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Police Use of Force in Mental Health Crises: An Analysis of Coronial Inquest Findings from Australia

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Abstract

Police are frequently the initial responders to situations involving individuals experiencing a mental health crisis. These situations sometimes escalate to the point where police resort to the use of force, resulting at times in injury and, less often, loss of life. This study draws on data from coronial inquest reports of cases involving police use of fatal force against persons with mental illness from one Australian jurisdiction. It examines the contextual factors leading up to these incidents, the personal backgrounds and mental health histories of the individuals in crisis, and the tactical approaches employed by police leading to the use of deadly force. Understanding these insights is crucial as they can potentially guide efforts to reform police practices in dealing with individuals in mental health crises and ultimately may help to prevent fatal outcomes.

Keywords: Policing; use of force; mental illness; fatal; coroner; crisis.

Introduction

While Australian police rarely use lethal force (Miller, 2015), statistics from the Australian Institute of Criminology (AIC) revealed a record high number of fatal police shootings in 2019–2020 (Doherty & Sullivan, 2021). These primarily occurred in Queensland and New South Wales (Doherty & Sullivan, 2021). During 2022–23, Queensland's particularly high fatality rate of one shooting death every four weeks surpassed all other Australian states and territories combined (Zillman, 2023). A troubling majority of these cases involved individuals suffering a mental health crisis (Cooper, 2022). The scale of this issue is further highlighted by data from 1989–2011 (Lyneham & Chan, 2013). This revealed 200 of the overall 500 police custody-related deaths and 44 of the overall 61 police fatal shootings in Australia involved persons with mental illness (Lyneham & Chan, 2013). In most cases (85%), the deceased was brandishing a potentially deadly weapon before being killed by police (Australian Institute of Criminology, 2013).

While some cases of fatal police use of force are viewed as necessary by the community and media, these cases are rare. One such example is the widely praised female officer who fatally shot Joel Cauchi, the Bondi Junction stabbing attacker, in April 2024 (Rose, 2024). Cauchi, who had a significant history of complex mental illness, had killed six people and wounded others (Rose, 2024). While the police response in that case generated positive public sentiment, police interventions in mental health crises—particularly when they result in fatalities—frequently raise significant concerns (Atfield, 2023; Herrington & Pope, 2013).

Cases involving police fatal use of force against individuals with mental illness highlight the critical intersection of public safety and mental health care, particularly the "complex web" of decision-making faced by police (Jones & Mason, 2002, p. 75). Like many developed nations, Australia operates under a deinstitutionalised, community-based mental healthcare model, which can create barriers to accessing treatment and lead to increased encounters with police during crises (Clifford, 2021). Research indicates that police often perceive individuals in mental health crises as dangerous, which heightens their perception of the potential for violence (Watson et al., 2004). This perception frequently results in the use of coercive measures by police, with the level of force determined by the individual's behaviour, use of violence, and compliance with police commands (Richmond & Gibbs, 2020). However, police may not fully grasp the nuances of mental illness or how it affects a person's behaviour and ability to comply, leading to criminalising and, at times, tragic outcomes (Godfredson et al., 2010; Richmond & Gibbs, 2020).

Understanding the circumstances leading to fatal police use of force against individuals in crisis is essential. These incidents can undermine public confidence in policing (Bowler et al., 2022) and contribute to long-term emotional trauma for the officers involved (Vickers et al., 2014). This study examines fatalities arising from police use of force against persons in a mental health crisis by analysing coronial inquest reports from a large state in Australia.

Police as First Responders to Mental Health Crises

Police have a 24/7 mandate to serve as de facto mental health responders to incidents involving individuals in crises (Herrington & Pope, 2013). Over recent decades, interactions between police and individuals with mental illness have increased significantly (Hartford et al., 2005; Short et al., 2014). In Australia, for example, up to 30% of police time is spent managing mental health-related incidents (Kruger, 2020).

Individuals in crisis may experience extreme distress, terror, and desperation, leading to an increased risk of self-harm or harm to others (Lyons et al., 2009). Police are often called in situations involving threats to life, such as suicide, harm to others, and hostage scenarios (Australian Institute of Criminology, 2013; Chidgey et al., 2022; Steele et al., 2023). However, without adequate de-escalation training (Clifford, 2010), officers may resort to forceful tactics to gain compliance (Meade et al., 2017). Police use force in response to behaviours like resisting arrest, possessing a weapon, or attempting to flee (Kesic et al., 2013). In such cases, if an individual resists or acts threateningly, officers may escalate force to control the situation (Morabito et al., 2017). Although mental illness may not directly influence the decision to use force, it indirectly affects police decision-making in crisis situations (Morabito et al., 2017).

