSW police at Seven Hills, NSW, while officers were executing a bench warrant. Confronted by Mr Russell, who was armed with an axe and knife, two constables shot him five times within seconds. The coronial inquest found that police planning was deficient; officers had seen warnings of Mr Russell's history of self-harm but failed to review underlying case notes, did not consider alternatives to forced entry, and did not engage Aboriginal community liaison or disability advocacy services that may have enabled a safer, voluntary resolution. Two of the four officers also failed to activate body-worn video during the shooting. No criminal findings were made against the officers involved (NSW Coroners Court, 2023).

Continued reliance on police responses is untenable and unjust

Given this reality, it stands to reason that public confidence in policing has fallen noticeably over time, especially in recent years. As recently as May 2026, BOCSAR reported significant drops across all measures between 2019 and 2025: fewer people believe police bring people who commit crimes to justice; meet the needs of victims; handle cases promptly; respect the rights of the accused; and treat the accused fairly (BOCSAR, 2026). While this reflects



multiple factors, the frequency of distressing police encounters with people in mental health crisis contributes to the erosion of trust, particularly in First Nations communities that already have strained relationships with law enforcement.

Indeed, continued reliance on the NSW Police Force as a response to mental health crises does not only risk harm in the immediate encounter. It actively reinforces community fear and distrust, making it harder for people to seek help when they need it (Bradbury et al., 2017; Dowse et al., 2021). When the prospect of police involvement acts as a barrier to help-seeking, it constitutes a policy failure of such magnitude that it has itself become a source of the harm it was intended to address. And where a system repeatedly produces foreseeable and preventable harm, independent examination becomes a matter of public necessity. The LECC should therefore support a Royal Commission or equivalent independent public inquiry into police responses to people with mental illness.

Recommendation 3: That the NSW Police Force undertake a comprehensive review of policies, practices and Standard Operating Procedures (SOPs) to prioritise the reduction of unnecessary police involvement in mental health crisis responses.

Recommendation 4: That the LECC call for and support a Royal Commission or equivalent independent public inquiry into police responses to people with mental illness.

Case Study: 'Louise'

Louise is a young Aboriginal woman on parole who receives case work support from CRC. She was experiencing significant personal and emotional stress due to her children being removed from her care and being required to engage regularly with child protection services. On the evening before a scheduled parole appointment, Louise learned that her children's carers were seeking permanent guardianship. The news triggered an acute deterioration in her mental health and she engaged in self-harm, sustaining visible cuts to her arm.



Despite her distress, Louise attended her parole appointment the following day with support from her CRC worker who waited outside. During the appointment, her parole officer noticed the injuries and expressed concern about her wellbeing, indicating that they may need to call 000.

The prospect of police involvement immediately heightened Louise's distress. She contacted her CRC worker during the appointment, fearful that police attendance would lead to a parole breach, arrest and a return to custody. Her reaction reflected previous experiences with police involvement that were punitive rather than supportive.

At the time, Louise was not presenting a risk to public safety and a plan was already in place for her to attend hospital for mental health support following the parole appointment. Through direct communication with the parole officer, the CRC worker provided context about Louise's circumstances, clarified the level of risk and confirmed that appropriate supports were already in place. As a result, the situation was de-escalated and the parole officer decided not to call 000.

Louise was able to leave the appointment safely and access planned mental health support without further escalation.

8. OPPORTUNITIES WITHIN CURRENT NSW POLICE FORCE PRACTICES

The NSW Police Force has established specialist structures, interagency agreements and legislative diversion pathways intended to support more therapeutic responses to people experiencing mental distress. However, the existence of these mechanisms does not necessarily indicate that they are consistently operationalised, adequately resourced or achieving their intended outcomes. Accordingly, alongside consideration of broader system change, there are opportunities to improve how current police responses are delivered in practice. Importantly, strengthening police capability should complement, rather than replace, specialist health and peer-led expertise.

Specialist mental health policing structures require greater accountability

The NSW Police Force has established several organisational mechanisms intended to improve responses to mental illness, including the Mental Health Intervention Team (MHIT),



the Mental Health Strategic Action Plan, and more recently a dedicated Mental Health Command. Collectively, these initiatives indicate recognition that mental health related incidents require specialised capability and coordination rather than standard law enforcement responses.

However, the available public information focuses predominantly on organisational commitments, training structures and strategic intent, with comparatively limited visibility regarding implementation, outcomes, fidelity to practice models or measurable indicators of success. This creates difficulty in assessing whether existing initiatives are reducing coercive interactions, increasing diversion to care or improving the experiences of people with mental illness who come into contact with police.

There is an opportunity to strengthen existing structures through clearer accountability mechanisms, including public reporting on mental health related incidents, use of force, diversion outcomes and operational performance indicators linked to least restrictive and trauma-informed practice.

Interagency commitments must be translated into operational practice

The Memorandum of Understanding (MOU) between NSW Health and the NSW Police Force provides an important framework for coordinating responses to people experiencing mental health crises and reflects principles including dignity, least restrictive care, collaboration and minimisation of harm (NSW Ministry of Health & NSW Police Force, 2018). However, the MOU is primarily principles-based and relies substantially on discretionary language rather than enforceable operational expectations. As a result, there may be variability in how these principles are translated into frontline decision making, particularly in high pressure or high-risk environments.

