The Garda Síochána and CHILD MENTAL HEALTH

An tÚdarás Póilíneachta
Policing Authority

UCD DUBLIN

The Garda Síochána and Child Mental Health: An investigation of pathways to crisis mental health care

Dr Louise Rooney, Dr Deirdre Healy and
Prof Fiona McNicholas

Department of Child and Adolescent Psychiatry, UCD School of Medicine and UCD Institute of Criminology and Criminal Justice, Sutherland School of Law.

University College Dublin

03 November 2021

Disclaimer: This research was funded by the Policing Authority. However, the views expressed in this report are those of the authors, and not necessarily those of the Policing Authority.

Contents

List of Tables and Figures

Acknowledgements

First, the Authors would like to extend their gratitude to the Garda Síochána, Children Health Ireland, and Tusla for their participation in this study. In particular, we would like to give special thanks to the Garda members, Psychiatrists, Doctors, Nurses and Social Workers who so kindly gave up their valuable time to participate in the interview process. Without your generosity, this study would not have been possible.
Secondly, we would also like to thank all the members of our Expert Advisory Panel who provided their expertise and guidance throughout the research process; namely Dr Blánaid Gavin, Ms Kate Mitchel, Dr Aogan Mulcahy, Dr Etain Quigley, and Dr Mairead Seymour.

Thirdly, we are also grateful to Dr Ingrid Holmes, who was an integral part of the research team in the early stages of the project, and Ms Caoimhe Fenton who contributed substantially to data transcription.

Finally, we would like to extend our thanks to the Policing Authority, specifically Dr Sophia Carey, Dr Aoife Delaney, and Ms Michal Alfasi-Hanley for their valuable support throughout the research process.

Dr Louise Rooney, Dr Deirdre Healy, and Prof Fiona McNicholas

Authors

The Principal Investigator, Prof Fiona Mc Nicholas, is Chair of Child and Adolescent Psychiatry in University College Dublin and Consultant Child & Adolescent Psychiatrist in Lucena CAMHS and CHI Crumlin. She is a seasoned clinician and researcher with a track record of successful grant applications and publications nationally and internationally. She is passionate about ensuring equitable access to evidence based treatment and support for children and families with mental health difficulties. Over the years, she has worked with many support organisations, teachers, HSE and advocated for improved resources and dissemination of knowledge. She has contributed to teaching and public education though her position as chair in UCD and the Lucena Foundation, established to enhance research, training, and practice within child mental health services in Ireland.

Dr Deirdre Healy is Director of the UCD Institute of Criminology and Criminal Justice and Associate Professor at the Sutherland School of Law. Deirdre's teaching and research interests include desistance from crime, community sanctions, criminological theory, and victimisation. She has published extensively in international and Irish journals, contributed book chapters to edited volumes, and authored a series of books.

Dr Louise Rooney is a Criminologist working as a Postdoctoral Research Fellow in University College Dublin's School of Medicine. She is a mixed-methods researcher with experience in conducting evidence-based research in both the criminal justice and health sector. Dr Rooney has also lectured on numerous master's level criminology and criminal justice programmes in University College Dublin, Maynooth University and Technological University Dublin.

Glossary of Terms & Abbreviations

Terminology

Persons aged under 18 years old: Child

Abbreviations

CAMHS: Child and Adolescent Mental Health Services

CAST: Community Access Support Teams

CIT: Crisis Intervention Team

F-CAMHS: Forensic Child and Adolescent Mental Health Service

GS: The Garda Síochána

HSE: Health Service Executive

JLO: Juvenile Liaison Officer

MH: Mental Health

NGO: Non-Government Organisations

Executive Summary

Rates of mental distress and illness are relatively common in youth (10-20%) and are growing worldwide (WHO, 2020). Approximately half of all mental illnesses begin by age 14 and three-quarters by the mid-20s (Kessler et al., 2005; WHO, 2020). National research identifies high rates (one in five) of youth with emotional distress (Lynch et al., 2006; Sullivan et al., 2004), and high rates engaging in self-harm (8-25%) (McMahon et al., 2010). Early onset illness is associated with poorer prognosis, poorer response to treatment and has widespread effects on the individual, family and society (Cannon et al., 2013).

Despite an increased awareness of the prevalence and adverse effects of youth mental illness, access to services remains problematic. Child and adolescent mental health services (CAMHS) provide specialist services to youths with mental illness. It has long been recognised that CAMHS are underfunded and under-resourced, with little access to 'out of hours' services, leaving youth distressed in the community or presenting to emergency departments for assessment and admission (McNicholas, 2018; McNicholas et al., 2020). Further, when the Garda Síochána become involved due to lack of services, the child may end up in the criminal justice system, leading to a concern about the criminalisation of the mentally ill in both the adult and juvenile offender population[1].

Given the increased prevalence of child and adolescent mental health (MH) issues, and difficulty in accessing CAMHS, it is understandable that the Garda Síochána (GS) have become increasingly involved in matters of MH as first responders over the past few decades. Such encounters are likely to be emotionally stressful to those involved, and need to be guided by clear pathways, adequate training and supports.

Whilst recent years have witnessed an upsurge in governmental policy intended to safeguard vulnerable groups, such as children, adolescents and the mentally ill, there is a dearth of research regarding the proficiency and operability of these directives in practice. Moreover, even less is known about child and adolescent pathways to crisis MH care once first responders, specifically Garda members, are called upon to intervene and assist, and the impact such encounters have on Garda members and children.

