

Mental Health Commission  
An Garda Síochána

Report of  
Joint Working Group on  
Mental Health Services  
and the Police 2009







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# Acknowledgements

The members of the Working Group wish to extend their appreciation to a number of people who assisted in the compilation of this report and provided valuable insight and information:

- Ms. Anne Colgan, Colgan & Associates who facilitated the focus groups;
  - Mr. Donal O'Keeffe, Research Psychologist - engaged to prepare the literature review;
  - Dr. Jon Dowd & Dr. Shaun Parsons representing Northumbria Police & the University of Newcastle - Police Mental Health Awareness Training;
  - Ms. Noeleen Hartigan, National Campaigns Manager, Simon Communities of Ireland;
  - Mr. John Redican, Chief Executive Officer, Irish Advocacy Network;
  - Mr. John Saunders, Schizophrenia Ireland;
  - Dr. Julie Norris, Garda Training College, Templemore;
  - All Focus Group Participants;
  - Ms. Marina Duffy, Secretary to the Group.
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# Joint Statement An Garda Síochána & Mental Health Commission

An Garda Síochána and the Mental Health Commission welcome the publication of this report from the Working Group on Police and Mental Health Services. The joint working group was established by both organisations to review national and international best practice models in joint working between the police and mental health services and to make recommendations in relation to enhanced liaison between An Garda Síochána and the mental health services in Ireland.

Internationally, we know that model prototypes and programmes have been developed to enhance liaison between both services. Reports on these initiatives describe the valuable and positive outcomes of such collaborative systems for the police, mental health personnel, and especially service users and their families. Reported outcomes for service users include less frequent use of restraint and restrictive options of care, increased understanding of illness, enhanced respect for the person in crisis and a reduction in the stigma associated with mental illness.

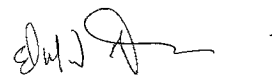
The recommendations from the Working Group require a multifaceted approach from a number of agencies including, An Garda Síochána, the Health Service Executive and service user organisations. The recommendations emphasise the importance of collaboration and joint working while respecting the different areas of expertise and responsibilities of all those involved.

We would like to thank the members of the working group for their expertise and input to the preparation of the report. We wish to express a special word of appreciation to all those who participated in the focus groups - hearing the experiences of those directly involved is critical.

We hope this report will influence and inform the future development of joint working between An Garda Síochána and the mental health services in Ireland.



**Commissioner M. F. Murphy**  
An Garda Síochána  
August 2009



**Dr. Edmond O'Dea**  
Chair, Mental Health Commission  
August 2009



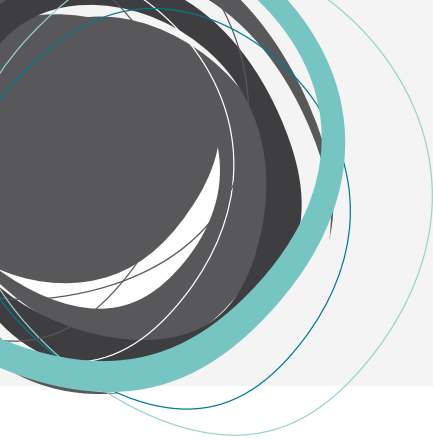




# Prologue

The publication of this report comes at a most appropriate time given the recent series of tragic incidents nationally involving individuals in acute social stress. While not all social crises in the community are of a psychiatric nature a considerable proportion are. These crises involve both adults and children and are often connected not just with mental illness but with a range of other social factors including alcohol and drug abuse and family breakdown. The appropriate response to these crises usually involves inputs from a range of services and disciplines. Crises can occur at any time and at any place so that relevant services need to be available on a 24 hour, 7-days a week basis. The need for these emergency services has been increased by the general move from institutional to community care across a range of disciplines. In the case of mental health services the shift to community care, while it has been taking place over the last 25 years, is still by no means complete. While the previous institutional provision for mental health care has been greatly reduced, the appropriate alternative community mental health structures have been slow to materialise. Many mental health services provide their community mental health services from an institutional mind set and have limited understanding of the nature of mental illness as it exists in the community. The need for cooperation and alliances with service users, families, carers and the range of other disciplines has not been fully realised. Other professional groups such as An Garda Síochána, General Practitioners, social service departments, housing agencies and a range of voluntary organisations that care for the disadvantaged in the community, all have a particular relevance and part to play in dealing with crises situations. An Garda Síochána are the only agency immediately available day or night to respond to crises in the community and are often unfairly and inappropriately left to deal with mental illness and associated social crises with very limited support.

The Mental Health Commission and An Garda Síochána established this working group in an attempt to resolve these issues. The recommendations of the report are founded on joint discussions between the Mental Health Commission and An Garda Síochána, aided by data obtained from clinical directors in the mental health service, GPs and from focus groups set up to ascertain service users experience of their interactions with An Garda Síochána at times of crisis. The views of these stakeholders have been published in this report and provide valuable insights into the reality of current practices. Similarly, a literature search was undertaken on models of mental health service and police initiatives in other jurisdictions. What is striking with regard to the literature information is the limited degree to which these important interface areas of service provision have been addressed. It does, however, provide possible models for developments in Ireland. Again, these models are described in the report and are worthy of serious consideration.



The report has seven main recommendations. The first two recommendations highlight the urgency of implementing national policy in relation to the document “Vision for Change” and the Primary Care Strategy. These reports have, for some years, been accepted government policy and the failure to implement them in full is a matter of great concern. The third recommendation recognises the need for the creation of a 24 hour, 7-day a week statutory social work service. This need has been advocated for some years and its lack has been highlighted in a recent tragic incident. Recommendations four and six emphasise the importance of an expanded training for An Garda Síochána on community and social services, together with mental illness in crisis. In addition, they highlight the importance of joint protocols between the mental health services and An Garda Síochána, together with associated formal liaison systems. The participation of users and carers in the drawing up of these protocols is salient. Recommendation five recommends a feasibility study on jointly staffed crisis intervention teams, made up of mental health personnel and members of An Garda Síochána. The working party fully appreciated the difficulties attached to this recommendation, not least the ethical considerations. The setting up of a number of crisis intervention teams in appropriate areas and on a pilot basis would provide valuable information on the more widespread establishment of these bodies. Recommendation seven recognises the lack of adequate court diversion programmes for dealing with minor criminal matters involving individuals with mental health problems. The ascertainment of these individuals and the implementation of court diversion programmes at District Court level are sorely needed.

The recommendations of this report should not involve significant financial outlay involving, as they do, the reorientation of service delivery and the reallocation of current service personnel. The nature of the issues involved in this report are such that they will need to be continued to be addressed in the setting of evolving services over time.

As Chairman of the Working Group, I would like to thank the Mental Health Commission and An Garda Síochána for their enthusiastic support in the preparation of this report. Similarly, I wish to thank all those agencies and individuals who contributed.

**Dr. John Owens**  
Chairman Working Group



1

Introduction

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## Background

During the last 30 years, we have witnessed in Ireland, the gradual movement away from institutional type care for people with a mental illness to the development of a community based model of intervention. This change in policy and service provision presents a challenge across the broad spectrum of society and creates new demands and responsibilities on a wide range of service providers including housing authorities, social services, primary care and An Garda Síochána.

The World Health Organisation, in its seminal report "Mental Health: New Understanding, New Hope." (2001) identified ten core elements of a modern mental health service. These include:

- Providing treatment in primary care
- Providing specialist care in the community
- Developing intersectoral links

At the World Health Organisation European Ministerial Conference on Mental Health which took place in Helsinki in 2005, a mental health action plan for Europe was endorsed requiring action by member states in twelve key areas, of which the following are of particular relevance to this report:-

- Protection of mental well-being for all
- Tackling stigma and discrimination
- Ensuring access to good primary care for mental health problems
- Offering effective care in community based services for people with severe mental health problems
- Establishing partnerships across sectors

In January 2006, the government outlined national policy on mental health with the publication of "A Vision for Change". Government policy describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community based specialist services for people with a mental illness.

Key recommendations include:

- The involvement of service users and their carers should be a feature of every aspect of service development and delivery.
- Mental health promotion should be available for all age groups, to enhance protective factors and decrease risk factors for developing mental health problems.
- Well-trained, fully staffed, community-based, multidisciplinary Community Mental Health Teams (CMHTs) should be put in place for all mental health services. These teams should provide mental health services across the individual's lifespan.
- To provide an effective community-based service, CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families.
- A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user's particular needs, goals and potential and should address community factors that may impede or support recovery.
- Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised.

A key theme which permeates all the above reports is the ongoing effect of stigma and discrimination experienced by people with a mental illness. In the consultation associated with the publication of "A Vision for Change" and consultation conducted by the Mental Health Commission in 2004, people expressed deep concerns about the ongoing impact of the stigma associated with mental illness and the discrimination experienced by people with a mental illness. We know that this stigma can lead to social exclusion and also can affect accessibility to a wide range of social and community services. The World Health Organisation advocates the establishment of strong collaborative networks across services that are essential to the quality of life of users and carers such as social welfare, labour, education, justice, transport and health.

## Mental Health Services and the Interface with Law Enforcement Agencies

Traditionally the police (law enforcement agencies) have had an ongoing role in responding to people with a mental illness in crisis. This involvement covers a wide spectrum of situations including assisting or escorting a person to a psychiatric unit, intervening in a potentially volatile situation in the community or responding to requests from families/carers for advice and assistance. There is a growing body of literature on the interface between police and mental health services. The reported increase in interventions by the police, it is concluded, is related to movement away from the institutional model of care and the slow development of appropriate community responses (Lamb *et al* 2002, Fry *et al* 2002, Watson *et al* 2007, Canadian Mental Health Association 2003). Associated with this trend is the development of new practices and interventions by the police in their responses to people with a mental illness in crisis, especially in USA, Canada and Australia and more recently in England.

A number of factors contribute to this involvement by the police. The police are legally obliged to respond to calls, 24 hours a day, 7 days a week. Mental health services in general provide a more time-limited response and the police may be the only resource in times of crisis. Most countries have also introduced legislative provisions which allow the police to intervene in situations where there is a serious likelihood that a person with a mental illness may harm himself/herself or other persons.

# Introduction

Reported studies on the level and context of this involvement by police mostly emanate from Australia, Canada or the USA. Fry *et al* in a survey of police officers in Sydney reported that more than ten percent of police time is spent dealing with people with mental health problems. The police department in Montreal reported in 2002 that they dealt with 3000 calls annually requiring intervention with people who have a mental illness (Canada Police/Mental Health Forum). Fry reported in 2002 that the police department in New York City responds to a call involving a person with a mental illness once every 6.5 minutes. These calls however, apart from the actual number involved, take a considerable amount of time. De Cuir and Lamb (1996) estimated that in 1985 the Los Angeles Police Department spent over 28,000 hours in each 28 day deployment period handling such calls. Pogrebin (1986) found that on average, each call involving mental health issues, took 74 minutes.

## Mental Health Services and An Garda Síochána - Ireland

Information obtained by the working group showed varying levels of collaboration and joint working between An Garda Síochána and mental health services. In general this contact focused on the management of individual cases and the implementation of mental health legislation in regard to involuntary admissions (now Mental Health Act 2001, previously prior to November 2006, the Mental Treatment Act 1945).

With the commencement of the Mental Health Act 2001 in full since November 2006, information is now available on the involvement of An Garda Síochána in certain aspects of the involuntary admission process. The Mental Health Act 2001 provides for the involvement and intervention of An Garda Síochána in specific circumstances. These relate to a member of An Garda Síochána being an applicant for a person to be involuntarily admitted (Section 9), taking a person into custody when there is a serious likelihood of the person causing immediate and serious harm to himself or others (Section 12), assisting in the removal of a patient to an approved centre (Section 13) and returning an involuntary patient to an approved centre (Section 27). An Garda Síochána have developed a joint protocol with the Health Service Executive in relation to these provisions of the Act.

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The Mental Health Commission as part of the review of the operation of Part 2 of the Mental Health Act 2001 (involuntary admissions) analysed the categories of persons who applied for a person to be involuntarily admitted under Section 9 of the 2001 Act during 2007. Members of An Garda Síochána accounted for 15% of the applicants. See table 1.

**Table 1 Analysis of Applicant: Involuntary Admissions 2007 (Adults)**

Form Number	Type	Number	%
1	Spouse/Relative	1,034	69%
2	Authorised Officer	102	7%
3	Garda Síochána	235	15%
4	Any other Person	132	9%
TOTAL		1,503	100%

## Training: An Garda Síochána

The current Garda Síochána Student/Probationer Education/Training and Development Programme is a two year Diploma course accredited by FETAC. It is a competency-based programme consisting of five separate but integrated phases that are conducted both at the Garda Síochána College, and at designated Garda training stations throughout the country.

The Student/Probationer Education/Training and Development Programme requires, that students, in addition to the acquisition of pre-determined levels of knowledge/experience in police related subjects and technical skills (learning outcomes), also display the development and achievement of particular skills/behaviours or 'professional competencies', which are deemed as essential for the carrying out of the policing function in a professional and competent manner. The programme consists of studies in the subjects of Social and Psychological Studies which covers the area of mental illness.



## Joint Working Group

The Mental Health Commission, an independent statutory agency was established in April 2002 under the provisions of the Mental Health Act 2001. The mandate of the Commission pursuant to the Mental Health Act 2001 is:

- to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and
- to take all reasonable steps to protect the interests of persons detained in approved centers under the Act (Section 33.1 Mental Health Act 2001).

The remit of the Commission incorporates the broad spectrum of mental health services including general mental health services, mental health services for children and adolescents, older people, people with learning disabilities and forensic mental health services.

While acknowledging the joint working initiatives that had developed between An Garda Síochána and mental health services it was recognised that such initiatives had developed in an ad hoc manner and were often based on the contacts that had developed between the personnel involved rather than on best practice models of collaboration.