An opportunity exists to strengthen the existing framework by introducing clearer operational requirements and review mechanisms. This could include expectations regarding documentation where least restrictive responses are not adopted, stronger guidance regarding proportionality and de-escalation, clearer thresholds for police involvement where health responses are available, and mechanisms for incorporating lived experience and cultural safety considerations into local implementation arrangements.



Mental health capability must extend beyond introductory training

In the absence of a fully implemented alternative crisis response system, specialised police training is an important harm-reduction measure for people experiencing mental distress who come into contact with police.

Specialist mental health training delivered through NSW Police Force MHIT represents an important recognition that general policing approaches are not appropriate for mental health related incidents. MHIT delivers an advanced Enhanced Police Practice Module (EPPM) for selected members who become accredited Mental Health Intervention Officers. These officers act as priority responders and are supported by designated Mental Health Contact Officers across commands. The training aims to reduce injury risk, improve officer awareness, strengthen collaboration with health services, and streamline the transfer of individuals into care (Donohue and Andrews, 2012; Police Association of New South Wales, n.d.).

However, standard recruit exposure to mental health remains limited and may not reflect the frequency, complexity and acuity of mental health presentations encountered in operational policing. Brief introductory training may improve awareness but is unlikely to develop confidence in distinguishing distress from threat, responding to trauma presentations, reducing escalation or understanding available diversion pathways.

There is an opportunity to strengthen current training arrangements by moving from a predominantly introductory model toward ongoing capability development across the policing career lifecycle. This could include mandatory refresher training, greater emphasis on practical de-escalation skills, stronger content addressing stigma and threat perception, and training co-design and co-delivery with mental health professionals and people with lived experience of mental health crisis responses.

Opportunities for early diversion should be prioritised

NSW already provides legislative and operational mechanisms intended to divert people experiencing mental illness away from criminal legal responses and toward treatment and support. These options extend to include exercising discretion not to arrest or charge where no immediate law enforcement response is required, facilitating voluntary engagement with



health services, referral to community mental health supports, consultation with specialist mental health clinicians, and transport to a declared mental health facility under section 22 of the *Mental Health Act 2007* (NSW). Later-stage court-based diversion under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) also recognise that treatment and support may often be more appropriate than criminal sanctions.

However, the continued reliance on court-based diversion may indicate that opportunities for earlier intervention are being missed. Where people are diverted only after charges are laid or court proceedings commence, they may already have been unnecessarily drawn into the criminal legal system despite the availability of therapeutic alternatives at the point of first contact.

There is an opportunity to strengthen early diversion by improving officer understanding of available pathways, increasing operational guidance regarding their use, and monitoring referral patterns and outcomes to identify barriers to implementation. Greater emphasis on diversion at the earliest point of contact may reduce unnecessary criminal legal system involvement and better align practice with the therapeutic intent of existing legislation.

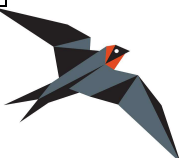
Recommendation 5: That the NSW Police Force strengthen the implementation of existing mental health response, diversion and health-led initiatives.

Recommendation 6: That the NSW Police Force commit to a comprehensive independent review and audit of NSW Police Force mental health training.

Case Study: ‘David’

‘David’ is a man in his early 30s who has received a diagnosis of paranoid schizophrenia, and experiences significant anxiety shaped by a history of trauma. He has spent much of his life in custody since adolescence. His longest period of stability in the community was for 18 months, and occurred in his 30s with the support of his CRC worker.

At the time of the incident, David was not taking his prescribed medication and was using substances, contributing to a drug-induced psychotic episode. His paranoia was closely



connected to a past traumatic event involving conflict within his community, leading him to believe he was at risk of retaliation and in immediate danger.

While experiencing acute psychosis at a train station, David became overwhelmed by fear and confusion. Believing he needed protection, he approached a nearby police vehicle and attempted to enter it to seek help. Police interpreted his behaviour as threatening and moved to physically intervene. In response, David panicked and lashed out at officers. He was rapidly restrained, forced to the ground and arrested. During the incident, he sustained visible injuries to his face and wrists.

David has very limited recollection of the incident due to his mental state at the time. He later expressed significant remorse, stating that he felt especially distressed about this event because he had been seeking help and did not understand what was happening.

Following the incident, David was charged and processed through the criminal legal system. However, with intensive advocacy from CRC, including referral to mental health and alcohol and other drug services, the provision of support letters and a psychiatric report, he was ultimately granted a diversion order under section 14 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW). Achieving this outcome required substantial effort to ensure his mental health needs and circumstances were properly recognised.

David was reconnected with mental health treatment and support, including appropriate medication and entry into an opioid treatment program. Over time, he was able to stabilise and substantially reduce his substance use.