Aims and Methodology

The primary aims of the research were to:

I. Examine the current care pathways of Irish youth experiencing a crisis MH event from the commencement of the GS involvement through to the initiation of psychiatric care.

II. Obtain expert insight from interviews with key stakeholders (e.g. Child and Adolescent Psychiatrists, emergency department Doctors and Nurses, Tusla Social Workers) regarding their experiences of pathways to child and adolescent psychiatric care involving the GS.

III. Identify the opportunities and challenges associated with the pathways to child and adolescent psychiatric care via the criminal justice system from the perspective of the Garda members.

IV. Conduct an international literature review identifying innovative practice in the area.

This study adopted a qualitative research design incorporating semi-structured interviews that were carried out in two phases. **Phase 1** interviews were conducted with a sample (N=18) of Garda members, of varying ranks (Garda, Sergeant, Juvenile Liaison Officers). **Phase 2** interviews were conducted with a sample (N=11) of other professional stakeholders involved in the care pathway under investigation; namely, Consultant Child and Adolescent Psychiatrists, Emergency Department Doctors and Nurses, and a Tusla Social Worker.

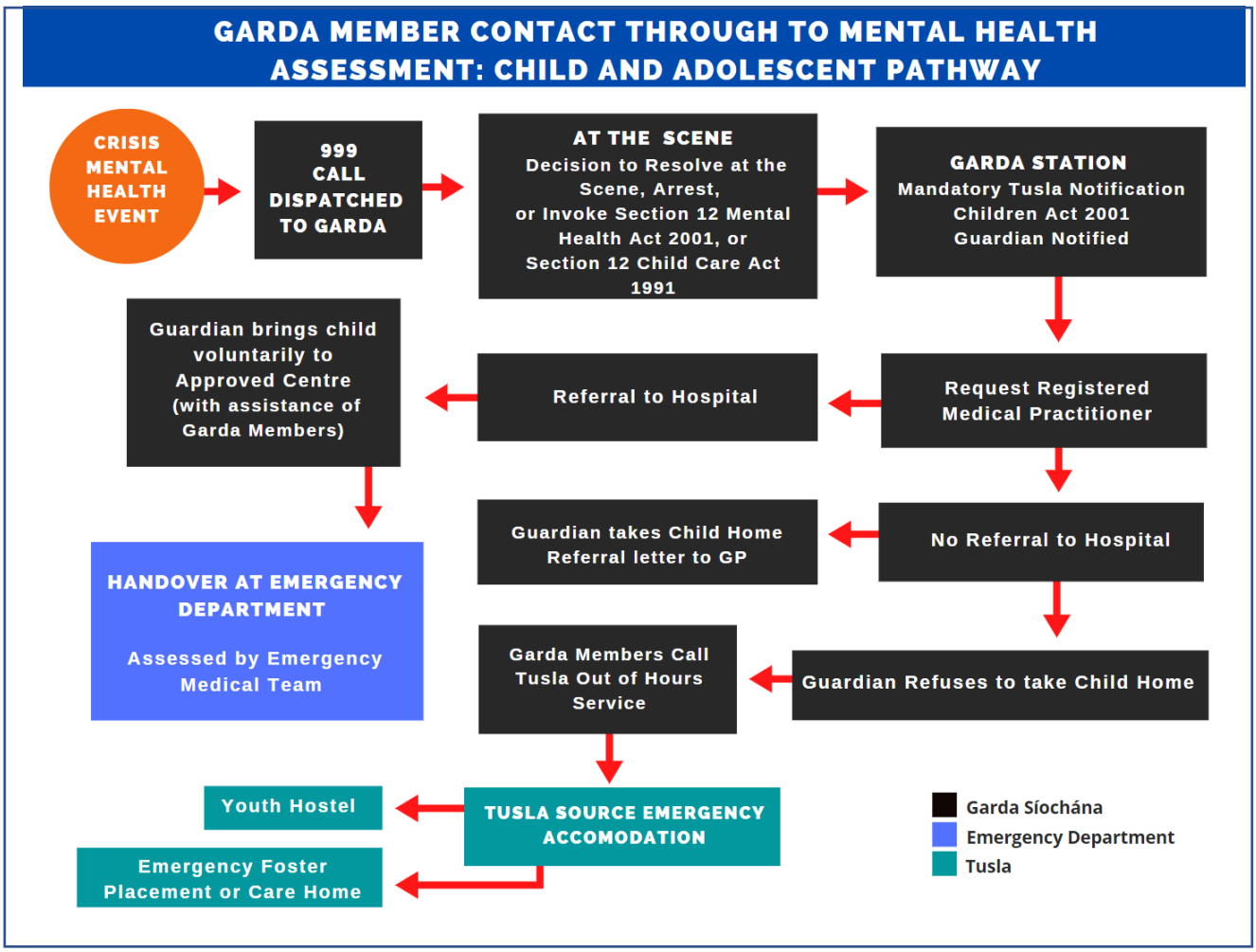
[1] In April 2021, the establishment of a High Level Taskforce to consider the mental health and addition challenges of persons interacting with the criminal justice system was announced. (Department of Justice, 2021).

Subsequently, Thematic Analysis was conducted on interview data to capture frequently cited and meaningful information relevant to the overall research questions. It is important to note that both the small sample size and exploratory nature of the present study makes the findings outlined in this report tentative. Accordingly, further research is needed to fully explore the issue at hand.