The Mental Health Commission and the (former) Garda Commissioner Noel Conroy established a joint working group in May 2005 with the following terms of reference:-

*“to review current national and international best practice models in joint working between the police and mental health services and to make recommendations in relation to enhanced liaison and joint working systems between An Garda Síochána and the mental health services in Ireland. The joint working group will in particular, identify operational boundaries, which will facilitate the establishment of liaison committees and regionally based fora, which will promote and review joint working arrangements”.*

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The working group whose membership was multidisciplinary consisted of the following members:

- Dr John Owens, Chairman (2002-2007), Mental Health Commission & chair of the working group;
- Ms. Brid Clarke, Chief Executive Officer, Mental Health Commission;
- Dr. Mary McGuire, Consultant Psychiatrist, Clinical Director, Roscommon County Hospital;
- Dr. Philip Wiehe, General Practitioner, Dublin;
- Superintendent John Shanahan, Crime Policy Unit, Garda Headquarters, Phoenix Park; (Superintendent Fergus Healy replaced Superintendent John Shanahan in September 2008) assisted by Sergeant Michael McNamara, B.L., Legal Section, Garda Headquarters.
- Ms. Vicki Somers, Principal Social Worker, Health Service Executive, Mental Health Commission Member 2002 – 2007 & 2007 – 2012’;
- Mr. Diarmaid McGuinness, Senior Counsel, Mental Health Commission member (2002 – 2007);
- Mr. Gerry Coone, Psychiatric Nurse, Mental Health Commission member (2002 – 2007);
- Mr. Martin Connor, Director of Nursing, St. Ita’s Portrane. (Retired 2008).

The first meeting of the working group took place on Wednesday 25th May, 2005. Between 2005 and 2008 14 meetings of the working group took place.

A number of presentations were made to the working group which focused on relevant areas such as training, liaison systems, service user and family involvement, and issues affecting people who are homeless.



# 1

## Introduction

In September 2005 the Mental Health Commission wrote to all Clinical Directors informing them of the formation of the Joint Working Group and seeking their views on the local arrangements between the mental health services and An Gardaí. These are summarised in Appendix 1.

Focus groups were also held with representatives from An Garda Síochána, and service user representative groups i.e. the Irish Advocacy Network, Schizophrenia Ireland and Simon Communities of Ireland. The outcome of these focus groups is detailed further in Appendix 1.

A literature review is summarised in Appendix 2.





2

Way Forward

## Key Findings and Recommendations

It is evident from the focus groups that were organised to inform the recommendations of this working group that relationships between An Garda Síochána and the mental health services have developed in an adhoc manner. This impacts on all involved, but in particular the absence of interagency working impacts negatively on the welfare and dignity of services users and their families.

All the stakeholders involved, service users, patient advocates, voluntary organisations, those involved in responding to homelessness, together with the Gardaí and the mental health service providers themselves - expressed dissatisfaction with the current situation and acknowledged the need for change. Perhaps significantly, mental health service providers showed less dissatisfaction with the current state of collaboration with the Gardaí than did other groups. The Gardaí, on the other hand, expressed great concern about the lack of cooperation between the two services, particularly in the area of dealing with mentally ill people in acute crisis<sup>1</sup>. This is understandable, in that Gardaí are frequently directly involved in responding to these situations and have a sense of not being supported in resolving these problems. The consequences of poor coordination between services is that people with mental health problems are not receiving required services and are having to tolerate unnecessary stress, particularly when they become acutely ill.

<sup>1</sup> It is important to differentiate between a "critical incident" and a "crisis incident". An Garda Síochána define "critical incident" as "incidents involving hostage or near hostage situations, regardless of motivation whether domestic, mental health, criminal or political etc. and includes the following: siege/barricaded subjects and suicidal subjects". (On Scene Commanders' Manual). A "crisis incident" refers to a situation where a person with a mental illness is experiencing acute and severe emotional and mental distress, and the person's behaviour could potentially lead to the person causing serious harm to themselves or others.

### Rationale - Recommendation Number 1

An Garda Síochána and the mental health services are moving towards community models of service delivery. There is renewed emphasis on community policing, establishment of joint policing committees. This community orientation is much more evident within An Garda Síochána. For many years it has been national policy for the mental health services to move from a hospital-based system of care to care in the community. However, this move has been seen by some people as precipitative particularly in relation to a lack of community resources for individuals who have ongoing illness. As a result, many services remain predominantly hospital-oriented with a bed-based approach to the management of mental illness. Such services are isolated from the extent and consequence of illness in the community and, in the context of limited bed availability, can be reluctant to engage with other agencies that have contact with people who have mental health difficulties. It is evident, therefore, that mental health services need further significant reform. This necessary reform has been described in detail in the national government mental health policy "Vision for Change" (2006).

The core element of the community-based mental health service model is the Community Mental Health Team (CMHT). Government policy assigns a number of functions to CMHTs. These include:

- provide support and advice to primary care providers on the management of mental health problems in the community, and to facilitate appropriate referrals;
- provide prompt assessment and treatment of complex mental health disorders;
- provide a range of interventions for service users with specific disorders, drawing on evidence-based and best-practice interventions. They also ensure and coordinate any additional specialist care required;
- gain a detailed understanding of the mental health needs and priorities of the local population and establish a database of local resources available to users;

## Rationale - Recommendation Number 1 (continued)

- assist users and carers in accessing relevant agencies and community supports, so that they can achieve and sustain maximum re-integration in the community.

CMHTs which include the core disciplines of psychiatry, nursing, clinical psychology, social work and occupational therapy, it is recommended, should provide multidisciplinary team home-based treatment and assertive outreach. These teams operate on an 18 to 24 hour basis, 7 days a week. Working in the community provides the ideal foundation for developing links and joint working arrangements with relevant local statutory and voluntary agencies including An Garda Síochána and facilitates an integrated response to the needs of service users.

## Recommendation Number 1

Acceleration in the move to community-based mental health services with specialist multidisciplinary community mental health teams. These will include assertive outreach and home-based treatment options for people with an acute illness in crisis.

This recommendation can be achieved by the implementation in full of government policy as outlined in Vision for Change.

**Responsible Agencies:** Health Service Executive, Voluntary and Independent sectors.





# 2

## Way Forward

### Rationale - Recommendation Number 2

In general a person's first contact with the mental health services is through a general practitioner. This was confirmed in the study conducted by Dr. Elizabeth Dunne for the Mental Health Commission on "The View of Adult Users of the Public Sector Mental Health Services" (2006). Contact in general whether initiated by the service user/family member or as a result of an involuntary admission, was with a general practitioner. Families and carers, in the study, also reported on their reliance for support and advice from the general practitioner. General practitioners also have the primary role in recommending an involuntary admission pursuant to Section 10, Mental Health Act 2001. In instances where a member of An Garda Síochána has reasonable grounds for believing a person is suffering from a mental disorder and takes the person into custody, an application must also be made to a registered medical practitioner (Section 12, Mental Health Act 2001). (Note: "registered medical practitioner" is defined in the Mental Health Act 2001 as a person whose name is entered on the general register of medical practitioners.) Therefore the recommendation could be made by other medical practitioners apart from a general practitioner.

Following on from the publication of Quality and Fairness - A Health System For You, the government published a major policy document "Primary Care: A New Direction" in 2001, thereby acknowledging the central role of primary care in the future development of health services, and also as a gatekeeper of specialist services such as mental health services.

Primary care is defined as "an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services". The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being." (*Primary Care Strategy*).

## Rationale - Recommendation Number 2 (continued)

The weakness of the current system as identified in the report included:

- Poorly developed primary care infrastructure and capacity;
- Current system fragmented from user's perspective;
- Out-of-hours services underdeveloped.

The primary care strategy recommends the availability of primary care out-of-hours services and the development of integrated care pathways between the primary care and secondary care (includes specialist mental health services). A Vision for Change addresses the specific issue of mental health in primary care. The recommendation that consultation/liason models be developed between primary care and community mental health services is key to enhancing the health services response to people with a mental illness of crisis.

## Recommendation Number 2

The implementation of the Primary Care Strategy and the enhancement of collaborative models between primary care teams and community mental health services.

**Responsible agencies:** Health Service Executive; Department of Health and Children.

### Rationale - Recommendation Number 3

As one of the few 24 hour, seven day a week service, the Garda Síochána are often the first point of contact for social crises. Such crises can be of a predominately social nature, although there may be mental health issues as well. In such situations, social work services may be the most appropriate agency to respond. Currently, in Ireland, social work services are available on a Monday to Friday basis, with a limited out-of-hours service in the Dublin area for adolescents out of home.

### Recommendation Number 3

Reorganisation of statutory social work services to allow for 24 hours, seven day a week emergency response availability.

**Responsible agency:** Health Service Executive

## Rationale - Recommendation Number 4

The mission of An Garda Síochána is “to achieve the highest attainable level of personal protection, community commitment, state security. The core activities of An Garda Síochána include the prevention of and reduction of crime, protecting national security and ensuring road safety. This role in responding to people with a mental illness in crisis is not their primary function. Training of An Garda Síochána must focus on equipping the members of An Garda Síochána to deal effectively with their key responsibilities. Training for Gardaí and others in relation to handling of crisis situations was highlighted by all the focus groups and was in particular stressed by the service user focus group. All respondents identified the skills, knowledge and experience required to handle such situations. The Gardaí, in their response, stated that in their view, dealing with crisis situations is a very specialised area.

Current training curriculum for Garda trainees consists of a module on social studies which includes a general broad based overview on mental illness, including mental health legislation.

Training has been identified as a key factor in enhancing the effectiveness of police in crisis situations. There is an extensive range of literature outlining the elements of such training programmes. However training on its own will not be effective unless the liaison partnership models of community mental health services are established.

## Recommendation Number 4

A training programme which facilitates members of An Garda Síochána in recognising and responding appropriately to people with a mental illness in crisis and providing information on community and social services is required. Such a programme should include involvement of service users, families and representatives from the mental health and social services. This training should be included in the overall training programme for garda recruits and also be included in ongoing professional programmes for members of An Garda Síochána.

**Responsible agency:** An Garda Síochána

### Rationale - Recommendation Number 5

A review of international models of cooperation between the police services and mental health services suggests that the most effective model for dealing with acute mental health crises is the development of Crisis Intervention Teams (CIT). The effectiveness of these models depends on the availability of mental health services in the community that can be easily accessed on a 24/7 basis. The provision of dedicated, staffed "place of safety" is also viewed as a critical success factor. These teams are composed of police officers who have advanced training in mental health issues and have detailed knowledge of local mental health and social services. Such officers are members of designated teams who respond to people with a mental illness in crisis. In some jurisdictions, the CITs are jointly staffed by personnel from the police and mental health services.

### Recommendation Number 5

A feasibility study on the appointment of Crisis Intervention Teams jointly staffed

- (a) by members of An Garda Síochána and mental health personnel should be undertaken and published.

**Responsible agencies:** Health Service Executive, An Garda Síochána and Mental Health Commission

- (b) The Health Service Executive should consider the establishment of a 24 hr crisis team on a pilot basis in a designated urban area.

**Responsible agencies:** Health Service Executive

## Rationale - Recommendation Number 6

The feedback from the focus groups and evidence from other jurisdictions highlights the absence of formalised communication systems between the police and mental health services leading to communication failures, disjointed responses and poor responses to service users and their families and carers. In order to achieve best possible outcomes for service users, families, wider community, staff within mental health services and Gardaí, close communication, collaboration and joint protocols are required. Essential elements include regular liaison and contact by designated personnel in the mental health services and police and the progression and evaluation of procedures at local and national level.

Since the commencement of the Mental Health Act 2001 in full on 1st November 2006, work has been ongoing between An Garda Síochána and the mental health services on the development of joint protocols in relation to relevant sections of the Mental Health Act 2001. This work and its continued review have provided an opportunity for further joint initiatives between An Garda Síochána and mental health services. Suggested areas to be included, while acknowledging the need to adapt to local circumstances are:-

- Contact by An Gardaí Síochána with the Mental Health Services
- Contact by Mental Health Services with An Garda Síochána
- Education & Training
- Information Sharing and Compliance with relevant legislative provisions

## Recommendation Number 6

The ongoing development of a joint protocol between mental health services and An Garda Síochána and the development of formal liaison systems between the mental health services and An Garda Síochána. The involvement of service users and families in the development of the protocols and in liaison systems is essential.

**Responsible Agencies:** Health Service Executive and An Garda Síochána, National Service Users Executive.

### Rationale - Recommendation Number 7

There is a growing body of evidence to indicate that the establishment of Criminal Diversion Schemes including the establishment of mental health courts (also known as community courts) reduces the inappropriate criminalisation of people with a mental illness.

The earlier recommendation in relation to assertive outreach teams and joint Gardaí / mental health responses are essential components of such a scheme. The development of mental health courts is an integral element of an overall criminal diversion scheme. Mental health courts are a relatively recent development in other jurisdictions. In the late 1990s only a few mental health courts existed in the United States of America. By 2008, 150 have been established and more are planned. The first community court in England and Wales opened in Liverpool in 2004. In 2006, the UK government announced the expansion of the initiative to ten other areas, including London.

Two key principles underpin the system for mental health courts. Collaboration between the criminal justice, mental health, substance abuse and related social care systems is essential. Secondly it must be recognised that mental health courts are not a panacea. A comprehensive strategy, as outlined, in the earlier recommendations, is required. Mental health courts are just one element of the overall strategy.

### Recommendation Number 7

To examine the introduction of the court diversion programmes at District Court level, in line with the recommendation from the National Crime Council. Such a scheme should be introduced on a pilot basis initially. Evaluation of the pilot scheme would inform future developments.

**Responsible Agencies:** Department of Justice, Equality and Law Reform, Director of Public Prosecutions, Courts Service, An Garda Síochána, Health Service Executive, National Service Users Executive.







Appendix

**1**

# Views of Stakeholders

# Views of Stakeholders

Report of Joint Working Group on  
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## A. Liaison Between Mental Health Services and An Garda Síochána

### 1.1

During 2005 it was agreed that the Joint Working Group on Police and Mental Health Services would make contact with the area mental health management teams, seeking information on any collaborative arrangements between the police and mental health services.