9. COMMUNITY-LED RESPONSES TO MENTAL HEALTH CRISES

Across Australia and internationally, governments are increasingly investing in community-led, health-led and alternative first responder models as a response to concerns about the safety, effectiveness and cost of police involvement in mental health, behavioural and situational crises. These models aim to connect people with appropriate care at the earliest opportunity, reducing unnecessary criminal justice involvement and preventing crises from escalating, while evidence suggests they can improve outcomes for individuals and communities and reduce demand on police, emergency departments and other public services.



Benefits of community-led responses

A growing body of international research suggests that community-led, civilian and health-led crisis responses can deliver better outcomes for people experiencing mental distress while also reducing unnecessary police involvement, improving service access and supporting more efficient use of public resources. The principal benefits include:

- Reduced criminalisation, arrest and unnecessary police contact (Jachimowski et al., 2021; Vera Institute of Justice, 2020).
- Reduced pressure on police and emergency services (Crime and Justice Institute, 2024; Compton et al., 2024).
- Reduced reliance on emergency departments and inpatient care (Balfour & Zeller, 2023; White Bird Clinic, 2020).
- Safer and less coercive responses to crisis (Balfour & Zeller, 2023).
- Improved engagement with support and continuity of care (Balfour & Zeller, 2023; SAMHSA, 2024).
- Greater trust, dignity and experience of care for people in crisis (Bazelon Center for Mental Health Law, 2024; SAMHSA, 2024).
- Recognition and utilisation of lived experience expertise (NSW Ministry of Health, 2025; SAMHSA, 2024;).
- More culturally responsive and community-centred support (Legislative Assembly Committee on Law and Safety, 2026; National Justice Project, 2025; SAMHSA, 2024).
- Potential system-wide cost savings and more efficient resource allocation (City and County of Denver Department of Public Health and Environment, 2026; White Bird Clinic, 2020).

Principles, policies and practices for community-led responses

While community-led responses to mental health crises differ across jurisdictions, several principles, policies and practices consistently emerge as critical to the safe and effective design of co- and alternative first responder models.

Robust triage and dispatch mechanisms

Effective models require dedicated call-taking, screening and dispatch processes capable of identifying suitable incidents and directing them to co-response or alternative responders.



Dispatch systems should support dynamic reassessment and transfer between services where circumstances change (SAMHSA, 2025).

Co-design with affected communities and people with lived experience

Targeted consultation should occur throughout design, implementation and evaluation, including with people with lived and living experience of mental distress, First Nations communities, culturally and linguistically diverse (CALD) communities, LGBTQIA+ communities, young people, carers and mental health professionals.

Peer workers and lived experience expertise are recognised as core practice resources

People with lived and living experience should not be positioned solely as advisors but embedded within governance, workforce and service delivery models (NSW Ministry of Health, 2025).

Cultural safety and place-based responses are prioritised

Responses for First Nations communities should be culturally safe, community-led and adapted to local contexts, particularly in regional, rural and remote areas where service systems and relationships differ substantially. Aboriginal Community Controlled Organisations (ACCOs) are particularly well positioned to provide culturally safe, place-based responses that reflect local community priorities, strengthen self-determination and build on established relationships of trust that may not exist with mainstream services (National Justice Project, 2025).

Workforce composition reflects community needs and avoids unnecessary medicalisation

Consideration should be given to when mental health clinicians, psychologists, social workers, peer workers and other practitioners are most appropriate, and for whom. Clinical responses do not guarantee less coercive or carceral practices and may reproduce surveillance, control or involuntary intervention if implemented without safeguards (Dowse et al., 2021).

Investments in infrastructure and alternatives to emergency departments and custody

Crisis response reform requires access to adequately resourced third spaces, throughcare and follow-up supports, including drop-in centres, respite options, crisis accommodation services and ongoing outreach support. Without these pathways, responder reform risks shifting rather than resolving crisis demand (Balfour & Zeller, 2023).



Sustained investment and independent evaluation in pilot programs

Pilot programs should be appropriately resourced, implemented with clear outcomes frameworks and evaluated independently to assess impacts on safety, service access, coercive interventions, police contact and lived experience outcomes (City and County of Denver Department of Public Health and Environment, 2026).

Active avoidance of ‘reformist reforms’ that expand the reach of carceral systems

Co-response and alternative first responder initiatives should be designed to reduce unnecessary surveillance, coercion and criminalisation rather than relocate these practices into health or social care settings (Critical Resistance, 2020; Rowe et al., 2022).

Recommendation 7: That the NSW Police Force commit to the incremental reallocation of the portion of their budget currently being utilised for unnecessary and inappropriate police responses to mental health crises, in line with a justice reinvestment approach.

Recommendation 8: That the NSW Police Force and partner agencies, in the design, expansion and implementation of co-responder and alternative first responder models, adopt a holistic and multidisciplinary approach that recognises mental health crises are often shaped by intersecting social, economic and health factors.

Recommendation 9: That the NSW Government ensure that Aboriginal Community Controlled Organisations are adequately resourced and prioritised to provide culturally safe alternatives to police responses for Aboriginal and Torres Strait Islander peoples.