Summary of Key Findings

Child and adolescent crisis MH call outs typically occur in three environmental settings: the scene (e.g. child's home, a community setting), the Garda Station, and the Emergency Department (see Figure 1). Progression through the pathway depends on a number of factors, the most important being the severity of the child's distress. Some call outs are resolved at the scene, some are resolved at the station, and some require progression to the Paediatric Emergency Department. Thus, not all children in crisis experience all three environmental settings.

Figure 1: Garda member Contact through to Mental Health Assessment: Child and Adolescent Pathway[2]



[2] See Appendix 1 for larger image

- Garda members demonstrated a great deal of care and thoughtfulness towards the children they encountered, particularly in the context of a MH event. This was evidenced by the high level of compassion, patience and understanding described by participants in their accounts of managing crisis MH call outs. Findings revealed that the child's best interests seem to be at the forefront of Garda members' minds.

- Garda members and Medical Professionals felt that the Mental Health Act 2001 provides them with little guidance when it comes to managing a youth crisis MH event. In particular, participants felt the Mental Health Act 2001 lacks clear provisions regarding the practical application of the act to persons under 18 years of age.

- The lack of youth specific provisions in the Mental Health Act 2001 meant that Garda members were not always confident using it in the context of a youth MH crisis event. As a result, some Garda members described addressing the criminal aspect of the call out (i.e. a public order offence) and they opted to use the criminal law as a means of bringing the child back to the station for assessment by a Doctor. Such findings provide evidence for the unintentional criminalisation of children during a MH crisis callout within the Irish context.

- All 18 Garda members interviewed were unaware of any specific protocols or HQ Directives to guide practice when attending a crisis MH call out involving a child. This perceived lack of formal guidance was a source of significant apprehension and uncertainty for members managing MH crisis incidents at the scene, the Garda Station, and/or the Emergency Department.

- All Garda members interviewed for this study felt strongly that the Garda Station is not the appropriate place to manage a child experiencing a MH crisis. Such sentiments were based on concerns about their ability to ensure the child's safety, the lack of an appropriate room/space to accommodate children in a distressed state, and the potential to cause further psychological distress to the child and their guardians.

- All Garda members felt significantly undertrained in matters of MH and neurodiversity, and ill equipped to manage children experiencing a crisis MH event.

- In the absence of specialist training and formal procedure, Garda members reported employing numerous informal practices to mitigate the distress experienced by children and their guardians, such as making environmental accommodations at the scene/station, offering to have a follow-up call with parents/carers, adopting an age-appropriate interaction style, and involving children and their guardians in the decision-making process. Participants described such practices as being learned on-the-job and informed by common sense, but expressed a wish for more formal and structured training.

- Garda members described an undercurrent of dread and fear when dealing with individuals under 18 years, particularly in the context of a crisis MH call out. These negative emotions were related to a perceived lack of knowledge, feeling professionally ill-equipped to deal with such cases, and fear that they might make the situation worse as a result.

- Garda members were fearful about the personal, family and professional implications of their actions, and often carried these anxieties with them well beyond the crisis event itself.

- All participant groups (Garda members, Medical Professionals, Social Worker) expressed concerns about the management of MH crises by the Garda Síochána alone, in the absence of other supports.

- All professionals interviewed for this study referred to the lack of an appropriate environment to assess and treat children experiencing a crisis MH event. The multiple settings and professional bodies involved mean that children and their parents/carers must endure a disjointed and drawn-out care pathway that has the potential to exacerbate their distress.

- A high level of mutual respect and camaraderie was detected across professional groups. However, a lack of detailed understanding regarding the nature of each individual's and organisation's role, along with the legislative and bureaucratic parameters within which each professional works, were highlighted as major instigators of interagency tension and conflict. Participants believed that increased interagency training could be a game changer in terms of strengthening interagency rapport, which would in turn enhance future collaborative working, information sharing, and communication.

Conclusions

This study reveals that children and adolescents who experience mental illness in Ireland represent a neglected cohort when it comes to policy and planning of care pathways. It also demonstrates that the resource requirements of Garda members acting as frontline personnel, responsible for providing emergency care services to this vulnerable group are similarly overlooked.

Insufficient training, a lack of procedural guidance, and an absence of clear youth-focused MH legislation all emerged as significant challenges for Garda members. They described feeling as though they are stumbling around in the dark when faced with crisis MH call outs.

In the aftermath of crisis mental health call outs involving children, Garda members described feeling fearful and unsure about the validity of their decision-making, are cognizant of personal and organisational responsibilities to these children, and plagued by the 'what ifs' of the case well past case resolution. These findings identify child and adolescent crisis mental health events as source of significant psychological burden for Garda members.

Summary of Recommendations

Specialist Education and Training

Implement an education programme for new Garda recruits and qualified Garda members that specifically focuses on the child/family-officer interaction, communication and positive engagement. Psycho-education on child and adolescent mental health in general and crisis presentations specifically, including the area of neurodiversity, were considered essential to better equip Garda members. Mental health training should be developed and delivered collaboratively with frontline Garda members with experience in the field and with mental health experts.

Providing Information to the Public

Develop an information leaflet containing a list of MH resources and services that are available to parents/carers and children. This resource should be made available for distribution by professionals working on the frontlines of youth crisis MH events.

Youth Focused Protocol and Procedure

Establish an interagency protocol that maps out the crisis MH care pathway and provides a clear definition of the roles, jurisdiction, and responsibilities of each professional/agency.