### 1.2

A questionnaire was issued to each Clinical Director seeking information on their local arrangements with the Gardaí. The following questions were posed in the questionnaire:-

- (1) *Do you meet with local Gardaí on a regular basis? YES/NO  
If YES, please describe the nature and frequency of this contact.*
- (2) *Have there been an opportunities for joint training between the Gardaí and Mental Health Services in your area? YES/NO  
If YES, please outline the content of the training programme and who was involved.*
- (3) *Have there been any joint initiatives between the Gardaí and Mental Health Services in your area? If yes, please give a brief description.*
- (4) *How would you rate the overall level of co-operation between the Gardaí and Mental Health Services in your area?  
Very Satisfactory - Satisfactory - Reasonable - Not Satisfactory - Very Unsatisfactory.*
- (5) *Can you identify any factors which would enhance collaboration between the Gardaí and Mental Health Services in your area?*
- (6) *Are you aware of any research conducted in Ireland on the interface between the Gardaí and Mental Health Services? YES/NO  
If yes, could you provide references please.*
- (7) *Any other comments?*

# Views of Stakeholders

## 1.3

37 questionnaires were distributed to the services. The working group received 27 completed questionnaires, giving a response rate of 73%.

## 1.4

Responses to questionnaire:-

**Do you meet with local Gardaí on a regular formal basis?**

YES - 3  
No - 24

**Comments from those who responded 'Yes' describing nature and frequency of contact.**

Meetings were held 2 to 3 times per year.

**Comments from those who responded 'No'.**

Meetings had taken place previously but not in recent times.

**Have there been any opportunities for joint training between the Gardaí and Mental Health Services in your area?**

YES - 3  
No - 24

**Comments from those who responded 'Yes'**

- Training organised around alcohol and drug abuse
- Student Gardaí have two week placements where they work side by side with nursing staff on all the units.

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## Comments from those who responded 'No';

- This was raised however, it was considered that this was a role for the Mental Health Commission.
- Discussions only reference common issues. No training

Have there been joint initiatives between the Gardaí and Mental Health Services in your area? If Yes, give a brief description.

YES - 5  
No - 22

## Comments from those who responded 'Yes'

Joint initiatives encompassed meetings and consultation on case by case basis, discussion on management of involuntary admissions.

How would you rate the overall level of co-operation between the Gardaí and Mental Health Services in your area? Please tick the relevant box:

Out of total of 27 respondents:

Very Satisfactory	5
Satisfactory	8 <small>(one respondent commented that they have not needed involvement of Gardaí to his knowledge)</small>
Reasonable	11
Not Satisfactory	3
Very Unsatisfactory	

Can you identify any factors that would enhance collaboration between the Gardaí and Mental Health Services in your area?

Responses included:-

- The appointment of a Liaison Garda Síochána to the Mental Health Services;
- Small catchment population. Familiarity with local Gardaí. Structured meetings;

## Views of Stakeholders

- Joint group based on Garda Divisional Areas to identify key issues and initiate training in *Mental Health Information, Mental Health Act 2001, Crisis Intervention, Escort Issues*;
- More formal regular contact at consultant group/CMT level would be more helpful. However, informal links very good at local level;
- Regular liaison meetings - Identified Gardaí with responsibility/interest in mental health issues and to liaise with sector teams;
- Shared knowledge of how each system operated, and clear regulation of working responsibilities and boundaries;
- Research - Joint Working Groups;
- A forum for discussion of ongoing management issues which are of mutual concern to both;
- Clarity on responsibilities/Meetings management and senior staff Gardaí at least annual basis - local services/Joint training for escort duties/An annual conference on issues of joint interest (at national level).

**Are you aware of any research conducted in Ireland on the interface between the Gardaí and Mental Health Services? If Yes please provide references.**

NO - 27

Any other comments?

The relationship between Gardaí and G.P.s also important. In my experience where the GPs have good relations with Gardaí they tend to co-operate more. Suggest any initiative on joint working between Gardaí and mental health services should be discussed with GP organization as well.

# Views of Stakeholders

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While there is generally good relationships between the Gardaí on an informal basis, we have never achieved total harmony!

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We have requested and have been promised meetings with Senior Garda Management but have been put off time and time again. I think a formal recommendation from Garda Commissioner and Mental Health Commission is essential to achieve improved co-operation between our two services.

## B. Service Users - C. Carers and Families - D. An Garda Síochána

### 2.1

It was decided that focus groups were the most effective method of ascertaining the views of stakeholders on the interaction with An Garda Síochána and the interface between the mental health services and An Garda Síochána, especially in times of crisis.

The main objective of the consultation was to capture service users' experiences of their interactions with An Garda Síochána, particularly in times of crisis. The consultation aimed to provide people with an opportunity to provide the Working Group with their ideas and possible solutions.

As a first step in designing the consultation process, the Mental Health Commission held discussions with advocacy organisations and organisations representing service users and families. The organisations participating in those discussions were:

- The Irish Advocacy Network
- Schizophrenia Ireland
- The Simon Community

# Views of Stakeholders

These organisations agreed to partner the Commission in setting up a consultation process with service users and families. An independent consultant was appointed by the Commission to support the work of designing the consultation process, and to prepare an independent report of the findings.

A planning group comprising representatives of the agencies, staff of the Mental Health Commission, and the independent consultant was established and met on a number of occasions to plan for the consultation process. The planning of the consultation with Gardaí was undertaken with a member of garda management who is involved in the Working Group.

## 2.1.1 The Methodology

The planning group agreed that a focus group methodology would be the best means of providing a range of views to the Working Group in a relatively short time.

### *Participants*

It was agreed that the focus groups should include:

- Service users from rural and urban areas
- Older people and younger people
- Family members
- Male and female participants
- People with mental illness who are homeless

Consideration was also given to the need to gather views from Travellers with mental health problems, and from people from new European countries, refugees or asylum seekers. In the event, it has not proved possible to gather views from these groups.

# Views of Stakeholders

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In the case of people who are homeless, the advice was that the focus group methodology would not be appropriate. Instead, a focus group was held with staff working with people who are homeless and experience mental health problems,

Six (6) focus groups were held. Three of the focus groups involved service users. One group was made up of family members. One group was made up of staff of a service working with people who are homeless, while the sixth group were members of an garda síochána, all of whom were sergeants with extensive experience of crisis situations in rural and urban areas.

### *Facilitation*

The planning group agreed that facilitation for the focus groups would be provided by the organisations mentioned above, in order to ensure that facilitators had good knowledge, skills and experience in working with people with mental health problems, as well as facilitation skills.

### *Planning the design of the focus groups*

A planning meeting was held with facilitators in order to design a common approach to running of the focus groups, including the invitation to participate, the provision of support to participants, if needed, confidentiality issues and assurances, and the best use of the focus group in order to provide participants with a good opportunity to give their views and ideas.

### *Recording*

The proceedings at each of the focus groups were recorded, with the permission of the participants. The transcripts were examined by the independent consultant, and key themes raised by the groups were identified.

The report on the consultation summarises the main points made and issues raised by each of the groups in respect of each theme.

Section 2.2 draws attention to some features of the focus group discussions that should be borne in mind by the reader in examining the feedback, and describes the key themes emerging from the consultation.



# Views of Stakeholders

*Section 2.3* and *Section 2.4* summarise the main issues raised by participants about their experience, both positive and negative, of crisis situations, and their observations on those experiences.

*Section 2.5* and *Section 2.6* describe the views of participants as to how best the experiences of service users in crisis situations can be improved. These sections summarise views about the need for training of Gardaí, and address the scope for improved structures and systems.

*Section 2.7.* draws together views and suggestions about new kinds of staffing and structures that would help to create a strong support system and structure for managing crisis interventions at local level.

*Section 2.8.* deals with views about the wider context in which crisis situations occur and ways in which that wider context, and the provision of mental health services more generally impact on the handling of crises. Although these views may not be directly related to the terms of reference of the Working Group they are recorded here because participants felt that they impacted strongly on the scope for managing crisis situations.

*Section 2.9.* draws together a brief overview of some of the key issues emerging from the consultation process.

## 2.2 The Themes Emerging From the Consultation: Some Initial Considerations

### 2.2.1 The Web of Relationships

The topic that stakeholders were being asked to consider was not a simple one. The participants were drawing on their experience of what is a complex and multi-faceted set of engagements - between Gardaí and the person with a mental illness, between Gardaí and families, between families and the service user and medical personnel, and between Gardaí and the various medical and psychiatric service personnel. Inevitably, in their responses, the participants gave differing weights to particular sub-sets of these relationships.

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## 2.2.2 The Changing Legal Context

The consultation process was happening in the cross-over period of old and new legislation. Further complexity arose from the varied reasons for and circumstances of garda involvement. Some events concerned crises in the family home while others related to public situations. There were experiences of situations involving alleged criminal offences. Family or service providers may have called Gardaí or the person in crisis may have presented himself or herself to Gardaí.

It was evident that many stakeholders from all of the groups were speaking from differing understandings about roles, responsibilities, protocols, and in particular the legal powers and duties of Gardaí, hospital-based mental health personnel, community based mental health services and the general practitioner in these different sets of circumstances.

In considering the feedback, this needs to be borne in mind, as it would not have been possible or appropriate for facilitators to check with participants throughout the focus group meetings as to the correctness or otherwise of their understandings of the law.

## 2.2.3 Types of Engagement

The main types of engagement between Gardaí, service users and families, and mental health services discussed by participants were the following:

- When Gardaí are called by family, a member of the public or a third party
- When Gardaí are asked to escort a person to hospital
- When a person with a mental illness presents himself or herself to the Gardaí
- When Gardaí arrive at a psychiatric hospital with a person with a mental illness (either as escort or on foot of forming an opinion that a person has a mental illness)

# Views of Stakeholders

## 2.2.4 Key Themes

The key themes that emerged, linked to these different circumstances of the engagement between Gardaí, mental health services, GP and other services, and the service user and family were as follows:

### *Themes relating to managing the interaction*

- Who can help, when Gardaí are called to a crisis
- Managing the engagement with Gardaí
- The interface with the hospital personnel

### *Themes relating to support systems*

- The need for training
- Improving the infrastructure of support for crisis encounters
- The wider context

The ideas and suggestions from the focus group discussions are concerned with ways of improving the engagement between the various parties in the course of crisis situations. Some of the ideas refer directly to ways of strengthening the interaction between mental health services and the Gardaí. However, many others are concerned with ways of improving the engagement between the Gardaí and the service user or family in such a crisis, and only indirectly address the relationship of Gardaí and mental health services.

## 2.3 Who Can Help, when Gardaí are Called to a Crisis

### 2.3.1 The Views of Service Users

The view was that a crisis situation would be helped by the presence of a doctor who the person with mental illness would trust and who knows the person or has worked with them. This might be the family GP. On the other hand, a GP perceived as neutral by the service user may be more acceptable to them. Family members are also needed, it was felt.

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There was a view that the person with mental illness should be asked who they want present, rather than simply bringing someone who happens to be available.

In response to a discussion about whether the professional mental health services personnel should have a stronger presence than Gardaí, this was seen to depend on the situation. Gardaí may have a good established relationship with the person; in addition, the level of danger in the situation may call for a strong Garda presence.

## 2.3.2 The Views of Families

Like service users, family members believe that Gardaí should link with a mental health specialist in the area when they have a crisis situation on hand. Gardaí need to talk both to that professional and to the person's family, or a carer who knows the person well.

For the family who is involved in such a crisis, the question was asked as to why they should have to call Gardaí in an emergency? Gardaí, they felt, respond in a manner that is appropriate to their view of the situation, but which is not necessarily what the person needs. The view was that families should have access to a medical professional at such a time.

## 2.3.3 Views of Staff Working with People who are Homeless

Where workers in a centre for people who are homeless have background knowledge of a person with a mental health problem, they believe their presence can assist the Gardaí and the person concerned in a crisis situation.

Staff focused on the communication between all the parties who may be involved in a crisis situation; there was a view that effective communication is a problem, and that background knowledge of the person with a mental illness is difficult to share. Staff were especially concerned that there appears to be a lack of accountability when communications break down - an issue also raised by family members. They feel that this communication problem results in a 'blame game' between the services and the responsibilities of the health services are passed on to others.

# Views of Stakeholders

Staff also described their experience of and concern about a lack of clarity about the respective roles of the GP and the psychiatrist in a crisis situation.

## 2.3.4 The Views of Gardaí

The main consideration from the garda perspective was that anyone involved in a crisis situation should be trained to deal with that situation. The need for a female garda to be present in situations involving a woman was also stressed.

In terms of roles and responsibilities, they expressed concern and frustration about the role of the general practitioner in such situations; where the person is already known to mental health services, access to background information will be good; however, garda experience was that GPs can be extremely unwilling to certify the person, particularly when they know the family.

Roles and responsibilities in relation to transport may also become blurred in rural areas, where access to ambulances can be restricted.

Gardaí were clear that it is essential to have family involved, but also that there may be huge conflict when family members do not want the person to be certified. They were concerned about the lack of clarity among family members as to the role of Gardaí under legislation in a crisis situation; Often, families may have expectations about the garda's role and responsibility that are in conflict with the facts.

Gardaí also felt that there may be problem with volunteer workers assisting Gardaí. They asked if there was an insurance issue involved?

## 2.4 Managing the Interaction between Gardaí and Service Users

### 2.4.1 The Views of Service Users

#### *The relationships 'in the moment'*

Service Users placed strong emphasis on the quality of the human interaction with Gardaí 'in the moment' of an encounter or a crisis situation.

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The recurring themes were the need for trust, respect, empathy, sensitivity, sympathy and understanding. To be treated with respect, and treated 'as a person' matters a great deal. Service users spoke about the need for Gardaí be able to 'step into the person's shoes' and understand their feeling and emotions at such a time.

