Report on a Roundtable Symposium with International Collaborators to Explore the Feasibility of Implementing a Community Safety Co-response Model in Ireland

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Dedication

This report is dedicated to the memory of the late Dr Vicky Conway, who was a strong advocate for the subject area of this research study. Vicky was personally known to the authors and is a person who has made an exceptional contribution to policing, and policing discourse, through her academic research and during her roles with the Policing Authority and the Commission on the Future of Policing in Ireland. Coincidently, Vicky supervised the Principal Investigator's thesis when completing a LLB degree at the University of Limerick. That study related to policing persons with mental health difficulties and focused on the specialist interventions examined in this report. Vicky was instrumental in the inclusion of a recommendation for a co-response model in a report of the Commission on the Future of Policing in Ireland, and the Principal Investigator will continue to work towards achieving its implementation.

Authors

The Principal Investigator, Andrew Lacey, is a Superintendent in An Garda Síochána (AGS) based in Limerick city. He joined the force in 2001 after graduating with a BA in Insurance & European Studies from the University of Limerick (UL). Over his career, Andrew has served in community policing, crime investigation and training in Dublin, Limerick, Clare and Tipperary. He was awarded an LLB in Law (Graduate Entry) in 2008 and a BA in Human Resource Management in 2010 from UL. In 2013, he completed a Master in Criminal Law (LLM) in University College Cork. Andrew recently completed his PhD research with UL (Centre for Crime, Justice and Victim Studies). The research examined the departure from adversarialism in the Irish criminal justice process and the emerging transition towards dispositive justice and diversion. Relevant to today's event, Andrew was appointed as the implementation team leader for the establishment of full-time crisis intervention teams in Ireland, which involves significant multi-agency collaborations and a broad range of local, national and international experience in law enforcement and mental health. In January 2022, the Minister for Further and Higher Education, Research, Innovation and Science, Simon Harris TD, announced IRC funding for 77 New Foundations projects, which will bring researchers and community organisations together to collaborate on projects that will have a tangible impact on societal issues. Andrew is the first member of An Garda Síochána to be awarded funding from the IRC. Finally, Andrew was part of the interdepartmental High Level Task Force that published a report in September 2022 on the mental health and addiction challenges of those who come into contact with the criminal justice sector.

Dr Alan Cusack is a Senior Lecturer in Law at UL, where he also holds the position of Director of Policing Studies within the School of Law. Alan is a graduate of University College Cork (BCL, LLM, PhD), University College Dublin (Dip. Emp) and the Law Society of Ireland (Solicitor 2012). Alan's research interests lie at the intersection of vulnerability and the criminal process with a particular emphasis on the experience of persons with intellectual disabilities. Alan's research has been widely published in national and international journals. He has acted as an Expert Advisor to the Minister for Justice, Garda Commissioner, the Strategic Human Rights Advisory Committee, the European Commission, the High Level Taskforce on Mental Illness, Rape Crisis Network Ireland (RCNI) and the Department of Justice and has provided expert analysis on the treatment of vulnerable witnesses for national media outlets in Ireland, including Drivetime (RTÉ Radio 1), Newstalk FM and the Irish Examiner.

Bláithín O'Shea is a 3rd year PhD student in the University of Limerick's School of Law. She is a graduate of the University of Limerick (first class honours LLB, 2017) and University College Dublin (first class honours LLM, 2019). In September 2019, under the supervision of Dr Susan Leahy and Dr Alan Cusack, Bláithín began her doctoral studies. Bláithín's PhD takes a socio-legal approach to investigate whether the principle of prison as a last resort would be an appropriate and effective way to manage persons with intellectual disabilities in the Irish criminal justice system. This principle aims to reduce imprisonment through use of diversion programmes for defendant's pre-trial and non-custodial sanctions for offenders post-conviction. The aim of this research is to formulate recommendations to promote changes in policy and practice that will bolster the rights and outcomes for persons with intellectual disabilities in the Irish criminal justice system. Her research interests include human rights law, criminology, penology and disability law. While carrying out these studies,

Bláithín lectures in Company and Partnership Law in the University of Limerick. She is also a Peer-Tutor at the Regional Writing Centre; a social media account manager for the School of Law in the University of Limerick; and the Copy-Editor for the bi-annual peer-reviewed Irish Judicial Studies Journal.

List of Abbreviations

Abbreviation	Meaning
ACE	Adverse Childhood Experiences
AGS	An Garda Síochána
AO	Authorised Officer
BEST	Boston Emergency Services Team
BPD	Boston Police Department
BPS	Biopsychosocial (model of mental health)
CAD	Computer Aided Dispatch
CAMP	Case Assessment Management Program
CAST	Community Access Support Teams
CIT	Crisis Intervention Team
CoFPI	Report of the Commission on the Future of Policing in Ireland
CSP	Community Safety Partnership
DBI	Distress Brief Intervention
ED	Emergency department
ERT	Encampment Response Teams
FOCUS	Furthering Our Community by Uniting Services
GP	General practitioner
GSAS	Garda Síochána Analysis Service
HLTF	High Level Task Force
HSE	Health Service Executive
IRC	Irish Research Council
LAPD	Los Angeles Police Department
MAPPA	Multi-agency public protection arrangements
MCITs	Mobile crisis intervention teams
MHA	Mental Health Act
MoU	Memorandum of Understanding
MWRDAF	Mid-West Regional Drugs Task Force
NHS	National Health Service
PSNI	Police Service of Northern Ireland
PULSE	Police Using Leading Systems Effectively
SIM	Sequential Intercept Model
SMART	Systemwide Mental Assessment Response Team
TPS	Toronto Police Service
UL	University of Limerick
US	United States

International Models

Model	Description
Police Scotland	Distress Brief Intervention (DBI): A two-tiered, collaborative service model with the common goal of providing a compassionate and effective response to those in distress. Suitable for non-acute presentations where mental health issues, intellectual or psychosocial disabilities are evident.
Toronto Police Service (TPS)	Mobile Crisis Intervention Teams (MCITs): Collaborative partnerships between participating Toronto area hospitals and the Toronto Police Service (TPS). The programme partners – a mental health nurse and a specially trained police officer – respond to situations involving individuals experiencing a mental health crisis. This model will inform the on-scene response intervention.
Police Service of Northern Ireland (PSNI)	Multi-Agency Support Hub: Helps vulnerable people get access to the right support, at the right time, from the right organisations within their local area. The aim was to have a support hub set up to align with each local council area. Derry/Strabane is our collaborative model and will sit well with proposed legislation (General Scheme of the Policing and Community Safety Bill).
Framingham Police (FPD)	Pre-Arrest Co-Response Program in Massachusetts: Clinicians train and work alongside police officers to help respond to crises and determine appropriate outcomes. Cross-training between the police and the embedded clinicians has resulted in mutual understanding and respect for each other's roles. With a focus on diversion from the criminal justice system, it is influencing our training design.
Boston Police Department (BPD)	BEST (Boston Emergency Services Team): Mental health clinicians co-respond with BPD officers to improve response to mental health-related calls for service. These clinicians can also assist with holding cell evaluations, providing critical follow-up and assisting with mental health training of BPD officers. BEST operates independently from the BPD and maintains its own confidential client database.
Los Angeles Police Department (LAPD)	Mental Health Evaluation Unit: Multi-layered approach that includes triage by trained dispatchers, a 24-hour triage line, co-response teams, follow-up case managers and focused community engagement. Involves embedded mental health professionals in police agency with a comprehensive data collection and information-sharing procedures.

Executive Summary

On 21 April 2022, an international roundtable symposium was convened at the University of Limerick (UL) to explore the feasibility of implementing a community safety co-response model in Ireland. The event was followed on 19 August 2022 by an interagency practitioner workshop entailing expert input by members of An Garda Síochána and the Health Service Executive (HSE). The findings excavated from both the symposium and subsequent workshop have centrally informed, and continue to inform, the design and implementation of a pilot community safety co-response model in Ireland, known as Community Access Support Teams (CAST). In brief, co-response models typically involve adaptive first responses from specialist police officers when dealing with incidents involving suspected mental ill-health either alone or alongside mental health and addiction professionals. The model intends to increase safety in encounters and, when appropriate to do so, divert persons with mental illness from the criminal justice system to mental health treatment (Kane et al. 2017). This report encapsulates not only the insights and knowledge shared at the symposium but also a survey of extant international and national research on the effectiveness of these schemes.

In representing the first event of its kind in Ireland, the roundtable symposium provided a unique opportunity to promote and nurture experiential information exchange with respect to best practice approaches to addressing the needs of vulnerable individuals in their interactions with law enforcement officers. In doing so, the project represented a constituent element of An Garda Síochána's realisation of the procedural reforms raised by the Mental Health Commission in 2009 and, a decade later, by the Commission on the Future of Policing in Ireland (2018). Specifically, with regard to the latter imperative, the roundtable symposium was prompted by a desire to address the Commission's recommendation that "multi-agency Crisis Intervention Teams should be established in all police divisions, with round the clock response capabilities" (2018, p. ix).

A CAST (Community Access Support Teams) pilot was subsequently proposed by a Joint Steering Committee comprising representatives from An Garda Síochána Limerick and HSE Mid-West and was approved by the senior management of An Garda Síochána and the HSE. Currently, preparatory works are ongoing to initiate the project pivots starting with the recruitment of key posts and budgetary approvals. The pilot is intended to create a specialist uniform unit within An Garda Síochána, which will work conjointly with health professionals to provide a rapid and integrated 24/7 response to persons with mental health issues. It is anticipated that the CAST pilot will foster a human rights-based approach to policing in line with An Garda Síochána's Human Rights Strategy (2022–24). The pilot will also act as a vehicle to implement the inclusionary principles outlined not only in the *National Standards for Adult Safeguarding* (HIQA and MHC 2019) but also in *Sharing the Vision – A Mental Health Policy for Everyone* (Department of Health 2020), which delineates a policy framework for the continued development and enhancement of mental health services in Ireland from 2020 to 2030. A central element of the pilot is the design and implementation of a person-centred CAST training plan, which will help Gardaí to provide supports and signposting earlier in the individual's pathway. This will serve as a preventative measure with the potential to yield a better outcome in the long term, reducing future presentations and interactions with Gardaí or other blue light services (police, ambulance service and fire brigade).

In recognising the need for multidisciplinary cohesion in the operationalisation of any such co-response model, the roundtable symposium invited contributions from an international network of expert speakers from a range of related disciplines, including law enforcement, the mental health profession, psychiatry, medicine, criminal justice and community agencies from Ireland, the United States (US), Scotland, Canada and Northern Ireland. To this end, the School of Law at UL was delighted to welcome delegates from the HSE; An Garda Síochána; Department of Further and Higher Education, Research, Innovation and Science; Department of Health; Policing Authority; Faculty of Forensic Psychiatry at the College of Psychiatrists; Medical School, UL; Toronto Police Service; Framingham Police Department; Police Scotland; PSNI Derry City & Strabane; Worcester State University; William James College Center for Crisis Response and Behavioral Health; and the Department of Justice to engage in a constructive dialogue at the symposium and practitioner workshop.

The international presenters at the roundtable discussed the experience of other common law jurisdictions that implemented co-responder programmes. Significantly, all of the international models that were presented at the roundtable event were found to have achieved success in terms of reducing the number of formal arrests in their divisions and minimising calls to blue light services as well as limiting the number Emergency Department (ED) presentations. These models also revealed an increase in the level of diversionary activity and a greater willingness amongst criminal justice agencies to refer vulnerable persons to community-based care services. In bearing testimony to the effectiveness of a co-responder policing programme, all participants expressed a view that they could never return to a situation where such a scheme did not operate in their respective jurisdictions.

Summary of Methodology

The Minister for Justice, Ms Helen McEntee TD, has recognised that Crisis Intervention Teams (CIT) have become a globally recognised co-response mechanism within contemporary policing for safely and effectively assisting people who experience mental health crises or related problems within the community.[1] The CIT model promotes strong community partnerships amongst law enforcement, health professionals and appropriate follow-on support agencies. Early onset mental health illness is associated with poorer prognosis and poorer response to treatment and has widespread effects on the individual, family and society (Cannon et al., 2013). The aim of the roundtable symposium was to explore the outcomes associated with a multi-agency approach to responding to mental-health-related incidents with a view to informing the design of a co-response model in Ireland.

To achieve this aim, the collaboration partners were asked to present a series of plenary papers on the salient features of co-response models that operate in their respective jurisdictions (see Appendix B). The partners were then tasked with considering a series of hitherto unaddressed urgent questions concerning best practice police responses to the needs of vulnerable persons in police custody. These questions included:

(i) Whether it is appropriate for members of An Garda Síochána to act as the *de facto* response agency to mental health calls in Ireland
(ii) Whether there is capacity for a medically informed response to such incidents

[1] Dáil Éireann Debate, Tuesday, 26 July 2022, Minister for Justice Helen McEntee, Parliamentary Questions (1503, 1504) (33rd Dáil), Houses of the Oireachtas (accessed 8th September 2022)

(iii) Whether Irish police procedure can learn from other international best practice models
(iv) Whether evaluation of other co-responder models can assist in the implementation and design for the Irish pilot
(v) What lessons were learned through international implementation that can inform the Irish pilot
(vi) Whether the international practitioners can identify key dependencies for the pilot's success and pivotal outcomes

In building on the success of the roundtable symposium, the subsequent practitioner workshop entailed a mixture of plenary papers and directed dialogue involving national and international collaborators (see Appendix C).

While coordinating these engagements, the Principal Investigator was, at all times, cognisant of his role as an operational and serving member of An Garda Síochána and, in particular, his appointment as the implementation team leader and member of the Joint Steering Committee designing the Community Access Support Team (CAST) pilot project. In this role, the Principal Investigator had unique access to internal Garda research data encompassing two years of incident analysis that was of assistance in defining this project's goals and the themes for both the roundtable symposium and practitioner workshop. This autoethnographic influence yielded additional value in that the Principal Investigator also had direct access to the experiential views of first-line responders both in Ireland and abroad.

Summary of Key Lessons Learned

Resting at the heart of the symposium and, indeed, the wider Irish co-response pilot scheme, was, and remains, a desire to explore, identify and operationalise alternatives to arrest for vulnerable persons and to mainstream institutional risk assessments and first contact policing responses that are more aligned to the community healthcare model. Where appropriate, diverting suitable persons out of police custody and, more broadly, the criminal justice system was a priority for this project. With a view to achieving this objective, the roundtable symposium and associated preparatory activities yielded the following seminal findings:

- In many instances, policing and mental health professionals in Ireland already informally operate in collaboration with one another. This inter-agency co-operation is driven by relationships and a sense of local ownership for addressing mental health challenges in their own communities.
- There is an absence of specialist training and formal procedure relating to first responder interaction with persons experiencing mental health crisis in Ireland.
- Implementing co-responder programmes increases the frequency with which trained officers direct people with mental health issues to mental health services using a variety of skills and approaches.
- The importance of developing interagency relationships across sectors that engage with vulnerability and mental health services needs to be developed and periodic forums must be created to establish care pathways. The existence of joint training for the CAST pilot would enhance interagency rapport, communication and information sharing.

- Police officers should not be the *de facto* responder to mental health crises. However, the multi-agency approach will frequently see intervention at the police custody stage. In practice, members of a co-responder model can communicate key considerations to doctors attending police custody suites.
- Consultation and communication are important. In particular, it is important to be aware of what other agencies are required to do to support the co-responder/CIT pilot.
- Building the infrastructure to strengthen the co-responder model and sustain the programme, including revised policies and procedures, staffing and data collection, is crucial.
- Co-responder programmes vary between jurisdictions internationally. Some variations are intentional and derive from the needs of a given jurisdiction while others are the result of local realities that prevent a full model from being implemented as intended (Compton et al. 2010; Compton et al. 2011).
- It is not the specific percentage of police officers that are trained that is the most important factor. Rather, it is getting the right officers trained. This theme was prevalent across the roundtable and workshop events.
- At its core, co-responder is a model of collaboration, and ensuring the clinical or social care staff are embedded into the pilot is critical to success.
- The practitioners highlighted the necessity to maintain a level of patience towards the early implementation of the pilot. The involved personnel need to be resilient and progress through the project where lessons will be learned and the design shaped accordingly.
- Sequential Intercept Model (SIM), therapeutic jurisprudence and the Biopsychosocial (BPS) models of mental health offer a holistic approach to the presence and severity of mental health issues in the population. The models empower clients to actively engage in the therapeutic process. They encourage multidisciplinary collaboration and seek to treat the 'whole person'. The approach blends philosophy and practice through joint agency services.
- The roundtable participants complimented the long-term, strategic collaborative planning of the CAST project. Other jurisdictions expressed regret that they did not approach implementation in the same manner.
- The cost per crisis response reduces with the introduction of the co-responder models due to a reduction in hospitalisation.
- To enhance the overall vision for the programme, it is important to have strategies in place for training, data management, quality improvement and evaluation.
- There was a consensus that having more clinicians on the co-response team would give rise to better interventions and care.
- It was advised that mental health issues and addiction are like any other medical condition: early intervention improves outcomes, and stigma is the number one reason why people do not ask for help.