Developing Interagency Relationships

To alleviate friction and promote interagency rapport, communication, and information sharing between the GS, Tusla and Medical Professionals, efforts should be made to increase opportunities for structured interagency engagement, such as joint training.

Crisis Intervention

Explore the feasibility of rolling out a multi-agency Crisis Intervention model of care for adults and children, specifically designed for crisis MH management as outlined in the report published by the Commission on the Future of Policing (2018). The recent launch of a pilot crisis intervention programme within the Limerick Garda Division is a welcome step towards this goal. It is recommended that careful consideration be given to the pilot programs applicability to youth crisis MH events.[3]

Garda Wellbeing

Consideration should be given to how current GS systems and procedures may be improved to alleviate Garda member stress and burden. This may be achieved by locating gaps in knowledge and procedure, and adopting a collaborative bottom-up approach involving key stakeholders (e.g. first responders) to update policy and procedure in a way that is beneficial for the organisation, its members and the public.

Future Research

Further inquiry is needed to understand the intricacies of these complex encounters between the GS and children in crisis. Specifically, a nationwide study with a representative sample of Garda members, General Practitioners, Emergency Department Medics, and Social Workers is required to provide a comprehensive understanding of youth crisis MH pathways, from contact with the GS through to MH assessments and treatment. Future research exploring the experiences of the children and families who have had contact with the GS because of a youth crisis MH event is also essential to ensure that the perspectives of all parties are represented and explored.

[3] Reply to PQ Ref 29840/21, Dáil Debates, 03 June 2021

Chapter 1: Literature Review

1.1. Introduction

The level of police involvement in matters of mental health as 'first responders' has increased substantially over the past few decades (Commission on the Future of Policing in Ireland, 2018). A significant portion of children living in Ireland aged between 11-24 years are reported to experience mental ill health (RCSI, 2013). The prevalence of child and adolescent mental health (MH) issues coupled with an increase in the role of the Garda Síochána (GS) as first responders in MH call outs, means that Garda members are more likely to encounter a child experiencing a crisis mental health event than ever before.

Whilst recent years have witnessed an upsurge in governmental policy intended to safeguard vulnerable groups, such as children and the mentally ill, there is a dearth of research regarding the proficiency and operability of these directives in practice. Moreover, even less is known about child and adolescent pathways to crisis mental health care once first responders (Garda members) are called upon to intervene and assist. This study sets about exploring how crisis mental health events involving children are experienced by the officers who are called to assist, along with the opportunities and challenges associated with this pathway to mental health care.

1.2. Background

Mental health (MH) may be defined as "*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*'' (World Health Organization [WHO], 2014). Mental ill health, or psychiatric illness may be described as a broad spectrum of clinical disorders such as depression, anxiety, eating disorders, personality disorders, psychosis, and substance misuse (Ibid). Typically, such disorders cause the individual impairment and benefit from intervention.

It is estimated that between 10-20% of children and adolescents experience mental health disorders worldwide (WHO, 2020). Moreover, approximately half of all mental illnesses begin by age 14 and three-quarters by the mid-20s (Kessler et al., 2005; WHO, 2020). A small body of domestic research also evidences the extent of the issue. A study investigating the prevalence of psychiatric disorders and suicidal behaviours in a population of adolescents aged 12-15 years in a defined geographical area found that 15.6% met criteria for a psychiatric disorder (Lynch et al., 2006). Similarly, a cross-sectional national research study conducted by the Royal College of Surgeons in Ireland found that one in six children aged 11-13 years were identified to be experiencing a mental illness. More notably, census data from 2016 indicates an 8% increase in self-reported MH issues among children aged 13-18 years (Central Statistics Office, 2020).

Research from across the globe attests to the fact that the mentally ill are significantly overrepresented within the criminal justice system (Adamis et al., 2019; Lee et al., 2009). Indeed, this phenomenon is so profound that policymakers and practitioners have labelled this trend the 'criminalisation of the mentally-ill' (Markowitz, 2011; Mulvey et al., 2017). Whilst most of the scholarship in the area is based on findings from the USA, Canada and Australia, an emergent body of research conducted on home soil suggests that Ireland is no exception. Penrose's Law (Penrose, 1939) postulates that as the number of patients admitted to psychiatric units declines, the number of prisoners increases. Kelly's (2007) analysis of census data collected between 1963 and 2003 suggested the occurrence of the Penrose Law phenomenon in Ireland, with findings showing a five-fold decrease in psychiatric inpatients (81.5%) and a corresponding five-fold increase in the prison population (494.8%) (Kelly, 2007). An investigation of psychiatric morbidity amongst the male prison population reported that almost half of remand prisoners and a third of sentenced prisoners had a history of contact with community psychiatric services as outpatients and/or inpatients (Curtin et al., 2009). Findings also showed that one quarter of prisoners (remand and sentenced) had a lifetime prevalence of psychiatric illness, the most

common of which were drug and alcohol abuse, anxiety disorders and depressive disorders (Ibid). A significant cohort of children with mental health difficulties are also being 'managed' in the Irish youth justice system (Curran et al., 1999), suggesting that the age of the offender does little to mitigate the criminalisation of the mentally ill.

It is important to both define and differentiate forensic MH and crisis MH events that warrant the assistance of the police.