The themes of **fear, suspicion and anger** were named. Service users placed emphasis on how frightened a person may be in these circumstances, and how suspicious they may be of people present. They described how a perceived breach of trust might cause the service user to be angry. The service user may be especially suspicious of anyone whom they do not know, or whose 'credentials' are not known to them.

Participants understood very clearly that the nature of the interaction 'in the moment' could be coloured for the Gardaí by the very same factors that affect the service user - fear, suspicion, and uncertainty about who they are dealing with. They recognised the possibility that an aggressive encounter may be triggered by the behaviour of either party, in response to that fear and suspicion. They felt, however, that Gardaí should not show aggression to the person with mental illness.

The theme of **safety** also arose in the discussions. Some participants spoke of the way in which the presence of the Gardaí made them feel safe in a crisis. However, they were clear too about the ambivalence they can experience - feeling fearful on the arrival of the Gardaí, while at the same time welcoming their presence.

Participants spoke about the possible negative reaction of a mentally ill person to the Garda as **authority** figure, and the need to try to make the encounter less formal, so as to reduce the tension or feeling of intimidation that a person may feel.

The challenge for Gardaí in managing such a complex encounter that has contained within it such a range of emotions and of requirements was summed up by a participant who spoke about the need for Gardaí to be 'both strict and compassionate' and by a participant who named the expectation that the Gardaí should be 'everyone's ally'.

## Views of Stakeholders

### *The physical presence of Gardaí*

Closely linked to the emotional quality of a crisis encounter was the question of how Gardaí should manage their physical presence at a crisis setting. This issue concerned such matters as garda cars, uniforms, numbers present, and how Gardaí manage their presence in the home or other location of the crisis. The sense of the predominance of male Gardaí in such settings was also raised.

Service users were again very conscious of the ambivalent feelings that a person with a mental illness may experience towards uniforms, in particular. On the one hand, the arrival of a uniformed garda can evoke fear of having done something wrong; the person may feel intimidated by the garda presence, and by the negative association of the uniform with authority. The person with a mental illness may also have a sense of stigma associated with the arrival and presence of the Gardaí.

On the other hand, there were references to the way in which the presence of the uniformed Gardaí created a climate of safety and trust - more so than if the garda did not wear a uniform. The need for a community uniform was suggested.

The question of use of handcuffs was raised, and appeared to evoke strong feelings among participants, sometimes expressed in terms of relief about situations where they were not used.

### *Using good strategies to manage the interaction*

The strategies used by the Gardaí should focus on de-escalating, reducing tension, and avoiding any confrontational action that could frighten or intimidate the person. In particular, the following were seen as helpful actions or strategies:

- Understanding the person's fear, and knowing how to reassure the person
- Using a calm tone of voice
- Using the person's name
- Talking directly to the person
- Keeping an appropriate distance and giving the person space
- Avoiding 'towering over' the person
- Having one garda approach, while others stay in the background, rather than having several Gardaí approach the person
- Having, where possible, background knowledge about the person, and what might stress or de-stress them.

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## 2.4.2 The Views of Families

### *The relationship 'in the moment'*

Family members focused on the trauma for them when a crisis happens and the Gardaí are called. This experience was evidently painful, and not easy for people to talk about. Tensions and dilemmas face families as they struggle to manage their concern for their family member who is ill and may be violent, with their responsibility to other family members and to themselves. One family member spoke of how glad they would have been to see the guards coming; on the other hand, this experience can be filled with stress, and anxiety. Participants felt that Gardaí need to understand what families are going through in these situations.

In situations involving violence or threatened violence, family members described a huge dilemma they faced; they felt 'caught' between the choice of pressing charges against the family member, or being left with the crisis, if they did not wish to bring charges. However, bringing criminal charges against a family member was seen as sometimes being the only way of getting help for the person from the mental health services.

Families also experience anxiety about the impact on younger siblings of involving Gardaí in a crisis in the home, and the sense of stigma that they may feel. They see a need for Gardaí to have ways of reassuring the young person, and 'normalising' the relationship with Gardaí after the crisis event.

Like service users, families were very aware of the dilemmas arising from the different perspectives and obligations of the parties involved in a crisis situation; families see a patient needing help while Gardaí are addressing the need to 'contain' a situation.

### *The physical presence of Gardaí*

The main point raised by family members was to the need for Gardaí to listen to them and be advised by them about use of handcuffs or other restraints. Some concern was also expressed about the arrival of Gardaí to a home 'with lights blazing and in uniform'. However, this issue did not appear to preoccupy family members or attract a high level of discussion.

Families identified the need for Gardaí to be experienced in using specific strategies to manage a crisis. These strategies would require use of communication skills and listening skills, as well as knowledge of good ways of responding in such situations. Participants also referred to the need for clear



## Views of Stakeholders

protocols to govern the actions of Gardaí, and, in particular, the use of force, in crisis situations.

### *Using good strategies to manage the interaction*

Family members stressed the need for Gardaí to have access to a person's medical history, and to knowledge of what might be causing them to behave in a violent or threatening way; again, the need to understand the person's fear was emphasised. Gardaí should have clear information about who to contact for advice and assistance. Family members also mentioned the value of knowing the person's name and calling them by their name in a crisis.

For young siblings of a person with mental illness, who may have been present in a crisis situation, family members suggested that a follow up call to the family and reassurance for the child or young person about how they are seen by Gardaí would be helpful.

### 2.4.3 The Views of Staff Working with People who are Homeless

Staff members spoke about the need for understanding and sympathy for the person who is mentally ill. While they felt that some Gardaí may have an 'attitude', their general experience was of Gardaí (referring particularly to community Gardaí) who were understanding, sympathetic and helpful. They described the calm response of a garda to a person threatening suicide as particularly helpful.

Like other groups, staff felt that the formal garda uniform may not help in a crisis, but that it is still useful to have a type of uniform in order to retain a necessary degree of authority and respect. Also echoing a theme in the contributions from other groups, staff felt that handcuffs and batons should not be visible when Gardaí attend a crisis situation. Staff spoke about situations that can involve high levels of risk and danger, and the need for Gardaí to arrive quickly to deal with such situations; there was mixed experience of the timeliness of response.

### *Planning to intervene early*

The strongest concern of staff was their experience when a crisis situation is known to be building up over time, and the frustration for them and for the Gardaí arising out of what they see as ineffectiveness or inaction on the part of mental health services, or by a breakdown in communication between and within services, including poor communication of information within the Gardaí.

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Staff described scenarios where, in their view, early and appropriate interventions could have avoided a crisis, but such intervention appeared to be frustrated by communication deficits, by limits on the roles of various professionals, or by differing understandings about their roles, or by mental health service provision.

## 2.4.4 The Views of Gardaí

It was the experience of Gardaí that, over time in an area, especially in rural situations, people with mental health difficulties may develop a good relationship with one garda who may spend a lot of time talking to that; while this is positive, they felt that the Gardaí may be left carrying the responsibility for the relationship in a crisis.

With regard to the demeanour of Gardaí in a crisis, and, for example, the impact of uniforms, Gardaí, like other groups, were well aware of the contradictions that may present for the person who is mentally ill; on the one hand, the uniform may be connected with negative images and experiences of power and authority; on the other hand, the uniform can make the person feel safe. In their experience, the person may draw lines about who is 'on their side' and a garda in plain clothes might make the person edgy.

Gardaí felt that family, more so than the person who is ill, may react badly to the stigma that may be associated with the presence of the garda car and uniformed Gardaí.

Gardaí felt that it is up to garda to bear themselves in a manner that is not confrontational and non-aggressive - a modern way, irrespective of uniform.

Gardaí see the need to deal with crisis situations in a sensitive manner. They believe that garda are good at doing this, at teasing things out, pulling back, and avoiding escalating a situation. They feel that Gardaí in Ireland are different from other police forces in their willingness to engage with the person in crisis. However, Gardaí would be fearful that, even with the best intentions, their approach to an individual might 'set the person off'

# Views of Stakeholders

## 2.5 The Interface with the Hospital Personnel

### 2.5.1 The Views of Service Users

Service user groups also discussed the experience of being brought to hospital (though they did not differentiate between the various circumstances through which this might come to pass). They raised questions about this experience, as well as making suggestions.

The questions raised concerned the rights of the person being brought to hospital - what rights does the person have? What must they be told about those rights? Can they have access to an advocate? What safeguards are in place to protect their interests?

Participants made suggestions as to how the services can co-operate in order to minimise the trauma of being brought to hospital. The actions that would help in this situation were seen as similar to the actions that would be helpful when the Gardaí initially become involved in the crisis. The focus was on trying to ensure that, in this difficult event, the person with a mental illness would not feel completely disempowered; participants saw a role for the GP or community nurse or family member who would talk to and consult with the person; the view was that, well handled, a person might agree to go voluntarily to hospital rather than be required to go there on an involuntary basis.

Participants had factual questions about the role and responsibility of Gardaí once they have brought a person to hospital (for example is the Garda required to stay with the person), and when their responsibility ends. People had different experiences about how this works in practice, and did not have a clear understanding of what is legally or procedurally required of the Gardaí and hospital personnel.

### 2.5.2 The views of families

Family members also expressed uncertainty and concern about the role and responsibility of the Gardaí, once they bring a person to hospital. In particular, they felt that family members should not be left on their own to manage a situation that had been serious enough to warrant the Gardaí's involvement in the first place.

There was a view that the person with mental illness should be brought to a psychiatric hospital, and not to the casualty unit of a general hospital.

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## 2.5.3 The Views of Staff Providing services to people who are Homeless

Staff expressed a high level of frustration around the area of admission to hospital for people with mental illness with whom they deal. Staff were also very aware of the frustrations experienced by Gardaí, who may bring a person to a hospital following their intervention in a crisis, and have to bring the person away again when the person is not admitted.

Staff also spoke of their perception of differing perspectives between community psychiatric services and hospital services and a mismatch in what they are trying to achieve.

There was an evident lack of clarity about the role of Gardaí in respect of bringing a person to hospital; there were questions about the escort role, when it does and does not apply; staff described an apparent absence of knowledge 'on the ground' about how involuntary admissions should be handled under new legislation, and perceived an absence of admission protocols in hospitals.

Staff felt that discharge policies and protocols are as important as admission policies in crises for the client group who are homeless, and that both must be looked at together in order to avoid a cycle of homelessness and crisis.

## 2.5.4 The Views of Gardaí

The experience of Gardaí in bringing people to hospital following a crisis was clearly a source of a great deal of frustration for Gardaí themselves and one which raised concerns for them about the well being and best interests of the person with mental illness.

They expressed frustration about the consequences when doctors were reluctant to certify a person, where doctors would differ in the same hospital, and where hospital doctors differ from GPs in the view about the need for admission.

Gardaí see the need to involve families as closely as possible in such situations, so that they will take responsibility for the person at the point where they may need to take them home if they are not admitted to hospital. This can often result in a change of view on the part of the family about involuntary admission as the family may have endured many years of violent behaviour and disruption.

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One of the Gardaí's concerns related to what happens when a person is not admitted. They raised questions about their ongoing role and responsibility for the person; the person cannot be left miles from home, but Gardaí need clarity as to whether they have appropriate authority or responsibility to bring them home.

However, their more significant concern was for the safety of the person themselves and for the family. Where a person's behaviour has been sufficiently serious to warrant garda intervention in the first instance, Gardaí were left with the concern about what might happen to that person. They described difficult experiences where a person was not admitted to hospital and then committed suicide. In a strongly expressed opinion, one view was that medical caution could cost lives.

Gardaí were aware of the challenges facing doctors in relation to diagnosis and compliance with legislation. The biggest gap in the system, from their perspective, was the absence of a facility for doctors and hospitals to respond to a short-term crisis, irrespective of formal diagnosis, by admitting the person temporarily for assessment and observation. Gardaí felt that such a facility could enable the person to be helped or to become calm, and thus avert a more serious crisis.

Like other groups, Gardaí spoke about the mismatch and dissonance between the perspectives of various professionals; hospital doctors may take a long term view of the person's needs and diagnosis, while Gardaí and family see the need for urgent short term action.

## 2.6 The Need for Training

### 2.6.1 The Views of Service Users

Not surprisingly, the need for training for Gardaí and others in relation to the handling of crisis situations was discussed by the service user groups. The need for certain types of skill, knowledge and experience is embedded in all of the themes already described, but the training issue was explicitly raised and recommendations made by the service user groups.

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## *The scope of the training*

Service user groups felt that all Gardaí should have training to equip them to deal with crisis situations involving people with mental illness; this training should be compulsory and should be the subject of testing, as would any other aspect of training. Gardaí should have refresher courses from time to time; established Gardaí should be expected to undertake the training as well as newcomers to the Force. There was a view that service providers should also undertake this training.

## *The content of training*

Participants felt that training should cover areas of skill and knowledge. In particular, they saw a need for training in areas such as:

- Counselling skills
- Communication skills
- Listening skills
- Crisis management strategies
- Implications of different types of mental illness

Participants were of the view that Gardaí should not be expected to engage in diagnosis, but rather to have enough knowledge to undertake their particular role.

## *The training process*

Participants placed strong emphasis on an experiential approach to training. They recommended that the training model should include role-play and case studies.

Participants felt that Gardaí should have opportunities to meet with and learn directly from people with mental health difficulties about the nature of those difficulties. The Gardaí should have negotiated opportunities to spend time in centres and units, including centres in the community, and to get to know people on a personal basis. They were strongly of the view that this would be a more appropriate model of training than giving Gardaí an exclusively professional perspective on mental health and mental illness.

Participants also raised the question as to whether people with mental health difficulties might have training in how to engage with Gardaí.