Summary of Recommendations

1. **Establish a support hub as part of the co-responder programme**: In line with neighbouring jurisdictions, establish a multi-agency support hub framework to increase the capacity to link people in mental health crises to the appropriate community services. The development of self-management strategies and intensive case management support hubs in Ireland will reduce presentations and, as a consequence, the number of visits to Garda stations and psychiatric unit settings.
2. **Establish a co-response, on-scene crisis intervention model**: A co-response model under the CAST pilot programme should be developed to provide prompt assessment and support to a person experiencing a crisis. Training as part of the on-scene, co-response pilot will improve officers' de-escalation skills and prevent harm to persons in crisis, first responders and the public. It will also increase the likelihood of early intervention and assessment.
3. **Call dispatcher training**: Training for regional CAD (Computer Aided Dispatch) centres should be provided so call takers are trained to identify mental disturbance calls and assign these calls to co-responder trained officers. The officers who will be assigned to CAST will be trained to use de-escalation techniques if necessary and assess if referral to services or transport for mental health evaluation is appropriate. It is recommended that full-time dispatch personnel go through co-responder training alongside the CAST assigned officers.
4. **Develop a Distress Brief Intervention model for Ireland**: The implementation of the CAST pilot should include a connected, compassionate, early-intervention process for people experiencing distress. The goal is to improve inter-agency coordination, collaboration and cooperation across a wide range of care settings, interventions and community supports. This will provide compassionate and effective care for those experiencing situational trauma or mental health problems. The Irish model will have to examine the capacity capabilities of non-acute/community agencies that are provided with funding under section 39 of the Health Act 2004.
5. **Strengthen community linkages and partnerships**: Mental health, community, justice and public service systems are interconnected and adopt and refine policies to identify and close gaps between them. This should include providing 'warm hand-offs' and other necessary supports to help individuals navigate between the systems in which they are engaged. This could be achieved through a well-structured CAST support hub.
6. **Deliver international standard training**: Provide training and awareness programmes for all resources attached to the CAST pilot project. In addition to existing training, such as ASIST (Applied Suicide Intervention Skills Training) and SAFETALK (Suicide Alertness for Everyone), delivering training in mental health first aid, de-escalation and CIT would equip the officers and care workers with the skills and knowledge to identify the signs and symptoms of mental illness, which is imperative to early intervention and diversion from the criminal justice system and EDs. Providing high-level training and exposure to lived experiences will encourage a new emphatic approach. Training should include information on signs and symptoms of mental illnesses, mental health treatment, co-occurring disorders, legal issues and de-escalation techniques.
7. **Provide information**: Garda members and medical professionals should provide information leaflets that give a list of resources and services that are available to individuals in crisis who present to first responders.

8. **Embrace criminal diversion and discretion**: Introduce programmes and initiatives to divert adults with mental illness, emotional disorders or severe situational trauma from justice settings to the community care setting. These programmes should operate at all intercept points across the sequential intercept framework and be required to function in collaboration with AGS, HSE and probation services.
9. **Recruit the right personnel**: It was accepted during the roundtable discussion that not all officers or healthcare workers are suited to be co-responder/CIT officers. Those who volunteer and are accepted into the programme may have a particular disposition and interest in handling mental health calls. This better prepares them to use CIT training to become effective in responding to mental health crisis calls. It is recommended that as part of the CAST pilot implementation, 20% of the Limerick Garda Division be co-responder trained to ensure the sustainability of the pilot. It is recommended that pre-hire 'ride-alongs' are organised for healthcare applicants to provide the opportunity to see the realities of the role and decide if it is for them.
10. **Evaluation the pilot**: Key to the successful implementation and sustainability of the CAST pilot throughout all Garda divisions is intensive evaluation. Recorded figures relating to clinical evaluations, health referrals, arrest diversions, dispatched calls and ED diversions are the core indicators of a successful co-responder programme. It is recommended that the lead agencies and a third-level institution collaborate to attain research funding for this important pilot.
11. **Resource the lower-level problem-solving services**: The roundtable practitioners described a heightened awareness of mental health and vulnerability within the population that coincided with a lack of lower threshold options. Because not everyone needs acute problem solving and care, it is crucial that the community-based agencies are resourced to alleviate the demand on acute services and enable early intervention.
12. **Design a hybrid uniform and reduce vehicle identification markings**: Based on international experiences, the CAST pilot should use a hybrid uniform that is distinguishable from the police uniform and can support de-escalation. Similarly, the vehicles used should have subtle identification markings only. This distinct, specially designed uniform will support de-escalation.
13. **Communicate guide/signs of safety training/Adverse Childhood Experiences (ACE) training**: Training for those dealing with persons in crisis to be made available to all CAST trained officers.
14. **Memorandum of Understanding**: It is recommended that as part of the CAST project, a joint policy document with standard operating procedures be drafted so that there can be no ambiguity in respect of call types or processes. The dissemination of policy as part of the joint training would be advisable. The framework and structure of the support hub would be included in this document.
15. **Design and dissemination of algorithm guide for frontline Gardaí**: It is recommended that a user-friendly human rights-grounded algorithm guide for frontline Gardaí interfacing with people with mental health issues, intellectual or psychosocial disabilities be developed and incorporated into the CAST pilot. This guide has the potential to assist first responders who have limited training to identify mental health problems and make more informed decisions or simply identify a specialist need.
16. **Establish a mandatory review for licenced firearms**: Similar to some jurisdictions, the co-responder/CIT model in Ireland should review crisis presentations and establish if licensed firearms are held and make decisions in the interest of safety to the individual

and public pursuant to the Firearms Act 1925 as amended by the Criminal Justice Act 2006.

17. **Adopt data-driven solutions**: It is recommended that the pilot examine the relevant data pertaining to mental illness, vulnerability and crisis. Evidence-based public policy and practice requires reliable, comparable and scalable data from which to identify, quantify and analyse individual and community outcomes and thus implement best practices. This is especially important in the Irish context of resources and recruitment capabilities in the area of psychiatric nursing where the allocation of skilled posts must be justified and of value to mental health services.
18. **Statutory provisions for data sharing**: The international practitioners shared similar experiences pertaining to the need for legislative clarity required for the sharing of sensitive information between support agencies. For the multi-agency model to work, those within the care settings need to be safe in the knowledge that they are legally empowered to share information in the interests of a vulnerable data subject. While this falls outside the scope of the implementation, it is a recommendation for the wider CAST pilot to share with the governmental departments responsible for implementation as part of the pilot evaluation.
19. **Enhancement of the human rights**: The CAST pilot should further strengthen a human rights-based approach to policing persons with mental health and vulnerability challenges. The rights of all individuals are enshrined in law. In Ireland, the European Convention on Human Rights Act 2003 requires An Garda Síochána to perform its functions in a manner compatible with the state's obligations under the European Convention on Human Rights (ECHR).[2]
20. **Further research**: Research relating to crisis mental health events and co-response remains in its infancy in this jurisdiction. This gap contributes to a lacuna in knowledge with regard to how the police respond to these complex scenarios and the systems in place to guide frontline practice. Further research is needed to help provide a comprehensive understanding of these issues.
21. **Disseminate a clear objective and function of the services**: A clear definition of services brings value to the operation. The pilot and wider mental health services would benefit considerably if the public were made aware of the actual services in operation. Ideally, an awareness campaign on access requirements for acute psychiatric units should be conducted. This approach would manage expectations and provide guidance on appropriate care in community settings.
22. **Provide effective community-based services**: A more integrated system of caregiving must be designed to reduce the number of persons who fall through the cracks into the criminal justice 'net' and to provide effective community services to persons who are arrested and released.
23. **Develop family supports and gather client feedback**: As identified through the roundtable discussions and lived experience findings, supports should be provided to families during and after crisis interventions.
24. **Post-implementation review**: It is recommended that a post-implementation review be conducted to enable management to confirm the benefits of the project by evaluating whether or not the business and system goals have been achieved. The review will identify areas that may need additional attention to promote project

[2] Section 3 of the 2003 Act

benefits, such as adopting organisational change, providing operational support or revising new processes and procedures for further rollout amongst divisions.

25. **Focus on health-led solutions**: While the project originates under the umbrella of policing in Ireland, the authors and the implementation team are acutely aware that the project is primarily dependent on clinical services and health-based supports.

By excavating the above recommendations and promoting strategies to embed a best-practice co-response policing model in Ireland, this project has endeavoured to offer a pathway to meaningfully vindicate the human rights of persons with mental illnesses in accordance with Ireland's international obligations under the European Convention on Human Rights, the UN Convention on the Rights of Persons with Disabilities and the EU Recommendation on Procedural Safeguards for Vulnerable Persons Suspected or Accused in Criminal Proceedings (2013/378/02). The research has also examined existing international models to develop a quality and efficient model for Ireland that will deliver service needs to those experiencing crisis and their families and will alleviate existing pressures within Ireland's health service.

1. Background

1.1 Setting the Scene

A number of recent publications and actions have influenced the work of this report, including *The Future of Policing in Ireland* report (Commission on the Future of Policing in Ireland 2018); *Sharing the Vision: A Mental Health Policy for Everyone* (Department of Health 2020); the establishment of a high-level taskforce to consider the mental health and addiction challenges of persons interacting with the criminal justice system (Department of Justice 2022); and *Delivering Custody Services* (Garda Síochána Inspectorate 2021). In particular, the latter report found that one in four people in Garda custody over a 12-month period had "poor mental health" or had engaged in self-harm. Moreover, the Inspectorate concluded that in excess of 2,000 adults and 60 children were taken into Garda custody under section 12 of the Mental Health Act 2001 during the period studied. In light of these discoveries, the Inspectorate recommended that consideration be given to embedding healthcare professionals in custody facilities across Ireland and, to this end, it advocated for the establishment of a cross-sectoral group to explore developing a range of diversion and intervention services for persons in custody.

These recommendations, which were aimed at addressing the unmet need for specialist pathways to assist persons in mental health crises in police custody, echoed calls made more than a decade earlier by the Joint Working Group on Mental Health Services and the Police, which recommended the establishment of a diversionary scheme as well as a specialist Crisis Intervention Team (Mental Health Commission 2009, p. iv):

> Recommendation five recommends a feasibility study on jointly staffed crisis intervention teams, made up of mental health personnel and members of An Garda Siochána … 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.

Despite these calls for reform, it remains the case that, at the time of writing, the preferred response of Ireland's criminal justice system to such individuals is ostensibly criminalising in nature. Indeed, unlike the established diversionary scheme that exists for juveniles, Ireland's criminal justice landscape currently fails to accommodate a non-dispositive route for addressing the needs of adults with mental health conditions. This absence of provision was noted by Ryan and Whelan (2012, p. 1):

> "At present, if people with mental disorders appear before the criminal courts in Ireland, unless they are unfit for trial or not guilty by reason of insanity, the system governing their case will be the general one which applies to all criminal cases."

The damaging repercussion of this lacuna was formally revealed by O'Neill (2006), who, in one study, found that 26 informal diversions were recorded for offenders with mental health concerns during 2005. Most of these cases were dealt with in the District Court, which ordered bail or made an order for non-custodial disposal of the case.

Significantly, however, the study revealed that these patients had spent an average of 66 days on remand prior to being diverted. According to O'Neill (2006, p. 87):

> "Prisons are toxic and inappropriate environments in which to manage people with major mental illnesses. The mentally ill are vulnerable in such settings. Where involuntary treatment is required, this is not permissible in a prison setting. The poor conditions in prison settings have been highlighted in the wake of a recent homicide at Mountjoy prison. The right of the mentally ill to the best available healthcare in the least restrictive appropriate environment has been made clear by the United Nations and should apply to mentally disordered offenders "to the fullest extent possible".

In addition, to the enduring unmet need for a targeted diversionary scheme for adults with mental health conditions, Ireland's criminal justice architecture currently fails to accommodate the type of inter-agency crisis intervention model advocated by both the Joint Working Group on Mental Health Services and the Garda Inspectorate. Indeed, a recent qualitative study (Rooney et al., 2021) revealed that members of An Garda Síochána, in the absence of a formal support model with health care specialists, often adopt a range of informal approaches and techniques when dealing with individuals experiencing a mental health crisis. This skillset was characterised as being informed by common sense and on-the-job experience. Accordingly, and perhaps unsurprisingly, the study recommended the development of improved protocols and training:

> "Despite inconsistencies in the level of training received by newer members and long serving officers, every single Garda member interviewed for the present study believed they required more training in matters of identifying and managing crisis MH presentations and neurodiversity. It is important to note, that in the absence of specialist training, Garda members described themselves both industrious and dynamic in their approach to youth crisis MH events. This is evidenced by their ability to supplement formal procedure with informal practices they developed via their on-the-job experience, gut instinct and common sense. These informal practices shared one common objective; to put the child at ease and minimise distress. These findings emulate those of Shannon (2017, p.167) who not only found an overreliance on 'on-the-job' learning within the GS but that members actively tried to reduce the trauma experienced by children/children when removing them to a place of safety under Section 12 of the Child Care Act 1991. The uncertainty they experience when dealing with children is of particular concern given their level of contact with this cohort across a variety of different contexts (i.e. crime, MH, child protection, road traffic accidents) (Rooney et al. 2001, p. 61)."

A similar concern relating to the possible inconsistent adoption of best practice approaches to vulnerable persons has been raised in the context of suspects with intellectual disabilities in Ireland (Cusack et al. 2022a; Gulati et al. 2021). According to Cusack et al. (2022b, p. 426):

> "According to the research, suspects drawn from this constituency can encounter significant challenges within the Irish criminal justice system in comprehending, not only the seriousness of their alleged crime and its impact on others, but also how their own responses may lead to further difficulty for them. They can also encounter difficulty in indicating that they require additional support which, in

> turn, can prevent them from understanding information relating to important legal safeguards (including the police caution). There is also a risk that the behaviour of these individuals will be misinterpreted and their responses under interrogation will be biased by questioning tactics that neglect the ontological dimensions of intellectual impairment including, in particular, the heightened vulnerability of some individuals to acquiescence and suggestion. The inquiry also highlighted the challenges experienced by law enforcement officers in recognising the presence of a disability and the importance of this as a crucial first step to offering the necessary supports."

Given these challenges, it is perhaps unsurprising that, in line with the experience of persons with mental health conditions, individuals with intellectual disabilities have been found to be equally over-represented at the terminus of Ireland's formal criminal process. For example, the leading study in this field discovered a potential prevalence of 28% of "significant degree of intellectual disability" in Irish prisons (Murphy et al. 2000, p. 1). Additionally, addiction and substance abuse can be a prevalent feature of this population. A study by the UK Department of Health suggested that 75% of users of drug services and 85% of users of alcohol services experienced mental health problems while 44% of mental health service users reported drug use (Weaver et al. 2002).

When viewed in light of the wider ontological blindness of traditional Irish pre-trial procedure, the continuing over-representation of persons with intellectual disabilities and mental health conditions in Irish prisons is concerning (Cusack, 2020). It raises questions, not only about the adequacy of the safeguards and supports that are in place to assist vulnerable suspects as they journey through the criminal process once accused of a crime but also about accessibility and fairness of the wider adversarial criminal process. Indeed, this point has been raised convincingly by Gulati et al. (2020, p. 2) in an Irish context:

> "The answer to reducing prison prevalence of intellectual disabilities may lie, in part, in increased awareness of the disability by criminal justice agencies at various points in the criminal process, and the development of a structured and enhanced information sharing process across relevant agencies This would permit interventions at the points of arrest, detention, charge, prosecution, trial and sentencing, *permitting alternatives to criminalisation and incarceration to be considered in appropriate circumstances"*.

In an effort to realise this alternative, non-dispositive vision of Ireland's criminal law, the intention of the roundtable symposium was to promote and nurture dialogue that would assist in developing a best-practice co-response model in Ireland in order to keep, as far as possible, individuals in crisis out of emergency rooms and Garda Síochána custody suites. It is important to note, in this regard, that while diversion is a central component of most co-response models, the two primary objectives of such a scheme are to improve services and outcomes and develop appropriate pathways and responses for individuals who experience a mental health crisis.

1.2 The Origin of Crisis Intervention Teams

Crisis intervention as a model was developed in the 1960s based on Kaplan's research into community mental health and the experiences of individuals with acute mental health problems (Kaplan, D.M. 1962, pp. 15-23). The Memphis Crisis Intervention Team (CIT) was an innovative police-based responder programme that has become internationally known as the Memphis Model. Championing the concept of better equipping police to intervene in crisis situations, the model can be traced back to 1987. The Memphis police department developed crisis intervention training, also known as the Memphis Model, to train police to assist, rather than arrest, people exhibiting signs of mental illness. It is a model of pre-arrest jail diversion for those in mental health crisis. The programme provides enforcement based on crisis intervention training for helping those individuals with mental illness. Crisis intervention training has been implemented in an estimated 3,000 of the 15,000 police agencies in the US, and it typically involves approximately 40 hours of specialised training for officers. The Memphis CIT Model relies on three components: collaboration amongst mental health providers, police officers, family advocates and other stakeholders; the specialist training programme to teach police officers therapeutic skills; and continued stakeholder and family involvement to oversee and improve programme development (Douglas et al. 2014).