A crisis MH event may be characterised as a degree of behavioural disturbance, (involving criminal behaviour or not) or a period of significant distress, that escalates to a point where an individual is believed to be a risk to themselves or to others. It is this significant and immediate potential risk of harm to self or others that necessitates the presence of the police. In cases involving children, a parent/guardian or peer may feel ill equipped to manage other mental health disturbances, even in the absence of significant and/or immediate risk, and they will call on the police for assistance.

Forensic MH refers to the care needs of offenders with a serious mental disorder. Forensic MH services usually come into play once a person has been charged with an offence or if they are in prison custody. Forensic MH teams do not typically play a role in the immediate crisis/emergency service, but may be called in in the immediate aftermath.

In Ireland, people with Forensic MH needs fall under the remit of the National Forensic Mental Health Service, comprised of a multidisciplinary team led by a Consultant Forensic Psychiatrists. The main function of this specialist service is to carry out assessments and provide treatment for offenders with mental illness. They also prepare psychiatric court reports, provide expert opinion regarding a defendant's capacity to participate in trials, advise the court about offender risk, and make recommendations regarding treatment (HSE.ie, 2021).

1.3 The Role of the GS as First Responders

The high prevalence of MH issues coupled with the over-representation of individuals with mental illness within the criminal justice system indicate that criminal justice professionals, specifically the police, have regular contact with this vulnerable cohort, both in a custodial setting and in the community. International criminal justice research indicates that the police have played a long-standing role in the management of individuals experiencing a crisis MH event. For instance, a seminal study conducted by Bittner (1967, p.288) identified the provision of "*Psychiatric First Aid"* by law enforcement when dealing with persons with suspected mental illness. In 1979, Punch deemed the police force a '*secret social service'* because of a lack of inquiry and understanding by academics and policymakers as to the welfare-oriented roles of police officers (Punch 1979, p.103). Fast forward 40 years to the present day, while the level of interest in the field has gathered momentum, some scholars argue that the public health aspect of everyday policing still has a tendency to be undervalued and overlooked (Wood and Watson, 2017). This research indicates that the police often serve as gatekeepers in deciding whether a person who has come to their attention because of a MH crisis event requires psychiatric assessment or a criminal justice response (Lamb et al., 2002). If these cases are not appropriately managed, they can not only result in the unnecessary criminalisation of the mentally ill, but also compound the distress experienced by the person in crisis.

International research indicates that call outs involving persons experiencing mental health crises can be particularly problematic for police officers (Watson and Fulambarker, 2012). For instance, officers do not always feel adequately trained to respond appropriately to mental health crises, mental health call outs may be time-consuming and divert officers from other police related activities, and officers have experienced substantive resistance from MH providers during crisis scenarios (Cooper et al., 2004; Vermette et al., 2005; Wells and Schafer, 2006). Moreover, police perceive mental health related call outs as particularly high risk, unpredictable and dangerous, and worry that their lack of expertise in the area could potentially lead to a worsening of the situation for everyone involved (Ruiz and Miller, 2004).

Over the past few decades, the level of police involvement in matters of mental health has increased in the Republic of Ireland (Commission on the Future of Policing in Ireland, 2018). The GS are called upon to manage and provide assistance across a wide range of situations and scenarios concerning MH (Ibid). For example, in 2016 and 2017, 25% of all involuntary admissions under Section 9 of the Mental Health Act 2001 were carried out by Garda members (Mental Health Commission, 2016; 2017). More frequently, other circumstances that require police involvement include escorting individuals to psychiatric facilities, intervening in potentially volatile situations in primary health care settings and in the community, and/or assisting families/carers during a crisis MH event (Mental Health Commission and An Garda Síochána, 2009). For instance in 2020, of the 1,919 involuntary admissions to mental health facilities, the largest number of applications came from the Garda Síochána (32%) for the second year running (Mental Health Commission, 2020)

The augmentation in contact between police and individuals with MH difficulties has been attributed to the movement away from institutional care, which was commonplace from the mid-20th Century, and the slow development of community-based MH services in its place (Fakhoury and Priebe, 2007; O'Sullivan and O'Donnell, 2007). The GS respond to calls for assistance 24 hours a day - 365 days a year. Thus, from a purely logistical standpoint, it follows that Garda members are often the only resource available to the public in times of crisis (Mental Health Commission and An Garda Síochána, 2009). This is certainly the case outside traditional hours of business (Monday to Friday, nine to five) when access to MH professionals and social workers is restricted (Mental Health Commission and An Garda Síochána, 2009; Commission on the Future of Policing in Ireland, 2018). This has resulted in occasions where children experiencing a crisis MH event have been placed in holding cells overnight while awaiting access to appropriate MH care (Irish Penal Reform Trust, 2014; McNicholas et al., 2019). For some, it has meant entering the youth justice system without the necessary MH screening. A survey conducted in the recently closed St Patrick's Institution for young offenders aged 16-21 found that 23% screened at reception had an at-risk mental state. Similar rates have also been documented in 15–17-year-olds attending Oberstown Children's Detention Campus[4] (Deirdre Malone, Dáil Debates, 23 May 2018).

1.4 International Best Practice

The latter half of the 20th century witnessed increased inquiry regarding police interactions with vulnerable groups, particularly in the United States. Such scrutiny prompted the development of specialised police training and multiagency working to improve law enforcement responses to individuals with mental illness (Wood and Watson, 2017). A variety of approaches for managing crisis MH events have been developed across the globe. A growing body of research in the area indicates that the Crisis Intervention Team (CIT) model is the most popular of these approaches.