## Views of Stakeholders

### 2.6.2 The Views of Families

Family members also regard training for Gardaí as essential. They believe this should not be optional, and should be an ongoing through a garda's career. They believe that it would be unfair to expect Gardaí to deal with crisis situations without the relevant skills and knowledge; to do so would place everyone involved at risk, and could make the situation worse. The capacity of a garda to manage a crisis situation should not be dependent on personal characteristics or ability, but on knowledge and skill. Like service users, family members felt that training should deal with:

- Knowledge of mental illness, and of the symptoms of various types of mental illness
- Understanding of how a person in a crisis situation is feeling
- Ways of communicating with the person in a crisis, and how to reassure the person, and avoid escalating the situation
- Ability to assess the crisis situation
- Ways of using restraint without using handcuffs
- Insight into and respect for the situation of family members and siblings, and what they are going through
- The role and responsibility of the Gardaí

Family members should be invited to contribute their experiences, both positive and negative, as part of the training process;

### 2.6.3 The Views of Staff Working with People who are Homeless

Staff were also clear about the need for training for Gardaí for their involvement with people with mental illness in a crisis situation. They felt that awareness and insight into what the person may be feeling and experiencing is essential; they also stressed the need for good knowledge of ways of responding to the person in crisis, through use of their name, and other ways of keeping a situation calm.

Like other groups, staff felt that the direct experience of people who are homeless should be used in the design and delivery of training programmes.

# Views of Stakeholders

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## 2.6.4 The View of Gardaí

Gardaí felt that dealing with crisis situations is a very specialised area. Even a small amount of training could provide Gardaí with useful knowledge of how to respond in such situations. Gardaí also felt that medical personnel should be trained in an understanding of the garda role.

The routine involvement of Gardaí in responding to people with mental health problems who drop in to garda stations also needs to be acknowledged and support provided. Gardaí spend a great deal of time just talking to people who are depressed. This work has a strong preventive function, but Gardaí worry that, even with the best intentions, they may not be equipped to help a person in the appropriate way.

## 2.7 Improving the Infrastructure of Support for Crisis Encounters

### 2.7.1 The Views of Service Users

Service users groups proposed some new developments in staffing and structures that, in their view, would help to ensure that crisis encounters would be handled in the least traumatic and most helpful way for the service user and other parties to the encounter. The main proposals were for designated personnel in both the garda services and in the mental health services who would be available to provide support in a crisis. The proposals were as follows:

#### *Community Garda liaison officer*

Each district should have a named Garda liaison officer, with special responsibility in relation to liaison with mental health services and people with mental health difficulties.

This garda would have a remit that is broader than the provision of support for crises. He/she would have a preventive role, and a role in maintaining contact with service users. Through this role, the garda would have knowledge of service users that could be drawn upon by Gardaí in the event of a crisis situation.



# Views of Stakeholders

## *Gardaí with specialist knowledge*

Each district should have a number of Gardaí with specialist knowledge, over and above the basic training available to all Gardaí. One of these Gardaí would be available on every shift to support colleagues in a crisis situation.

## *Liaison person within psychiatric services*

A named liaison person should be available in every area within the psychiatric services to accompany Gardaí in a crisis situation. The liaison person should be assigned to specific garda units. They should be independent of the garda or the psychiatric services; their task would be to ensure the best possible outcome for the service user.

## *Family access to liaison person*

Families should have direct access to family liaison person.

## *Use of the PULSE system*

The potential of the PULSE system to provide Gardaí with background information in respect of a person with mental illness, who may have had previous crises, and was known to garda as a service user of mental health services, was seen as a positive development, and a good way of giving a garda some insight in the event of a crisis.

## 2.7.2 The views of families

Like service users, families see the need for a comprehensive and integrated response to crises, in which Gardaí and mental health services link together and attend a crisis situation as a team. At the least, a doctor should be available on call, and the number of doctors on call should be proportionate to population size.

Families also believe that a garda with specialist knowledge should be on duty on every roster, or at least available on call.

Families would like to see an emergency response unit in place to deal with acute mental health crises, and 24-hour telephone access for families to a medical support helpline.

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Family members suggest that Gardaí should build up connections with carer groups in their locality, who could offer support, in the same way that they offer support to each other.

Ambulance services should take a person with mental illness to the hospital where their records are held, rather than to another hospital, for example, in the case of an overdose.

## 2.7.3 The Views of Staff Working with People who are Homeless

The main focus of staff views was on the need for communication and co-ordination, in order to provide for a joined-up response to people with mental health problems. They see the need for that co-ordination to span mental health provision at community and hospital level, as well as the interaction between both, and not to look in a fragmented way at management of crisis situations.

### *Co-ordination*

Co-ordination should provide for:

- Linkages between Gardaí, HSE and voluntary service providers, and common agreement on communication channels, admission policies, discharge policies, provision following discharge, early intervention and crisis intervention
- Linkages between homeless agencies and Gardaí and sharing of knowledge (but avoiding setting up a special co-ordinating structure for homeless people)
- Co-ordination at national as well as local level
- Linkages between community Gardaí with knowledge of an area and local service providers
- Shared agreement on good models of service in relation to crisis intervention

## Views of Stakeholders

### *Accountability*

Structures of accountability are needed. This could be achieved through a review mechanism through which actual cases were reviewed; the review would examine how different agencies had addressed their responsibilities.

### *Specialist garda team*

A specialist garda team should be available, with training provided for Gardaí on the team.

## 2.7.4 The Views of Gardaí

Gardaí identified a range of new developments needed to ensure crisis situations are handled well.

### *Scope for short term monitoring*

The most essential and significant development, from the Gardaí's perspective, would be a facility in hospitals for a person in a crisis situation to be monitored for a short period, while a determination is made about their longer term needs and their diagnosis. Such a facility might allow medical staff to take steps alleviate the person's crisis, even if they did not intend to admit the person formally.

### *Clear protocols and information*

Gardaí see a need for clear protocols governing the roles and responsibilities of the various parties. These protocols should translate the requirements of the Mental Health Act into what it means for practice 'on the ground'. The responsibilities of district officers, of Gardaí and of directors of mental hospitals should be clearly described.

Doctors should be aware of the limits of the garda role and responsibility. A code of practice in respect of escort duties should be set down and adhered to.

### *Specialist psychiatric support*

Gardaí should have 24-hour access to personnel within the psychiatric services, especially in rural areas. This civilian should be part of team on duty or a phone call away.

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## *Garda with specialist training*

Each unit should have a garda with specialised or additional training.

## *Case conferences and meetings with HSE*

There was a view that such meetings and conferences will not in themselves resolve the issues of authority, accountability and the need for follow-up action in individual cases.

## *Support for Gardaí*

Gardaí need support following crisis incidents.

## 2.8 The Wider Context

### 2.8.1 The Wider Context of Mental Health Services

All the groups discussed the wider context of the mental health services, and how the quality, availability, or organisation of those services impacted in the crisis engagement; it was often difficult to disentangle the specific aspects relating to crisis handling from that wider picture; it was implicit in the views of some stakeholders that it would not be possible or useful to separate these issues completely.

Participants also raised other issues affecting the management of crises, such as media influences.

### 2.8.2 The Views of Service Users

#### *Media influences*

Participants expressed concern about the way in which the media portrays mental illness. They felt that this portrayal, and the language used, contributes to making things difficult for people in crisis situations. The view was that some language used to describe mental health difficulties could be regarded as racist.

#### *Use of mental illness as a defence in criminal trials*

Participants felt that when mental illness is used by people in criminal trials as a way of defending their actions, this services to create a public perception that confuses criminality with mental illness.

# Views of Stakeholders

## *Need for awareness raising*

It was felt also that the Mental Health Commission could play a valuable role in raising awareness and addressing negative attitudes to mental health problems.

## 2.8.3 The Views of Families

### *Accountability*

Family members felt that medical/psychiatric personnel in particular should be more accountable for their actions, and for delivering on their responsibilities to people with mental illness.

### *Catchment areas*

Family members expressed a wish that the person with a mental illness who presents voluntarily at a hospital should not be turned away because of catchment area considerations.

## 2.8.4 Views of Staff Working with People who are Homeless

For staff of this particular service for homeless people, the wider context of provision of mental health services was seen as a critical context for their views in relation to the garda involvement in crisis situations.

### *In-patient provision*

There was a view that wider national policies regarding the role of psychiatric hospitals, as well as staffing and training levels within those hospitals, were impacting on admission and discharge decisions in a negative way.

### *Provision of supported accommodation*

Staff felt that there is not sufficient supported accommodation for people being discharged from hospital.

### *Definitions under the Mental Health Act*

Staff were concerned about how definitions of mental illness, and, in particular, the situation of people with personality disorders. They had questions about the role of Gardaí in crisis situations involving a person who may have such a disorder, and the risk that being arrested and charged with a criminal offence may be the most likely outcome for them, if they may not be regarded as mentally ill.

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## *The right to treatment*

Staff also raised questions about the extent of a person's right to treatment.

## Catchment areas

Staff also raised concern about the size of catchment areas for mental health services; they felt that staffing levels in such large areas were such that it is very difficult to access a community psychiatric nurse.

## 2.8.5 Views of Gardaí

### *Community services*

Gardaí too felt that provision for the handling of crisis situation could not be separated from the wider need to provide community-based follow up for people discharged from hospital; their experience has been that the absence of follow up, monitoring and support leads to a 'revolving door' situation.

Every area should have a drop-in centre where young people in particular who are in need of support can go and can meet a counsellor face to face. These preventive measures could reduce the incidence of crisis situations. While Gardaí would not be directly involved, they could participate in planning for these services.

Voluntary organisations have good ideas about the setting up of such facilities, but HSE appears to be concerned about insurance issues.

### *The impact of litigation*

Gardaí felt that the fear of litigation is a major problem factor in cautious decision-making about hospital admissions.

## 2.9 Overview and Conclusions

### 2.9.1 Perspectives of Stakeholders; Common Ground and Emphases

There was a high level of common ground among service users, families, staff working with homeless people and Gardaí about the issues and challenges involved in dealing well with crisis situations, and also about solutions. Differences tended to be differences of emphasis.

## Views of Stakeholders

### *The quality of the 'encounter' is a high priority for service users and families*

Service users in particular placed a very strong emphasis on the emotional quality of the encounter with Gardaí in the moment of a crisis situation, and the kinds of interpersonal interactions that make a difference for the person with a mental illness. They stressed the need for empathy, respect, sensitivity and understanding. Families also emphasised the importance of managing this encounter well.

### *Admission protocols a source of frustration for Gardaí*

Gardaí placed much emphasis on problems they and the person with a mental illness experienced in relation to hospital admissions. The sense of the frustration involved in bringing people to hospital arising from crises or incidents in the community, and having to bring the person away again, was very strong.

### *The absence of scope for advance planning and preventive action in individual cases is a concern for staff working with people who are homeless*

Staff working with people who are homeless had similar concerns to Gardaí, but also placed a lot of emphasis on the extent to which the absence of community services, and the absence of clear channels of communication among Gardaí, mental health services and voluntary service providers leads to problems for them and for people with mental illness. They stressed the need for planning to intervene early when a person is showing signs of an impending crisis, rather than waiting for crises to happen.

### *Clear roles and protocols*

One of the strongest common themes concerned the need for clarity and shared understanding among Gardaí, general practitioners, and mental health professionals in hospitals and in the community about their respective roles and about each other's roles, and the need for protocols and code of practice governing the professional interactions.

### *Shared goals and the impact of dissonance of roles*

The groups drew attention to the problem that arises where different professionals have differing core responsibilities and objectives in respect of the same person in a situation of crisis. Families, staff, and Gardaí highlighted the challenge of constructing shared, person-centred goals for a person with mental illness in a crisis.

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## *Knowledge of the law*

Shared understandings have to be based on knowledge of the practical workings of the new legislation, according to participants. It was evident from the focus groups that there were very different levels of awareness, knowledge and understanding of the powers, responsibilities and roles of Gardaí and mental health professionals in crisis situations, and the rights of the person with a mental illness.

## *The importance of training*

All the participant groups stressed the need for all Gardaí to get training in aspects of mental health and mental illness, to equip them to deal with crisis situations. The participants described the need for particular skills and knowledge. Service users and families were especially clear that Gardaí should meet with and learn directly from people who have experienced mental health problems, and from their families.

## *The wider context of mental health services*

The need for improvements in community services, better levels of supported accommodation, follow up for people discharged from hospital, were among the improvements needed in the wider service provision for people with mental illness as part of the response to dealing with and reducing the incidence of crisis situations.

## *The importance of review*

It was suggested that the Mental Health Commission should review the operation of the legislation after five years, and should consult widely with stakeholders as part of that review.