Research suggests that crisis intervention training reduces the number of arrests and tends to improve officers' confidence in responding to people with mental illness. Studies generally find that CIT has beneficial officer-level outcomes, such as officer satisfaction and self-perception of a reduction in use of force. CIT also likely leads to pre-booking diversion from jails to psychiatric facilities (Rogers, McNiel et al. 2019). However, the results are by no means definitive or uniform, which indicates that there are potential limitations to the implementation of co-responder programmes.[3] In addition, crisis intervention training works in partnership with those in mental healthcare and provides a system of services that are friendly to individuals with mental illness, family members, police officers and other stakeholders within the sector. CITs have become a model within contemporary policing for safely and effectively assisting people within the community who experience mental health crises or related problems. The CIT or co-responder model promotes strong community partnerships amongst policing bodies, health professionals and appropriate follow-on support agencies. The Principal Investigator has observed a movement of change resulting in pathways to community support and recovery. Policing and mental health professionals have joined together and are driven by relationships and a sense of local ownership for the challenges of mental health in their own communities, which is central to the ethos of the CAST pilot programme.

At its core, CIT is a model of collaboration to improve how police, mental health services and communities respond to mental health crisis. The model brings stakeholders together to advocate for the implementation of CIT, develop a programme tailored to the community, implement the training and support interagency agreements, and provide ongoing collaboration (Watson and Fulambarker 2012). For a CIT programme to be successful, several critical core elements that are central to the success of the programme's

[3] Limitations or barriers could be caused by resource deficits, capacity to recruit, localised problems or legislative barriers.

goals need to be present, i.e., ongoing, operational and sustaining (Dupont et al. 2007). The necessary underlying components of each element are outlined below.

Ongoing elements

1. Partnerships: law enforcement, advocacy, mental health
2. Community ownership: planning, implementation and networking
3. Policies and procedures

Operational elements

1. CIT/Co-responder: officer, dispatcher, coordinator, follow-up
2. Curriculum: crisis intervention training
3. Mental health receiving facility: emergency services

Sustaining elements

1. Evaluation and research
2. In-service training
3. Recognition and honours
4. Outreach: developing CITs in other communities

This report explores multiple international responses to mental health crisis presentations by frontline services and examines their compatibility to a co-response model in the Irish jurisdiction, which is currently under design. Throughout this report, the authors make reference to both CIT and co-response models. Both terms refer to the convergence of policing and healthcare professionals to achieve early skilled intervention to prevent harm and avoidable use of frontline police officers or acute psychiatric care. It would be accepted that more contemporary and blended programmes are categorised as co-response programmes as a significant volume of the calls for service involve vulnerability that may not require acute crisis intervention but rather community-based care.

1.3 Aims of the Roundtable

The central objectives of the roundtable symposium were as follows:

- Enhance the design and implementation of a community safety co-response model in the Irish jurisdiction through external practitioner collaborations
- Inform the ongoing project and assist in developing a co-response model to keep people in crisis out of emergency rooms and Garda Síochána custody
- Learn of international evidence and experiences that demonstrate improved outcomes for people requiring the intervention of frontline services at times of mental health crises
- Evaluate data from established international co-response models
- Apply a multi-agency and cross-disciplinary approach to the implementation of the project
- Identify aspects of international co-response models that are compatible with the Irish legal framework and statutory services
- Reach out to the CIT communities to learn about international best practice
- Help with the design of a training and development programme for Ireland
- Identify worthwhile components to incorporate into the Irish co-response model

- Learn of suitable role profiles and recruitment practices for implementing a co-response model
- Conduct an international model review identifying innovative practice in the area.
- Obtain expert insight from interviews with key stakeholders regarding their experiences in crisis intervention and the policing of mental health.

2. The International Landscape

2.1 The Framingham Police Co-Response Model

As part of this research and the author's involvement in the development of the Community Access Support Teams (CAST) project in Limerick, collaborations developed with the Advocates Pre-Arrest Co-Responder Jail Diversion Program, which was first established in Massachusetts in 2003 at the Framingham Police Department. With almost two decades of experience in the implementation, funding and growth of the programme, the team from Framingham has contributed significantly to the research on which the design of the Irish co-response model is based. The Framingham model has been successfully replicated in 30 other cities and towns across Massachusetts. Dr Sarah Abbott, Associate Professor at the Center for Crisis Response and Behavioral Health at William James College, Massachusetts, co-presented with Chief Lester Baker and Deputy Chief Sean Riley of the Framingham Police Department at the roundtable symposium. As the first clinician in the Framingham co-response programme, Dr Abbott highlighted that such initiatives are founded on the understanding that by working together, clinicians and law enforcement personnel can respond most appropriately to the needs of individuals in the community who are in crisis. Symposium attendees were informed that individuals with mental illness and substance-use disorders are over-represented in the criminal justice system (Jennifer & Bronson 2021) compared to their representation in the general population. Dr Abbott responded to thousands of 911 calls alongside law enforcement personnel and helped de-escalate, stabilise and divert individuals away from the criminal justice system and hospital emergency departments (EDs).

Dr Abbott described how the model developed out of frustration with an unresponsive system that continually saw individuals presenting repeatedly, repeat involuntary hospitalisations and no observable change. The early clinicians became known as "boundary spanners", defined as individuals whose positions "link two or more systems whose goals and expectations are likely to be at least partially conflicting" (Miles 1980, p. 62). The programme changed systemic structures and operations and removed barriers and service gaps. Dr Abbott believes that co-response models recognise the fundamental principles of therapeutic jurisprudence – voice, validation and voluntariness – by providing options and opportunities for individuals in crisis that will empower rather than relegate them. The term therapeutic jurisprudence (Wexler and Winick 1991) refers to an interdisciplinary method of legal scholarship that aims to reform the law in order to positively impact the psychological wellbeing of the accused person. Now getting international traction, the approach blends philosophy and practice through joint agency services.

Chief Baker and Deputy Chief Riley outlined that the co-response model in Framingham required extensive collaboration between the clinician and the patrol division. To this end, joint training took place to enhance responses to crises and determine appropriate outcomes. The cross-training between the police and the embedded clinicians has resulted in a mutual understanding and respect for each other's roles. The Framingham co-response model pairs social workers and police officers on patrol to co-respond to calls for service. On scene, the responders use their skills to assess and de-escalate the situation and coordinate the required services. After 20 years in operation, the visible outcomes of the Framingham model include arrest diversion, ED diversion, reduction in force used and shifts in attitudes

of law enforcement personnel. Presenters outlined that working in the field with co-response clinicians affords police officers the opportunity to deliver rapid mental health services to those they encounter. The Framingham Police Department confirmed that the number of recurring calls has decreased as people are referred to more appropriate services.

Dr Abbott stated that the decision to arrest and incarcerate individuals with a mental illness is challenged in police departments with a co-responder programme. This is not to suggest that all individuals with a mental illness should be given a pardon or not be held responsible for their behaviours. There will always be those who deserve to be incarcerated for their serious and violent crimes but police agencies are realising that there must be alternatives to arrest for individuals who commit minor nuisance offences and have developed programmes like Framingham to address this need. Although the police have the power to intervene and arrest individuals with a mental illness, police officers also have a great deal of discretion in the commission of their duties. The manner in which they use this discretion greatly impacts the individual at hand, other police officers and the community at large.

In conjunction with co-response jail diversion clinicians, the Framingham Police Department continually evaluates its service; the presenters referred to data for 2003 to 2020 at the symposium. The research recorded figures relating to clinical evaluations, arrest diversions and ED diversions, which are three core indicators of a successful co-responder programme. In 2003, the programme's inaugural year, 357 evaluations and 56 arrest diversions were recorded; data were not attained for ED diversions. By 2010, the programme recorded 875 evaluations, 138 arrest diversions and 59 ED diversions. The most recent figures (2020) recorded 940 evaluations, 114 arrest diversions and 249 ED diversions, the highest figures to date.

The Massachusetts presenters made reference to the Sequential Intercept Model (SIM). The SIM highlights criminal process interventions with community-based actions so that individuals with mental and psychiatric conditions would not have to further penetrate the criminal justice system. Primarily it is the police officers who make the initial critical decision as to whether or not an individual should be arrested. It is at this intercept that officer discretion comes into play but it can be supported by organisational policy or culture. The SIM relies heavily on community and policing agencies to change the pathways of persons experiencing mental health crises and vulnerability. The later intercepts in custody settings can be more challenging. For more details on the SIM, refer to section 2.4 and Appendix D.

Chief Baker outlined that the multi-stage hiring process aims to select top-tier candidates and includes a background investigation and pre-hire 'ride-alongs' to give the applicants the opportunity to see the realities of the role and decide if it is for them. Coupled with a policy of embedding co-response clinicians in the Framingham Police Department through roll calls and community taskforces, the comprehensive screening process has helped with quality recruitment and retention. The success of the Framingham model can also be attributed to the fact that the clinicians are well trained before joining the police department and to the trust that develops between the officers and their clinician counterparts. This familiarity facilitates informal debriefings of critical events for officers; crucially, the clinicians are accessible to the entire department, regardless of shift or role.

The presenters outlined the following recent progressions in the Framingham co-response model:

- Additional clinicians 24/7
- The creation of a hub to identify individuals most at risk
- Engagement with South Middlesex Opportunity Council, which improves the quality of life of low-income and disadvantaged individuals and families by advocating for their needs and rights, providing services, educating the community, building a community of support, participating in coalitions with other advocates and searching for new resources and partnerships/outreach workers downtown
- Opioid follow-up
- Death notifications
- Keeping the programme within the Framingham culture
- Sharing the success of the programme locally, nationally and internationally

2.2 Police Scotland

2.2.1 Distress Brief Intervention

The Principal Investigator learned about responses to people in distress through research collaborations with Police Scotland. The Distress Brief Intervention (DBI) model was included in actions 4 & 6 of Scotland's Suicide Prevention Action Plan 2022–2025 (Draft for Public Consultation). The new model links mental health pathways to policing. Chief Inspector Elaine Tomlinson from Police Scotland presented at the symposium and participated in the roundtable discussion. She cited that only 20% of the calls to Police Scotland were traditional policing calls "of jail and the bad guys" while the remaining 80% were non-crime-related, which places a substantial demand on police officers. As a consequence, the Scottish Government, Police Scotland, the Strathclyde Fire Brigade and the Scottish Ambulance Service met with their National Health Service (NHS) colleagues to explore how the system could be improved. Collaborative dialogue followed, after which the DBI initiative was designed and launched. The DBI is still in the pilot phase but has been approved by the First Minister of Scotland.

The overarching aim of the DBI is to provide a framework for improving inter-agency coordination, collaboration and cooperation across a wide range of care settings, interventions and community supports with the shared goal of providing compassionate and effective care for those experiencing situational trauma or mental health problems. Since its inception, the vision of the DBI has been to provide connected, compassionate, early intervention to people experiencing distress through wide and far-reaching national and regional collaboration between health, social care, emergency services and the third sector.

The DBI 'ask once get help fast' approach has two levels. DBI Level 1 is provided by frontline ED staff, Police Scotland, primary care and the Scottish Ambulance Service. These groups received DBI Level 1 training, devised by the University of Glasgow, on how to ease a person's distress and provide a compassionate response. Level 1 involves offering to the distressed person, with confidence and clarity, a seamless referral to a DBI Level 2 service. DBI Level 2 is provided by commissioned and trained third-sector staff who contact the person within 24 hours of referral and provide compassionate, problem-solving support, wellness and distress management planning, supported connections and signposting for a

period of up to 14 days, thereby reducing the person's immediate distress and empowering them to manage future distress. The person's doctor is notified of the outcome of referral by the DBI service.

While Chief Inspector Tomlinson outlined that police officers demonstrate incredible compassion to a person in need, it is accepted that a police officer is not the right person to help and that being there for a prolonged period, in uniform, can add to the person's trauma. Furthermore, taking the person to a hospital or police station in a marked police vehicle can exacerbate the situation and create unnecessary embarrassment for the person. Therefore, to reduce the trauma, a DBI is used to ensure that police officers get the distressed person the help they need by referring them to a Level 2 provider. This referral will lead to a third-sector mental health agency[4] contacting the person within 24 hours (although usually within two to four hours) to offer them 14 days' support. Fourteen days is offered so that the person has a chance to reach a more positive frame of mind and feel more able to cope with their situation. The ultimate aim of the DBI is that at the end of the 14 days, the individual feels they can manage their life stressors better and, consequently, no longer feels the need to call the police, the fire service or an ambulance. In situations like this, the DBI model is more progressive, emphatic, compassionate and professional.

Since DBIs were first used in 2019, Police Scotland alone managed to make 2,433 referrals (54% female and 46% male) to the DBI pilot. Analysis shows that almost 78% of people engaged with further support beyond the first supportive intervention.

2.2.2 Mental Health Pathways

Related to DBI, Mental Health Pathways (MHP) is an NHS 24[5]/Scottish Ambulance/Police Scotland initiative. Since August 2020, callers to Police Scotland on '101' or '999' experiencing mental ill health/distress are referred, subject to certain criteria, directly to the NHS 24 Mental Health Hub to receive compassionate care at the earliest opportunity. Additionally, mental health nurse practitioners employed by NHS 24 are co-located in control rooms to provide tactical advice to staff and officers dealing with dynamic incidents. Police Scotland uses the TRIVE (Threat, Risk, Investigation, Vulnerability and Engagement) assessment tool on triage calls to establish whether or not the call can be transferred without a police officer going out to the caller and to ensure the individual is given proper clinician advice. If one of the other agencies subsequently requests police assistance because of a particular circumstance, officers will attend in accordance with Police Scotland's mission of *keeping people safe*. Two of the 10 actions in the Scottish Suicide Prevention Action Plan are directly linked to Police Scotland action. It is planned to incorporate other actions, such as supporting families affected by suicide and digital awareness on suicide prevention, into the plan in the near future. Research investigating the benefits of implementing CITs in England and Wales was discussed; it indicated that trained officers are more likely than non-trained officers to direct people with mental health issues to mental health services and to use a variety of skills and approaches when dealing with

[4] In Ireland, this refers to non-acute/community-based agencies that are provided with funding under Section 39 of the Health Act 2004.

[5] Scotland's national telehealth and telecare organisation

vulnerable individuals, such as active listening, positive engagement and negotiation (Kane et al. 2017; 2018).

The following is a frontline policing example of the DBI service in practice: A male in his mid-20s was caught shoplifting (food that was worth only a few pounds), and the store called Police Scotland. A young police officer who had undertaken DBI training attended and established that the man had, in effect, been left homeless following a family bereavement. The man had no possessions, knew nobody locally, was struggling financially and felt low and isolated. After relating the man's distress to these contributing factors, the officer felt the man might benefit from a DBI referral, which was then made with the man's agreement. The man stated that he wanted to get support to look for work. Without the DBI, the man might well have been placed in custody and possibly charged.

Subsequent DBI actions included the following:

- The DBI worker supported the young man to complete a distress management plan.
- A safety plan was made, and triggers for the hopelessness were addressed.
- The DBI worker used NHS-approved websites to support the management of anxiety, confidence and how isolated and down the young man had been feeling.
- The young man was supported to register with a general practitioner (GP) and to receive a food parcel.
- The young man was accompanied to appointments with a homeless team and was given help completing housing application forms.
- The young man was directed to the local job centre, where he enrolled on a construction skills certification course.
- The young man was encouraged to self-refer to addiction services for support.

Outcomes and experiences:

- Compassion Level 1 was recorded as 10 out of 10 by the young man.
- His distress level was reduced to 3 by the end of the DBI.

2.3 Toronto Police Service: Mobile CIT Programme

As part of the research and works associated with the CAST project in Limerick, the Principal Investigator collaborated with the Toronto Police Service (TPS) and learned how the Mobile Crisis Intervention Team (MCIT) programme, a collaborative partnership between six Toronto hospitals and the TPS, is used to improve responses to people experiencing mental health crises. Sergeant August Bonomo, who at the time of the roundtable symposium was the MCIT Coordinator and is now the supervisor of the Incident Response Teams at Toronto Police College, presented at the symposium and participated in the roundtable discussion. Sergeant Bonomo informed the attendees that Toronto MCIT involves 13 teams in 16 divisions that are deployed for 14.5 hours a day, seven days a week. Acting as secondary responders to those experiencing mental health crises in the community, MCIT comprises a mental health clinician and a police officer trained to respond to such situations.