United States

In 1988, following the fatal shooting by Memphis armed police of a man with a history of mental illness, the first community task force, known internationally as the Memphis Crisis Intervention Team (CIT) Model, was established (Dupont and Cochran, 2000). The Memphis CIT Model relies on three components: collaboration among MH providers, police officers, family advocates and other stakeholders; a 40-hour training programme to teach police officers therapeutic skills; and continued stakeholder and family involvement to oversee and improve programme development (Douglas et al., 2014). This model aims to increase safety for practitioners and the public, reduce harm, divert persons with mental illnesses away from the criminal justice system and streamline pathways to MH assessment and treatment (Ellis, 2014; Watson and Fulambarker, 2012). Research evaluating the impact of the Memphis CIT model reveals improved police attitudes toward individuals with

[4] Oberstown Children Detention Campus provides a safe and secure environment for young people sentenced or remanded by the Courts. The principal objective of the campus under the Children Act 2001 is to provide appropriate care, education, training and other programmes to young people between 12 and 18 years with a view to reintegrating them successfully back into their communities and society. See https://www.oberstown.com/

MH issues, increased referrals to MH services, a reduction in the likelihood of arrest, and a decrease in the use of force by officers (Compton et al., 2017; Kubiak et al., 2017).

Some states in the USA have set up youth focused CITs, Juvenile CITs, Youth CITs or CIT Youth (Douglas and Lurigio, 2010, 2014; Kubiak et al., 2019). Although there are numerous youth focused CIT programs in operation (at least 8 in 2014), a lack of independent evaluation to assess program pathways and outcomes has meant that very little is known about their efficacy, in contrast to adult models (Doulas et al., 2014). However, a recent study by Kubiak and colleagues (2019) reports that a youth focused CIT training program delivered to law enforcement enhanced participants' ability to recognise crisis MH situations, increased awareness of local MH services, and improved de-escalation skills (Ibid).

England and Wales

There are a number of crisis MH interventions employed by the police force in England and Wales; namely Liaison and Diversion (L&D), Street Triage and specialist staff embedded in Police Contact Control Rooms (CCRs), and Co-response/CITs (Kane et al., 2017).

Specifically designed to manage vulnerable persons who may have committed an offence, Liaison and Diversion units (L&D) aim to divert individuals away from the criminal justice system at their earliest point of contact (McKenna et al., 2019). Specialist MH teams are sourced at police stations to assess and refer individuals to MH services where appropriate. An evaluation of L&D revealed that police officers perceived the information provided by L&D personnel as useful and found the model effective for engaging children in crisis (Disley et al., 2016). Similarly, research investigating the efficacy of L&D referrals indicates a high rate of appropriateness and clinical accuracy. For instance, Forrester (2016) reports very high levels of MH issues in a sample of referred participants, with the majority reporting well established MH issues (67%), a history of substance misuse (60%), and presenting with suicidal ideation (16%) on referral.

Street Triage and specialist staff embedded in the Police Contact Control centre is a pre-arrest diversion model used to identify crisis MH situations and despatch specially trained police officers who can make preliminary MH assessments and MH referrals at the scene (Taheri, 2016; Booth et al., 2017). This intervention aims to introduce MH expertise at the scene, reduce the likelihood of an unwell individual being detained in police custody, and mitigate the distress experienced by the individual in crisis (Puntis et al., 2018). A systematic review by Kane and colleagues (2017; 2018) compared studies investigating the efficacy of Street Triage and CITs. Findings revealed Street Triage programs working in conjunction with CITs are the quickest and most appropriate response overall. Results also indicated reductions in formal detentions and a decrease in the time spent by first responders on-scene (Ibid).

England and Wales have expanded Crisis Intervention Teams (also known as Co-Response Teams) beyond trained police officers to include MH professionals who attend MH call outs when necessary. This intervention typically operates outside of traditional working hours (during evening and night shifts) (NHS, 2020). Research investigating the benefits of implementing CITs in England and Wales indicates that trained officers are more likely than non-trained officers to direct people with MH issues to MH services and use a variety of skills and approaches when dealing with vulnerable individuals, such as active listening, positive engagement and negotiation (Kane et al., 2017; 2018;). Moreover, CIT training is linked to lower rates of arrest and reduced referrals to acute psychiatric services (Paton et al., 2016; NHS, 2020). These findings demonstrate just how beneficial the roll out of CIT training can be for vulnerable members of the community and law enforcement officers.

Scotland

Research conducted with children in contact with the Scottish criminal justice system identifies a high prevalence of childhood trauma (Dierkhising et al., 2013). Furthermore, this contact often results in the re-traumatisation of children, specifically when it involves arrest, court appearances, and or custodial sentences (Ko and Sprague, 2007). Accordingly, policy makers and experts in the field called for the adoption of Trauma