Compounding these challenges is the limited availability of mental health professionals to assist police, particularly in regional and remote areas (Senate Select Committee on Mental Health, 2006). While interagency programs like co-responder models and crisis intervention teams have been shown to provide more therapeutic responses to mental health crises (Morgan, 2024), these schemes are frequently under-resourced, leaving police to handle most crises alone (Fleming, 2010). Without adequate training and support, police sometimes use lethal force against individuals during mental health crises (Gooding, 2017; Saligari & Evans, 2016).

Coronial Inquests into Police Fatal Use of Force

In Australia, fatal incidents involving police use of force are typically subject to a coronial inquest—an inquisitorial hearing where a coroner gathers information about the circumstances and cause of death (Phillips et al., 2015). Inquests aim to ensure impartial investigations (Mok, 2014), providing findings or recommendations to improve public safety and the administration of justice, and prevent similar incidents (Phillips et al., 2015). In cases involving police use of force, coroners scrutinise police actions, assess the justification of use of force, and consider whether non-lethal alternatives were available (Australian Institute of Criminology, 2013).

Coronial reports offer valuable insights for researchers on the understudied topic of fatal encounters between police and individuals with mental illness (Bowler et al., 2022; Crissman, 2019). For example, Kesic et al. (2012) examined Victorian coronial reports from 1980 to 2008. A significant proportion of the deceased in their sample were found to have exhibited aggressive behaviour or resistance to arrest or were armed at the time of the shooting. Notably, 86.7% of deceased persons

had a mental disorder, with 69.2% of those also having a substance use disorder. Crissman (2019) analysed Queensland inquest findings from 2005 to 2015 for people with serious mental disorders who died during a police encounter or while in police or corrective services custody. Her research revealed suicide as the leading cause of death, and mood and psychosis disorders as the most common forms of mental illness. More recently, Bowler et al. (2022) examined 106 deaths in New South Wales and Victoria. About three-quarters of these deaths were found to involve "indirect" police actions, such as self-inflicted injuries, medical emergencies, or accidents during police pursuits. However, most "direct" deaths, including shootings, occurred in cases involving individuals experiencing mental illness (Bowler et al., 2022).

These studies provide valuable insights into the underexplored realm of fatal encounters between police and persons with mental illness. They also reveal the challenging nature of the intersection between policing and mental health. However, existing research has not primarily focused on understanding fatal encounters involving police use of force against individuals experiencing mental health crises. There is a particular dearth of research into circumstances where such deaths result directly from police actions, including but not limited to, police shootings. This focus adds nuance by specifically targeting interactions where lethal force was employed, unlike studies that included a broader range of death causes, such as suicides.

The Current Study

The aim of this study was to investigate the circumstances and contextual factors that lead to police use of fatal force against individuals experiencing mental health crises. To achieve this, a comprehensive analysis of coronial inquest reports was conducted, focusing on incidents involving police use of force against individuals with mental illness in crisis. This analysis explored the contributing factors surrounding these fatal encounters, including the personal backgrounds and mental health histories of the persons in crisis, and the specific tactical responses employed by police that ultimately led to their deaths. The central research question guiding this study was: *What recurring themes emerge from coronial inquest reports regarding the interaction between police and persons experiencing mental health crises that resulted in the individual's death?*

By identifying these patterns and themes, the findings may potentially inform efforts to reshape police responses to persons in crisis and improve police policies and practices concerning the use of force (Bowler et al., 2022). They may also offer valuable insights for police and health-related organisations on mitigating the risk of future fatalities and adopting a multifaceted approach when encountering persons in crisis.

Methods

This study examined coronial inquest findings from one Australian jurisdiction, focusing on police-related deaths involving individuals in crisis. Deaths in custody or during police operations are considered "reportable" deaths in that jurisdiction and must go to an inquest, unless the coroner is satisfied an inquest is unnecessary. All publicly available coronial findings on the Coroners Court website from 2004 (the first year reports are available) to October 2023 were searched. Keyword searches were used for "police", "mental", and "use of force" (using the Boolean connector "AND" to search for documents containing all three keyword terms). The initial 278 search results were then screened using keyword terms and, where necessary, the full document to ascertain possible relevance. A total of 30 documents of possible relevance were identified and reviewed in full[1]. Individual cases were included in the final sample if: (1) the deceased person had a mental health problem or was suffering from the symptoms of a mental illness, (2) the person died during or shortly following an interaction with police officers, and (3) police officers had applied some form of force against the person (e.g., using restraint, Taser[2], or a weapon). Using these inclusion criteria, 24 documents representing 26 persons in crisis remained for inclusion in this study[3]. Inquests were held between 2005 and 2022 by four different coroners and the year of death ranged from 2001 to 2020.

