Aboriginal Health and Medical Research Council of NSW

Mental Health and Policing Interactions In NSW

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Executive Summary

Aboriginal people who experience mental illness or distress deserve a safe and supportive emergency response that can get them the care they need without stigmatisation or violence. Unfortunately, this is not the case in New South Wales.

Aboriginal people who experience mental distress are more vulnerable to police violence, criminalisation, and systemic discrimination, and this disparity will not be addressed without the establishment of a NSW Police and Community Mental Health Strategy and an overhaul of the current mental health training regimen for NSW police officers.

The topic of mental health exists within a complex and intersecting system of determinants and factors, including race, access to services, substance use, homelessness, and trauma. To begin working towards safer conditions for people with mental illness, mental health must be considered within this ecosystem. Policing, as well, is not a neutral position. Police exist within a historical and contemporary context that intersects with the systemic and violent criminalisation of marginalised communities, particularly Aboriginal people.

NSW Police responses to people with mental illness and people experiencing mental distress are routinely inappropriate and damaging to the NSW Police reputation. Due to a lack of training, structural support, or strategic development, NSW Police responses are stigmatising, violent, and fail to recognise the obligations of the NSW Police to care for all NSW citizens. NSW Police officers will encounter people experiencing mental illness across all aspects of their work and should be equipped with the resources they need to make safe decisions and provide the care that the public deserves.

The AH&MRC Recommendations

1. The development of a comprehensive NSW Police and Community Mental Health Strategy that will guide a suite of new trainings and policies, developed in collaboration between NSW Police, peak bodies, people with lived experience and Aboriginal communities.
2. The establishment of a multi-disciplinary advisory council made up of stakeholder representatives, including people with lived experience, to oversee the development of the NSW Police and Community Mental Health Strategy.
3. The immediate overhaul of the NSW Police Mental Health Command and roll out of comprehensive, evidence-based and culturally informed mental health first-aid training for police officers.

About the AH&MRC

The AH&MRC, formerly the Aboriginal Health Resource Co-op (AHRC) was established in 1985 following a recommendation of the Brereton Report by the NSW Aboriginal Task Force on Aboriginal Health in 1982-83.

The AH&MRC assists the ACCHO Sector across NSW to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities.

As the Peak Body for Aboriginal Health in NSW the AH&MRC represents the rights and interests of 52 Member Services. The AH&MRC is committed to the delivery of four key priorities. These are:

- Aboriginal Community Control and Innovation

- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC works collaboratively with the ACCHO Sector across NSW to ensure accessibility, sustainability and adequate resourcing of a skilled workforce providing comprehensive primary health care services for Aboriginal communities.

Opportunity to review

Thank you for this opportunity to make a submission to the Law Enforcement Conduct Commission regarding mental health and policing interactions in NSW. As the peak body for Aboriginal Community Controlled Health Organisations (ACCHOs) it is incredibly valuable for us to respond to the current state of policing in NSW and the violent way that policing intersects with the current crisis in mental healthcare provision. Aboriginal people are especially vulnerable to violence and criminalisation through inappropriate police responses to mental health crisis.

The focus of this submission will be on the need to establish a police response to mental health and inadequacies of mental health training for police officers. While we understand that the LECC is unable to make comments or recommendations regarding other agencies, co-response and secondary response models are undoubtedly the policies that will make the greatest difference to the rate of critical incidents involving people in mental distress. The NSW Police Force has a responsibility to do everything possible to become accommodating to the adoption of these models, including the standardisation of mental health first aid and deescalation training.

For this submission, we will be respectfully referring to all Aboriginal and Torres Strait Islander people as Aboriginal people. It is important to note that mental health encapsulates a broad spectrum of experiences, and there is no single term that can account for all of them. For this reason, the AH&MRC will be referring to people with mental illness, and people experiencing mental health crises, with acknowledgement that these terms are inadequate to describe the complexity of individual circumstance.

AH&MRC response

The mental healthcare system has become increasingly fragmented, and Aboriginal communities are unable to access adequate care before mental health concerns become mental health emergencies.