Informed Practice (TIP) throughout the criminal justice sector. It is reasoned that such an approach may greatly assist justice professionals to recognise children as a vulnerable offender cohort, address their specific welfare needs, and advocate for less restrictive criminal justice outcomes (Courtois and Gold, 2009; Crosby, 2016; Conradi et al., 2011). The adoption and implementation of trauma informed approaches for all professionals who encounter potentially traumatised youth has been recommended by several major MH and youth focused organisations, such as the Substance Abuse and Mental Health Administration (SAMHSA) (2014) and Barnardo's (2019). Accordingly, Scotland's National Health Service has developed, and is currently rolling out, a nationwide TIP education programme called 'Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce' (NHS Education for Scotland, 2017). It aims to provide the core knowledge and skills needed at all tiers of the Scottish workforce to ensure that the needs of trauma affected individuals "are understood and responded to in a way that recognises individual strengths, acknowledges rights and ensures timely access to effective care, support and interventions for those who need it" (Scottish Police Authority, 2019, p. 3). The police force is one of many government agencies receiving this educational program, along with social workers, health professionals and teachers. Whilst it is early days in terms of evaluation-based research investigating the impact of this program in Scotland, international studies have shown the efficacy of TIP in various youth focused agencies, such as schools (Day et al., 2015), youth MH programs (Hummer et al, 2010), child protection and social work (Ko and Sprague, 2007) and juvenile justice (Schwalbe and Maschi, 2012).

Sweden

The high rate of suicides and suicidal behaviours (over 1,500 suicides and 15,000 suicide attempts) reported annually in Sweden led to the development of a Psychiatric Emergency Response Team (PAM) (Hollandare et al., 2020). In 2016, Stockholm's health care services established the world's first Psychiatric Emergency Response Team (PAM) resourced with an ambulance for the sole purpose of attending to MH emergencies. While the outside appearance of the ambulance does not differ from any other seen on the streets of Sweden, inside it contains stretchers, comfortable seats and dimmed lighting, and is staffed with two MH nurses and one paramedic (Apolitical, 2017). Preliminary data to evaluate the PAM team's first year of service revealed they attended 1,254 incidents, or 3-4 cases per day. A total of 96 individuals were attended to on more than one occasion and one third of all attended cases resulted in no further action after a psychiatric assessment and/or crisis intervention was carried out on site (Bouveng et al., 2017). Moreover, qualitative research conducted with a small sample of individuals who requested the PAM team's assistance revealed a series of positive outcomes. Patients described their care as person-centred, felt they actively participated in the decision-making surrounding their care, and believed that staff created a trusting and caring environment where they felt safe (Lindstram et al., 2020). Whilst these preliminary findings are extremely positive, further research is ongoing to ascertain whether this innovative service not only decreases the risk of suicide but also assists police and the public as first responders. It will also examine the economic benefits and feasibility of a nationwide scale-up (Ibid).

The fact that several different MH crisis intervention models are being successfully implemented across a number of jurisdictions demonstrates international recognition of the issue at hand. The international scholarship discussed above not only exposes the significant void in crisis intervention services here in Ireland, it also provides valuable insights into the ways in which the public and professionals stand to benefit from the roll out of similar services on home soil. Further research and service development is urgently warranted.

1.5 Garda Powers

Section 7 of the Garda Síochána Act 2005 states that the function of the GS is to provide policing and security for the State with the objective of preserving peace and public order, protecting life and property, maintaining the human rights of each individual, protecting the security of the State, preventing crime, bringing criminals to justice, regulating and controlling road traffic, and improving road safety.

When it comes to the management of juvenile MH call outs, Garda members have three key pieces of legislation to guide their practice; namely, the Mental Health Act 2001, the Children Act 2001, and the Child Care Act 1991. The paragraphs that follow outline sections from each of the Acts that specifically apply to the management of children by An Garda Síochána during a crisis MH event. A flowchart of the care pathway outlining where key legislation comes into play is provided below (see Figure 2: Garda member Contact through to Mental Health Assessment: Child and Adolescent Pathway)

Mental Health Act 2001

When it comes to Garda Powers and the management of a crisis mental health event involving a child, Section 12 of the Mental Health Act is the most important. It allows Garda members to bring a person into custody in the absence of a crime being committed and/or without having to make an official arrest. Once in custody, Garda members are obligated to contact a registered medical practitioner for a recommendation. There are three possible outcomes:

1. *No Further Medical Assessment Required*

   The medical professional advises that no immediate medical intervention/assessment is required. At this point, the person must be released. In cases involving a child, Garda members must release them into the custody of a parent/guardian. If a parent/guardian is unavailable or is unwilling to take the child home, the child must be placed in the care of Tusla.

2. *Voluntary Admission*

   The medical professional may provide the person with a referral to an approved centre. For adults this can be an Emergency Department with established links to a psychiatric team/department or a Psychiatric Facility. This referral is made on a voluntary basis, meaning the person can choose whether they want to seek further medical intervention or just be released. Alternatively, children are referred to the Paediatric Emergency Department. Again, this referral is made on a voluntary basis, meaning it is up to the parent/guardian to decide whether to use the referral and bring the child for further medical intervention, or bring the child home.

3. *Involuntary Admission*

   The medical professional can make an application to admit a person who they believe to be suffering from an acute mental disorder to an approved centre on an involuntary basis. In this instance, the person has to comply with the referral for further treatment/admission to an acute unit. An involuntary admission involving a person under 18 would only be necessary if their parent/guardian refused to seek urgent treatment recommended by a medical professional. The involuntary admission of a child requires a petition to the District court. These procedures are outlined in Section 25 of the Mental Health Act 2001. However, the Mental Health Commission's 'Guidance Document for Application for the Examination, Admission or Treatment of a Child under the Mental Health Act 2001' (2001) states that the majority of children who require treatment will be admitted at the request of a parent/guardian and only a minority will be admitted involuntarily (against the wishes of their parents/guardians).