The reports differed in depth of information and ranged in length from nine to 159 pages. All reports contained narrative information, drawing from various sources, including details of the individual's history, medical and mental health, and the events leading up to their death. This information was collected through submissions made on behalf of various relevant parties (such as family members), oral evidence given during the inquest (from police, ambulance officers, and other witnesses, for example), and documentary evidence.

To analyse the narrative information in the coronial reports, a thematic analysis approach was employed, using NVivo qualitative research software and Excel spreadsheets. Thematic analysis enables the organisation of qualitative data into clear codes or themes (Boyatzis, 1998), which helps describe the phenomenon under investigation (Fereday & Muir-Cochrane, 2006) and address the research question (Braun & Clarke, 2006). The thematic analysis unfolded in two phases. Initially, an inductive coding approach was adopted, where the themes emerged directly from the data (Braun & Clarke, 2006). For instance, the coroners' accounts of the circumstances leading to the individual's death were coded, as well as

police officers' narratives. This was followed by a second coding round focused on specific details of interest, such as the incident location, the time elapsed between the police's arrival and the individual's death, and the use of force techniques employed by the police. This dual approach allowed us to understand the circumstances surrounding the person's death while also capturing essential contextual information related to the case.

Three members of the research team read each report several times to ensure familiarity with the data and to extract and code information. This included the demographics of the persons in crisis, the location and cause of death, the reason for police involvement, any previous police or criminal justice involvement, and details of the person's mental health. Disagreements over coding were discussed and resolved by agreement between two or more members of the research team. This study was approved by ACU Human Research Ethics Committee (2024-3772X).

Findings

Background Variables of Persons in Crisis

Consistent with previous research (Doherty, 2021), the individuals in this sample were aged between 23 and 65 years, with an average age of 39 years (see Table 1 for age and other demographic characteristics of the sample). All were male. The reports did not consistently identify other demographic information, such as ethnicity, place of birth, relationship status, or employment status. For example, ethnicity was only identified in six cases, with two individuals identified as First Nations, two as Vietnamese, one as Māori, and one as Caucasian[4]. Place of birth was identified in 14 of the cases, with six individuals born in Australia, five in New Zealand, two in Vietnam, and one in South Africa.

Table 1

Demographic Information about Individuals with Mental Illness

	Person with mental illness (*N* = 26)	
Variable	***n***	***%***
Mean age (years)	39	
Gender (male)	26	100
Ethnicity		
Caucasian	1	4
First Nations	2	8
Māori	1	4
Vietnamese	2	8
Unknown	20	77
Place of birth		
Australia	6	23
New Zealand	5	19
South Africa	1	4
Vietnam	2	8
Unknown	12	46
Employment status		
Disability Support Pension	5	19
Employed	2	8
Unemployed	6	23
Retired	1	4
Unknown	12	46
Marital status		
Married/current de facto	7	27
Separated	6	23
Single	5	19
Unknown	8	31
Parental status		
Had children	15	58
No children	1	4
Unknown	10	38

Note. Percentages may not total 100% due to rounding.

Relationship status revealed that seven of the individuals were married or had a current de facto partner at the time of death, six had separated from a former spouse, and five were single. In 15 of the cases, the person in crisis was identified as being a parent to one or more children, while one person was identified as having no children, and parental status was not identified in the remaining 10 cases. Employment status was not stated in 12 of the cases, while six of the persons in crisis were unemployed at the time of their death, five were on a disability support pension, two were in current employment, and one was retired.

Offending History

According to the coronial documents, many of the individuals had a reported criminal history (n = 18), while in eight cases the individual either had no reported criminal history or this information was not provided. In cases where an offending history was mentioned, most of the offences were of a moderate nature (e.g., theft, property damage, offences against justice procedures and orders, and drug offences). The most reported offences amongst the sample included assault (in 12 of the cases), offences against justice procedures and orders (12 cases), and drug offences (11 cases). Less commonly, sexual offences and fraud were each mentioned in one case, harm or endangering persons in two cases, and burglary in three cases.