After the publication of the Richman Report in 1983 following the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled, New South Wales underwent a period of deinstitutionalisation. During this transition, there was a comprehensive reprioritisation of funding away from legacy institutions towards decentralised, community-based mental health services with the last of the large residential centres closing in 2019[1]. The process of deinstitutionalisation has been interwoven with the establishment of the National Disability Insurance Scheme (NDIS) in 2013 which solidified a policy shift towards a market-led neoliberal approach to mental health provision[2]. In the decades since the Richman Report the mental health system has suffered chronic underfunding and services have become increasing disjointed and fragmented. In a paper addressing Australia's National Mental Health Strategy, authors wrote that *'based on the prevalence and burden of mental ill health among Australians*[3]*.'* This has resulted in more and more Australians being unable to access mental health treatment in the community.[4]These issues have already been investigated many times before, most recently in the Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales, which came out with several exhaustive recommendations regarding police, none of which have been implemented[5].

The impact of such a fragmented system is especially apparent in rural and remote areas[6], and in Aboriginal communities[7]. According to the Australian Institute of Health and Welfare, mental illness and substance use disorders are the leading cause of total disease burden among Aboriginal people[8]. This has been well known for some time, and there are many proposed reasons for why, from the impact of the Stolen Generations, social and economic disadvantage, the loss of language and culture, to the experience of racism within Australia's health systems. This prevalence of mental illness in Aboriginal communities exists alongside incidents of mental distress, and mental health emergencies which may occur in the absence of mental illness.

Aboriginal Community Controlled Health Organisations (ACCHOs) have been instrumental in attempting to fill the gaps left by deinstitutionalisation with a wrap-around holistic health model, exemplified by a framework of social and emotional wellbeing (SEWB). Where the term 'mental health' is hindered by its narrowness and origins in western and paternalistic understandings of wellness, SEWB has much greater applicability to the broader and more comprehensive

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[1] Howard, A., Johnston, L., Tseris, E., & Joseph, P. (2024). "Not just a new house": The complexities of undoing institutional practices and identities in transitions to community living. *Australian Journal of Social Issues*. https://doi.org/10.1002/ajs4.315

[2] Howard, A., Johnston, L., Tseris, E., & Joseph, P, "Not just a new house".

[3] Rosenberg, S., Salvador-Carulla, L., & Rosen, A. (2023). Mental health reform in Australia – unfinished business. *BJPsych International*, *20*(4), 99–101. https://doi.org/10.1192/bji.2023.19

[5] Portfolio Committee No.2. (2024). Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. NSW Parliament.

[6] Rosenberg, S., & Roberts, R. (2021). Models of Service delivery and funding of Mental health services. In *Handbook of rural, remote, and very remote mental health*. Springer. https://doi.org/10.1007/978-981-15-6631-8_8

[7] Page, I. S., Leitch, E., Gossip, K., Charlson, F., Comben, C., & Diminic, S. (2022). Modelling mental health service needs of aboriginal and torres strait islander peoples: A review of existing evidence and expert consensus. *Australian and New Zealand Journal of Public Health*, *46*(2), 177–185. https://doi.org/10.1111/1753-6405.13202

[8] Australian Institute of Health and Welfare. (2022). Australian burden of Disease study: Impact and causes of illness and death in Aboriginal and torres strait islander people 2018, summary. In *Australian Institute of Health and Welfare*. https://www.aihw.gov.au/reports/burden-of-disease/illness-death-indigenous-2018/summary

Aboriginal approach to health[9]. SEWB accounts for not only specific mental disorders, but to the individual and community experience of mental difference. It prioritises the crux of the matter, wellbeing, and centres that wellbeing within the community rather than the isolated individual[10]. ACCHOs have utilised this model to manage the inaccessibility of service options that are often either prohibitively expensive in the private sphere, culturally unsafe in the public sphere, or completely unavailable in either[11].

It is important to recognise the crisis in mental health care provision as important context for the current position of NSW Police, which will be explored in the next section.

The NSW Police Force is ill-equipped to respond to people in the community experiencing a mental health crisis and require a comprehensive and trauma-informed Mental Health Strategy.

The role of police in responding to people with mental health is one of default. Police are available 24/7 and best equipped to respond to perceived or imagined risk of people experiencing mental health crises[12]. In the wake of deinstitutionalisation and the ongoing failure to fund community mental health services, police have become the default emergency response to mental illness in the community. The problem with this expansion of the police role is that the incidents they are attending are most often medical emergencies, incongruous with a law-enforcement response. The function of the police is to detect crime, and protect life, and to fulfil these functions, police officers are equipped with a specific and historic set of tools such as arrest, detainment, and violence[13]. These are not the tools that an emergency service should be using to respond to a mental health crisis; they are fundamentally incompatible.