Co-responder models

Co-responder models involve collaboration between police and health services to provide a more clinically informed response to mental health crises, with the aim of improving diversion to care and reducing involvement with the criminal legal system. We include several notable models below. However, this should not be taken as an endorsement of police involvement as a default feature of crisis response. While these models may reduce some of the harms associated with police-only responses, there remain many situations in



which an entirely health-led, non-police response is likely to be safer, less coercive and more appropriate.

Police, Ambulance and Clinical Early Response (PACER) in NSW, Australia

PACER is a NSW Health and NSW Police co-responder initiative that embeds mental health clinicians alongside police to provide real-time assessment, de-escalation and referral at the point of crisis. A recent review of PACER programs across Australia and New Zealand found that the model is associated with reduced reliance on emergency departments, increased community-based resolution of mental health crises, improved inter-agency decision-making and more person-centred responses. Consumers also reported feeling safer, less criminalised and better understood when clinicians were involved in crisis responses, while police and paramedics reported greater confidence in assessment and referral decisions (Skopek & Khan, 2026).

Community Access Support Team (CAST), Limerick, Republic of Ireland

CAST is a joint mental health crisis co-response pilot operating in Limerick, Ireland, delivered through a partnership between An Garda Síochána (Irish Police) and the Health Service Executive (HSE) Mid-West Mental Health Services. The model deploys multidisciplinary teams including Garda members, clinical nurse specialists, social care practitioners and social work staff to respond to selected triaged 999 calls involving mental health crises or situational trauma. CAST comprising an on-scene crisis co-response and a multi-agency community support forum for follow-up and coordinated case management. The model is designed to divert individuals away from arrest, custody and emergency department presentation toward health-led, trauma-informed intervention and sustained community support, with early reporting indicating reductions in arrests and improved service linkage outcomes (An Garda Síochána & Health Service Executive, 2024; CKT, 2024).

Community Triage and Distress Brief Intervention (DBI), Scotland

DBI is a two-tiered model designed to provide rapid, compassionate support to individuals presenting in emotional distress and to reduce unnecessary escalation to emergency and policing services. At Level 1, trained frontline practitioners (initially including Police Scotland, the Scottish Ambulance Service, National Health Service (NHS) Accident and Emergency (A&E), primary care, and later NHS24) provide an immediate, de-escalating



response and, where appropriate, refer individuals within 24 hours to Level 2 support. Level 2 is delivered by third sector mental health organisations and consists of a brief (approximately 14-day), community-based, problem-solving intervention focused on stabilisation, coping strategies, and the development of a structured Distress Management Plan. Evaluation findings show rapid engagement and high rates of successful follow-up after crisis contact, a reduction in reported distress between from program entry to exit, and reductions in the need for further emergency service utilisation in the short term (Distress Brief Intervention Programme, 2022; Scottish Government, 2018).

Case Study: 'Cassie'

'Cassie' is a woman in her forties, who identifies as Aboriginal. She receives support from CRC in the context of significant lifelong disadvantage, including involvement in the child protection system, long-term substance use, homelessness and multiple periods of incarceration. She experiences complex mental health challenges and has previously been diagnosed with schizophrenia.

During a period of acute mental distress, Cassie disclosed to her CRC worker that she felt she was unsafe both to herself and to the community. CRC workers responded immediately and contacted emergency services and advocated for a health-led response with only paramedics in attendance, and specifically requested that police do not attend. The worker explained Cassie's circumstances directly to ambulance staff, including her history of criminalisation during previous mental health incidents and the likelihood that police involvement would escalate her distress.

The ambulance service responded appropriately and collaboratively. Paramedics attended without police, accepted a detailed handover from CRC workers, and transported the client directly through the ambulance intake pathway rather than requiring her to enter through the emergency department waiting environment.

The client was admitted for extended psychiatric treatment and underwent a reassessment of her diagnosis. Clinicians determined that her earlier diagnosis had been inaccurate and instead diagnosed her with schizoaffective disorder and drug-induced bipolar disorder. This led to more appropriate medication and treatment planning.



Case Study: 'Miles'

'Miles' is a man in his 30s with an intellectual disability and a long history of substance use beginning at around 12 years of age. He has experienced episodes of drug-induced psychosis and presents as a highly vulnerable individual with complex mental health and behavioural needs.

During periods of acute mental health distress, Miles may call an ambulance himself to seek help. However, due to a documented history of aggression toward paramedics, police routinely attend alongside ambulance services when responding to these calls. This dual response reflects a precautionary approach based on past incidents, rather than the circumstances of each individual presentation.

According to staff working with Miles in his supported independent living arrangement, the involvement of police in these situations has, in practice, been appropriate and measured. Rather than escalating the situation unnecessarily, officers have generally responded in a way that supports the primary goal of ensuring Miles receives mental health support.

When attending alongside paramedics, police have assisted in safely managing the situation and facilitating his transport to hospital. In instances where he is experiencing severe psychosis or poses a risk to himself or others, Miles has been taken to hospital and admitted under mental health legislation, allowing for assessment and stabilisation in a clinical setting.

Alternative first responder models

Across jurisdictions, alternative first responder models favour unarmed, plain clothes mental health clinicians, paramedics and peer workers who are highly trained in trauma-aware and compassionate de-escalation techniques to support people in crisis to access critical resources including relationship mediation, mental health support, emergency accommodation, alcohol and other drug support.