It was also reported in 11 cases that the individuals in crisis had previous sentences of imprisonment, while three had reported forensic orders[5], one of which was active at the time of death. Other reported sentences in the sample included suspended sentences (in five cases), probation (four cases), community service (two cases), good behaviour bond (one case), and fines (four cases). Six individuals were identified as being on bail, probation, or parole at the time of their deaths, while four had outstanding charges. In 17 of the cases, allegations of domestic violence were mentioned in the coronial report. Of these, five individuals in crisis were respondents to reported protection orders, with two individuals listed as respondents in multiple orders. Additionally, four individuals had an active protection order at the time of their death.

Mental Disorders and Mental Health Treatment

A person's mental health history was much more consistently reported across the coronial documents. Consistent with other studies (Crissman, 2019), psychotic disorders (46%) were the most prevalent reported disorders among the individuals in this sample (see Table 2). Psychosis was reported to have been symptomatic of a history of schizophrenia and/or drug-induced. A large proportion (42%) of the individuals were reported to suffer from a history of drug and/or alcohol addiction. Mood disorders (often comorbid with anxiety disorders) were also prevalent (31%). The least prevalent disorders were anxiety disorders (23%), post-traumatic stress disorder (PTSD) (8%), and unspecified/unknown (4%).

While the coroner cited mental disorders as being a factor in all the cases, there is much disparity in the reporting regarding known diagnosed mental disorders and suspected mental disorders. As such, the figures presented in Table 2 are an aggregate of diagnosed and suspected disorders. Comorbidity (coexisting disorders) also presents challenges for categorising and quantifying disorders, especially given the likelihood of comorbidity amongst people suffering from complex mental illness (Wallace et al., 2004). Many individuals were reported to have experienced more than one diagnosed or suspected mental disorder at the time of death. Therefore, mental disorders are counted separately and not per person.

Table 2

Types of Mental Disorders and Extent of Mental Health Treatment

	Person with mental illness (*N* = 26)	
	n	***%***
Mental disorder		
Anxiety	6	23
Mood	8	31
Personality	1	4
Psychotic	12	46
PTSD	2	8
Substance use	11	42
Unspecified/Unknown	1	4
Mental health treatment		
Significant history of treatment	15	58
Limited treatment	8	31
No treatment	3	12

Note. Column totals add up to more than *n* = 26 or 100% because of comorbidities of disorders.

Most of the persons in crisis (89%) were known to mental health services and had received treatment for their mental illnesses. Most were deemed to have had a "significant" history of mental health treatment in care facilities (58%), such as several years of in-patient and out-patient medical care as well as being medicated using psychotropic drugs. Some of the individuals (31%) were reported to have received only "limited" mental health treatment, such as brief interactions with a general practitioner or receiving an involuntary mental health assessment under mental health legislation. These cases were deemed "limited" since the person did not attend follow-up treatment and/or only received sporadic and minimal mental health assistance. Only 12% of the individuals had not sought treatment or were not known to health agencies or police regarding their mental health. Yet, these individuals were deemed to be suffering a mental health crisis at the time of their death.

The Incident: Reasons for Police Intervention

The incidents took place at various times throughout the day and night (see Table 3). An equal number of incidents (27%) occurred in the afternoon (between 12 pm and 5 pm), evening (between 5 pm and 11 pm), and night-time (between 11 pm and 5 am). Fewer incidents (19%) occurred during the morning hours (between 5 am and 11 am).

Table 3

Incident-related Information

	Person with mental illness (*N* = 26)	
Variable	***n***	***%***
Time of day of incident		
Morning (5 am–11 am)	5	19
Afternoon (12 pm–5 pm)	7	27
Evening (5 pm–11 pm)	7	27
Night (11 pm–5 am)	7	27
Reason for police intervention		
Family/friends seeking assistance	13	50
Deceased persons called police	7	27
Concerned neighbours	2	8
Members of the public	2	8
Police seeking out deceased	2	8
Location of incident		
Private residence	16	62
Public location	10	38
Deceased's use of weapon		
Edged weapon (knife, sword, tomahawk)	18	69
Gas/petrol/lighter	2	8
Other (e.g., metal pole, replica gun, Taser)	5	19
Gun/rifle	1	4
No weapon	4	15

Note. Column totals add up to more than *n* = 26 or 100% due to rounding and given the use of multiple weapons in some cases.