Note: With 2026 changes to the NDIS and the National Disability Insurance Agency it is anticipated that people with psychosocial disabilities will be removed from the scheme. It is likely this will lead to people with psychosocial disabilities falling through the cracks and experiencing greater exposure to NSW Police.

In a study of people with mental illness who had been apprehended by police, one Aboriginal participant remarked: *"I'm cowering on the nature strip, because I had a lot to do with the deaths in custody stuff, and I'm curled up on the nature strip going "Please don't kill me", because I thought they were going to take me back to the police station and bash me[14]."* This is not an unreasonable fear. [15].

This case is far from isolated. According to data obtained and published by The Guardian Australia, 52 people experiencing mental health emergencies were killed in

[9] Australian Indigenous HealthInfoNet. (2017). *Social and Emotional Wellbeing*. Australian Indigenous HealthInfoNet. https://healthinfonet.ecu.edu.au/learn/health-topics/social-and-emotional-wellbeing/

[10] Dudgeon, P., Bray, A., D'Costa, B., & Walker, R. (2017). Decolonising psychology: Validating social and emotional wellbeing. *Australian Psychologist*, *52*(4), 316–325. https://doi.org/10.1111/ap.12294

[11] Zhang, L., Hou, X.-Y., & Liu, Y. (2024). Measuring mental health service accessibility for Indigenous populations: A systematic review. *Journal of Racial and Ethnic Health Disparities*, *12*(1). https://doi.org/10.1007/s40615-023-01899-6

[12] Clifford, K. (2010). The thin blue line of mental health in Australia. *Police Practice and Research*, *11*(4), 355–370. https://doi.org/10.1080/15614263.2010.496561

[13] Dodd, S., Morgan, M., Weir, B., & Bowyer, J. (2024). Police use of force in Mental health crises: An analysis of Coronial inquest findings from Australia. *International Journal for Crime Justice and Social Democracy*, *14*(4). https://doi.org/10.5204/ijcjsd.3560

[14] Randall, R., Kennedy, H., Karanikolas, P., Bashfield, L., Rayner, A., Nguyen, F., Wu, L., Martin, R., Thomas, S., & Maylea, C. (2024). "I was having an anxiety attack and they pepper sprayed me": police apprehension in mental health contexts in Australia. *Policing & Society*, *35*(1), 1–16. https://doi.org/10.1080/10439463.2024.2372354

[15] Users News (UN). (2024, September 5). *In NSW, cops are first responders to mental health emergencies, but are there other options?* Users News (UN). https://www.usersnews.com.au/home/in-nsw-cops-are-first-responders-to-mental-health-emergencies-but-are-there-other-options

interactions with NSW Police between 2019 – 2023[16].In 2023, the Law Enforcement Conduct Commission (LECC) published a report, revealing that almost half of the people involved in critical incidents were experiencing a mental health crisis, and 12% were Aboriginal people[17]. People involved in such incidents report unnecessary use of force, the use of tasers and pepper spray, being handcuffed, thrown around and fearing for their lives during their interactions with police[18]. In a LECC report into complaints made by Aboriginal people, 34% were regarding police use of force[19].

The police are the decision-makers when they are on scene with people in mental distress, and this level of discretion can be detrimental to a person's chances of receiving treatment and poses the risk that they may be criminalised rather than cared for[20]. On scenes where both paramedics and police are present, there is a lack of genuine collaboration and a lack of cohesion between emergency services. This can damage individuals' relationship with not only the police service but with paramedics and undermines the health care approach taken by members of NSW Ambulance.

Aboriginal people are particularly vulnerable to police discretionary decision-making, and this is demonstrated in the disproportionate numbers of Aboriginal people being criminalised. Aboriginal people are the most incarcerated population on the planet[21], and over 40% of incarcerated Aboriginal people are estimated to have some kind of mental health condition[22]. Racism is pervasive within all police forces across Australia, including NSW, but goes unrecognised within official reporting. In NSW especially, racism can be attributed to individual officers and instances, but there is no appetite to acknowledge the historic and systemic racism that supports the criminalisation of Aboriginal people. A culture of racism within NSW Police accommodates racist policing and contributes to the overrepresentation of Aboriginal people in use-of-force events and incarceration more broadly.