A range of innovative models show promise, with most only requiring police back up on rare occasions. Several examples of notable models are below:

Indigenous Night Patrols are community-controlled safety initiatives operating across many Northern Territory communities. Staffed by local Aboriginal people, patrols provide culturally informed, non-police responses to conflict, intoxication, youth vulnerability and



community distress. Drawing on local authority, relationships and cultural knowledge, patrols seek to prevent harm and de-escalate situations before they require police intervention, representing a practical example of community-led safety and Indigenous self-determination in justice responses (Porter, 2016, 2018).

Crisis Assistance Helping Out on the Streets (CAHOOTS)

CAHOOTS in Eugene, Oregon, US is a mobile crisis response program operated by White Bird Clinic in partnership with the Eugene and Springfield public safety systems. It deploys unarmed teams of a medic and a crisis worker to selected 911 calls involving mental health crises, substance use, homelessness and non-violent welfare concerns, with the aim of providing de-escalation, basic medical care, psychosocial support and linkage to services rather than police enforcement. The program is widely cited as a leading alternative first responder model and has been operating since 1989 as part of the local emergency response system. Of the roughly 24,000 calls CAHOOTS responded to in 2019, only 311 (1.29%) required police backup. This indicates a substantial diversion of calls away from law enforcement (White Bird Clinic, 2020; Vera Institute of Justice, 2020). Additionally, the model operates at a cost equivalent to approximately 2% of the local police budget while responding to around 17% of all emergency calls in its service area, highlighting the potential for more efficient allocation of public resources (White Bird Clinic, 2020).

The Support Team Assisted Response (STAR)

The STAR program in Denver, US is a civilian-led model that dispatches unarmed teams composed of mental health clinicians and paramedics to selected 911 calls involving behavioural health crises, substance use, homelessness and other low acuity incidents. STAR operates independently of traditional police dispatch for eligible calls and prioritises de-escalation, medical assessment, harm reduction and connection to ongoing health and social services. Early findings indicate reductions in low-level crime and re-offending in areas served by the program and low rates of police backup requests, with only around 6% of STAR-eligible calls involving joint STAR and police response (City and County of Denver Department of Public Health and Environment, 2026).



The Holistic Empathetic Assistance Response Team (HEART)

HEART in Durham, North Carolina, US dispatches unarmed teams consisting of mental health clinicians, peer support specialists and emergency medical technicians to selected 911 calls involving mental health and other behavioural health crises. HEART teams focus on de-escalation, psychosocial assessment and connection to services, with police involvement limited to situations where safety risks emerge. The program also includes a Crisis Call Diversion program that connects callers to mental health professionals when they or a loved one is experiencing a crisis. HEART's approach has resulted in a consistently low rate of requests for backup from other public safety departments and no major injuries to their responders (RTI International, 2023; Thompson, 2024).

10. RELATED FINDINGS AND RECOMMENDATIONS

The issues identified in this submission reflect broader and longstanding concerns that have been documented across multiple inquiries, reviews, coronial inquests and independent reports. CRC submits that LECC should have regard to the following findings and recommendations and encourage their implementation by the NSW Police Force where relevant.

Summary Internal Review of the NSW Police Force Response to Mental Health Incidents in the Community (2024)

Recommendation: The NSWPF recommends that the NSWPF work with NSW Health to explore models for responding to mental health incidents in NSW consistent with the principles of RCRP (NSW Police Force, 2024, p. 11).

Legislative Assembly Committee on Law and Safety – Community Safety in Regional and Rural Communities Final Report (2026)

Finding 4: Police are often called to deal with prisoner transfers, mental health incidents and truancy, but these matters would be more appropriately managed by other organisations or agencies (Legislative Assembly Committee on Law and Safety, 2026, p. 29).

Recommendation 8: That the NSW Government prioritise implementing a mental health response model that ensures police resources are used efficiently and that people with mental health needs receive appropriate, trauma-informed support (Legislative Assembly Committee on Law and Safety, 2026, p. 31).



Legislative Council, Health – Equity, Accessibility and Appropriate Delivery of Outpatient and Community Mental Health Care in New South Wales (2024)

Finding 14: That the attendance of police in mental health emergencies can escalate emotional and psychological distress and has been harmful in a significant number of cases (Legislative Council, Portfolio Committee No. 2 – Health, 2024, p. 107).

Finding 15: That a broad range of stakeholders including police representatives support a health-led approach to mental health emergencies (Legislative Council, Portfolio Committee No. 2 – Health, 2024, p. 107)

Recommendation 30: That the NSW Police Force improve mandatory comprehensive mental health training currently provided to police officers in consultation with consumers and carers (Legislative Council, Portfolio Committee No. 2 – Health, 2024, p. 107).

Recommendation 31: That in conjunction with NSW Health, NSW Police explore being activated as a secondary response to mental health emergencies only where required to support the safety of primary responders (Legislative Council, Portfolio Committee No. 2 – Health, 2024, p. 107).