The MCIT programme goals include:

- Providing prompt assessment and support to a person experiencing a mental health crisis
- De-escalating and preventing injury

- Linking people experiencing a mental health crisis to appropriate community services if follow-up treatment is recommended
- Reducing pressure on the justice system
- Reducing visits to EDs

According to Sergeant Bonomo, funding for MCIT nurses and training for new MCIT officers and nurses is sourced from healthcare and regional government supports. The TPS funds the programme's officers and equipment while the data analytics and leadership are funded through the usual hospital and police business sources. Prior to establishing MCIT, the TPS examined various models of crisis intervention, such as response by specialised police officers, response by police in consultation with mental health professionals and response by both police and mental health professionals in partnership. The third option was chosen for the Toronto MCIT. Sergeant Bonomo outlined that the 35,417 mental health calls received by the TPS by November 2021 were categorised into six mental health call types: (i) attempt suicide, (ii) threaten suicide, (iii) person in crisis, (iv) overdose, (v) jumper and (vi) elopee. On average, the TPS attends 97 mental health calls a day, or four calls per hour. However, Sergeant Bonomo cited recent research (Koziarski et al. 2020) that found that in one Canadian Police Service, the number of mental health calls amounted to 10.8% of all calls. Using this figure for the TPS, the number of calls involving mental-health-related calls could range from 110,000 to 220, 000, or 12.5 to 25 per hour, throughout the TPS area. With Ireland's population standing at 5.08 million and the City of Toronto's at 6.3 million, the figures are relative, albeit with varying demographics and emerging factors.

With the wider figures in mind, Sergeant Bonomo informed the symposium attendees that 10,816 calls were attended by MCITs as of November 2021. From these calls, the total number of clients seen by MCITs was 8,602, 3,891 (45.2%) of whom identified as repeat clients. It was recorded that there was almost the same number of calls outside MCIT service hours. The highest number of calls came from the 24 to 34 age group. The most prevalent locations for the calls were (i) private residence, (ii) exterior public space and (iii) shelters. With 60% of MCIT clients diverted away from hospital EDs, the progress and outcome benefits of the Toronto model in alleviating pressure on EDs are evident.

The attendees heard that MCITs are of great benefit to people experiencing mental health crises in Toronto because they bring care to the patient where they are – in the community – and the team takes the time necessary to de-escalate situations and ensure individuals in crisis are safe. This gives rise to better health outcomes for patients and reduces stress on caregivers and service providers.

The roles within MCIT are complementary yet distinctive:

Police Officer	**Healthcare Worker**
Ensures safety and security of everyone at scene	Completes mental health assessment
Utilises Section 17 of Mental Health Act (MHA)	Determines most appropriate continuation of care
Executes MHA forms	Collaborates with officer in apprehension decision-making
Determines need for follow-up	Facilitates improved communication with ED
	Determines need for follow-up

From 2013 to 2018, the citywide MCIT programme served approximately 35,000 persons in crisis. On average, the TPS received 80 calls a day from individuals in crisis, of which MCITs could attend only approximately 19. In 2014, the TPS received a total 1,922,176 calls for service, which included 22,386 ED calls. ED calls include all calls for service. Research outlined by Sergeant Bonomo (Lamanna, Maritt Kirst, Gilla Shapiro, Flora Matheson, Arash Nakhost & Vicky Stergiopoulos – Centre for Research on Inner City Health, St. Michael's Hospital, August 14, 2015) found that police officers find responding to these types of encounter challenging. This may be due to several factors, including a perceived lack of training on how to effectively respond to mental health crisis and uncertainty in relation to making referrals to appropriate community services.

In 2019, as part of the MCIT programme, a Case Manager pilot was introduced to provide short-term case management to clients who interact with MCITs. The pilot involves a social worker/mental health worker providing the following services:

- Contact within 48 hours (two business days) to connect and arrange an in-person meeting
- Short-term case management and peer support for up to three months
- Comprehensive assessment
- Collaborative development of a personal safety plan with a focus on strengths and resources
- Collaborative development and implementation of an individualised recovery/goal plan

Direct support is provided through:

- Education about the nature of mental illness
- Support and education to caregivers and/or the person’s support network, as appropriate
- Development and maintenance of self-management strategies
- Encouragement, emotional support and motivation
- Referring to and accessing other desired or needed community and primary healthcare services
- Assistance to re-establish or mobilise existing connections to community-based mental health services
- Encouragement to explore strengths, resilience and personal responsibility

In addition to MCIT, the TPS developed an innovative community safety and wellbeing initiative entitled Furthering Our Community by Uniting Services (FOCUS). Sergeant Bonomo outlined how this service aims to reduce crime and victimisation and improve community resilience and wellbeing. The model builds on lessons learned through the MCIT programme and brings together the most appropriate community agencies in a weekly situation-table setting to identify individuals, groups and places that are at a high risk of experiencing anti-social and/or criminal behaviour, either as perpetrators or victims. The multi-agency team applies a targeted, wrap-around approach to supporting such individuals. FOCUS Toronto supports local situation tables with coordination, administration and special tools to improve outcomes for vulnerable populations. By leveraging the skills and resources of diverse community partners and using multiple approaches, the initiative can respond to situations that carry an acutely elevated risk, thereby providing the community with the

best possible interventions to respond to safety risks. The first element of response happens within 48 hours of a meeting.

The term 'acutely elevated risk' refers to a situation involving individuals, families, groups or places where circumstances indicate that it is extremely probable that a person or persons will be harmed. Left unattended, such situations require a variety of emergency responses, including, amongst others, police, fire brigade, emergency medical technicians, and mental health and children's aid professionals. The acute nature of these situations is an indicator that either chronic conditions have accumulated to the point where a crisis is imminent or new compelling circumstances have contributed to severely elevating risk. If left unattended, such situations put people at serious risk of either self-inflicting or inflicting physical or psychological harm on others. FOCUS Toronto's membership has grown to over 106 agencies.

In evaluating MCIT in Toronto, Sergeant Bonomo referred to 2014, 2015 and 2017 reports that found that MCIT helps keep care in the community, minimises admissions to the ED and prevents unnecessary interactions with the justice system. Client feedback indicates overall satisfaction with MCIT encounters, including high levels of safety, respect and de-escalation. MCIT delivers an enhanced service and level of care arising from more time spent with clients and persons experiencing mental health crisis, more shared decision making between MCIT and clients, more sensitive communication and less stigma. As a consequence, MCIT has expanded through extended hours of operation, a broader MCIT steering committee, district crisis support officers providing 24/7 coverage, MCIT co-responders having a new uniform and new vehicles with subdued identification markings, a demand-based deployment model being developed and a call diversion pilot project being introduced.

The attendees learned of the 911 crisis call diversion pilot project, which commenced in 2021. The pilot is being evaluated on an ongoing basis, and potential outcomes include:

1. Diverting 911 calls that meet diversion criteria to a crisis worker for a non-police mental health crisis response
2. Improved community experience of mental health crisis response
3. Improved connection to needed services for callers in crisis
4. A proof of concept for a business model that could support government funding applications to enhance and expand community-based responses to persons in crisis to divert, where possible, from police and emergency services
5. A demonstration to the communities of Toronto that their police service takes into account their views, expectations and contributions when it comes to partnering in alternative models of service delivery for responding to community-based crises
6. A model of collaboration between TPS and an anchor partner that benefits the mental health community

2.4 Sequential Intercept Model (SIM) and Biopsychosocial (BPS) Model

Central to the success of the MCIT model in Toronto is the Sequential Intercept Model (SIM) (see Appendix D for details). This model is also aligned to Dr Abbott's work with the Jail Diversion work with Framingham Police Department. The SIM was developed over several years in the early 2000s as a conceptual model to inform community-based responses to the involvement of people with mental and substance-use disorders in the criminal justice

system. The SIM is effective when used as a community strategic planning tool to assess available resources, determine gaps in service and plan for community change. These activities are best accomplished by a team of stakeholders that span multiple systems, including, amongst others, mental health, substance use, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, people with lived experiences and family members. The use of the SIM comprehensively shows how people with mental and substance-use disorders flow through the criminal justice system. Furthermore, it facilitates the identification of resource gaps and support opportunities at each intercept and points to priority actions that can be taken to improve the system for those in crisis.

The symposium heard that expanding the SIM to prevent criminal justice involvement and reduce ED or crisis presentations can be achieved through health sector strategies and police strategies.

Tips for success as per the SIM include:

- Strong support from local official community partnerships
- Law enforcement training
- Behavioural health staff training

A health sector strategy crisis response provides short-term help to individuals who are experiencing a mental or substance-use crisis and can divert individuals away from the criminal justice system. Crisis response models include certified community behavioural health clinics, crisis care teams, crisis response centres and mobile crisis teams. A police strategy crisis response diverts individuals from disadvantaged and vulnerable populations away from the criminal justice system. Proactive police response models include CITs, homeless outreach teams, serial inebriate programmes and system-wide mental assessment response teams.

A study focusing on the implementation of mobile, police mental-health CITs in a large urban centre (Kirst & Francombe et al. 2015) examined programme satisfaction and consumer perceptions in Toronto. The study concluded that (i) consumers felt listened to and respected, (ii) consumers felt they were given options rather than told what to do and (iii) consumers in crisis preferred co-response to police only.

The SIM has linkage to the Biopsychosocial (BPS) model of mental health. The BPS model offers a holistic description of the biological, psychological and social factors that interact to influence the presence and severity of mental health issues in the population (Ghaemi 2011). In the past, psychiatrists, who are trained as medical doctors, saw people who have mental health conditions as being ill in the same way that someone can be physically ill. They saw conditions as a result of disturbances in the brain to be treated with drugs, surgery or other physical means. They reasoned that if something was physically wrong with your brain, it needed a physical cure. The biomedical approach was challenged because it did not take into account the many other factors that can influence mental health, and health in general. Factors such as upbringing, beliefs, coping skills, trauma and relationships did not enter the equation. Mental health encapsulates social and psychological determinants to health as well as just simply a person's biology. The holistic nature of the BPS model

empowers clients' to actively engage in the therapeutic process. It encourages multidisciplinary collaboration and seeks to treat the "whole person".

2.5 Police Service of Northern Ireland (PSNI) Multi-agency Support Hubs

2.5.1 Overview of Support Hubs

The Principal Investigator and the CAST implementation team worked closely with the Police Service of Northern Ireland (PSNI) Multi-agency Support Hub team. The team is based in the Derry/Strabane Community Council area, which is similar in demographics and geographical size to the Limerick division, where the co-response model will be piloted. Chief Inspector William Calderwood and Inspector Michael Gahan co-presented at the symposium and participated in the roundtable discussion. The theme of the presentation was that information sharing is at the heart of effective inter-agency working and the promotion of positive outcomes for vulnerable persons. The multi-agency support hubs were established in 2016 as part of the 'problem solving justice' approach being taken in Northern Ireland to tackling the root causes of offending behaviour and reducing harmful behaviour within families and the community. By 2022, the initiative had grown to encompass nine agencies, and there is now a support hub in every council area in Northern Ireland. Each hub helps vulnerable people to get access to the right support, at the right time, from the right organisations within their local area.

The attendees were informed at the outset of the presentation that only one in five calls for service in the PSNI relates to crime and that 40% of the calls relate to someone with an identifiable vulnerability. The attendees heard that the PSNI defined 'vulnerable' in 2016 as "a term used to describe a person who is in need of special care, support or protection because of age, disability or risk of abuse or neglect". In practice, it was accepted that definitions of 'vulnerability' can be very wide-ranging and open to interpretation. Every participating agency has a slightly different perspective, which can be manifested in different ways, including crisis, trauma and mental health, domestic abuse, addiction, offending and repeat use of emergency services. Community support hubs provide an early intervention for vulnerable individuals identified predominantly by statutory agencies. Support hubs bring together key professionals, including blue light services, health and social care staff and the voluntary sector as a cross-agency group to share information and make decisions to improve a person's situation.

2.5.2 Outcomes

Indicative evidence from support hubs shows how a collaborative approach can produce successful outcomes that cannot necessarily be achieved through one agency. Through outcomes-based accountability, support hub partners demonstrate that the hubs are addressing the root causes of concern for vulnerable persons and making a positive difference to people's lives while reducing repeat demand on public services. The attendees heard that as of January 2022, the Derry City and Strabane Multi-agency Support Hub had seen over 300 admissions, of whom 218 were discharged after six months or longer. The partner agencies collaborate on providing support to between 35 and 45 adults and children at any given time. There is usually a similar number of people on a six-month 'watch list', who have previously exited the support hub case management model. Collectively, the 218 individuals were involved in 3,499 incidents in the six months before they were admitted to

the hub and in 1,679 incidents in the six months after being discharged from the hub, which amounts to 1,820 fewer incidents (52%). This is a remarkable statistic and testament to the merit behind the support hub model.

The Derry/Strabane area had 729 successful partner interactions completed in 2020 and 2021. The person seeking help is referred into the hub through the identification system known as the Strathclyde Model (scoring system based on RFG score – recency, frequency and gravity of occurrences/incidents). The person is asked for their consent to be supported by the hub as the individual's opinions and welfare are at the centre of any decision and action taken. Using formulae, a score of between 1 and 100 is recorded, which acts as a guide for the support hub team. Currently, the team focuses on people scoring 70 or more and then considers if those people meet the criteria for attending the hub. However, other services working with the person (such as mental health or drug and alcohol addiction services) may suggest that there is no need to refer the person to the hub.

For the PSNI, in the context of support hubs, the term 'vulnerable person' equates to a 'person of concern', namely:

a) Young people susceptible to paramilitary influence/attack
b) Young people susceptible to organised crime gang influence
c) Repeat victims of anti-social behaviour
d) Repeat victims of hate crime
e) Older people subject to repeat incidents
f) Repeat victims generally
g) Repeat missing persons
h) Repeat caller to PSNI and vulnerability suspected

The support hub team looks out for signs of the following:

- The individual is considered vulnerable, and the vulnerability has an element of persistence.
- There is an element of risk for the vulnerable individual.
- Services are being repeatedly engaged but levels of vulnerability or risk are not being reduced.
- The wrong agency is being repeatedly engaged to help the vulnerable person.

Chief Inspector Calderwood and Inspector Gahan outlined the following valuable lessons learned on their journey of establishing and implementing the Multi-agency Support Hub:

- Heightened awareness: Lack of lower threshold options
- Community and voluntary sector: Not included and no consistent signposting
- No lower-level problem solving: Not everyone needs Tier 3 (see next section) problem solving
- Support hub referrals: Overwhelmed
- Diluting risk: "If everything is a priority, then nothing is a priority"
- Inconsistent service levels: Lack of quality assurance, inconsistent access to services
- Signposting/referrals: Did not match demand, officers confused and overwhelmed with different pathways

2.5.3 Hub Partners

Support hubs focus on reducing individuals' vulnerability. The following services are currently represented on the PSNI Derry/Strabane Support Hub: health trusts, mental health services, adult safeguarding, drug and alcohol addiction services, EDs, children's service (currently family response team), homeless nurse specialist, learning disability support, probation service, youth justice, Education Authority, Housing Executive, ambulance service, fire service and PSNI. The hub is chaired independently. Each service is represented by the same person at the monthly meetings and reported upon in relevant updates to key workers. The hub is very closely linked to the Family Intervention Service (FIS) and the 16+ Pathways Team.

The hub partners interact with each other outside of the monthly meeting. For example, a PSNI support hub representative communicates with recovery service, crisis service and personality disorder teams based in the area. The presenters described the monthly meeting as a "belt and braces" affair, during which an overview of current activity is given and decisions relating to admissions and discharges are made, but explained that the bulk of the work happens at the meeting between the key workers who are directly involved with the vulnerable person; it is at these meetings that positive action plans are formulated and agreed.

The Derry/Strabane Support Hub model incorporates the deployment of vulnerability navigators (police officers), who review divisional calls and create flags or follow-up calls within the Community Planning & Vulnerability Team, which is referred to as a Tier 2 service. Tier 2 individuals have their additional needs met by universal and targeted, albeit less intensive, services, such as engagement from neighbourhood or crime prevention officers, youth diversion or advocacy services/signposting. A case that persists or escalates or is more complex is classed as Tier 3, which requires an intensive, multi-agency response. The Tier 3 team reports to the sergeant (Community Planning Office). The full-time PSNI Community Planning & Vulnerability Team, which works within the support hub framework, comprises three hub officers and two vulnerability navigators and can be supported by crime prevention officers, juvenile liaison officers and divisional protective services officers. Shaping positive action plans are part of the ongoing work of the hub.

Chief Inspector Calderwood and Inspector Gahan outlined that every agency retains its own information as it is not necessary for all hub partners to be informed unless there is a crucial piece of information relating to vulnerability or risk. Relationships with agencies such as the drugs taskforce is vital to the success of the hub as these partners can share recent trends and practices to enhance the co-response approach. Interestingly, the attendees heard that body-worn cameras were used frequently when officers were reviewing crisis-related incidents, especially by the bridges in Derry city. The Derry City Community Safety Partnership (CSP) CCTV scheme has trained operators who identify crisis behaviour and can log for PSNI officers to view and take action. In place for a number of years (Northern Ireland CJ Act 2011), the CSP helps incorporate key personnel from the local authority, particularly community safety wardens, into the hub.