NSW Police officers lack the training to address a mental health crisis without needing to rely on detention, restriction, seclusion, or violence. In situations that are purely medical emergencies, they are unable to make mental health assessments or engage in any triaging process; their only capacity is to detain and transport people experiencing mental distress to overwhelmed and overwhelming emergency departments. In situations where a crime has been committed, or there is a definitive threat to life and safety, the police are still direly ill-equipped. Deescalating situations including people who may not be in their right mind requires clear understanding of how to recognise nuanced behaviours, and police have not been trained to respond safely. Sometimes a patient-centred and trauma-informed approach to people with mental illness may contradict regular police training altogether.

Despite the devastating impact of police responses to people with mental illness, NSW Police are still attending situations that are made more dangerous by them being there, ill-equipped to detect

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[16] McLeod, C., & Beazley, J. (2023). NSW police must speak with mental health experts rather than shoot our loved ones, stepfather says. *The Guardian Australia*.

[17] Law Enforcement Conduct Commission. (2023). *Five Years of Independent Monitoring of NSW Police Force Critical Incident Investigations*. Law Enforcement Conduct Commission of NSW .

[18] Randall, R., Kennedy, H., Karanikolas, P., Bashfield, L., Rayner, A., Nguyen, F., Wu, L., Martin, R., Thomas, S., & Maylea, C. (2024). "I was having an anxiety attack and they pepper sprayed me": police apprehension in mental health contexts in Australia. *Policing & Society*, *35*(1), 1–16. https://doi.org/10.1080/10439463.2024.2372354

[19] Law Enforcement Conduct Commission. (2024). *Analysis of complaints made by or on behalf of Aboriginal and Torres Strait Islander People - An Observations Paper*.

[20] Godfredson, J. W., Ogloff, J. R. P., Thomas, S. D. M., & Luebbers, S. (2010). Police discretion and encounters with people experiencing mental illness. *Criminal Justice and Behavior*, *37*(12), 1392–1405. https://doi.org/10.1177/0093854810383662

[21] Anthony, T. (2017). FactCheck: Are first Australians the most imprisoned people on earth? In *The Conversation*. https://theconversation.com/factcheck-are-first-australians-the-most-imprisoned-people-on-earth-78528

[22] Australian Institute of Health and Welfare. (2024). The health and wellbeing of First nations people in Australia's prisons 2022, summary. In Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/prisoners/the-health-and-wellbeing-of-first-nations-people-i/summary

genuine danger, and unable to provide the necessary care to keep people safe. This has been noted by NSW Police themselves in a report on the current police approach to mental health, stating: *'Consumer and lived experience sentiment highlights that police may not be the most appropriate agency to provide the primary response to the majority of mental health crisis and emotional distress incidents in the community*[23]*.'* The solution proposed by NSW Police in that report is to establish co-response and secondary responses that decentre police and while that is undoubtedly the correct trajectory for policy to go in, it is also a way for NSW Police to shirk their responsibilities to the public. NSW Police require a specific approach to mental health crises that is informed by lived experience, intersectional discrimination, and the needs of the community. There is no way for NSW Police to entirely avoid exposure to people with mental illness or people experiencing mental health crises, and they should be able to maintain safety in all instances.

It is unacceptable that Aboriginal people who experience a mental health crisis have a reasonable expectation that if the police attend to them, they may experience violence, including the use of lethal force. Aboriginal communities deserve a police force that represents safety and protection, rather than the threat of violence, and it is imperative that structures within NSW Police enact swift and effective change.

NSW Police training for their officers around mental health is wholly inadequate and represents a failure to fulfill the duty of care held by police.

There has been a call in recent years to reaffirm the police's role to detect crime and protect life, as well as to explore models that decentre police responses to mental health incidents. This has been echoed by the NSW Police themselves in their 2024 internal review, which cited their support for secondary and co-response models, recommending that '*the NSWPF work with NSW Health to explore models for responding to mental health incidents in NSW*[24]*.'* These are often referred to as secondary and co-response models, depending on whether police are present, and have already been successfully trialled across Australia and in NSW[25]. Secondary and co-response models can divert people away from involuntary hospital admission, back to community-based treatment through deescalation and in-the-field intervention. Peer-reviewed studies have found positive outcomes for co-responder models, and they are considered safer and more trustworthy by people with lived experience[26].