Recommendation 32: That the NSW Police Force publicly release their report on the UK Right Care, Right Person model (Legislative Council, Portfolio Committee No. 2 – Health, 2024, pp. 107–108).

Recommendation 33: That the NSW Government continue to explore the implementation of a health-led response to mental health emergencies, informed by the experiences of the successful South Australian Mental Health Co-Responder program, the Western Sydney Mental Health Acute Assessment Team and PACER, including informed risk assessment through access to medical records, as well as support for carers of the person experiencing crisis (Legislative Council, Portfolio Committee No. 2 – Health, 2024, p. 108).

Recommendation 34: That in seeking to develop a new approach to responding to mental health crises, NSW Police Force, NSW Health and NSW Ambulance ensure that any review or new model be co-designed with consumers and carers (Legislative Council, Portfolio Committee No. 2 – Health, 2024, p. 107).

Disability Royal Commission Final Report, Volume 8: Criminal Justice and People with Disability (2023)



Recommendation 8.20: Improving police responses to people with disability: That the Australian Government and state and territory governments and police services should collaborate with people with disability in the co-design, implementation and evaluation of strategies to improve police responses to people with disability. That all police services should introduce adequate numbers of dedicated disability liaison officers. That the Australian Government and state and territory governments should introduce an alternative reporting pathway for people with disability to report crimes to police (Disability Royal Commission, 2023).

Royal Commission into Aboriginal Deaths in Custody Final Report (1991)

The Criminal Justice System: Relations with Police

Recommendation 60: That Police Services take all possible steps to eliminate:

- a) Violent or rough treatment or verbal abuse of Aboriginal persons including women and young people, by police officers; and
- b) The use of racist or offensive language, or the use of racist or derogatory comments in log books and other documents, by police officers. When such conduct is found to have occurred, it should be treated as a serious breach of discipline.

Recommendation 61: That all Police Services review their use of para-military forces such as the New South Wales SWOS and TRG units to ensure that there is no avoidable use of such units in circumstances affecting Aboriginal communities.

Diversion from Police Custody

Recommendation 85: That:

- a) Police Services should monitor the effect of legislation which decriminalises drunkenness with a view to ensuring that people detained by police officers are not being detained in police cells when they should more appropriately have been taken to alternative places of care;
- b) The effect of such legislation should be monitored to ensure that persons who would otherwise have been apprehended for drunkenness are not, instead, being arrested and charged with other minor offences. Such monitoring should also assess differences in police practices between urban and rural areas; and



- c) The results of such monitoring of the implementation of the decriminalisation of drunkenness should be made public.

Recommendation 87: That:

- a) All Police Services should adopt and apply the principle of arrest being the sanction of last resort in dealing with offenders;
- b) Police administrators should train and instruct police officers accordingly and should closely check that this principle is carried out in practice;
- c) Administrators of Police Services should take a more active role in ensuring police compliance with directives, guidelines and rules aimed at reducing unnecessary custodies and should review practices and procedures relevant to the use of arrest or process by summons and in particular should take account of the following matters:
 - i. all possible steps should be taken to ensure that allowances paid to police officers do not operate as an incentive to increase the number of arrests;
 - ii. a statistical data base should be established for monitoring the use of summons and arrest procedures on a Statewide basis noting the utilisation of such procedures, in particular divisions and stations;
 - iii. the role of supervisors should be examined and, where necessary, strengthened to provide for the overseeing of the appropriateness of arrest practices by police officers;
 - iv. efficiency and promotion criteria should be reviewed to ensure that advantage does not accrue to individuals or to police stations as a result of the frequency of making charges or arrests; and
 - v. procedures should be reviewed to ensure that work processes (particularly relating to paper work) are not encouraging arrest rather than the adoption of other options such as proceeding by summons or caution; and



- d) Governments, in conjunction with Police Services, should consider the question of whether procedures for formal caution should be established in respect of certain types of offences rather than proceeding by way of prosecution.

Improving The Criminal Justice System: Aboriginal People and Police

Recommendation 214: The emphasis on the concept of community policing by Police Services in Australia is supported and greater emphasis should be placed on the involvement of Aboriginal communities, organisations and groups in devising appropriate procedures for the sensitive policing of public and private locations where it is known that substantial numbers of Aboriginal people gather or live.

Recommendation 215: That Police Services introduce procedures, in consultation with appropriate Aboriginal organisations, whereby negotiation will take place at the local level between Aboriginal communities and police concerning police activities affecting such communities, including:

- a) The methods of policing used, with particular reference to police conduct perceived by the Aboriginal community as harassment or discrimination;
- b) Any problems perceived by Aboriginal people; and
- c) Any problems perceived by police. Such negotiations must be with representative community organisations, not Aboriginal people selected by police, and must be frank and open, and with a willingness to discuss issues notwithstanding the absence of formal complaints.

Recommendation 228: That police training courses be reviewed to ensure that a substantial component of training both for recruits and as in-service training relates to interaction between police and Aboriginal people. It is important that police training provide practical advice as to the conduct which is appropriate for such interactions.