After a person has been discharged from the hub, the partner agencies continue to monitor, share information and attend meetings for a further six months. If the person's situation deteriorates, they can be brought back to the main cohort. Between 20 and 30 people

would be on the six-month list at any given time. Courts are often informed of safety/action plans before finalising criminal proceedings and can support mitigation.

2.5.4 Call Reduction Statistics

The presenters provided the following table:

Year	No. of support hub cases	Reduction in calls	Percent reduction
2017/18	18	157	79%
2019/20	60	445	47%
2020/21	50	567	55%

Furthermore:

- Since the establishment of the hubs in 2016, there were 54% fewer incidents after six months in the hub.
- Over the six-year period, 172 people were discharged from the hub after six months.
- Some people will remain in hub on a perpetuity list (long-term) due to the nature of risks they face
- The presenters outlined that the Derry/Strabane model has seen the demand from children decrease while the demand from adults has correspondingly risen, which is believed to be due to the post-Covid-19 disengagement from services for adults.

Quantitative data collected for administrative purposes are used to evaluate the support hubs.

2.5.5 Responsibilities of Dispatched Officers

When a dispatch officer attends a call for service and identifies vulnerability, such as an elderly person who may be at risk or a person with mental health issues, they will signpost as per standard protocol. However, if the officer identifies additional vulnerabilities or feels there are underlying issues, they fill in a tick-box Vulnerability Navigator Form and ensure they get consent for referrals. The form is emailed to a section mailbox, after which the Community Planning & Vulnerability Team assign a vulnerability navigator.

While not everyone will elect to engage with the appropriate service, a greater number will do so if the officers persistently and consistently identify appropriate support. Doing so means that (i) there is a greater chance that vulnerabilities will be identified after the police have dealt with a call and (ii) appropriate services and partners can be identified for dealing with vulnerability and that the individual can be connected with that service.

For those situations where complex, enduring and persistent vulnerabilities with risk require longer-term interagency cooperation, safety planning and information sharing, having successfully connected a vulnerable individual with an appropriate service or support greatly increases the effectiveness of Tier 3 problem solving (such as Multi-agency Support Hub).

2.5.6 Responsibilities of Vulnerability Navigator

The vulnerability navigator in the Derry/Strabane model:

1. Identifies partners and services in the district to whom vulnerable individuals can be assigned for help
2. Identifies vulnerability within calls that the police have attended (relating to, for example, addiction, mental health issues, learning difficulty, crisis or even Covid-19); identifies services that may be appropriate for the individuals in question and then makes contact to signpost or refer, as appropriate
3. Reviews CCTV incidents and repeat callers to identify patterns or trends of vulnerability
4. Engages in some Tier 2 problem-solving on complex issues (such as district top callers)
5. Identifies and maintains the rapidly changing list of vulnerable hostel and B&B residents

The vulnerability navigator does not negate the role police officers play in problem solving, signposting or referring. Rather, the role was established to complement the officers' role, thereby assuring the police service that everything possible is being done to identify and act on vulnerability.

3. The Irish Pilot

3.1 Origins

As Ireland's national police force, An Garda Síochána was tasked with implementing a number of recommendations included in *The Future of Policing in Ireland* (CoFPI) report, published in September 2018 by the Commission on the Future of Policing in Ireland. The report outlined the drivers for change and vision for the future of An Garda Síochána. As part of its recommendations, the report focused on inadequate support for people with mental health conditions. As identified by the CoFPI, much of the daily work of Gardaí (similar to other police services) is concerned with non-crime-related activity, such as preventing harm coming to people with addiction or mental health conditions and resolving issues for those who are homeless, the elderly, children and others at risk. The CoFPI has reignited the recommendations of the *Report of Joint Working Group on Mental Health Services and the Police 2009* (Mental Health Commission and An Garda Síochána 2009) and interdepartmental groups established in 2012 and 2018 to examine issues relating to people with mental illness who come in contact with the criminal justice system. These reports were produced in collaboration between the Department of Justice and Equality, Department of Health, HSE, National Forensic Mental Health Service, An Garda Síochána, Office of the Director of Public Prosecutions and Irish Prison Service.

In addition, the recommendations from *Sharing the Vision: A Mental Health Policy for Everyone* (Government of Ireland 2020) informed the preparatory work for the pilot community safety co-response model in Ireland. Recommendation 55 of *Sharing the Vision* states (p. 61): "*There should be ongoing resourcing of and support for diversion schemes where individuals with mental health difficulties are diverted from the criminal justice system at the earliest possible stage and have their needs met within community and/or non-forensic mental health settings.*'' In Ireland, people with forensic mental health needs fall under the remit of the National Forensic Mental Health Service, which comprises a multidisciplinary team led by a consultant forensic psychiatrist. The main function of this specialist service is to carry out assessments and provide treatment for offenders with mental illness.

The General Scheme of the *Policing, Security and Community Safety Bill 2021* (Department of Justice, 2021) states that the prevention of harm will be a specific statutory objective of An Garda Síochána. However, the Bill outlines that this objective will not rest with An Garda Síochána and the Department of Justice alone but will be effectively achieved as a 'whole of government' responsibility with departments and agencies such as health and social services, education authorities and local authorities, the Gardaí and the wider community working together (Head 95, p. 134, Duties of Departments of State and other public service bodies).

The Department of Justice publication *Final Report of the High Level Task Force to consider the mental health and addiction challenges of those who come into contact with the Criminal Justice Sector*, released in September 2022, included a firm recommendation that the CAST pilot project in Limerick should receive the government's full support to allow the development of the concept as an integral part of a diversionary model in Ireland.

The origin of the co-response pilot project can be traced to the following CoFPI recommendation: "*a specialist uniform unit who will work conjointly with health professionals to provide a rapid and integrated 24/7 response to persons with mental health issues" (*Ch. 4 para. 12, Ch. 17 para. 11 and 14). At the core of the project is a desire to explore, identify and operationalise alternatives to arresting vulnerable persons and to enhance assessments and non-conditional referrals that are more aligned to the community healthcare model. Where appropriate, diverting suitable persons out of EDs, Garda custody and, indeed, the criminal justice system more broadly, is a priority. The pilot also seeks to enhance the experience of the person in crisis by equipping Gardaí and co-responders with training that will deliver improved outcomes for the individual and their wider family.

3.2 Community Access Support Teams (CAST): Limerick Pilot Project

3.2.1 Overview of CAST

Entitled Community Access Support Teams (CAST), the Irish pilot project will be implemented in the Limerick Garda Division within the HSE Mid-West area. The aim of the project is for Gardaí to work together with HSE mental health professionals to provide a rapid and integrated 24/7 response to persons experiencing a mental health crisis. Service delivery is on two levels – during the crisis period and post-crisis follow-up. The project will see greater integration across services with an emphasis on collaboration between the HSE, An Garda Síochána and voluntary and statutory agencies. By co-responding to the public based on individual need, a key element of CAST will be to signpost members of the public to the right person, at the right time, in the right place. Central to this will be building on relationships with voluntary and statutory agencies.

To facilitate a supportive, sustainable response to individuals in crisis, a three-tier model is proposed for the Limerick pilot: (i) a call-handling service, (ii) a co-response team (CIT model) and (iii) a community response hub, which is a collaboration between the key agencies in the region. It is important to note that the proposal is subject to approval. Ongoing consultations with crucial pilot stakeholders will mould the final composition and operational rollout of the pilot. It is proposed that CAST will have elements of co-location and co-responding. While the project originates under the umbrella of policing in Ireland, the authors and the implementation team are acutely aware that the project is primarily dependent on clinical services and health-based supports. This dependency and specialisation have resulted in detailed collaborations between the lead agencies (HSE and An Garda Síochána), which will ensure that the implementation of the pilot is progressed. The final design will involve stakeholder inputs that are key to the operational delivery of the proposed service.

CAST Pilot: Three-tier model subject to modifications
Call-handling service
Co-response team (CIT model)
Community response hub

Firstly, it is proposed that during the crisis, the co-response team assess the individual and that the immediate pathway be established and implemented. Secondly, during the post-crisis follow-up, the project seeks to implement a multi-agency approach to responding to

presentations of mental health crisis or referring vulnerable individuals to the appropriate community-based supports available within the Mid-West region. This will be achieved by developing a community hub model that seeks to case-manage, through targeted action plans, individuals who present frequently. Finally, an initial nine-month pre-pilot will be conducted between HSE Mid-West Mental Health Services and An Garda Síochána Limerick Division. The pre-pilot will help to establish demand and capacity requirements. This will be followed by a full-year pilot. The lessons learned from the evaluation of the pilot will serve as the basis for the national rollout of CAST across all Garda divisions and regional health authorities. A particular matrix of calls has been identified as appropriate for CAST deployment. The matrix expands beyond acute psychiatric incidents to calls relating to vulnerability and welfare concerns that warrant early intervention and referral to community-based services.

A key element of the CAST model is the rollout of joint training to a percentage of frontline personnel in An Garda Síochána and the HSE. It is proposed that 15% to 20% of the divisional frontline uniform Gardaí in Limerick will receive specialist training. Gardaí will continue to work with their core units but will be assigned to CAST duty on a rotational basis. The 40-hour training programme will be led by the HSE, which will also have participants undergoing training as part of the CAST pilot model.

3.2.2 Implementation

The following key positions have been identified as part of the CAST pilot proposal: pilot project coordinator, senior social worker, social care workers, clinical nurse specialist, members of An Garda Síochána and support staff. All positions are subject to approval and finalisation of their respective role profiles. In addition to the recruitment of key personnel, it is hoped that the pilot project will establish a joint evaluation team, which will review the pilot's progress.

It is important to acknowledge two broad cohorts of individuals who come to attention due to mental health issues, both of which will be supported by the CAST model. The first cohort comprises individuals who suffer from occasional, mild to moderate mental health issues. This group comes to the attention of Gardaí when their coping skills temporarily break down. The trained CAST personnel will be in a position to provide supports and signposting to most of these individuals in terms of preventative measures, thereby reducing the number of subsequent presentations and interactions with Gardaí or other blue light services. The second cohort comprises individuals who suffer from recurring severe and enduring mental illness. In line with the on-scene, co-response CAST model, this cohort requires more intensive interventions to help them access appropriate care, potentially at the scene or, more likely, during the wider suite of interventions offered through the CAST model. The multi-agency wrap-around approach that includes designing positive action plans for individuals would be more appropriate for severe and enduring cases.

In March 2021, a Joint Steering Committee was established to develop a proposal for implementing co-responder/CITs within the Limerick Garda Division/HSE Mid-West area. The group comprises representatives of An Garda Síochána Limerick Division, HSE Mid-West and, on request, other persons deemed necessary to progressing the pilot project. The Joint Steering Committee has prepared numerous internal reports and proposals to progress the

implementation of the pilot. Members of the group attended the roundtable symposium and workshop events.

3.2.3 Internal Analysis of Mental Health-related Interactions with Frontline Services

Joint Steering Committee

This work included an internal analysis by the Joint Steering Committee of mental health PULSE incidents in the Limerick Division in 2019 and 2020. In total, 1,035 incidents were identified as mental-health-related that required Gardaí to attend. The Principal Investigator engaged with frontline responders, who provided valuable data through a questionnaire. The questionnaire has assisted with the design of the co-response intervention model in the Limerick Division. In total, 136 Gardaí responded to the questionnaire, some of whom were involved in multiple incidents across the 1,035 incidents identified. The questionnaire attracted a 100% response rate. The following results from the questionnaire were useful in the initial design stage of the Limerick co-responder/CIT pilot:

- 72% of the mental-health-related PULSE incidents occurred outside the hours of 07.00 and 17.00.
- In the incidents where arrests were made, 77% of respondents stated that if there had been an alternative to arrest, they would have used it.
- 64% of respondents felt that a co-response model would give rise to better outcomes.
- 53% of the individuals involved in the PULSE incidents were aged between 30 and 60 years.
- 61% of the individuals involved in the PULSE incidents were male.
- Alcohol abuse and drug dependency featured prominently in the incidents.
- 79% of respondents felt current legislation relating to mental health was inadequate.
- 40% of respondents would like additional training in mental health.
- 31% of respondents stated they would be interested in applying for the pilot co-response team.

In October 2021, to help with the design of the pilot, the Joint Steering Committee examined available crisis presentation data to accurately identify the volume of mental-health-related incidents within a defined four-week period and analysed the crossover between mental health services and the related interaction with the criminal justice system. The examination concluded that 221 incidents were directly suited to the CAST model for the four-week period and 102 incidents were classed as acute mental health presentations. In the period examined, 257 contacts were made with the out-of-hours Crisis Service team in Limerick.[6] These presentations comprised 148 individuals (of whom 20% had between two and five presentations and 2% had six or more presentations).

There were considerable crossover contacts between Gardaí and mental health services in Limerick during the defined period. The main reasons for Garda involvement were ambulance assistance, welfare checks and presentations to the Garda station, where they were detained under the Mental Health Act. Without expanding on the wider data attained, the Joint Steering Committee agreed that the CAST project had the potential to provide meaningful interventions earlier in the individual's pathway, which would yield a better

[6] Operated by HSE Mental Health Services in the Mid West

outcome in the long term and, in some cases, prevent exposure to the criminal justice system.

Lived Experience Interviews

At the heart of mental health services is a strong ethos of including lived experiences in the development and, latterly, delivery of such services. To inform this process, the Joint Steering Committee carried out lived experience research. It was clear from discussions with parties that a crisis that requires intervention by the Gardaí brings with it extreme fear for the individual. The word "terror" was used several times. Not only is the person in extreme mental distress, and possibly experiencing severe psychosis, but the intervention of the Gardaí, or those "in uniform", can add to their feelings of fear and exacerbate the situation. According to one of the roundtable participants:

> "From my perspective, if somebody who's dealing with a mental health issue, substance abuse issue, something of that nature, it's really helpful to have them there, to be able to be another voice that's not uniform, not somebody who's kind of a little bit more intimidated than the public. They break the ice for us. They make it easy for that person to sit there and say, okay, they are here to help me. They are here to get me the help that I need when somebody's dealing with the mental health crisis".

The parties who contributed to the lived experience research felt it was imperative that families be supported before, during and after a time of extreme crisis that involved Gardaí intervention. From the perspectives of those with lived experiences and their families, the potential benefits of CAST are twofold. Firstly, those interviewed considered that the presence of a person who could "be on their side", someone not in uniform and who clearly understands mental distress and mental illness, would potentially ameliorate the fear and turmoil associated with experiencing an acute crisis.

Section 12 of the Mental Health Act 2001

The Joint Steering Committee of the CAST project made a submission to the current review of the Mental Health Act 2001 as part of the public consultation on draft legislation to update the Act. The Mental Health Act 2001 sets out the law on how and why an individual is admitted to a psychiatric setting and the rights associated with the layered process. The review of the Mental Health Act is primarily concerned with revising existing provisions in the Act and updating and adding provisions in the context of the recommendations of a 2015 report (Department of Health 2015). The 2015 report contained 165 recommendations. The expert group that reviewed the Mental Health Act 2001 and the current Heads of Bill to amend the same Act recommends that the only person to sign applications for involuntary admission to an inpatient centre should be an authorised officer of the health service. The rationale for this is that it will have the effect of lessening the burden on families and carers while reducing the involvement of Gardaí in the admission process. This area was further explored during the practitioner workshop, which is covered later in this report.

Under section 12 of Mental Health Act 2001, a member of An Garda Síochána can make a decision to take into custody a person believed to be suffering from a mental disorder. The rationale for this decision is reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder, there is a serious likelihood of

the person causing immediate and serious harm to themselves or to other persons. Where a person has been taken into custody and brought to a Garda station, a member of An Garda Síochána will make an application for a recommendation to a registered medical practitioner to have the person admitted involuntarily. The application is made via precise documentary application.[7] If an application for a recommendation is refused, the person subject to the application shall be released from custody immediately. All applications under section 12 made to and refusals by registered medical practitioners are recorded on PULSE (Police Using Leading Systems Effectively) to enable An Garda Síochána to comply with its obligations in regard to the disclosure of previous applications for involuntary admission. The registered medical practitioner who attends the Garda station and refuses the application frequently issues a letter for the person subject to application to attend a community-based service at a subsequent date.

The submission identified that the pilot would not fundamentally change the existing legislative and procedural machinery associated with section 12 of the Mental Health Act 2001 but would enhance the service and, in suitable cases, divert persons in crisis away from ED and Garda custody. The latter provision has received significant scrutiny in terms of its use per annum by members of An Garda Síochána. Based on national and Limerick Garda Division figures provided by the Garda Síochána Analysis Service, the table below shows the number of arrests made nationally and in the Limerick Garda Division under section 12 of the Act from 2018 to 2021. The use of section 12 of the Act is a last resort for An Garda Síochána.