The NSW Police perspective is that most mental health incidents are best dealt with by medical professionals, and that mental health training for police officers, *'is unlikely to adequately address the needs and risk to people experiencing mental health conditions in the community*[27]*.'* While it is obvious that alternative models to mental health incidents are a necessity for the safety of the public, to propose that there is nothing wrong with the current regimen of police mental health training is a complete failure of oversight.

There has been much made of the fact that police officers are not medical professionals and should not be expected to be, but this attempt to distinguish between the role of police and

[23] New South Wales Police Force. (2024). *Summary Internal Review of the NSW Police Force response to mental health incidents in the community* . NSWPF, p.6.
[24] New South Wales Police Force. (2024). *Summary Internal Review of the NSW Police Force response to mental health incidents in the community* . NSWPF.
[25] Maylea, C., Kennedy, H., & Karanikolas, P. (2025, June). *Police aren't properly trained for mental health crises – but they're often the first responders. Here's what works better*. The Conversation. https://theconversation.com/police-arent-properly-trained-for-mental-health-crises-but-theyre-often-the-first-responders-heres-what-works-better-257641
[26] Randall, R., Kennedy, H., Karanikolas, P., Bashfield, L., Rayner, A., Nguyen, F., Wu, L., Martin, R., Thomas, S., & Maylea, C. (2024). "I was having an anxiety attack and they pepper sprayed me": police apprehension in mental health contexts in Australia. *Policing & Society*, *35*(1), 1–16. https://doi.org/10.1080/10439463.2024.2372354
[27] New South Wales Police Force, *Internal Review of Mental Health*, p.6.

medical first-responders fails to recognise the foundational obligations of all the emergency services. Police officers should be trained on how to respond to people with mental illness not because they are medical professionals, but because they have a duty of care to the public. If the purpose of the police is to detect crime and protect life, they have an obligation to properly equip their officers with the training they need to make safe choices that will save lives. This is an obligation that NSW Police have continuously failed to fulfil.

In 2008, NSW Police began delivering 4-day Mental Health Intervention Team (MHIT) training[28]. The initiative was based on the Memphis Model of Crisis Intervention Team, or CIT, developed in 1988 after a man with mental illness was fatally shot by Memphis Police.[29] CIT is not evidence based, and while it has been noted to have some effect in the short term, these effects have not been validated beyond six-months[30]. This initiative was initially supposed to create a population within NSW police officers who could be prioritised by dispatchers when responding to incidents including people with mental illness, but in the program's almost decade long run, this never came to fruition. It was later published in a report by the LECC that this population of specially trained police officers could never have been possible as the unit responsible for the training was staffed by only three officers and couldn't even train more police officers in a year than were annually recruited[31]. During the whole period between 2008 and 2019 only 2,420 officers were trained using the 4-day package[32], accounting for an absolute maximum of less than 15 percent of all police officers on the street today, though it is likely many fewer than that.

Despite the initiative ceasing the 4-day training in 2019, NSW Police still reference the training package in their 2024 internal review. The review describes the training as educating police to:

> *'Identify behaviours in the field indicative of mental illness and provides tools such as communication strategies, risk assessment, de-escalation, and crisis intervention techniques. It also allows for an understanding of the Mental Health Act 2007 and the accompanying MOU between the NSWPF, Ambulance Service and Ministry of Health[33].'*

Not one part of that curriculum could be described as anything less than absolutely necessary for the role of a police officer, and yet in 2020, the training package *'underwent a review and the curriculum was revised and condensed into a two-day training package[34].'* It has not been made public what was removed in this process, but the training was undoubtedly weakened. The new 2-day package became known as the Enhanced Policing Practice Module, and it has never been revealed to the public what is taught in the module.

Despite the first round of cuts to the training halving the face-to-face component, the training was halved again in 2022 and cut down to a one-day course[35]. This course was rolled out to all NSW Police officers as a standard annual training, with the option to additionally receive the 2-day Enhanced Policing Practice Module depending on an officer's experience level[36]. This would mean that the most specialised police officer would be someone with a total of three days' worth of training, which is less than even the initial 4-day training from 2008. Since changes in 2022

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[28] New South Wales Police Force, *Internal Review of Mental Health*, p.13.

[29] Watson, A., & Fulambarker, A. (2013). The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Practice Mental Health*, *8*(2).