Recommendation 231: That different jurisdictions pursue their chosen initiatives for improving relations between police and Aboriginal people in the form of police aides, police liaison officers and in other ways; experimenting and adjusting in the light of the experience of other services and applying what seems to work best in particular circumstances



CRC Submission to the Select Committee on Youth Justice (2026)

Recommendation 27: Government considering alternative first responders to the police.

CRC Submission to the UN Working Group on Arbitrary Detention (2025)

Recommendation 26: That governments implement alternative first responders to the police in instances that more suitably require a social or mental health response.

CRC Submission to the Mental Health Commission of NSW (2025)

Recommendation: Alternative first responders could improve mental health and wellbeing across our communities.

Recommendation 10: That the NSW Police Force undertake a comprehensive review of recommendations from previous Commissions, inquiries and reviews relevant to policing and mental health, and publicly report on their implementation status, ongoing relevance and any reasons for non-implementation.

11. RECOMMENDATIONS

Recommendation 1: That the LECC formally recognise and communicate, through its reporting and advisory functions, the evidence supporting alternative first responder models for mental health crisis response, including community-led and lived-experience-informed approaches that reduce reliance on police intervention.

Although the LECC has noted it cannot make recommendations about whether agencies other than police should act as first responders in NSW, it should avoid narrowing or limiting discussion on alternatives to police. There is substantial evidence that community-led mental health responses can reduce police involvement and improve outcomes for people experiencing mental health crisis and distress. The contrast between these rights-based, life-affirming approaches and current police responses to mental illness is directly relevant to the LECC's oversight role and should be openly acknowledged.

The LECC's credibility as an oversight body is strengthened, not compromised, by naming the limits of what policing can achieve in mental health crisis contexts. CRC calls on the LECC to use its reporting function to the fullest extent of its mandate, and to actively communicate to the NSW Government the significant body of evidence supporting



community-led, lived-experience-informed responses that reduce the need for police intervention in the first instance.

Recommendation 2: That the NSW Government recognise harmful policing practices toward people with mental illness as a public health issue.

The pattern of harmful police interactions with people experiencing mental health crisis is not a series of isolated incidents. It is a systemic and recurring feature of a system that has positioned police as both first and last resort for what are fundamentally health and welfare needs. CRC calls on the LECC to name this explicitly: the harms produced by police responses to mental health crisis constitute a public health issue, and should be understood and responded to as such.

The long-term goal of reform must therefore be a system in which police are called to mental health situations only where there is a genuine and specific risk to safety that cannot be managed otherwise. Achieving this requires sustained investment in the broader human services system, including community mental health services, civilian-led crisis support, stable housing, and the social infrastructure that prevents crises from escalating to the point of emergency response. Policing reform alone cannot achieve this reorientation. CRC urges the LECC to communicate clearly to the NSW Government that reducing police involvement in mental health crises depends on building the capacity of the systems that sit alongside and upstream of police in the continuum of community support.

Recommendation 3: That the NSW Police Force undertake a comprehensive review of policies, practices and Standard Operating Procedures (SOPs) to prioritise the reduction of unnecessary police involvement in mental health crisis responses.

The NSW Police Force has acknowledged that police are not the most appropriate first responders to the majority of mental health incidents. CRC recommends that the LECC call on the NSW Police Force to translate this acknowledgement into binding policy and operational practice including by setting measurable targets for reducing police attendance at non-violent mental health call-outs, and by prioritising community-based and health-led diversion wherever available.



Recommendation 4: That the LECC call for and support a Royal Commission or equivalent independent public inquiry into police responses to people with mental illness.

The scale of harm produced by police responses to people experiencing mental health crisis in NSW has reached a point that demands scrutiny beyond what existing oversight mechanisms have been able to provide. An average of approximately 10 deaths per year in NSW involving people in mental health crisis and police is a figure that, considered alongside the broader toll of non-fatal injury, trauma and criminalisation, points to a systemic failure of significant public consequence and public interest. While the current request for input will undoubtedly yield a range of survey responses and submissions that contain compelling and practical recommendations, these are unlikely to drive the institutional accountability and transformation needed to prevent ongoing harm to people experiencing mental health crises and their communities.

CRC calls on the LECC to recommend the establishment of a Royal Commission or equivalent independent public inquiry into police responses to people experiencing mental health crisis. Such an inquiry should have sufficient scope and independence to examine the structural, systemic and cultural factors informing use of force and criminalisation approaches during mental health responses, and the authority to make recommendations that are binding, or at minimum subject to a formal NSW Government response and implementation timeline.

People with lived experience of mental health crisis and police contact, and their families and carers, must be at the heart of any such inquiry, with their experiences, expertise and perspectives shaping the inquiry's priorities and processes, and guiding its recommendations.

The dehumanisation, injury and death of people experiencing mental health distress at the hands of police are not aberrations. They are the predictable consequence of a system that has not been subject to the level of public scrutiny its human cost demands. That must change.

Recommendation 5: That the NSW Police Force strengthen the implementation of existing mental health response, diversion and health-led initiatives.