Year	National	Limerick Division
2018	4,002	174
2019	4,816	223
2020	5,756	252
2021	6,315	234

In his most recent work in the CAST implementation role, the Principal Investigator attained data pertaining to arrest under section 12 of the Mental Health Act 2001 over a calendar month in 2022 in the Limerick Garda Division. This analysis is separate to the yearly figures given above and focused on capturing data relating to time spent by frontline Gardaí in this area. The methodology used was a short questionnaire for those members of An Garda Síochána who dealt with the 22 incidents identified over the month. The questionnaire was completed by 18 Gardaí, some of whom were involved in multiple incidents. The following results were recorded:

- 12 of the incidents occurred between 17.00 and 07.00.
- 10 of the incidents occurred between 07.00 and 17.00.
- In 13 of the incidents, attending Gardaí were aware that there was a mental health concern in respect of the call prior to arrival.

[7] MHC Form 3, Application (to a registered medical practitioner) by a member of An Garda Síochána for a recommendation for involuntary admission of an adult (to an approved centre). The recommendation by the registered medical practitioner is made on MHC Form 5, Recommendation (by a registered medical practitioner) for involuntary admission of an adult (to an approved centre).

- In 16 of the incidents, attending Gardaí made a decision to arrest under the Mental Health Act in less than 10 minutes.
- In 9 of the incidents, attending Gardaí said it was over 90 minutes before a Garda station assessment was completed.
- In 18 of the incidents, attending Gardaí stated that the individual arrested was not referred for assessment to a psychiatric setting.
- In the four incidents where Gardaí attended a designated psychiatric assessment centre, no respondent stated they were there for longer than two hours.
- In 15 of the incidents, attending Gardaí stated that a disclosure was made by the individual or a family member to them in respect of a mental disorder or diagnosed condition.
- In 7 of the incidents, attending Gardaí stated that individuals detained were under the influence of alcohol or drugs.
- In 10 of the incidents attended by Gardaí, the time from dispatch to completion was between three and five hours.
- After 15 of the incidents, attending Gardaí had no interaction or follow-up with the Individual or their family.[8]

3.3 Roundtable Discussion

3.3.1 Overview

At the conclusion of the symposium, some of the attendees who were involved in the CAST pilot model gathered for a roundtable discussion with the attending international collaborators and experts. The aim of the roundtable discussion was to draw on existing international research and experiences to gain an understanding of some of the challenges and successes associated with implementing a co-response model. Chaired by Professor Stephen Morreale (Chair and Full Professor of Criminal Justice at Worcester State University and Fulbright Specialist), the discussion centred on exploring practitioner experiences and observations from the field.

3.3.2 Roundtable Topics

The specific topics discussed at the roundtable were:

- Recruitment and introducing a co-response programme for the first time
- Clinical supervision and the clinical governance structure, which is a new departure when introducing a multi-agency approach for the first time in Ireland
- Uniform attire, logistics and safety concerns relating to co-responding models
- Information sharing between agencies and issues of privacy
- The role of evaluation and research after the pilot launch
- Challenges surveying this cohort of individuals
- The synergistic benefits of a multi-agency approach
- Cost-benefit analysis of co-response programmes
- Debriefings
- Lessons learned by co-responders
- Practitioner guidance for enhancing co-response programmes

[8] For clarity, no mandatory call-back policy exists for members of AGS attending mental-health-related calls.

Notes taken on some of these topics are given in the sections to follow.

Recruitment

This is a new departure and service for Ireland, which traditionally values a recruitment process that looks at people with lived experience.

In Toronto, most of the nurses have significant experience in community and clinical health, mental health and emergency medicine. Many of the nurses start in emerging medicine and then specialise in forensics. Those working in the MCIT programme have at least five years' experience but generally more.

Clinicians can be hired directly in the US by local police forces, which have anatomy to do so but, unlike a national police force, do not have standard policies in this regard. This is in contrast to the Irish model because of the primary role of the HSE. In the US and Canada, suitable qualifications include social work, clinical psychology, forensic psychology, clinical mental health, mental health and counselling. Current graduate education in the US is not adequately preparing students for these opportunities, and a multidisciplinary course would be beneficial. There was no corresponding qualification for crisis intervention until 2022, when the Center for Crisis Response and Behavioral Health was established at William James College in Massachusetts.

Workforce challenges exist in Ireland. If suitable candidates do not emerge, it may be necessary to rotate from existing resources for the pilot and supplement to the core service. The non-alignment of the working tours of the lead agencies can be problematic. Currently, in Ireland, both core policing and nursing share the same 12-hour roster between 07.00 to 19.00 and 19.00 to 07.00. This will benefit the CAST pilot implementation.

Uniform, Logistics and Safety Concerns

In Toronto, it was decided to put the officers back in uniform while the nurses could wear a more standard look. This decision went against the ethos for many co-response programmes but was based on the volume of calls and the fact that teams are not always going to be able to respond. While frontline officers attend many mental health calls, the TPS did not want to create a perception in the general public that if the MCIT did not arrive on scene, the service was inadequate. The solution was to go with a hybrid uniform that is distinguishable from the police uniform.

At the outset of the implementation of the Toronto model, nurses were expected to work police shifts. This was such a huge issue that it became impossible to recruit nurses. The importance of building flexibility into the model was a lesson learned by the Toronto operational committee.

Sustained funding over the duration of a pilot scheme was cited as being important, especially in the case of Ireland, where the pilot programme involves statutory agencies rather than private funding.

It was accepted that police officers perceive mental health-related callouts as particularly high risk and that the adversarial procedural and clinical nature of the field leads to concerns over a lack of expertise in the area.

Practitioners cited research supporting reductions in the use of force when co-responder models were in use.

Synergistic Benefits of the Multi-agency Approach

It was advised that making debriefings after critical incidents a mandatory component of the co-response programme would be very beneficial. Having a co-location facility for the pilot, if feasible to do so, was highly recommended so that the multi-agency partners would have a suitable location for such briefings.

The presenters agreed that the CAST project would require a joint policy document that included standard operating procedures and memorandums of understanding (MoUs) so that there could be no ambiguity in respect of call types or processes. The dissemination of policy as part of the joint training would be advisable. The framework and structure of the support hub would be included in this document.

Codifying specific police responses to persons with mental health conditions is an example of problem-oriented policing. The presenters felt that the emerging police-based specialised mental health response – involving clinicians or social workers with mental health training – is delivering positive outcomes. Establishing a co-located or remote consultation and advice to first responders is providing an informed and emphatic approach to this area.

Police departments coordinating with independent mental health systems and workers to cooperate on emergency responses in the field, with mental health workers as primary agents, is also a progressive model that will alleviate pressures from the acute services. The DBI model and the mobile crisis units fall within this category.

Information Sharing

With the emergence of the support hub, other jurisdictions have come to realise that the sharing of information can be a struggle because of issues of privacy. This is problematic as co-responders like to share information and get the job done right. In Framingham and Northern Ireland, consent is sought for hub support. With some of the highest-risk clients, this is attained before the clients reach a crisis so that they do not have to be asked to sign a waiver while in crisis. This could be achieved only by an established co-response programme.

Many of the involved agencies have information-sharing agreements limited to the scope of the law written into their MoUs. In Canada, the Health Privacy Act is permitted in emergency situations, and the criminal code trumps all other laws. Healthcare custodians who keep that information must disclose to the police if they meet certain criteria, and this is used as a joint risk analysis.

In Scotland, multi-agency public protection arrangements (MAPPA) are used to provide ministerial guidance to responsible authorities on the discharge of their obligations under section 10 of the Management of Offenders etc. (Scotland) Act 2005. This system looks at violent and sexual offenders, people who have had a conviction in the past and are considered at risk, and the single determinant of whether or not it works is information sharing. Information that is shared under MAPPA remains the responsibility of the agency that owns it, and sharing it must be in accordance with the law.

Role of Evaluation and Research

It was agreed that there are two undeniable data points that Ireland needs to consider and capture in order to establish if the pilot has value: diversion from arrest and diversion from EDs. An important question to ask is "If the co-response team were not there, would the incident likely have resulted in an arrest or hospital admission?"

It is important to note that the pilot will involve two different types of agency – policing and healthcare, both of which will capture data. Each side will have different metrics and objectives but it will be crucial to share the outcomes and crossover data.

The roundtable discussion concluded that we know enough about crisis teams from around the world to know they have positive outcomes but to be sure that the concept will work in Ireland, there are two important criteria to apply. The first is that an independent evaluator is assigned to the pilot and the second is that a control group is used to examine whether or not medication works because some medications can make people feel worse, not better.

Cost-Benefit Analysis of Co-response Programmes

People at high risk of relapsing and people with multiple service needs tend to be involved in the three systems relevant to this pilot: mental health, substance abuse and criminal justice. Therefore, the investment of new resources in the pilot can be analysed in cost-benefit terms for both policing and healthcare. While the policing side can be captured relatively easily, the mental health services side can be more complex. As it is accepted that the CAST pilot will involve more clinical resources from the HSE, it is, therefore, vital to evaluate the benefits of the pilot to each service, both of which are already under sustained pressure in terms of presentations and resource capacity.

There was agreement from the roundtable discussion that co-response programmes are initially expensive as populations include people who use and reuse services to a large extent. When systems are fragmented, access to the relevant services can be difficult. The CAST pilot will include the cost effectiveness of the model as part of the evaluation.

Practitioner Guidance for Enhancing Co-Response Programmes

Framingham Police Department has successfully embedded the ethos of diversion into its culture and has reaped the rewards. Diversion is now commonplace even in incidents where no clinician is present.

The roundtable participants complimented the long-term, strategic collaborative planning of the CAST project. Other jurisdictions expressed regret that they did not approach implementation in the same manner as they now find themselves dealing with the same people over and over again. TPS advised that as part of the overall vision for the programme, it is important to have strategies in place for training, data management, quality improvement and evaluation.

There was a consensus that having more clinicians on the co-response team would give rise to better interventions and care.

It was advised that mental health issues and addiction are like any other medical condition: early intervention improves outcomes, and stigma is the number one reason why people do not ask for help.

Listening skills were cited by participants as being of high value – people need someone to bear witness to their lives, to acknowledge their worth.

Lessons Learned by Co-responders

Each crisis is unique, and people respond differently to trauma and crises. According to one participant of the roundtable discussion, "Every caller is different … so is our response…".

Without some semblance of a relationship, trust cannot develop. In co-responder work, it is crucial to show empathy (the ability to emotionally understand what other people feel, to see things from their point of view and to imagine yourself in their place). Compassion and resilience are also required.

People are desperate to be heard, and an intervention is enough to stabilise the situation, thereby preventing unnecessary trips to EDs or arrests being made.

It takes anywhere from two to three years to help someone who has had significant mental health issues. A one-hour encounter – a crisis intervention – is not going to be enough. The pilot should seek to stabilise an acute crisis and then pass it on to the next level, which is the crisis response.

It is important to commence the support hub element of the pilot programme with a defined number of clients that is manageable, realistic and measurable.

Development of Practical, Quick-Reference Guide for Frontline Police Officers

The roundtable heard from Professor Gautam Gulati, a practising consultant forensic/general psychiatrist with the HSE and Chair of the Faculty of Forensic Psychiatry at the College of Psychiatrists of Ireland. Professor Gulati highlighted the commendable people-centred approach to policing in Ireland and discussed the need for informative tools to develop this further. Professor Gulati referenced his collaborative work in building psychiatry algorithms for primary care that provided a practical, quick-reference guide to psychiatric assessment and mental healthcare in general practice (Gulati et al. 2020). This work concentrated on healthcare professionals to enable that cohort to quickly assess mental health problems, make informed treatment decisions and understand when referrals to specialist mental health services are appropriate. Professor Gulati proposed that a similar practical, quick-reference guide for frontline police officers would help first responders who have limited training to identify mental health problems and make more informed decisions or simply identify a specialist need. A simple example would be a quickly accessible guide with algorithms and flowcharts that specify symptoms associated with different conditions and the medication and advice linked to each presentation. This tool would not replace clinical care but would assist frontline Gardaí at the initial presentation.

3.4 Programme Coordination Considerations

Programme coordination issues relating to administration, operations, client feedback, challenges and emerging trends, as listed below, were cited by the roundtable participants as being worthy of consideration for the Irish pilot.

Administration

- Setting strategic goals and vision
- Governance
- Accountability and oversight
- Quality improvement and innovation
- Data collection and analysis
- Managing partnerships
- Funding

Operations

- Recruitment
- Accountability and oversight
- Consultations with key stakeholders
- Collective bargaining agreements
- Ongoing training and development
- Managing interpersonal relationships
- Coordinating with nurse managers
- Managing different organisational and sectorial cultures

Client Feedback

- Gathering feedback can be challenging
- Difficult to survey people in crisis
- A co-response model does not provide ongoing support
- Stigma is a barrier
- Previous efforts include focus groups and paper surveys
- Families are crucial to the care of the individual

Other Challenges

- Continue to address challenges and complexities of a cross-sectoral partnership
- Hospital/ED interface (wait times)
- Rising numbers of person-in-crisis calls for service
- Standardisation
- Scope creep
- Information strategy around public awareness – what the service is and is not
- Lack of funding

Emerging Trends

- Special populations
- Access to services
- Social determinants of health
- Collaboration across sectors
- Technology

3.5 Practitioner Experiences – Workshop

On 19 August 2022, a practitioner workshop was hosted by the Principal Investigator at the University of Limerick. A follow-on from the roundtable event, the workshop brought together frontline practitioners in the area of mental health crisis response and frontline police operating in the Mid-West to share experiences and expertise and discuss the feasibility of the CAST pilot project in Limerick. The workshop heard from Ms Sarah Kelly, a former co-responder clinician with the Charleston Police Department in South Carolina and now residing in Ireland. The workshop also heard from Mr Paul Guckian, HSE Mental Health Services, who presented on the role of the authorised officer, and from Ms Anne Marie Sloane, Crisis Mental Health Service, University Hospital Limerick, who presented on crisis liaison nurse functions. The Principal Investigator presented on the CAST design and his experiences of visiting other co-responder programmes beyond those present at the roundtable event. Following the presentations, the attendees discussed the operational implementation of the CAST pilot project.

Co-responder Experiences in the Charleston Police Department

Ms Kelly has a wealth of experience as a clinician in ED psychiatric care and community mental healthcare in Massachusetts, from jail diversion programmes and CIT training in Virginia, as a Community Mental Health team member with the NHS in London and, most recently, as an embedded clinician in the Charleston Police Department (CPD), South Carolina. The presentation focused on Ms Kelly's time with CPD and included clinician needs, training, co-response coordination, crisis response, data collection, benefits and challenges. The Charlestown co-responder model was collocated within CPD's Central Detectives Division with one sergeant, five detectives, five civilian victim advocates and one clinician. The clinician is employed by the Department of Mental Health. The CPD model has a requirement for clinician familiarity with trauma therapy and crisis/suicide assessment. Ms Kelly stated that it is vital to get "the right fit" for rapport and trust within the co-responder team. The training programme is a comprehensive package that includes ongoing mental health training for officers for recertification.

The role of the co-responder includes providing occasional support for negotiators, out-of-hours support for critical incidents, education delivery about mental illness, substance abuse, trauma, officer wellness, critical incident debriefings for other departments and referrals to other service providers. The response can be initiated by either the police or a mobile crisis (family, mental health services). The on-scene assessment requires a police officer to be present so collateral information is attained. The determination of level-of-care options include divert to outpatient, voluntary hospitalisation, drop-off at clinic during business hours, involuntary commitment or arrest (jail term or possibly mental health court). Ms Kelly described the use of telehealth nursing, which utilises technology, specifically video conferencing, to deliver specialist-nursing care to individuals in crisis.

CPD introduced data evaluation improvements in 2021, which helped identify individuals who present frequently and the time police officers spend on the scene. The introduction of cross-reference analysis with Department of Mental Health records has helped make a case for future funding. CPD analysis from July 2021 to May 2022 shows that over 1,000 mobile crisis responses (which includes some co-responder clinician responses) were made in Charleston and Dorchester counties (population of approximately 570,000, which is close to twice the population of the Limerick Garda Division). Outside of crisis interventions, the

clinician attached to CPD conducts, on average, 30 mental health follow-ups a month. The analysis concludes that mobile crisis saves hospital systems millions of dollars each year in diversion efforts. The benefits of having the appropriate "boots on the ground" helps with intervention before decompensation. The challenges identified through experiences included recruitment; a lack of psychiatric inpatient beds; and compliance with the Health Insurance Portability and Accountability Act of 1996, a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

The Role and Process of the Authorised Officer

The role and process of the authorised officer (AO), as per the Mental Health Act 2001, was outlined by Mr Paul Guckian, Authorised Officer and Principal Social Worker within the HSE. An Authorised Officer is a mental health services staff member who is authorised to make an application to a registered medical practitioner for the involuntary admission of an adult to hospital. Section 9 of the Act lists applicants – relatives, AOs and members of An Garda Síochána – who can apply to a GP to commence the process of an involuntary admission. AOs are registered nurses, social workers, occupational therapists or psychologists who have worked for at least two years in community mental health services. AOs undergo specific training. Because of the independent, statutory nature of the role, an AO is not influenced by anyone to arrive at a specific outcome and places a strong emphasis on the service user's human rights. The AO is directly involved with individuals and families in a time of deep crisis and has a supportive role for family/carers.