[30] Davidson, M. L. (2014). A criminal justice System–Wide response to Mental illness: Evaluating the Effectiveness of the Memphis Crisis Intervention Team Training Curriculum Among Law Enforcement and Correctional Officers. *Criminal Justice Policy Review*, *27*(1), 46–75. https://doi.org/10.1177/0887403414554997

[31] LECC, *Five Years of Independent Monitoring of NSW Police Force Critical Incident Investigations*. Law Enforcement Conduct Commission of NSW, p.43.

[32] LECC, *Five Years of Independent Monitoring*, p.43.

[33] New South Wales Police Force, *Internal Review of Mental Health*, p.5.

[34] New South Wales Police Force, *Internal Review of Mental Health*, p.5.

[35] New South Wales Police Force, *Internal Review of Mental Health*, p.5.

[36] New South Wales Police Force, *Internal Review of Mental Health*, p.5.

NSW Police have since overhauled the MHIT unit, replaced it with the Mental Health Command, but not changed the actual training in any way[37].

This approach to mental health training is deeply tokenistic, disingenuous, and fails to recognise the duty of care that police officers carry with them throughout every interaction with every member of the public. In each iteration of the training, from the four-day to the one-day, there has never been education provided on personal bias, on racism or stigma. These tools have not been designed in collaboration with Aboriginal communities and will not equip police officers with the tools that they need to keep themselves and the public safe.

As well as demonstrating a genuine disregard for the safety of the public, the failures of NSW Police's mental health training regimen will jeopardise the development of secondary and co-response models that NSW Police have recommended. Police officers, who have only received one day of training in the last 12-months, will not be able to make informed decisions and will endanger their inter-agency colleagues, as well as the members of the public they are interacting with. In the Memorandum of Understanding between NSW Police, NSW Ambulance, and the Ministry of Health, NSW Police state that the *'Mental Health Intervention Team provides specialised, intensive mental health training to frontline police*[38]*,'* but that so-called intensive training has never been substantiated.

While it is obvious that in most incidents involving mental health, secondary and co-response models are the most appropriate option, there should be no forgetting that people with mental illness are not confined to incidents where the central matter is related to a mental health crisis. Police are obliged to protect all NSW citizens, including victims, perpetrators, witnesses, families, and communities, and they should not be a danger to those people at any time. These are reasonable standards for the state's police force, and it is deeply shameful that they have never been met.

[37] Rose, A. (2025, November 16). *Police mental health unit under the spotlight after the deaths of 10 people*. Abc.Net.Au; ABC News. https://www.abc.net.au/news/2025-11-17/nsw-police-mental-health-responses-criticism-from-coroners/105914846

[38] NSW Government , & NSW Police Force. (2018). *NSW Health – NSW Police Force Memorandum of Understanding 2018* (p. 7).

Conclusion

Before meaningful reform can occur, NSW Police must recognise that mental health crises are not something that can be merely passed to another emergency service. While expanding co-response and secondary response models are essential, police will continue to attend incidents involving people experiencing mental distress and must be equipped to do so safely, respectfully, and without causing harm. The current approach to mental health training is inadequate and fails to meet the duty of care owed to the community or to police officers themselves.

A comprehensive NSW Police and Community Mental Health Strategy, developed in genuine partnership with Aboriginal communities, people with lived experience, and mental health experts, is necessary to embed evidence-based, culturally informed practice across the organisation. This will need to include the establishment of genuine place-based partnerships with Aboriginal organisations and communities, in recognition of their lived-experience and expertise. This can only occur through a commitment to ongoing reform and structural change.

By implementing the AH&MRC's three recommendations, NSW can move towards a system that prioritises care over coercion, reduces preventable harm, strengthens public confidence, and ensures Aboriginal people experiencing mental distress are met with compassion, dignity, and culturally safe support rather than the risk of violence or criminalisation.

The AH&MRC Recommendations

1. The development of a comprehensive NSW Police and Community Mental Health Strategy that will guide a suite of new trainings and policies, developed in collaboration between NSW Police, peak bodies, people with lived experience and Aboriginal communities.
2. The establishment of a multi-disciplinary advisory council made up of stakeholder representatives, including people with lived experience, to oversee the development of the NSW Police and Community Mental Health Strategy.
3. The immediate overhaul of the NSW Police Mental Health Command and roll out of comprehensive, evidence-based and culturally informed mental health first-aid training for police officers.



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