In one-half of the cases, emergency services had been contacted by concerned family and/or friends of the person in crisis seeking police or Queensland Ambulance Service assistance. In these cases, the person in crisis was reported to be acting in a threatening or aggressive manner toward those around them or engaging in or threatening self-harm. In 27% of cases, it was the person in crisis who initiated contact with the police. In these cases, contact was made to report self-harm or an alleged crime, or because of delusions or psychosis that the person was experiencing at the time. In the remaining cases, concerned neighbours (8%) or members of the public (8%) contacted police, or police were seeking out the person to conduct a welfare check or to follow up on a reported parole breach (8%).

In 62% of the cases, the incident and the person's death occurred inside or in close vicinity to a private residence (whether that be the individual's residence or that of their family or partner). In 39% of cases, the deaths occurred in public areas, such as outside a shopping centre, at a train station, or along a public roadway.

Most incidents (69%) involved the individual's use of an edged weapon, such as a knife, sword, or tomahawk. Less often (19%), the person was armed with another type of weapon, including a metal pole, replica gun, or Taser. Flammable items (gas or petrol and a lighter) were present in 8% of cases, while one person in crisis was armed with a gun (4%). No weapon was present in 15% of cases.

Precursors to Fatal Use of Force

In most of the cases (77%), the individual was engaging in violent or aggressive behaviour toward police officers and/or others, including relatives, friends, or members of the public immediately before the fatal use of force. This violence took several forms, most commonly (in 62% of the cases) approaching and/or threatening police officers with an edged weapon. This was often accompanied by verbal threats or taunts, including the person in crisis telling the police to kill them. In those

cases, the coronial reports often detailed police officers' attempts to de-escalate the situation and to create a safe distance between themselves and the individual. Officers were also noted to have repeated verbal warnings to the person in crisis to drop their weapon and/or get on the ground. When those requests were ignored and the individual came within close proximity of officers (or others), the officers responded with force to neutralise the threat. Most often, this involved shooting the individual one or more times.

In some cases, the person in crisis was engaging in or threatening self-harm (38%) or appeared to be suffering delusions (23%). A minority of cases (12%) involved circumstances where the individual was not armed with any weapon but was resisting arrest. These deaths occurred shortly following the use of a positional restraint by police officers. Few cases (8%) involved siege or hostage scenarios.

Police Tactical Response

An average of two to four police officers were involved in the incidents. Most of these officers were ranked Constable or Senior Constable, potentially representing an overall lack of experience and seniority in the police service role. Aside from ambulances being called in all cases, there were limited other professional stakeholders involved. While some reports discussed how officers made attempts to contact a police negotiator, negotiators only attended one case. Police negotiators are a special branch of officers who are highly trained in communicative de-escalation tactics (Steele et al., 2023). Despite their expertise in peacefully resolving crises, officers described how negotiators were either unavailable or did not arrive on the scene in time. Mental health professionals or mental health co-responder units were not in attendance at any of the cases.

The time between police arriving at the scene of crisis and the person being declared deceased and/or an ambulance being dispatched varied significantly, from approximately nine seconds to two hours. The use of body-worn cameras (BWCs) proved important in timestamping unfolding events and providing other valuable evidence at the coronial inquest. In 65% of cases, officers were wearing BWCs. In cases where BWCs were not used, the officer/s had either failed to activate them properly or the case predated the universal rollout of this technology to officers in this jurisdiction.

Following the typology of Bowler et al. (2022), the form of death was categorised into "direct deaths" or "indirect deaths". Direct deaths encompass police operations whereby the death was the result of physical contact, such as shooting, Taser, or hands-on tactics (i.e., physical restraint). Indirect deaths were those attributed to non-physical contact, such as self-harm or medical emergencies (Bowler et al., 2022). Most of the deaths (88%) were direct deaths, leaving only 12% of deaths being indirect.

As shown in Table 4, the most prevalent tactical use of force choice in this sample was the use of a service firearm (Glock pistol) (65%). Verbal communication tactics were attempted to de-escalate the situation in 42% of cases but were generally presented as either ineffective or inadequate. For the latter, the officer was described as not having received effective training in using communicative de-escalation tactics with persons in mental health crises.