## *Service users said...*

*..one thing would be to calm the person down, and to try maybe a simple question like why are they distressed..*

*...and would you like me to call somebody...*

*...the tone of voice is important as well*

*Each policeman should be trained to deal with people as though anyone they are dealing with has a mental illness....you don't know whether people have mental illness or not until you have had a chance to observe them quite often...*



## Views of Stakeholders

*...they can approach the person with a mental health problem on an even keel sort of, be at their level, not towering over them...some people would find that very alarming and would retaliate, you know I would try to break free or whatever, so that would encourage them to use more force.*

*...what are the safeguards for the person as regards involuntary admission? Should they know their rights...maybe they feel they don't need to be admitted to hospital...access to an advocate maybe, to know what rights they have, because they are in a vulnerable state.....So it might help them if they knew...that they are not being completely disempowered...*

*...there should be a half way house in each hospital that is secure to police standards but is a hospital environment...*

*..if some of the Gardaí who might be afraid of service users came into the room here now and could listen to what...we are talking about these issues and trying to see both sides of the argument, they'd be very surprised.*

*...within each region there could be a psychiatric liaison person who would be seconded or assigned to a particular unit who could go out with the police... to perhaps defuse a situation...these could be independent ...just there to help the person and to assist the police to get the best outcome from a situation for everybody possible, so they have a win win situation.*

*...do the guards wait with the person when they bring them in if there is no doctor? I don't think they do, I think they put you somewhere and they just leave...*

*Yes, they leave immediately...*

*No, they don't...*

*I think it depends on the situation a bit...*

*They have to stay with the service user...*

*Yes, I saw them stay with the service user until they were medicated...*

*Well, I've seen them leaving, just leaving the person there...*

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## *Family members said...*

*I'm still a bit raw about the whole thing...I find it very emotional, but I would love to help...*

*...Listen to the carers who know the person.*

*...if someone in an involuntary admission and the person is handcuffed and the whole lot, and then they're brought into casualty...the handcuffs are taken off there and then and suddenly the carer is left with the patient in a general waiting room full of ordinary people and the guards walk off, so how come it was a dangerous situation for the last couple of hours and now its ok? I cant understand that, it doesn't make sense...*

*...you know you are going to be given all the suggestions, because that's where they are coming from, are you going to charge him?...they might go away, and you're left with this person...and they go away, because you are not going to charge him, but that is the scenario and its not the Garda's fault.*

*...we see them as patients, they see them as someone who needs to be contained...*

*...to respect and understand what they are, because what it does to us to have to send for them...*

*...When the older guards come along it's their very confidence, they have a kind of laid back attitude...they have such a wealth of experience, they have seen it...they may not know a lot about mental health, but they've seen these situations before and they know instinctively...they would use the person's name, instead of coming in with 'me boyo' sort of thing...they have that level of confidence and awareness of what they are dealing with, the whole thing is completely diffused.*

*...where the patient has nowhere to go but the only way for the rest of the family to survive was to put them out...a horrendous situation...for a guard to come in to a situation where everybody is distressed and upset and to put this guilt on a family by saying 'well do you know she has nowhere to go...how they could get all that into a half day's training, to understand the patient and the family and when there is a need for restraint and what type of restraint, and to consider what the family is going through...*

## Views of Stakeholders

### Staff said...

*..in this case the GP said I've got my own surgery, I wont be able to come down until one o'clock...and that was eight o'clock in the morning, so you're talking eight, ten hours. What's going to happen in between, anything at all?*

*...we are all coming from a different perspective, and what we have noticed...we are all trying to do something similar, we overlap sometimes, we don't know what other people are doing, and might suplicate the work. But it is [about] being clear, being concise, knowing and understanding that we all provide different services but we're all gearing towards the same objective and it is the need of the person, regardless of anything else, that is what matters.*

*They [Gardaí] might be even a little bit frightened themselves, they don't have any idea what is going on in this person's head, so...I found it helpful to pull the garda aside to tell them a little bit about the person...*

*..the training with the Gardaí is important...but if there is a weakness in it is that we don't know what is going to happen you know, when the person is presented to the psychiatric hospital...its almost a bit of a lottery...so I think they need to be involved and I think the community psychiatric nurses should be also, some of them at senior level should be able to do an admission.*

*...its part of a revolving door then, and the guards at the other end, I mean they get fed up to see the same person all the time, getting different responses from the hospital all the time, and if it was ok last month to take someone in why isn't it ok to take them in now, and we end up trying to pick up the pieces...*

*We've got two community guards that we liase with on most things, from court appearances or interventions when someone has a mental illness, and we found dealing with those two particular individuals...it lessened the amount of stress involved for the person because this particular guard would come in regularly on different issues, very casual approach, very understanding and a rapport developed over the last couple of years which means that when that person has to come over and intervene, you know, it's done with a minimum of distress...*

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## *Gardaí said...*

*...Garda stations are a magnet for depressed people, they come to the station and its three, four, five o'clock in the morning when they're...mentally at their lowest ebb, they're awake all night long...many's the night you'd be sitting there having a long conversation with a fellow at the door telling you how he is going to commit suicide...and you could spend hours there talking to him...we do our best to monitor them, but there is a huge amount being dumped on us at the moment because of the fact that doctors don't want to be sued...*

*...you are not a trained person and you don't know what, something you say could just set them off...with the best intentions in the world ...we're not qualified counsellors so we could end up doing more damage than good at times...*

*...you're there with this person who you know in your heart and soul is not right at this time, the problem is the doctor won't certify him, and then you're helpless because you just let them go back onto the street and you know ...that if they walk out that door within half an hour the phone lines are going to be hopping again that this fellow is walking out in front of cars or doing this or that, and you are caught in a no-win situation.*

*It is easy to look at it in a sterilised environment here...but the problem ends up with you taking a knife and cutting a fellow down off a tree,...or taking a body out of a river...we shouldn't be getting to that stage at all, because a lot of these people had they had earlier intervention, and quite often they would have had history of calling at the garda station...they might have been assessed previously, but nothing concrete was done for them.*

*...there is no leeway for [the doctor] ...he should have some power to say...we're going to keep you here for two or three days to monitor you...to assess them, based not only on the diagnosis but based on all the circumstances of the case and how the person arrived at the hospital, I don't think they can do that and I think that's where they get frustrated themselves inside the hospital. not so much from our diagnosis*

## Views of Stakeholders

*It is good to know that this commission is at least asking the people on the ground what they think...*

*...you would want the doctors, the ordinary GPs, plus the guards on the ground and then the staff of the hospital...and the psychiatrists...it'll never happen, but you'd imagine if they all met and knew what problems they were having they would try and work towards a common goal.*





Appendix

2

Literature Review

# Literature Review

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## 1.1

This review highlights some of the current international research that identifies and evaluates best practice models of joint working and collaboration between the police and mental health professionals. The review examines recommendations made by researchers in the area internationally and describes a number of different police education and training programmes.

There is a dearth of research on the Irish experience of this type of collaboration. While a considerable amount of research in this field has been conducted in the United States of America, Canada, Australia and New Zealand, European research in this field is scarce. There is a lack of availability of statistics, data and research in Ireland on the involvement of the Gardaí with people with mental illness.

Internationally, evidence indicates increased involvement of police forces in the lives of people with mental illness, which is largely due to policy changes such as deinstitutionalisation and consequent changes in treatment such as the provision of care in the community, underpinned by the philosophy of integration. Inadequate funding of outpatient treatment and community supports are also factors which have led to greater contact than before between people with severe and enduring mental illness and the community including the police (Keram, 2005).

## 1.2 Irish Context

The current Irish publications that are relevant to a consideration of joint working between An Garda Síochána and the Irish mental health services are *A Vision for Change (2006)*, *the Barr Tribunal Report (2006)*, *the Forensic Mental Health Services for Adults in Ireland Mental Health Commission Discussion Paper (2006)* and *the Mental Health Act (2001)* (*Mental Health Act 2001 discussed in Chapter 1*).

### *A Vision for Change (2006)*

As previously noted there is an absence of research focusing on the Irish experience of joint working between An Garda Síochána and the Irish mental health services. However, *A Vision for Change (2006)* makes a number of relevant recommendations in relation to forensic mental health services and court diversion schemes. This national government policy recommends that forensic mental health services should be available in all areas where law enforcement



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agents are likely to encounter individuals with severe mental health problems. Furthermore, recommendation 15.1.1 states:

“Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done”.

### *Barr Tribunal Report (2006)*

Following the fatal shooting of John Carthy at Abbeylara on 20th April 2000, the Barr Tribunal was established to investigate the facts and circumstances surrounding this shooting. Subsequently the *Barr Tribunal Report (2006)* was published. The report makes a number of recommendations in relation to partnerships between An Garda Síochána and the Irish mental health services. The tribunal recommended a review of the Abbeylara case to inform a revised structure for command and an appropriate scheme for dealing with siege situations involving individuals with a mental illness.

Specific recommendations were made in relation to:

- i) Garda training in mental illness and siege situations
- ii) Ensuring an adequate number of psychologists are employed by the state to provide the service of expert assistance in siege and other situations
- iii) The training of these psychologists in negotiation strategies
- iv) Establishing formal working arrangements between An Garda Síochána and state psychologists

### *Forensic Mental Health Services for Adults in Ireland: Mental Health Commission Discussion Paper (2006)*

*The Forensic Mental Health Services for Adults in Ireland: Discussion Paper (Mental Health Commission, 2006)* proposes that the forensic mental health services in Ireland provide: i) specialist assessments and consultation services to generic mental health teams, and ii) specialist assessments for court diversion schemes. In addition, the discussion paper defines and describes court diversion schemes currently being implemented in England and Wales. The discussion paper also

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provides a brief overview of current forensic mental health service provision in Ireland, describing the substandard physical facilities at the Central Mental Hospital, Dundrum and outlining the need for the development of new purpose built facilities in Ireland, providing a high, medium secure facility nationally and low secure facilities at regional level.

## 1.3 Barriers to Effective Interactions, Response and Disposition

There are many barriers to successful collaboration between police and mental health professionals. Differences between the two professions make collaboration difficult. Each profession has different primary goals. For the police, it is their duty to protect the public and for mental health professionals it is their duty to provide treatment and care to the individual service user (Cotton, 2003). Both professions also have different techniques, priorities, values, and orientations towards intervention (Dietz & Reese, 1986) and seek different outcomes from intervention. (Canadian Mental Health Association, 2003). Members of the police force and mental health professionals have different training experiences and both work within different organisational structures, which have different mechanisms of accountability (Cotton, 2003).

### Role Ambiguity and Blurring

Due to the complex nature of police and mental health service interaction, it is not surprising that role ambiguity, blurring and conflict are recurring themes that are prominent in the literature. This is an outcome of a lack of standardised procedures and clear policies detailing how this interaction should occur when responding to persons with mental illness in crisis.

To ensure the success of collaboration, clearly defined roles are essential. While some police officers may have received specialised training in mental illness and some mental health professionals may have received training in crisis intervention or dealing with siege situations, each profession must focus on their primary responsibilities. The primary role of the police officer is that of law enforcement, "providing security that reduces the threat of harm to persons with mental illness and to others as well as providing transportation to the most appropriate treatment centre" (Lamb, 2002). The primary role of the mental health professional in dealing with psychiatric emergencies is assessment, crisis resolution, and appropriate outcome. Establishing clearly defined roles for both professions is necessary to ensure successful collaboration between the two professions (Lamb, 2002).

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Focusing on role difficulties among the police in this context, Fogarty (1989) has outlined how the traditional (law enforcement) role of the police as a 'social controller', is in direct conflict with contemporary expectations that police be 'social supporters' and 'front-line mental health workers'. Buss (1995), Gee (1994) and Fogarty (1989) note that, there is continuing role conflict between traditional (law enforcement) and contemporary (social welfare) expectations of policing. Buss (1995) draws attention to this role conflict within the police force itself. For example, in response to a question asking police in New South Wales whether police should 'conduct initial assessments of the individual's mental state', 38% disagreed and 58% agreed. Among the police themselves confusion exists in relation to the responsibilities of the police with regard to responding to persons with mental illness in crisis. There is an uncertainty in relation to the expectations that are being placed on them (Fogarty, 1989; Hearn 1993; Meehan, 1995; Pogrebin & Poole 1987). Fry, *et al.* (2002) conducted a study to investigate the relationship between the police and mental health services in Sydney Australia. The majority of police surveyed do not see themselves as part of a larger mental healthcare agency; 26.1% of respondents believed that dealing with suicidal people was a police matter. There is evidence that police can be ambivalent about dealing with people with mental illness. One study found that some officers may refuse to respond to a call involving a person with mental illness. They tended to interpret the call as a situation that was solely the responsibility of the mental health system, rather than one that required them to protect or provide safety for the person with the illness (Canadian Mental Health Association, 2003).

According to Hamewicz, *et al.*, (1982) the social service role of the police has historically been evident. Fry *et al.* (2002) supports this assertion:

"This is particularly so in relation to the need for psychological support in times of crisis and the fact that police are often the first contact for people who are suicidal or have mental health problems, or who are victims of crime, domestic violence, sexual assault or homelessness. Thus, police have consistent involvement in the provision of mental health care for varied groups of people within society".

Delprino & Bahn (1988) have claimed that this involvement has always extended beyond the level of psychiatric 'first aid' and referral to early intervention programmes, collaboration programmes and cooperative initiatives between police and mental health services. Borum *et al.*, (1998), has concluded that law enforcement professionals provide up to one third of all emergency mental health referrals and that they interact with more persons with mental illness than any

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other occupational group outside the mental health field. Furthermore, frequently, police officers are the informal first responders of the mental health system (Canadian Mental Health Association, 2003).

A study examining the experience of 131 police officers in Sydney who were involved in responding to crisis situations involving persons with mental illness concluded that police officers feel torn between competing demands experienced in their work (Fry *et al.*, 2002). Often there is an ambiguity in relation to role definitions, responsibility and accountability. To tackle this problem the Canadian Mental Health Association (2003) has recommended 24 hour access to high level administrators to resolve any disagreements that arise. Thus, establishing clearly defined roles is vital to ensuring the best outcome for service users in crisis and their families.

### *Inadequate Advance Information*

It has been noted in the literature that often police feel that they have received insufficient information regarding whether or not a situation involves a person with mental illness or if the situation is dangerous. Police dispatchers commonly do not request such information or outline what to expect on arrival. Officers in the UK reported that situations they were called to were often ambiguous, confused and lacking context, making it difficult for them to recognise a psychiatric emergency (Canadian Mental Health Association, 2003).

### *Inadequate Information Systems*

Access to relevant information is paramount to determining successful response to crisis situations involving persons with mental illness. Generally speaking, police information systems do not indicate if a given person with mental illness has had previous contact with the police, nor do they indicate the number of people with a mental illness who come into contact with the police. Information in relation to successful prior interventions and the specific police officers involved in these interventions are details which are typically not recorded on police databases (Canadian Mental Health Association, 2003)

### *Lack of Responsiveness by the Hospital Emergency Departments*

Both in the UK and the US, records show that police often experience long waiting times in emergency wards (after escorting a person to hospital) during which police officers can not attend other duties. In the UK, police reported that they were not treated professionally in these situations and that medical staff did not

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always consider or make use of their knowledge of the individual and the situation (Canadian Mental Health Association, 2003).