On receipt of a written referral for an AO, an assessment from the appropriate person (community mental health teams, key worker or GP) takes place. The AO function is not an on-call service as the AO must review the referral, link in with the key worker, review history, if any, and assess risks before any intervention starts. The AO must assess whether or not the individual applicant has a mental disorder, and if not, recommend more relevant supports, either within or outside mental health services. If a mental disorder is identified, the AO must look for the least restrictive options. The report of the expert group on the review of the Mental Health Act 2001 (Department of Health 2015) made a number of recommendations pertaining to the AO role, including that all applications go through the AO route, thereby ensuring a 24/7 service and removing An Garda Síochána from the current involuntary admission process. The 2015 report is prevalent once again as the reform of the Mental Health Act 2001 is ongoing and represents a key step in the transition towards a person-centred, rights-centred and recovery-focused service.

The current AO framework is not resourced to deal with the number of involuntary admission applications. If, as proposed, the AO were the only designated officer to process the applicants, it would cause significant problems as it is not an on-call service at this time.[9] The proposed changes to the Mental Health Act will hamper the ability of AOs to make quick decisions in cases of serious mental illness. If a patient is found to be suffering from a mental disorder and fulfils the criteria for detention, it is critical that the process occur quickly. In the main, this currently rests with An Garda Síochána as people in these

[9]In the last two years, the number of AOs available to the state has fallen from 159 to just 126. Parliamentary Question: To ask the Minister for Health the number of AOs in each community healthcare organisation nationwide in 2019, 2020 and to date in 2021. 26th November 2021 PQ Number: 54675/21.

situations are understandably frightened or distressed and may be struggling to trust those around them.

Crisis and Liaison Mental Health Service

The final presentation in the workshop was delivered by Ms Marie Sloane, who is attached to the Crisis and Liaison Mental Health Service at the University of Limerick and who is actively involved in psychiatric assessment and frontline care in the Mid-West. The attendees heard that the first crisis nurses took up their roles in the ED in 1999 and aimed to reduce inappropriate admissions to psychiatric units and improve the expertise available to ED staff in assessing and managing acute presentations, especially out of hours. The primary focus of the service is to resolve acute issues, where possible; arrange mental health service follow-up, when appropriate; and establish links to addiction services and social care workers. A typical Liaison Psychiatry team includes a consultant, a non-consultant hospital doctor, ED nurse, a community nurse specialist and a psychologist. The service now operates 24/7 since 2021 unless there are staffing shortages.

ED presentations are generally classed as crisis presentations and include deliberate self-harm/suicidal thoughts, mental/behavioural disturbance due to illicit drug and alcohol abuse, depression/mania/psychosis and, sadly in some cases, all of the above in one presentation. The attendees agreed on the importance of involved parties (such as family or carers) and the general population understanding that under the current statutory provisions, involuntary admission requires the presence of a "mental disorder" as outlined under section 3 (1) of the Mental Health Act 2001. The provision states that a mental disorder means:

> "mental illness, severe dementia or significant intellectual disability where because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission and the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent."

Mental illness, severe dementia and significant intellectual disability is further explained under the Act but the definitions are specific to acute conditions, and not every individual in crisis will meet the criteria outlined. The Mental Health Act and involuntary admission is not suitable for a person who is suffering from a personality disorder, is socially deviant or is addicted to drugs or intoxicants. The latter presentation results in dual diagnosis. Dual diagnosis is the term used when a person suffers from both a substance abuse problem and another mental health issue, such as depression or anxiety. Most mental health services and addiction treatment centres in Ireland are currently not organised to treat such people holistically. However, of significance is the development of a pilot project aimed at helping people who are struggling with drug addiction as well as mental health issues in Limerick and the Mid-West (O'Keefe 2022). With the implementation of the CAST pilot, there is an opportunity to educate and foster an understanding of the existing process and support any other initiatives in the area. The attendees discussed the MoU between An Garda Síochána

and the HSE in relation to the removal to or return of a person to an approved centre in accordance with sections 13 section 27 and the removal of a person to an approved centre in accordance with section 12 of the Mental Health Act 2001. This is a key document that can act as a platform for further cooperation and enhancement of service delivery.

Visits to Other Co-responder Programmes

The Principal Investigator had the opportunity to visit and engage with co-responder programmes outside the Irish jurisdiction, some of which were represented at the roundtable symposium event including Framingham Police Department in Massachusetts and Derry City in Northern Ireland. The Principal Investigator also had the opportunity to observe co-response teams in action in Boston (Boston Police Department [BPD]) on 22 November 2021 and in Los Angeles (Los Angeles Police Department [LAPD]) on 30 July 2022.

The BPD's Co-Response Program was established in 2011 as a collaboration between the BPD and the Boston Emergency Services Team (BEST) based out of Boston Medical Center. As part of the programme, BEST clinicians ride along with BPD officers and respond with them to calls involving people experiencing mental health crises. The goal of the programme is to provide real-time, community-based psychiatric crisis services intended to stabilise non-violent persons experiencing psychiatric emergencies. The benefits of such a collaborative response include fewer arrests of mentally ill people in crisis, fewer trips to the local EDs and reduced time for the officers handling psychiatric emergencies, thus freeing them to return to calls for service. The Principal Investigator was particularly struck by the resource-intensive approach to homeless agencies and services with full-time liaison officers along with Encampment Response Teams (ERT). Such resources are required to deal with the large-scale on street homeless communities, which have significant mental health problems. The Principal Investigator witnessed first-hand the impacts of homelessness and the east coast opioid crisis and the correlation to mental health.

The Principal Investigator visited the Mental Health Evaluation Unit at the LAPD headquarters, where 89 specially trained police officers were collocated with 42 clinicians in a large-scale response to crisis presentations in Los Angeles. A multi-layered approach includes triage by trained dispatchers, a 24-hour triage line, co-response teams, follow-up case managers and focused community engagement. The Principal Investigator observed the mental health professionals who were embedded in a shared open-plan office space. This environment is conducive to controlled information-sharing and joint decision-making. The Principal Investigator attended several calls and observed the clinicians taking the lead in managing individuals involved in a police response. Dating back to the 1960s, the unit is one of the longest-established programmes of this type. The Principal Investigator observed comprehensive data collection and information-sharing procedures, which linked in with licenced firearms units and threat assessment teams. The programme has a robust training strategy, which includes 40 hours of mental health intervention training and frequent refresher courses.

The programme's SMART (Systemwide Mental Assessment Response Team) component was established to prevent unnecessary incarceration and/or hospitalisation, provide alternative care in the least restrictive environment and support patrol. In addition, CAMP (Case Assessment Management Program), which was established as a follow-up to SMART, investigates high users of emergency services, the use of force, targeted school violence,

incidents with increasing risk behaviour and incidents involving weapons and helps to link individuals to resources. The Principal Investigator learned that the LAPD responded to 18,230 calls for persons in a mental health crisis in 2021. SMART handled 7,469 of those calls, of which 6,138 resulted in involuntary hold applications (similar to section 12 of the Mental Health Act 2001 arrest in Ireland). The Mental Health Evaluation Unit seized 836 weapons, including firearms, throughout the same period (2021), which is a function of the co-responder model not observed elsewhere by the Principal Investigator.

Mid-West Regional Drugs Task Force (MWRDAF) QR (Quick Response) Code Initiative

As part of the practitioner workshop discussions, attendees from An Garda Síochána informed the group about the launch of a new poster and business card with its unique QR code, which links people directly to the drug and alcohol support services available in the mid-west region. This initiative is currently in place within the Limerick Garda Division and is linking individuals who are released from Garda custody with information around supports and networks. This initiative was identified by the group as a useful tool for first responders to highlight that supports can be of tremendous benefit to individuals and families who may be experiencing mental health problems or situational trauma[10]. The services operate on an outreach basis so disseminating the card code is the only function of the police officer, and information is not shared.[11]

[10] Situational trauma includes emotional or psychological trauma as the result of extraordinarily stressful events, family breakdown or addiction, all of which can shatter an individual's sense of security, making the person feel helpless and anxious.

[11] On the basis that students use their phones for almost everything, the QR code initiative was proposed by Claire Kearns, Nurse Practice Manager with UL Student Health Centre, and developed by the MWRDAF 3rd Level Drug and Alcohol Network in conjunction with Sergeant Shane Davern, AGS Limerick.

4. Conclusions and Recommendations

The roundtable event concluded that to ensure the best outcome, it is essential that all agencies involved in the CAST pilot contribute what they can to the design and delivery of the programme. As the agencies work together under this joint approach, each partner organisation will be fully aware of the complex issues faced by clients. This helps to paint a complete picture for the service provides and, ultimately, makes for a better service for the client. Gardaí need to avoid subject dependency within the support hub and during an on-scene response. The relevant professionals should lead the action plans to help individuals to recovery. The redirection from Gardaí is a key objective; within the co-responder/CIT programme, it is the responsibility of the police to present risks and hazards around mental health crisis and to clinical responders.

The CAST pilot will look to develop a process whereby the transfer of responsibility is reached as quickly as possible. The implementation of a co-response crisis intervention model in Ireland has enormous potential to enhance the approach taken to dealing with vulnerable persons and to expedite access to aftercare. The roundtable event and workshop with practitioners were unique and timely opportunities to gather critical information to help build the model of co-response in Ireland. The roundtable participants were certain that the long-term, strategic collaborative planning of the CAST project is a blueprint for future co-responder programmes. While it is accepted that the process is slow and methodical, other jurisdictions expressed regret that they did not approach implementation in the same manner. The Joint Steering Committee received praised for aligning its approach to the contradictory Latin phrase *Festina Lente*, which translated as “make haste slowly”. The CAST project is a remarkable opportunity to make a meaningful difference in Ireland to many people and families experiencing difficulties as a result of mental health-related issues.

This report will support the objectives associated with the Irish co-response crisis intervention model, which can be set out as follows:

- Provision of prompt assessment and support to a person experiencing a crisis
- De-escalation and prevention of harm to persons in crisis, first responders and the public
- Capacity to link people in mental health crises to the appropriate community services if follow-up treatment is recommended
- Development and maintenance of self-management strategies
- Intensive case management support hubs
- Provision of high-level training that supports a new emphatic approach
- Diversion from custodial settings and the criminal justice system
- Reduction in the number of the visits to Garda stations and psychiatric units
- Support and education
- Dissemination of appropriate information
- Enhancement of the human rights of persons experiencing crisis and vulnerability
- Provision of a 24/7 service nationally for more positive outcomes
- Collaborations between state agencies and strengthening of multi-agency approach

The endorsement of the CAST pilot in the High Level Task Force Final Report identified the concept as an integral part of a diversionary model in Ireland (Department of Justice 2022).[12] There is significant momentum and interest in these areas at this time. It is recognised that the solutions to these issues rest with the community and associated healthcare services and supports that rely heavily on the clinical expertise and knowledge of the HSE. The roundtable concluded that there needs to be a balance between urgency and diligence as implementation commences.

Recommendations

- Establish a support hub as part of the co-responder programme.
- Establish a co-response on-scene crisis intervention model.
- Roll out call dispatcher training.
- Develop a distress brief intervention model for Ireland.
- Strengthen community linkages and partnerships.
- Deliver international-standard training.
- Provide valuable information to those in crisis and their families at an early stage.
- Embrace criminal diversion and discretion.
- Recruit the right personnel for the co-responder/CIT programmes.
- Evaluate the CAST pilot at a high level.
- Ensure the lower-level problem-solving services are resourced.
- Design a hybrid uniform and minimise identification markings on vehicles to support de-escalation.
- Deliver a communication guide and signs of safety/ACE (Adverse Childhood Experiences) training.
- Develop an MoU joint policy document.
- Design and disseminate an algorithm guide for frontline Gardaí.
- Establish a mandatory review for incidents involving persons with licenced firearms.
- Adopt data-driven solutions.
- Introduce adequate legislation for data-sharing between appropriate services.
- Enhance the human rights of persons experiencing crisis and vulnerability.
- Conduct further research.
- Disseminate a clear objective and function of the services.
- Provide effective community-based services.
- Develop family supports and gather client feedback.
- Conduct a post-implementation review.
- Focus on health-led solutions.

[12] This report considers the mental health and addiction challenges of those who come into contact with the criminal justice sector.

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Appendices

Appendix A: Symposium Presenters, Invited Guests and Participants

Presenters

- **Prof. Stephen A. Morreale**, Event Moderator; Chair and Full Professor of Criminal Justice at Worcester State University and Fulbright Specialist
- **Dr Sarah Abbott**, LSW Associate Professor and Director of the Center for Crisis Response and Behavioral Health at William James College and former clinician with a co-response programme in Massachusetts
- **Chief Lester Baker**, Framingham Police Department, Massachusetts, USA; the eighth Police Chief in the history of the City of Framingham's Police Department; is responsible for Framingham's Jail Diversion Program
- **Deputy Chief Sean Riley**, Framingham Police Department, Massachusetts, USA; senior liaison with the Framingham Police Jail Diversion/Co-Response Model
- **Chief Inspector Elaine Tomlinson**, Police Scotland's national operational lead for Mental Health and Suicide Prevention and liaison for the Distress Brief Intervention Programme
- **Sergeant August Bonomo**, former Mobile Crisis Intervention Team Coordinator, Toronto Police Service and supervisor of the Incident Response Teams at Toronto Police College
- **Chief Inspector William Calderwood**, Police Service of Northern Ireland lead for innovative pilot programmes, including Adverse Childhood Experience and the Vulnerability Navigator programme
- **Inspector Michael Gahan**, Police Service of Northern Ireland Vulnerability Team Leader
- **Dr Alan Cusack,** School of Law, University of Limerick; Assistant Researcher

Invited Guests

- **Mr Niall Collins TD**, Minister of State with responsibility for Skills and Further Education at the Department of Further and Higher Education, Research, Innovation and Science (Mr Collins formally addressed the attendees)
- **Ms Mary Butler TD**, Minister of State with responsibility for Mental Health and Older People at the Department of Health (Ms Butler formally addressed the attendees)
- **Mr Bob Collins**, Funding Partner, Chairperson of the Policing Authority (Mr Collins formally addressed the attendees)
- **Assistant Commissioner Paula Hilman**, An Garda Síochána Roads Policing & Community Engagement; business sponsor of CIT APSFF Project (Assistant Commissioner Hilman formally addressed the attendees)
- **Ms Maria Bridgeman**, HSE Mid-West Community Healthcare Chief Officer
- **Assistant Commissioner Michael Finn**, Southern Region, Mental Health
- **Ms Helen Hall**, Chief Executive Officer of the Policing Authority (funding partner)
- **Ms Kate Mulkerrins**, Executive Director, Legal & Compliance, An Garda Síochána
- **Chief Superintendent Derek Smart**, An Garda Síochána
- **Chief Superintendent Brian Sugrue**, An Garda Síochána
- **Superintendent Aileen Magner**, An Garda Síochána, Community Engagement, Limerick Garda Division
- **Inspector Oliver Kennedy**, An Garda Síochána, Community Engagement, Limerick Garda Division

Participants

- **Superintendent Michael McNamara**, Crime Legal, An Garda Síochána
- **Ms Niamh Wallace**, Head of Service Mental Health (Joint Steering Committee CAST)
- **Dr Catherine Corby**, Consultant Psychiatrist (Joint Steering Committee CAST)
- **Ms Grace Sheahan**, Executive Officer, An Garda Síochána (Joint Steering Committee CAST)
- **Dr Deirdre Smithwick**, Assistant Executive, Clinical Director, HSE (Joint Steering Committee CAST)
- **Mr James Harrington**, Assistant Director of Nursing, HSE Mid-West (Joint Steering Committee CAST)
- **Dr Sophia Carey**, Senior Manager, Policing Authority Research Staff
- **Professor Colum Dunne,** Foundation Professor and Director of Research, School of Medicine, University of Limerick
- **Professor Gautam Gulati**, Consultant Forensic/General Psychiatrist, UL Adjunct Associate Clinical Professor
- **Mr Michael Murchan**, Assistant Principal Officer, Department of Health
- **Dr Eamon Keenan**, National Clinical Lead, Addiction Services, HSE
- **William Priestly**, An Garda Síochána Strategic Transformation Office
- **Superintendent Andrew Lacey**, An Garda Síochána; Principal Investigator
- **Bláithín O'Shea**, PhD student, School of Law, University of Limerick
- **Sergeant Noel Barry**, An Garda Síochána, Limerick