Table 4

Use of Force Tactics Employed by Police

	Frequency of type of force used	
	n	**%**
Use of force type		
Communication/verbal de-escalation tactics	11	42
Tactical withdrawal	4	15
Firearm/s	17	65
OC spray	5	19
Taser	5	19
*Physical restraint**	9	35
Baton	1	4

* Use of handcuffs, manual restraint, dogs

Note. Column totals add up to more than $n = 26$ and 100% given multiple tactics used by police during incidents.

OC spray (capsicum spray) and Tasers were each used in 19% of cases to try to temporarily immobilise the individual. However, they too were described as ineffective (aside from the cases where the Taser was the cause of death) or inappropriate. Officers described how using these "non-lethal" options was inappropriate in some cases due to the proximity of the person in crisis. Either they were too close to the police or too far away for the weapon (i.e., Taser, baton, mace) to be effective. In relation to the use of Tasers, some officers described how the person's baggy or thick clothing would have prevented the Taser barbs from contacting the skin. Others described how the Taser shock was not sufficiently strong enough to effectively incapacitate the individual.

In 35% of the cases, officers physically restrained the person in crisis before their death by using handcuffs or "open hand tactics". The latter includes wrist and arm locks, pressure point control tactics, and ground restraint (Queensland Police, 2024). While firearms were the most prominent use of force tactic used by police, most cases detailed that the officers had used (or attempted to use) a range of different tactics to subdue the individual before their death.

Cause of Death

In most cases (65%), the official cause of death was one or more gunshot wounds inflicted by police firearms. In the remaining cases, 12% involved cardiac-related deaths following the use of physical restraint techniques by police. In those cases, the individual was noted to have pre-existing or underlying health concerns that contributed to their death, including obesity, injuries, stress, and other coronary issues. In the remaining cases, 8% of the deaths were attributed to burns, and 4% each to self-inflicted stab wounds, aspiration due to alcoholic intoxication, and excited delirium[6] (likely caused by amphetamine toxicity-induced psychosis).

Discussion

This study analysed coronial inquest reports to examine fatal encounters between police and persons with mental illness, revealing key insights into the challenging intersection of policing and mental health crises. By examining cases where a person in crisis died during, or shortly following, a police interaction involving the use of force, the study revealed several important findings.

First, the study revealed a pronounced gender bias amongst the deceased, with every individual in crisis in the sample being male and often relatively young. This aligns with prior research showing that males in their late 30s, particularly those with criminal histories, are overrepresented in police fatal use of force incidents (Bowler et al., 2022; Crissman, 2019; Kesic et al., 2013). This is not surprising given past studies have shown police are more likely to use higher levels of force against males with suspected mental illness, compared to females (Kaminski et al., 2004). Research also suggests that police often perceive males as more threatening than females, as women are typically seen as less aggressive, less resilient to punishment, and more compliant (Schuck, 2004). The confluence of mental illness can compound these gendered perceptions, as mental illness is often stereotypically associated with traits like dangerousness and incompetence (Markowitz, 2005). Research suggests that males and females are detained under emergency mental health legislation at similar rates (Clough et al., 2023), yet females were notably absent from our sample. This finding arguably demonstrates how males experiencing mental health crises are perceived as more dangerous by police than their female counterparts.

Police perceptions of dangerousness may also be influenced by the type of mental disorder exhibited by a person in crisis, especially when psychotic disorders and substance abuse problems are involved, as seen in this sample. Consistent with prior research (Crissman, 2019; Lyneham & Chan, 2013), individuals with psychotic disorders like schizophrenia were found to be disproportionately represented in fatal police shootings, despite these conditions being rare in the general population (Waghorn et al., 2012). Psychotic disorders are heavily stigmatised and often associated with unpredictability and violence (Reavley & Jorm, 2011). However, studies suggest that those with psychotic disorders are more likely to harm themselves than others (Crowley-Cyr, 1999). Police with a lack of adequate training may face communication challenges posed by individuals whose behaviour and speech may be erratic and disconnected from reality (Morgan, 2024). Coupled with widespread misconceptions about psychotic disorders (Morgan & Miles-Johnson, 2022), this may lead police to rely on more forceful tactics when responding to people experiencing psychosis.

While there is some connection between psychotic disorders and violent behaviour, mental health experts have argued this link is often due to coexisting substance abuse or abstinence from medication (Jorm et al., 2012; Wallace et al., 2004). This study's findings revealed that many individuals had comorbid mental health disorders, as well as limited engagement with mental health services. Psychosis, depression, anxiety, and personality disorders were often combined with substance abuse. Studies have shown that individuals who experience co-occurring mental illnesses and substance use disorders are more likely to have prior justice system involvement (Peters et al., 2017) and may resist arrest or behave disrespectfully toward police (Novak & Engel, 2005; Watson et al., 2010).