The NSW Police Force has developed a substantial set of internal structures and interagency arrangements intended to support therapeutic responses to mental health related incidents, described at section 10 above. While imperfect, these frameworks represent a shift toward recognising mental health crisis as a health issue that requires specialist support and coordination rather than a default law enforcement response.

However, the existence of these mechanisms does not necessarily translate into consistent operational change at the point of crisis. There is limited visibility in publicly available information about how, and when, these opportunities are utilised, how consistently the least restrictive options are applied, and whether specialist capability structures are reducing coercion or escalation when police interact with people experiencing mental health crises. Strengthening this requires clearer accountability for how existing frameworks are implemented in practice, including more systematic reporting on use of force and criminal legal outcomes for people who come into contact with police during mental health distress.

Recommendation 6: That the NSW Police Force commit to a comprehensive independent review and audit of NSW Police Force mental health training.

Training reform is an insufficient but necessary step toward reducing harm to people experiencing mental health crises in the community. Existing training should be independently audited, with mental health organisations contributing to its development. There is an opportunity to improve how existing capability is distributed across the workforce. While the MHIT provides a higher level of specialist expertise, most frontline responses continue to rely on generalist training that is not sufficient for the complexity of mental health presentations. Improving consistency of practice would involve embedding ongoing skills development in compassionate de-escalation and trauma-informed responses across all officers and reinforcing the intended use of diversion pathways at the earliest point of contact.

Recommendation 7: That the NSW Police Force commit to the incremental reallocation of the portion of their budget currently being utilised for unnecessary and inappropriate police responses to mental health crises, in line with a justice reinvestment approach.

Where NSW Police Force resources are currently being utilised to respond inappropriately to mental health related incidents, there is a clear policy opportunity to reconsider the



allocation of expenditure in light of the NSW Police Force's position that these are not primarily policing matters. An incremental reallocation of this element of the NSW Police Force budget would allow funds currently used for mental health call-outs to be redirected toward alternative responder models and the broader health and social infrastructure and resources that would enable relational, holistic and non-coercive interventions. This would better reflect the underlying nature of mental health presentations and support the development of systems that reduce reliance on police as a default responder for people experiencing mental health crises.

Recommendation 8: That the NSW Police Force and partner agencies, in the design, expansion and implementation of co-responder and alternative first responder models, adopt a holistic and multidisciplinary approach that recognises mental health crises are often shaped by intersecting social, economic and health factors.

People experiencing mental distress frequently present with overlapping needs including homelessness, alcohol and other drug use, poverty, social isolation, trauma, disability and material disadvantage. These factors may contribute to, intensify, or prolong crisis and can increase contact with police in ways that are not resolved through clinical intervention alone. Effective first responder models should therefore integrate mental health support with housing, alcohol and other drug support, disability support and pathways to practical assistance and material resources, in order to reduce escalation and respond to the underlying drivers of distress rather than its immediate presentation.

Recommendation 9: That the NSW Government ensure that Aboriginal Community Controlled Organisations are adequately resourced and prioritised to provide culturally safe alternatives to police responses for Aboriginal and Torres Strait Islander people.

In light of the well-documented harms of the over-policing of First Nations communities, community-controlled responses are likely to be more trusted, more effective and more consistent with principles of self-determination than mainstream service models. In collaboration with Aboriginal Community Controlled Organisations, communities should have the authority to design and deliver responses that reflect local priorities, cultural knowledges and local understandings of safety and wellbeing.

Recommendation 10: That the NSW Police Force undertake a comprehensive review of recommendations from previous Commissions, inquiries and reviews relevant to policing



and mental health, and publicly report on their implementation status, ongoing relevance and any reasons for non-implementation.

Decades of Commissions, inquiries and independent reviews have repeatedly identified many of the same risks, failures and opportunities for reform in police responses to people experiencing mental health crisis. CRC recommends a comprehensive and publicly reported review of the implementation status, ongoing relevance and outcomes of these recommendations, including but not limited to those discussed in section 12, to ensure lessons already identified are not continually rediscovered at the cost of preventable harm.

12. CONCLUSION

From CRC's perspective, the LECC's request for input has implications that reach well beyond individual crisis encounters. Many of the people we work with have moved through a predictable and preventable sequence flowing from unmet mental health needs and a crisis response that defaulted to police, with entry and re-entry into the criminal legal system on charges arising from distress rather than criminal offending. The well-documented harms of incarceration, including separation from family and community, loss of housing, trauma and institutionalisation, deepen the very conditions that triggered the original crisis.

The evidence presented throughout this submission points to a simple conclusion: mental health crises are fundamentally health and social welfare events, not law enforcement problems. While police may continue to have a role in a small number of situations involving serious and immediate risks to safety, the default reliance on police as first responders has produced avoidable injury, death, criminalisation, trauma and distrust on a scale that cannot be regarded as acceptable or defensible.

Responses to mental health crises that do not rely on police, particularly for non-violent, welfare-based contacts, have the potential to meaningfully reduce the number of people who enter the criminal legal system based on unmet need. This is both a humanitarian argument and a practical one. It would reduce the harms people experience through the criminal legal system, reduce the costs borne by that system, and support a more inclusive and effective approach to individual and collective wellbeing, as well as community safety.



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