Appendix B: Roundtable Symposium Event Schedule

Irish Research Council and Policing Authority Roundtable Symposium Event

Appellate Court, Glucksman Library, University of Limerick

Thursday, 21 April 2022

09.10–09.20	Photographs at Plassey House with international presenters, members of the Oireachtas, funding partners and representatives from An Garda Síochána, Health Service Executive and University of Limerick
09.15–9.45	**Registration and Welcome** Glucksman Library
09.45–09.50	**Event Opening and Welcome Address**: Superintendent Andrew Lacey
09.50–10.00	**Event Introductory Addresses** – Ms Mary Butler TD, Minister of State at the Department of Health with responsibility for Mental Health and Older People – Mr Niall Collins TD, Minister of State at the Department of Further and Higher Education, Research, Innovation and Science with responsibility for Skills and Further Education – Mr Bob Collins, Chairperson of the Policing Authority
10.00–10.05	**Welcome and Format Outline**: Prof. Steve Morreale, Event Moderator
10.05–10.50	**Part 1: Practitioner Presentations** 1. *The Co-Response Model: Lessons Learned from 20 Years of Police/Mental Health Partnerships* – Deputy Chief Sean Riley, Framingham Police Department, Massachusetts – Chief Lester Baker, Framingham Police Department, Massachusetts – Dr Sarah Abbott, Inaugural Director of the Center for Crisis Response and Behavioral Health, William James College, Massachusetts
10.50–11.15	2. *Distress Brief Interventions (DBIs): An Innovative Way of Supporting People in Distress – Police Scotland's Collaboration Journey* – Chief Inspector Elaine Tomlinson, Police Scotland Partnerships, Preventions and Community Wellbeing Department
11.15–11.25	**Break**
11.25–11.55	3. *Toronto Police Service's Mobile Crisis Intervention Team Program* – Sergeant August Bonomo, Toronto Police Service, Mobile Crisis Intervention Teams (MCIT) Supervisor
11.55–12.15	4. *Human Rights Implications and Enhancement through the CIT Model* – Dr Alan Cusack, School of Law, University of Limerick; Assistant Researcher

12.15–12.50	*5. The Role of the Vulnerability Navigator and the Multi-Agency Support Hub in Supporting Those in Crisis and Experiencing Mental Health and Additional Challenges* – Inspector Michael Gahan, Derry City & Strabane Community Planning & Vulnerability Team – Chief Inspector William Calderwood, PSNI Derry City & Strabane
12.50–13.25	*6. Structured Q&A with International Presenters* – Prof. Steve Morreale and Dr Sarah Abbott
13.35–14.00	**Lunch** Served on Floor 2 of the Glucksman Library, University of Limerick
14.00–15.15	**Part 2: Library Boardroom, Floor 2** *Roundtable Discussion: International Collaborators and the CAST Implementation Team* • Recruitment • Clinician's perspective • Information sharing within the multi-agency approach • Impact of legislation • Role of evaluation and research post launch • Training the greatest catalyst for enhanced service • How is success measured? • Contemporary trends – what has changed? • Barriers • MoUs and partnerships
15.15–15.30	**Break**
15.30–16.15	*Q&A and Discussion on Next Steps* – Prof. Steve Morreale
16.15	**Close of Symposium** Presenter photographs taken on UL campus

Appendix C: Practitioner Workshop Schedule

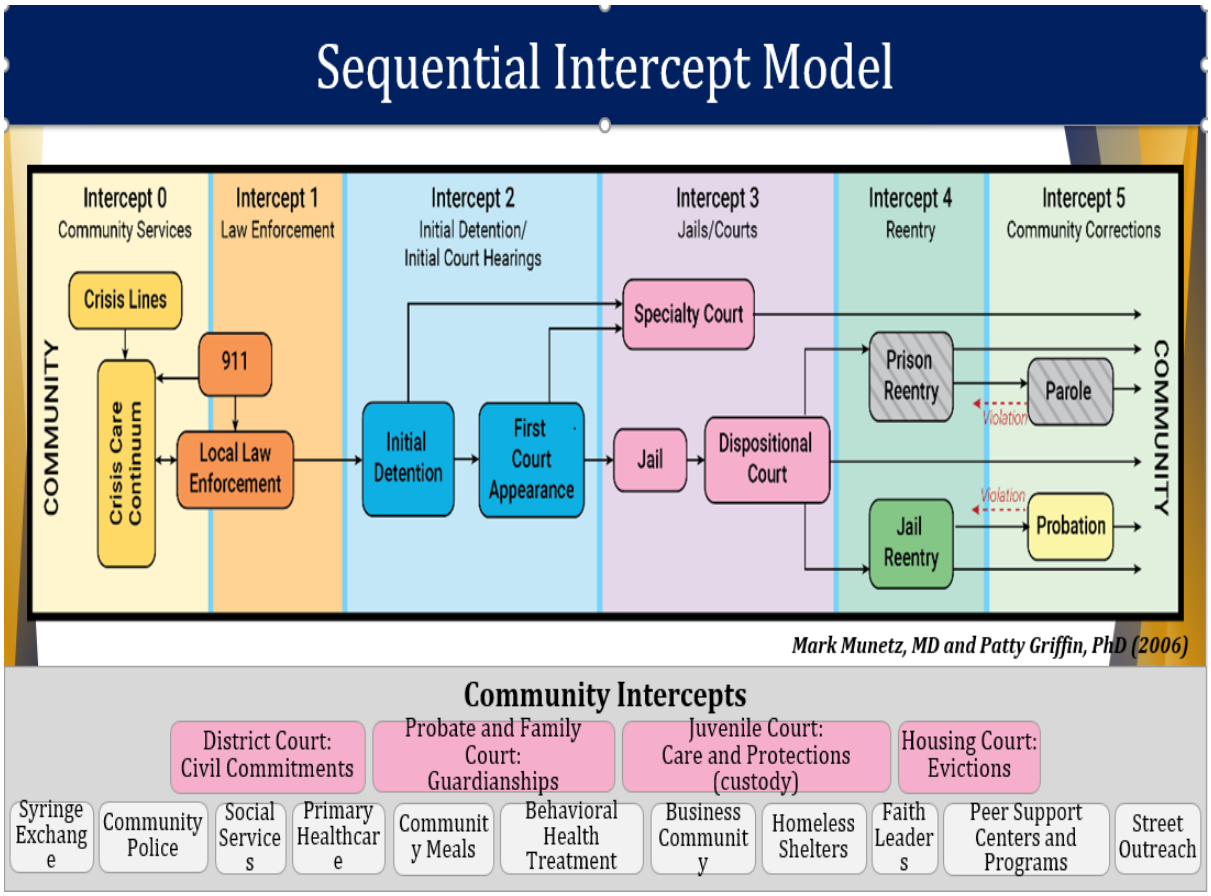
Irish Research Council and Policing Authority Practitioner Workshop Event

School of Law Boardroom, University of Limerick

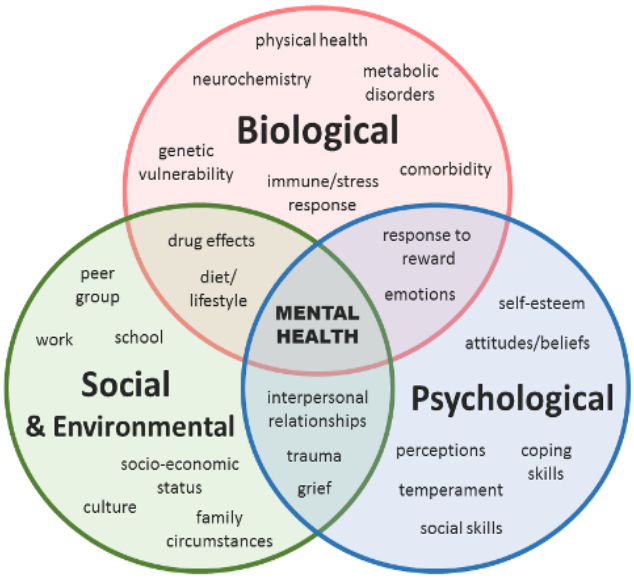
Friday, 19 August 2022

10.30–11.00	**Registration and Welcome** Café Allegro, University Concert Hall
11.00–11.15	**Event Opening and Welcome Address** UL School of Law Boardroom – Superintendent Andrew Lacey (research awardee) and Mr James Harrington, Area Director of Mental Health Nursing Mid-West
11.15–11.45	**Overview** Brief overview of research and CIT project progress: Superintendent Lacey
11.45–13.30	**Part 1: Practitioner Presentations** 1. *Crisis Liaison Nurse Functions* – Ms Marie Sloane, Crisis and Liaison Mental Health Service, University Hospital Limerick 2. *CIT USA Co-responder Experiences* – Ms Sarah Kelly, Clinical Social Worker 3. *The Role of the Authorised Officer* – Mr Paul Guckian, HSE Principal Social Worker
13.30	**Lunch Café Allegro**
14.00–14.30	**Part 2: Practitioner Discussion**
14.35	**Close of Workshop** Presenter photograph

Appendix D: Sequential Intercept Model (SIM) and Biopsychosocial Model (BPS)



Biopsychosocial Model (BPS)



Appendix E: Questionnaire

Implementation of Full Time Divisional Crisis Intervention Teams

Limerick Division – Pilot Scheme

You are the experts as front line members. We value your input as we build towards a pilot CIT Model in Limerick Division. Looking to reduce harm within the community via collaborated approach

Nominated Supervisor or Supervisory Sergeant should allow each member time to complete

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Question 1

Describe the Location of the incident responded to –

-house

-apartment

-public place

-commercial outlet

-licenced premises/hotel

-support accommodation/direct provision

- Healthcare facility

-other

Question 2

What was the perceived Gender of person in crisis?

-male

-female

Question 3

Age bracket

-Under 15

-15-18

-18-30

-30-60

- 60 or over

Question 4

What day of the week was the incident? 7 day option

Question 5

What time of the day was the response required?

7am-5pm 5pm-11pm 11pm-7am

Question 6

Was there violence/threatening behaviour involved?

Question 7

Was there a use of force involved in the incident? Yes/No

Question 8

Did the ASU (Armed Support Unit) attend the call in any capacity? Yes/No

Question 9

Did you have a previous interaction with the person involved? Yes/No

If yes please give a brief explanation of the prior interactions with the individual to help identify if the person was in ongoing crisis with repeated AGS interaction

_____

Question 10

As part of your response did you have interaction with mental health services? Yes/No

Question 11

Outline how long it took to deal with the call start to finish-

-less than 1 hour

-1 to 2 hours

-3 to 5 hours

-more than 5 hours

Question 12

Was there a de-briefing process post incident Yes/No

Question 13

In your opinion what was the primary contributing factor requiring the Garda/Emergency response

-Alcohol

-drug dependency

-mental illness diagnosis

-traumatic exposure or bereavement

-domestic difficulties

- Intellectual disability

-other please expand

_____

Question 14

Did you arrest the person? Yes/No

If Yes was it a) under Mental Health Act 2001 b) arrest power for criminal offence

Question 15

If there was an alternative to arrest available in this incident would you have used it? Yes/No

Question 16

If there was a mental health professional available to you would it have enhanced the response with this person who was in crisis Yes/No /Don't know

Question 17

Are you Assist trained Yes/No

Question 18

Did your training in AGS to date have you prepared to deal with this situation adequately Yes/No

Question 19

What advanced training if any would you recommend?

Question 20

Would you be interested in applying for the pilot co response unit? Yes/No

Question 21

If yes may we follow up with you to enquire about your interest in the role? Yes/No

Question 22

On average, how many contacts do you have per month with persons in crisis?

≤ 1

1–2

3–4

≥ 5

Question 23

In your view would CIT-related co response supports help with officer procedures in similar incidents and achieve improved responses? Yes/No

Please feel free to expand on your answer

Question 24

In order of importance (1-7) please rank the following co-response benefits

Safety

Shared information

Access to appropriate after care

Diversion from custodial setting and criminal justice system

Expertise and enhanced skills

De-escalation

Reduction of police resources

Question 25

Do you feel there is available resources to place the person in crisis in another relocation as an alternative to custody? Yes/No

Question 26

How would you describe the current legislation and associated protocols pertaining to the area of mental health?

Adequate

Strong

Inadequate

Question 27

Was any secondary information (Pulse data/external data/family input) made available to the Garda at scene?

Yes/No/unsure

Question 28

What else should we be thinking about? Your thoughts and suggestions will help the implementation of this ground-breaking project.

Name (Optional) – Contact number (optional)

Appendix F: Questionnaire

Implementation of Full Time Divisional Crisis Intervention Teams
Limerick Division – Pilot Scheme
Quantitative Research Questionnaire
Analysis of Arrests Under Section 12 of The Mental Health Act 2001

Dear Colleague,

As part of the Policing Service For the Future (APSFF) Plan the Limerick Division has been identified as the pilot location for the implementation of Full Time Divisional Crisis Intervention Teams within An Garda Síochána.

The project objective is to **"stand up specialist divisional crisis intervention teams who work conjointly with health professionals to provide a rapid and integrated response 24/7 to persons with mental health issues and who require enhanced services/acute intervention for a defined short period of time"**.

The project in the Limerick Division is known as the Community Access Support Teams (CAST) Pilot Project.

The following questionnaire seeks to objectively collect and analyse data that will assist in the design and implementation of the project as a start date nears. The data is sought from members of An Garda Síochána who have made arrests under Section 12 of The Mental Health Act 2001 over the defined period and who are operating in the mid-west.

As front line members you're the experts and we value your input as we build towards a pilot co-response intervention model in Limerick Division.

This should take approximately 5 minutes to complete.

NB – Members are required to fill out a questionnaire for each incident they attended as each experience may have different variations and circumstances

Question 1

Between what times were you dispatched to the call?

Delete where appropriate

5pm-7am
7am-5pm

Question 2

Were you aware that there was a mental health concern in respect of the call prior to arrival?

Delete where appropriate

No
Yes

Question 3

How long after your arrival did you make a decision to arrest?

Delete where appropriate

- Less than 10 minutes
- 10-25 mins
- Over 25 mins

Question 4

How long after the arrest before a GP made a decision in respect of the individual involved?

Delete where appropriate

- Over 90 minutes
- Between 1 hour and 90 minutes
- Less than hour

Question 5

Was the individual

Delete where appropriate

Released following examination with follow up action referred for assessment to psychiatric setting

Question 6

If referred to a psychiatric setting how long did you spend at that location before returning to policing duties?

Delete where appropriate

- Less than 45 minutes
- Between 45 and 120 minutes
- Over 120 minutes

Question 7

During your interaction with the individual was there a disclosure by him/her/family member in respect of a mental disorder or diagnosed condition.

Yes
No

Question 8

During your interaction with the individual was it known if he/she under the influence of alcohol or drugs

No
Yes

Question 9

What was the combined time spent at the incident from dispatch to conclusion?

Question 10

Post incident had you any interaction or follow up with the Individual or their family.

No
Yes

Thank you for your assistance.

Appendix G: Photographic Collage

International Practitioner Group


POLICE

Symposium presentations, 21 April 2022


POLICE
CRISIS TEAM

Roundtable Discussion, 21 April 2022

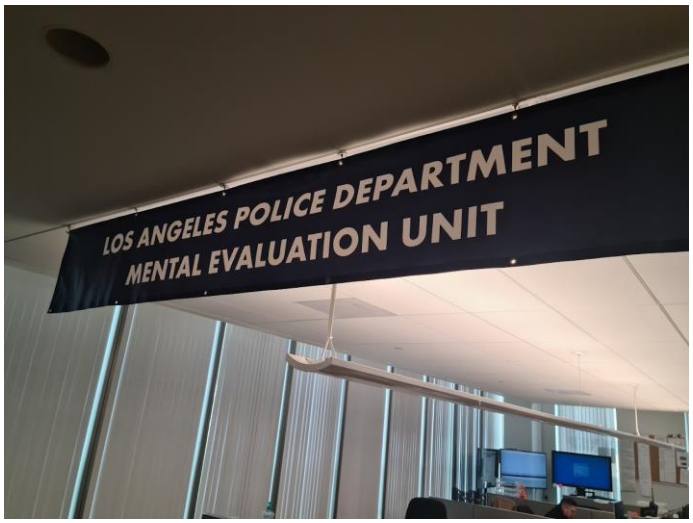
Workshop, School of Law, University of Limerick, 19 August 2022

Boston Police Department – BEST Team, November 2021

Framingham PD role call with Co-Responder Clinician, November 2021

Framingham Police Co-Response Team: Bonnie, Georgia and Cassie

LAPD Mental Health Evaluation Unit visit, July 2022



Co-Responder Conference, William James College, Massachusetts

MCIT Co-responder Nurse

Low-visibility police decaling to further support de-escalation and stigma

PSNI visit, Community Planning and Vulnerability Project, February 2022

Roundtable presenters' visit to Henry Street Garda Station, Limerick