The high prevalence of previous criminal histories among individuals in our sample highlights the intersection between mental illness and the criminal justice system. Individuals with prior police interactions may be perceived as more dangerous, leading officers to more readily perceive the use of force as necessary (Kesic et al., 2013). Further, the significant number of individuals with prior police and justice system interactions reflects the challenges in managing this population within the community. It highlights the need for comprehensive, integrated mental health interventions tailored to address individuals' multifaceted needs.

Despite prior contact with mental health services, the individuals in this study's sample still encountered fatal outcomes, pointing to systemic failures in mental health care. This raises significant concerns about the adequacy of mental health services in Australia, which have long struggled with underfunding and insufficient resources due to several decades of neoliberal policy shifts (Gooding, 2017; Whiteford & Buckingham, 2005). These gaps have left police as the primary responders to community mental health crises, a role for which they are ill-equipped.

Notably, 50% of the cases in this study involved police or emergency services being contacted by concerned family and/or friends. In 27% of the cases, the person in crisis made contact themselves. Despite these attempts to access help, individuals in distress were ultimately unable to receive an appropriate intervention, leading to tragic outcomes. Adding to these concerns, police negotiators were present in only one case and mental health professionals were absent in all cases.

Although the attending police officers often attempted verbal de-escalation, the effectiveness of communication tactics was limited, particularly in cases involving individuals with severe mental health disturbances. This is likely because, in many cases, police had limited time (often mere seconds or minutes) between arriving at the scene of the incident and the fatal use of force. These issues call for greater availability of mental health co-responder units whereby police respond to crises in unison with mental health clinicians (Furness et al., 2016). Co-responder units have been shown to reduce police use of force with individuals in crisis since they allow specially trained clinicians to apply therapeutic de-escalation tactics while police oversee any security concerns (Furness et al., 2016; Robertson et al., 2020).

Another important finding of this study was that in two-thirds of the cases, the individual in crisis died as a result of being shot by police. The predominant use of firearms as a police tactical response raises concerns about the escalation of force and the need for enhanced training in crisis intervention techniques, including lethal force alternatives. Police in Australia are trained to immediately draw their firearm when presented with an "offender" brandishing an edged weapon to prioritise the safety of the officer over the individual in crisis (Morgan & Miles-Johnson, 2022). While such tactics may be justified from an occupational hazard perspective, they are likely to override effective attempts to peacefully negotiate a resolution to the crisis (Morgan & Miles-Johnson, 2022).

To that end, while police in Australia are routinely equipped with Tasers, concerns over their efficacy in reducing immediate threats were often raised. While Tasers were used in some cases to temporarily immobilise the individual, they were often described as ineffective or inappropriate. This suggests a lack of trust and confidence in the use of Tasers as a "non-lethal"[7] use of force option, which arguably accounts for the high proportion of fatalities resulting from gunshot wounds in our sample. In Queensland, police are trialling the novel Taser 10 which is reported to be more accurate, have a range of more than triple the distance (13.7 meters) of the Tasers currently used, and can be discharged 10 times without being reloaded (O'Flaherty, 2023). The efficacy of this improved technology in reducing fatalities will take time to assess.

It is important to understand the context of these data and their limitations. This study is confined to coronial reports from a single Australian jurisdiction. Given that each Australian jurisdiction has governance over its policing and health services, the systems in each jurisdiction may vary. Differences in legal frameworks, investigative protocols, and service provision models may influence the outcomes in ways not accounted for in this study. As a result, generalising these findings across other Australian jurisdictions should be approached with caution.

Further, the study's findings are based solely on the information provided in the coronial reports. Coronial inquest hearings are complex, lengthy, and involve evidence from multiple parties. However, the final inquest report presents a curated selection of evidence, as determined by the coroner. This selective presentation of information may not capture the full scope of the events and potentially omit critical nuances in cases. Thus, while these documents offer valuable insights, they are shaped by the coroners' interpretations and the available evidence.

The study's exploratory nature and small sample size also present an important limitation. With only 26 cases, the findings should be regarded as preliminary, highlighting potential trends rather than definitive conclusions. This limited sample, albeit drawing from all documents available since 2004, may not capture the full spectrum of mental health-related police fatalities, and the absence of comprehensive demographic data further constrains our findings. For example, key variables

such as ethnicity, background, and engagement with health services were often incomplete. As such, any conclusions about demographic patterns must be drawn with caution.