Police officers have expressed frustration in relation to disagreements between different mental health professionals in relation to certification of the individual concerned. A GP may feel that a person's behaviour warrants admission to an approved centre, however personnel in the approved centre may disagree. Mental health professionals may challenge the judgment of the police officers and refuse to admit the person, or refuse to quickly admit the person who could be capable of harming themselves or others (Lamb, 2002). In these cases there is often a lack of other service alternatives (Canadian Mental Health Association, 2003)

### *Lack of a Single Entry Point that Accepts All Referrals*

Researchers have drawn attention to the need for single entry point for the mental health services that accepts all referrals. In the absence of such an entry point conflict over responsibility for the patient exists. Mental health services often establish criteria for admission that result in excessive barriers to care (Dupont & Cochran, 2000). Frequently, a service user will not be admitted if he/she has certain medical conditions or significant impairments (for example an intellectual disability or dementia). Persons with mental illness in crisis will not be admitted to hospital if they are under the influence of alcohol or other illegal substances. As a consequence of this, police officers have to search for specialised treatment facilities before an assessment is carried out which can sometimes lead to the use of the police as a taxi service from one crisis centre to another, resulting in "turf battles and patient dumping" (Dupont & Cochran, 2000)

### *Lack of Resources*

Deficits in resources and services, noted repeatedly by police, result in a lack of, or inadequate treatment, homelessness, criminalisation and imprisonment of mentally disturbed people, often because suitable services are unavailable (Blaauw et al. 1997, Hearn 1993, Hodgins 1993, Kneebone et al. 1995)

### *Bias*

Research conducted in the 1960's and 1970's in the US has suggested that at this time police officers maintained negative attitudes toward people with mental illness and that this bias was largely due to lack of information (Borum, 2000). Police often have a lack of knowledge of the signs and symptoms of mental illness

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(Canadian Mental Health Association, 2003). Education is crucial in order to alter misconceptions about people with mental illness. It is important that all police officers understand that

- Mental illness does not automatically infer a threat of harm to self/others
- Not all people who threaten/attempt suicide have mental health problems or a mental illness
- Not all people with a mental illness in crisis require hospitalisation.

Alternative responses are often more appropriate forms of crisis intervention. These include: problem solving techniques, de-escalation techniques, cognitive behavioural therapy and counselling (Fry *et al.*, 2002).

Findings of a study conducted by Watson *et al.* (2004) suggest that police officers are less likely to take action based on information provided by victims and witnesses with mental illness, underlining how the label of mental illness influences judgments made by police officers. Pruett & Teplin (1992) and Teplin (1984) found that officers are more likely to arrest persons with mental illness than those who do not have a mental illness.

## 1.4 Police Mental Health Education and Crisis Intervention Training

### **General Mental Health Awareness Training**

According to Lamb (2002), there is evidence to suggest that police training is generally inadequate to prepare police officers to identify and deal with persons with mental illness (Husted *et al.*, 1995; Borum, 2000; Kimhi, 1998). Research has also concluded that police officers themselves believe that they lack adequate training to manage persons with mental illness (Husted *et al.*, 1995). A large body of literature now exists which promotes the training of the police on issues related to mental illness and crisis intervention. This training is divided into two distinct categories:

- General mental illness awareness training
- Training for officers who specialise in mental health

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With regard to developments in Ireland, the Barr Tribunal Report (Government of Ireland, 2002) makes a number of recommendations in relation to the training and education of the police and mental health professionals in this context. Included in the recommendations of the Barr Tribunal report are the following:

- i)** Local area superintendents should undergo basic instruction on mental illness
- ii)** All Gardaí should have detailed courses of instruction of not less than two weeks duration which include particular reference to siege situations where the subject is believed to be motivated or affected by mental illness
- iii)** The training of garda recruits (and all officers by way of refresher courses) should include basic instruction on mental illness and how a person so afflicted should be dealt with, including the need for urgent consultation with his/her medical advisor and the importance of calming the subject
- iv)** State psychologists should undergo periodic training in negotiation strategies

In the literature a number of recommendations have been made in relation to specialised and general training and education in mental health:

- Training is required for all officers, not just for new recruits or for police officers who specialise in mental health (Kimhi, 1998)
- Police officers need to be retrained on an ongoing basis (Dupont & Cochran, 2000)
- Training needs to be conducted by all stake holders: service users, mental health professionals and the police (Canadian Mental Health Association, 2003)

According to Lamb (2002) police officers have requested training in the following areas:

- Recognising mental illness and the various symptoms of mental illnesses
- Dealing with mental illness/psychotic behaviour
- Handling violence or potential violence among these persons

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- Dealing with an individual who is threatening suicide
- Determining when to call the mental health service mobile crisis team

According to Borum (2000) police officers also require education in relation to:

- Knowledge of the different community resources that are available to them and how to access them
- Knowledge of the different dispositional alternatives available to them

Furthermore, the Canadian Mental Health Association (2003) recommends that general police training should include the following topics:

- Education regarding psychotropic medications
- Crisis intervention and de-escalation techniques
- Confidentiality
- Making appropriate referrals to the mental health system

### *Crisis Intervention Training*

One example of a comprehensive, practically orientated police mental health awareness training and crisis intervention training programme is that designed by the University of Newcastle and the Northumbria Police Force. This training comprises of educational workshops in the following areas:

- Mental Health Legislation
- Substance Abuse
- Psychosis
- Mania and Mood
- Older People and Alzheimers
- Post Traumatic Stress Disorder



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- Intervention Techniques
- Personality Disorder
- Suicide/Self Harm
- Symptoms and Violence
- Learning Disabilities

Specialised workshops are also delivered on the perspectives of service user groups, social workers and carers.

(Source from Northumbria Police Force Mental Health Awareness Training Programme, University of Newcastle)

The police mental health awareness training and crisis intervention training (CIT) programme has been adopted by police departments in Seattle and Olympia (Washington, USA) and Northumbria (Newcastle, UK). However, Cochran & Dupont (unpublished) have recorded some preliminary research findings relating to the programme's success. Two hundred police officers in Seattle and Olympia, Washington USA and 200 police officers in Northumbria, Newcastle UK were administered a questionnaire and interviewed to evaluate the programme and to assess its effects on police officers' attitudes and behaviour. Results were as follows:

- 85% of respondents surveyed agreed that CIT provides an advantage when working in the field
- CIT officers were three times more likely to correctly identify violent/non-violent mental health symptoms
- 100% of CIT officers felt confident about recognising mentally disturbed behaviour compared to only 54% of non-trained officers
- Before CIT 75% felt confident about recognising this behaviour, immediately after this rose to 85% but after 6 months this rose again to 100%

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## 1.5 Collaboration

Internationally, models of collaboration have often been developed in response to tragedy. The tragic shooting of a person with mental illness in crisis by a police officer in Memphis Tennessee led to the development of an innovative programme for joint working between the police and mental health services: the Memphis Police Crisis Intervention.

The desire for collaboration between the two professions has come from both sides: police have voiced a need for rapid on-site assistance from mental health professionals at the sites of crisis situations involving people with mental illness (Lamb, 2002), and mental health professionals who are working as members of psychiatric emergency teams have expressed a need for police support so that they are equipped to handle crisis situations involving people with mental illness in the field (Lamb *et al.*, 1995; Gillig *et al.*, 1990; Zealberg *et al.* 1993).

Experience has shown that when persons with mental illness in the community are in crisis, neither the police nor the emergency mental health system alone can serve them effectively and that it is essential for the two systems to work closely together (Zealberg *et al.*, 1996).

There is a growing body of evidence to indicate that close collaboration and formal liaisons between the police and mental health systems facilitate a more effective response to psychiatric emergencies in the community. Close collaboration has been shown to result in more positive outcomes for service users, resulting in a reduction in homelessness, a reduction in re-arrests and a reduction in inappropriate criminalisation

### Models of Collaboration

While education, training, and clear role definitions all contribute to improving the response of the police to persons with mental illness in crisis, the adoption and implementation of the model of collaboration that is best suited to the jurisdiction and population concerned is critical to successful response. Appropriate infrastructure and adequate support systems to support the chosen model are also necessary. Four models of collaboration as reported in the relevant literature are outlined:-

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### *Joint Police/Mental Health Team Based in Mental Health System*

This model is based on the 'Car 87 model' adopted by the Vancouver police department. It employs a specialised police mental health crisis intervention team of plain clothed police officers and mental health professionals who respond in unmarked police cars. These teams will either defuse the situation on site or if necessary the individual can be transported to a psychiatric hospital and admitted (Canadian Mental Health Association, 2005).

This model is widely seen as a successful example of police/mental health system collaboration and has been replicated in several Canadian centres, including Surrey, Hamilton and Ottawa. An apparent limitation of this model is in the capacity of this team to respond to only one call at a time and respond only during specific hours (Canadian Mental Health Association, 2003).

### *Joint Police/Mental Health Team Based in Police Force*

There are two variations of this model. In the model adopted in Birmingham, Alabama, mental health professionals are employed as community service 'civilian officers' within the police force to respond to police calls involving mental illness. These individuals do not carry weapons or have the power to make arrests, however they are police officers in all other respects. In the New Orleans, Louisiana model, trained crisis intervention volunteers assume this role. Both of these model variations can successfully resolve the majority of police calls involving mental illness, which frees regular police officers for other duties or allows them to leave an incident sooner (Canadian Mental Health Association, 2003). Following an investigation of the outcomes of the Birmingham, Alabama model variation, Steadman *et al* (2000) recorded that 64 of the 100 mental health crisis dispatch calls examined were resolved on scene by the specialised police mental health team, a result which represents the highest number of on site resolved cases amongst the models investigated.

This model however, is less feasible in larger metropolitan areas, since it would entail employing or training a large number of mental health specialists at relatively high expense to the police. Steadman *et al* (2000) have drawn attention to lack of availability of the community service "civilian officers"(particularly on weekends and nights), noting that in Birmingham, Alabama at the time of the evaluation, there were only six of these officers for a police force of 921, resulting in only 28% of mental disturbance calls receiving a specialised response. This low response rate is related to "the challenges inherent in travelling over large geographical areas ...having a single unit in an urban area means that it was not

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available for all calls in all locations" (Canadian Mental Health Association, 2003). Consequently, police often make decisions and take action without involving the Joint Police/Mental Health Team.

### *Reception Centre*

In Knoxville, Tennessee all officers are trained to recognise the signs of mental illness. Following the recognition of such symptoms, officers then transfer the individual to a reception centre where specialised personnel (including police) conduct a thorough assessment and evaluation of the case and refer the individual concerned to mental health services, if it is deemed to be the most appropriate response. Where violence is involved in these situations, a negotiation team intervenes.

This model ensures that people with mental illness are transported to care and seen by officers with specialised training in mental health. It also offers greater breadth of coverage than Vancouver's Car 87 model. Unfortunately however, similar to the Car 87 model, the unit's lengthy response times pose a significant barrier to use of the service by the police (Steadman *et al*, 2000). Another challenge of the reception centre model is its limited capacity to resolve incidents on-site, which in many cases may be a less traumatic means of intervention (Canadian Mental Health Association, 2003).

### *Specialised Police Crisis Intervention Team*

This model, which originated with the Crisis Intervention Team in Memphis, Tennessee is the most widely studied and replicated. Officers volunteer for a training programme which enables them to become a member of a Crisis Intervention Team and then are selected on the basis of personal characteristics such as empathy and communication skills (Canadian Mental Health Association, 2003). After being selected for the programme, they receive 40 hours of specialised training from mental health professionals, family advocates, and mental health consumer groups, who provide information about mental illness and techniques for intervening in a crisis. Following training these officers are then issued crisis intervention team medallions that allow immediate identification of their role in a crisis situation. (Steadman *et al*, 2000). At least one specialised officer is scheduled to work each shift in each catchment area, engaging in mental health crisis intervention along with regular police duties. The incidents are either resolved on site, or the person is transported to a medical centre for treatment or referred to other types of mental health services, as appropriate. The medical centre connected with the Crisis Intervention Team implement a "no reject

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policy" ensuring that no one referred to them is refused medical or psychiatric attention within 15 minutes of arrival (Canadian Mental Health Association, 2005). The success of this programme relies on the mental health system making a commitment to providing crisis and acute care services, and to other forms of community mental health services, since the CIT team relies on both for support and referral (Canadian Mental Health Association, 2003).

Of all the aforementioned models, the CIT model is the most proficient at transporting the individual directly to a treatment location. In Steadman *et al.* (2000)'s study 75 % of mental disturbance calls resulted in a treatment disposition. In contrast to the low percentage of calls resulting in the responding of specially trained officers onsite in the Birmingham and Knoxville models, specialised police officers were on site for 95 % of mental disturbance calls. The 2 % arrest rate of the CIT model is also the lowest arrest rate of all models evaluated, suggesting that this model was most successful at criminal justice diversion. The model is able to respond to the highest proportion of calls, compared to other models. The success of the model has been attributed to its comprehensiveness and the opportunities it offers team members to practice and 'put into play' the skills and knowledge imparted through the training on a daily basis. One drawback of this model is that compared to Joint Police/Mental Health Team Based in Police Force model, incidents are less likely to be resolved on-site (only 23 % of calls received) and the individual concerned is more likely to be transported to hospital (Steadman *et al.*, 2000)

### *Benefits for Service Users*

A systematic examination of service user outcomes following the response of Specialised Police Crisis Intervention Teams to persons with mental illness in crisis has been carried out. The following improved service user outcomes were reported:

- Police used restraints and deadly force less often
- Fewer service users were sent to jail
- Ongoing and more positive relationships developed between police and those who have a mental illness
- Stigma and the perception of danger associated with mental illness was reduced

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- Involuntary commitments decreased from 40% to 25%
- Consumers demonstrated 15% fewer criminal offences a year after intervention
- Access to care was provided for those who have been least served by the mental health system
- In 92% to 97% of cases response times were 10 minutes

(Canadian Mental Health Association, 2003).

Deane *et al* (1998) provides further evidence for the effectiveness of crisis intervention teams in relation to response times. Using 100 randomly drawn police mental health crisis events, in 94% of cases a CIT officer was on the scene in under 10 minutes, and in the majority of cases the officer responded in 5 minutes. This is in comparison to 8% 10 minute response rate for the mobile crisis team model.