Additionally, the quality and reliability of the evidence in some cases raise concerns. Inquests that lacked BWC footage relied heavily on police testimony, which can be subject to bias. One inquest report acknowledged potential problems with police investigations into police conduct, since officers "may have a natural affinity for one another and may be open to allegations of being non-partisan". The absence of independent evidence, particularly in cases without BWC evidence, therefore, raises questions regarding the reliability of coronial data for research purposes.

Finally, while there is limited research about police use of force on Indigenous peoples in Australia and internationally (Laming, 2023), existing studies show that First Nations Australians are overrepresented in police use of force cases, including those resulting in death (Doherty, 2021; Porter, 2013). In this study, ethnicity was rarely reported, yet even two deaths of First Nations individuals in a sample of 26 cases reflects an overrepresentation of fatalities in police use of force cases involving persons in crisis. Given that ethnicity was unreported in most cases, the actual proportion of First Nations individuals may be even higher. However, the small sample size precluded a detailed examination of this issue.

Conclusion

This study highlights the difficult intersection of mental health crises and the police response. Improving this critical juncture requires shifting from a police-only approach to a collaborative model where police partner with mental health professionals to therapeutically respond to mental health crises (Morgan, 2024). The United Kingdom's "Right Care, Right Person" model exemplifies a successful interagency partnership that has reduced police-only responses to mental health crises (Metropolitan Police, n.d.). In this model, emergency call handlers are trained to determine whether to deploy police, a combined team of police and mental health professionals, or just mental health professionals (Metropolitan Police, n.d.).

Given most individuals in our sample were armed when in crises, it is realistic to expect that police will continue to play a key role in responding to such situations. This highlights the need for a co-responder model where mental health clinicians accompany police during crisis interventions, which has shown promise in reducing force and improving outcomes for individuals in distress (Furness et al., 2016). People with lived experience of mental illness who have interacted with police also recommend involving mental health professionals (Livingston et al., 2014).

Scaling up these programs, particularly in under-resourced rural and remote areas, would ensure that people in crisis receive therapeutic care, rather than a criminalising response. Expanding the role of mental health professionals in crisis response teams and training police in de-escalation is crucial. Embedding mental health expertise within crisis response frameworks could shift the approach from punitive measures to a more compassionate, effective response for vulnerable individuals.

Problematic police responses to mental health crises reflect broader neoconservative policies that restrict community mental health care (Vitale, 2017). In Australia, mental health funding has remained at 7.3% of total health funding since 1991–1992 (Rosenberg et al., 2023). This study's findings highlight two key implications of austerity. First, the sample had limited contact with mental health services, despite often having significant histories of complex mental illness. Second, police are relied upon when families seek help for individuals in crisis. Individuals and their families are often left to navigate an underfunded and fragmented system (Morgan & Higginson, 2023), leading to an overreliance on police to manage welfare issues they are not equipped to handle (Gooding, 2017).

To reduce fatal police encounters, community-based mental health services must be adequately resourced to provide timely interventions before crises escalate to requiring police involvement. Governments need to build collective resilience (Fineman, 2010) to public health issues by expanding access to preventative mental health care, early intervention programs, and ongoing support for individuals with severe mental illness. These measures could prevent crises and reduce the demand for police involvement.

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[1] The remaining 248 results were determined not to meet the three inclusion criteria. For example, the full-text review of some documents confirmed that the deceased person was not known, or thought, to have suffered from mental illness at the time of their death.
[2] Taser is the brand name for a "conducted energy weapon".
[3] Some documents addressed multiple cases within a single inquest.
[4] In the case of the "Caucasian" individual, this information was noted in the coronial report as part of a witness statement.
[5] Forensic Orders, issued by the Mental Health Court, apply to those charged with serious offenses deemed mentally unfit at the time of the offence or for trial, allowing involuntary treatment and potential detention in mental health or forensic disability services.
[6] Excited delirium is a condition often defined as a person exhibiting signs of: paranoia, extreme agitation, aggression, violence, impulsivity, increased physical strength, delusions, hallucinations, pupil dilation, fever, rapid pulse rate, erratic breathing and body movement.
[7] Whilst largely considered a "non-lethal" use of force option, Tasers shocks have been known to occasionally result in death.

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