### *Benefits for the Police*

Researchers investigating programme satisfaction from the perspective of the police have found that 47% to 80 % of police officers rated their programmes as 'effective in meeting the needs of mentally ill people in crisis'. Officers have a positive perception of the programme and report that it increases their confidence in their ability to handle crisis events (Bormum *et al*. 1998)

The following benefits of CIT programmes for the police have been identified by researchers:

- Officer downtime is significantly reduced for crisis events
- Police spent less time in hospital emergency rooms
- Improved police morale
- Police, those with mental illness, and others experienced fewer injuries

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- Implementation of CIT programmes involve minimal costs
- A decreased need for more intensive and costly police responses

### *Benefits for the Mental Health System*

- Police report better informed health care professionals in hospital emergency rooms
- Less violence occurs in the medical centre

From these findings one can conclude there is a substantial body of evidence which suggests that the Memphis CIT model of police response to psychiatric emergencies is associated with many positive outcomes for the service user, the police, and the mental health system. It is important to note however that all of the evaluations of these models of collaboration investigate how often specialised professionals responded to dispatch calls for 'emotionally disturbed persons' and how often they were able to resolve situations without arrest. A key assumption of these studies is that decriminalisation and court diversion are positive outcomes and that they enhance the quality of life of the service user. As Eastman (1999) has discussed this not true in all cases. In his opinion decriminalisation and criminal justice diversion schemes deprive individuals of their rights and civil liberties by promoting the administering of discretionary life sentences, a practice which in certain cases can be "ethically and professionally indefensible" (Mullen, 1999).

When determining which model is best suited to provide a service to a particular jurisdiction, it is important to consider the size of the catchment area concerned. The single mobile crisis team tends to work well in smaller cities, multiple teams work better in larger cities. Different models should be adopted in different catchment areas. Models should be selected depending on the requirements of specific populations (Canadian Mental Health Association, 2003).

### **Key Success Factors**

The following is a summary of conclusions and recommendations from the main studies in the area, on how to optimise collaboration and manage interaction between the police and mental health services. These components are features of successful models of collaboration and joint working between the police and mental health professionals.

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### *Contact*

In their analysis of police experiences of their interactions with mental health services, Fry *et al.* (2002) concluded that regular meetings are essential to the establishing of collaborative relationships between the police and mental health services. Both professions should meet regularly to discuss mental health issues in general, clients in common, role blurring and concerns. This will foster an appreciation for each others roles and will provide a platform to discuss the limitations of both services. It has also been suggested that these meetings be both formal and informal.

### *Access to Information and Records*

To facilitate evaluation and appropriate case outcomes, it has been recommended that access to criminal records, records of police contacts and complete mental health history be made available to the mental health professional on the specialised crisis intervention team. This information would include past psychiatric treatment, diagnosis, and the name of the person's case manager, if any (Lamb, 2002). In Los Angeles, police officers that are members of mobile outreach units have access to mental health records of referrals and mental health professionals have access to police records on arrests, warrants, prior contacts and weapon ownership (Canadian Mental Health Association, 2003). It must be noted here however that legal and ethical issues of confidentiality and autonomy must be addressed in this approach.

### *Accessible Comprehensive Coverage*

The range of coverage and the accessibility of the service are fundamental factors related to the success of any model of collaboration. It has been recommended that a specialised crisis response team be available in every mental health catchment area to provide 24 hour mental health services on a national basis (Canadian Mental Health Association, 2003). Furthermore, according to Fry *et al.* (2002) prompt, immediate service at any time is a characteristic of successful models of joint working between the police and mental health services.

In Knoxville, Tennessee, one evaluation unit serves the city. This team provides full coverage during the day, evening and night, and team leaders provide weekend coverage. In Birmingham, Alabama, the unit members are on duty 7 days a week for 15 hours per day and on-call the rest of the time. In Vancouver, daytime coverage is not available and regular police officers or the mental health emergency team responds to calls. A single team covers each of these cities at any one time. The drawback of this is that if they are already answering a call, they are



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not available for other calls that come in. In Vancouver, if the unit cannot respond immediately to other patrol officers, they will provide advice to assist officers to manage and/or intervene in the meantime (Canadian Mental Health Association, 2003).

### *Quality Control*

Rigorous and ongoing evaluation of response programmes is an important component contributing to success. In Madison, Wisconsin, a police liaison officer position has been created within the police force. This individual is responsible for reviewing all police contacts with people who have a mental illness to ensure that police understand and respond appropriately (Canadian Mental Health Association, 2003).

With regard to police crisis intervention teams, response times should be measured on a regular basis (Dupont & Cochran, 2000). Surveys should be conducted routinely among randomly selected police officers investigating their views on the usefulness and effectiveness of these teams. Arrest rates and the mental health alternatives chosen need to be evaluated regularly to ensure that appropriate dispositions are being made and that mental health facilities are cooperating with these efforts (Lamb, 2002). Broad dissemination of the results of these evaluations is also recommended (Canadian Mental Health Association, 2003).

### *Careful Selection of Specialised Police Officers*

Not all officers are suited for working with persons with mental illness (Dupont & Cochran, 2000). A thorough selection process to determine a candidate's suitability for the role of police officer specialising in mental health is key to the success of any model of collaboration. Officers volunteering to become members of the aforementioned crisis intervention teams require screening for their suitability. Officers should be selected who "demonstrate flexibility, empathy, calmness, creativity, intuitiveness and a willingness to try new techniques". Demonstrating independence and the ability to think on one's feet are also desirable characteristics. Furthermore, an undergraduate degree in the behavioural sciences is advantageous (Canadian Mental Health Association, 2003).

### *Clear Protocols and Procedures*

Fry *et al.* (2002) have stressed the importance of designing clear protocols that establish mechanisms for informal and formal liaisons at the local level and

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implementing clear procedures about police transport and escort duties, locations for detainment, time delays and communication. These protocols and procedures should address the barriers to mental health care and access to services.

### *Feedback*

Police officers have requested feedback following the referral of an individual to the mental health system. Feedback ensures that police officers know what methods of response lead to the best outcome for the service user. Feedback facilitates police in the development of problem solving strategies and best methods of response to persons with mental illness who are in frequent contact with the police. In Madison, Wisconsin, the police receive feedback in writing on all referrals that they make to the mental health system, and when an individual with mental illness is identified by the police as having many encounters with police officers, police are able to request a review of the person's treatment plan by the mental health system.

### *Respect*

Procedural justice theory postulates that the treatment of people with mental illness by the police signifies their social status, self-worth, and self-respect (Tyler, 2003). How police officers treat persons with mental illness may further marginalise them or support their identity as a member of the community. Successful application of this approach in the context of police and persons with mental illness in crisis involves the following: i) Participation - having the opportunity to present one's own side of the dispute and be heard by the decision maker; ii) Dignity - being treated with respect and politeness and having one's rights acknowledged by the decision maker; and iii) Trust - believing that the authority is concerned with one's welfare (Lind *et al.* 2002).

## 1.6 Court Diversion Schemes

### *Inappropriate Criminalisation*

Inappropriate criminalisation can occur when a police force who do not have the training, knowledge and experience to refer persons with mental illness in crisis to relevant mental health services. Inappropriate criminalisation can also occur as a consequence of a lack of available mental health services. This results in persons with mental illness needlessly becoming involved in the criminal justice system for minor offences. Inappropriate criminalisation can be the consequence of the 'no refusal' policy adopted by the police, because police officers have a legal

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obligation to respond to calls and to provide services 24 hours a day, seven days a week (Lamb, 2002).

Lamb (2002) has outlined the practice of 'mercy booking'. This occurs in situations where police officers have no appropriate alternatives to criminalisation available to them, where mental health services are not accessible at the time when a mentally disordered person requires assessment. Psychiatric services may be more accessible in jail than in the community. Arresting the person may be the only way to ensure an individual receives mental health services. According to Lamb (2002) there are a number of benefits for the police officer referring the person to the criminal justice system:

- i) Police can predict what will happen if they take a person into custody
- ii) Police can be certain that the person will be detained in a safe environment and that the criminal justice system will take responsibility for the person
- iii) Police can be confident that the person will receive a psychiatric evaluation and mental health treatment from the mental health professional attached to the court or jail
- iv) Arresting the person is a familiar response and they have more control over the process

### *Court diversion*

In the context of mental health, court diversion schemes are defined as programmes that seek to divert people away from the criminal justice system, where there can be a delay in the person receiving adequate and appropriate mental health treatment and care. Court diversion schemes seek to redirect them to mental health services instead, where the person can be assessed, their mental health needs identified and an integrated care and treatment plan can be designed to deal with their needs. These schemes can help prevent inappropriate criminalisation. Diversion schemes facilitate the assessment and appropriate placement of offenders with a mental illness allowing them access to treatment options rather than receiving a custodial sentence. (*A Vision for Change, 2006*).

The features of court diversion schemes have been described in *A Vision for Change (2006)*:

"Diversion schemes operate by performing or organising mental health assessments, gathering information and presenting a comprehensive report to the court with recommendations. All defendants coming before the courts have the

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right to due process and court diversion schemes operate by informed consent. A person charged with an offence may deem it to be in their best interests in particular circumstances to refuse diversion and instead opt for their case to be heard in the normal way under the criminal justice system”.

Diversion may occur at any stage of the criminal justice process. There are variations in the models employed by different jurisdictions. Some schemes attempt to screen all detainees, but most operate a filter system (Mental Health Commission, 2006)

*A Vision for Change (2006)* asserts that forensic mental health services in the future must widen their remit to work with An Garda Síochána in pre-charge, pre-court diversion schemes, although there is no actual or proposed statutory basis for this.

Recommendation 15.1.2 states that:

“Forensic mental health services should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place”.

The National Crime Council, a non-statutory body, was established in 1999 to facilitate broadly based, informed discussion on crime issues and to aid policy formulation. In 2007 the National Crime Council published a report on “The Case for Community Courts in Ireland”. The Council recommended the establishment of community courts in Ireland, with an initial community court being established in Dublin. The report outlines the type of offences that could be dealt with by a community court and the community court process, and the support services necessary to ensure that the community courts are effective. The report also recommends a dedicated research component to the work of the pilot community court and a formal independent evaluation of the pilot community court after three years of operation.

These schemes have been shown to have a number of benefits, including:

- Preventing inappropriate criminalization
- Providing access to early mental health assessment and intervention and a fast route to mental health treatment and care
- Facilitating appropriate placement of offenders with mental illness

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However, there are also drawbacks to court diversion schemes. According to Eastman (1999) criminal justice diversion schemes can deprive individuals of their rights and civil liberties by promoting the administering of discretionary life sentences. In Eastman's view these sentences intend to circumvent the European Convention on Human Rights, which prohibits preventive detention except for those of unsound mind. Eastman outlines the danger of an indeterminate but renewable order imposed by the court on evidence from psychiatrists which will remain in place if the person is deemed sufficiently dangerous to warrant it. In this context, mental health professionals act as public protectors. Coid & Maden (2003) however have noted that The Royal College of Psychiatrists has stated unequivocally that the only rationale for psychiatric intervention is for the benefit of patients' health and that public protection is secondary.

In the UK court diversion schemes are evaluated in terms of the degree to which they divert mentally disordered offenders from the criminal justice system to the mental health services. These schemes are not evaluated in terms of service provision or the outcomes of these schemes for service users i.e. - the impact that these schemes have on the quality of life of the offenders with mental illness concerned.

### 1.7 Conclusion

The skills and knowledge base of both police officers and mental health professionals need to be utilized in order to ensure the best possible outcome for service users in crisis and their families. Developing a strategy that is flexible enough to meet the needs of both rural and urban communities is a complex task and adopting one model of joint working between the police and mental health service may not meet these needs. It is perhaps best to focus on the development of best practice guidelines and a quality agenda relating to the development of services for persons with mental illness in crisis. Standards of service delivery to this vulnerable population should be constantly monitored and the outcomes of professional response evaluated.

There are many challenges and barriers to effective collaboration between the police and mental health system in this context including (i) the limited training on mental illness for police officers, (ii) the lack of structured contact and communication between police officers and mental health professionals; (iii) availability of relevant information; (iv) clarification of distinct roles and

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responsibilities of the professionals implicated in responding to these events. The issue of accountability also features in the literature. It is clear that a strong commitment on both sides to delivering a high quality crisis response service is desirable.

Through a genuine community partnership between police, mental health services and the mental health advocacy community, experience has shown that these obstacles can be overcome. It has been proposed that jointly funded collaborative partnerships could provide fertile ground for innovations in practice, education and research (Fry *et al.*, 2002). International experience has shown that the benefits of implementing clear policies in relation to collaboration are a reduction in inappropriate criminalisation, re-arrests and homelessness which represent positive outcomes for service users. It is also suggested that a comprehensive approach to service delivery be adopted to ensure that all service users be provided for and that specific policies be designed and implemented for specific groups to enable all persons with mental illness in crisis to gain access to the treatment system. Readily available and easily accessible mental health resources are required to facilitate this.



Appendix

3

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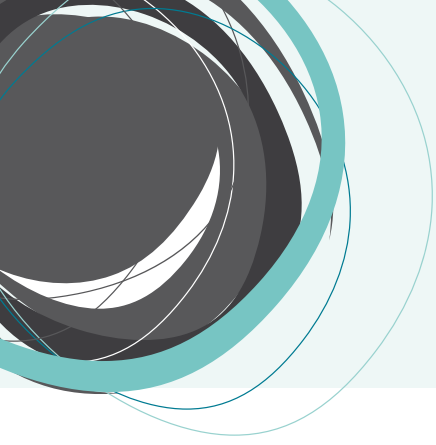
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# Notes

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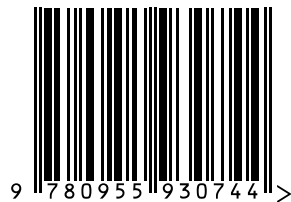


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ISBN 978-0-9559307-4-4



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