Whilst the Mental Health Act 2001 applies to both adults and children, it has been criticised for its lack of youth focused guiding principles. For instance, Mental Health Reform (2019)[5] point out that sections concerning children are spread out across different parts of the Act, which has led to confusion as to whether parts of the Act apply to children, adults or both. Moreover, the 'Report of the Expert Group Review of the

[5] Mental Health Reform is Ireland's leading national coalition on mental health. Their mission is to drive progressive reform of mental health services and supports, through coordination and policy development, research and innovation, accountability and collective advocacy. See: https://www.mentalhealthreform.ie/

Mental Health Act, 2001' (2015, p. 73) recommends that "*Provisions relating to children should be included in a standalone Part of the [Mental Health] Act and any provisions of the Child Care Act 1991 which apply should be expressly included rather than cross referenced*".

In July 2021, the Irish Government approved the draft Heads of Bill to amend the Mental Health Act. This draft was based on 165 recommendations emanating from the aforementioned Report of the Expert Group, as well as an extensive consultative process. (Gov.ie, 2021). Although the shape of the final Bill remains to be seen, the draft currently includes sections offering guiding principles for children, the involuntary admission of children, treatment of children under section 25, and the admission of children to inpatient facilities (Gov.ie, 2021) and thus, is a key piece of legislation for future research.

Child Care Act, 1991

Section 12 of the Child Care Act 1991 provides Garda members with the power to take a child to safety when they have reasonable grounds for believing that there is an immediate and serious risk to the health or welfare of a child. Once this legislation has been invoked, and a child has been removed, the GS must notify Tusla at their earliest convenience and arrange for the child to enter into the custody of Tusla.

This section of the Child Care Act 1991 may also be used by the GS to manage crisis MH scenarios involving children, specifically in relation to removing them from the scene. However, research suggests that the application of this legislation in crisis MH scenarios involving children is rare. Shannon (2017, p.72) reports that between 2008-2015, suspected "*mental health issues within the child*" accounted for less than 5% of the total number of times (n=560) in which Garda members exercised Section 12 of the Child Care Act 1991.

Children Act, 2001

Under Irish Criminal Law, persons under 18 years of age are deemed vulnerable due to their age and level of maturity. Accordingly, the law outlines that children should only be detained as a last resort[6]. It also sets out special provisions, which protect the personal rights of children being detained in Garda stations.

Section 55 of the Children Act 2001 states that:

> *"In any investigation relating to the commission or possible commission of an offence by children, members of the Garda Síochána shall act with due respect for the personal rights of the children and their dignity as human persons, for their vulnerability owing to their age and level of maturity and for the special needs of any of them who may be under a physical or mental disability, while complying with the obligation to prevent escapes from custody and continuing to act with diligence and determination in the investigation of crime and the protection and vindication of the personal rights of other persons."*

In the context of the present study, this legislation is of particular relevance if a child experiencing a crisis MH event is arrested and detained under criminal law. This legislation sets out numerous guidelines pertaining to the treatment of a child in custody. For instance, it specifically outlines that the child should be informed as to why they are being detained, that parents/guardians must be notified, that children must not have contact with adult detainees, and that Tusla should be notified if the child is in need of special care or protection.

[6] "The Children Act 2001, as amended, ("the 2001 Act") is the primary legislation governing the treatment of children in conflict with the law in Ireland. Part 6 of the Act is concerned with the treatment of child suspects in Garda Síochána stations. The Criminal Justice Act 1984 (Treatment of Persons in Custody in Garda Síochána Stations) Regulations 1987 also apply, and a code of practice concerning the attendance of lawyers during Garda questioning provides additional guidance (An Garda Síochána 2015)." (Kilkelly and Forde, 2021).

1.6 The Policy Landscape

The over reliance on the GS to manage MH difficulties in the community has become an important discussion point for government representatives, non-government organisations (NGOs) and the Irish media (see, O'Keefe, 2016; O'Regan, 2016), indicating a collective recognition and sense of urgency about the matter that did not previously exist. One of the possible reasons this issue has been slow to garner the attention it deserves is because fundamental legislation fails to provide a comprehensive overview of Garda member's roles and responsibilities. Specifically, there is an over emphasis on 'traditional' modes of policing, such as crime prevention and management, in the Garda Síochána Act 2005, whilst broader societal challenges that also fall under the remit of the GS, such as harm reduction, are overlooked (Commission on the Future of Policing in Ireland, 2018). This is problematic given that a significant proportion of the GSs time is spent providing services and assistance to reduce the amount of, and protect vulnerable individuals from, harm. These relate specifically to individuals with MH and addiction issues, individuals who are homeless, children, and the elderly (Commission on the Future of Policing in Ireland, 2018). With that being said, the 'General Scheme of the Garda Síochána (Powers) Bill, approved by the government in June 2021, outlines a series of measures intended to modernise Garda powers and improve police effectiveness. Of particular relevance to the present study are special measures for vulnerable suspects such as children and those with impaired capacity i.e., due to intellectual disability, mental illness, physical disability or intoxication (gov.ie, 2021). Such legislative developments are extremely positive and timely.

It is also important to note that a series of seminal government publications such as the 'Report of Joint Working Group on Mental Health Services and the Police' (2009), 'The Future of Policing in Ireland' (2018), and Mental Health Reform's 'Submission on review of A Vision for Change' (2017) have brought attention to the fundamental role Garda members play in the community with regard to harm reduction and protection, highlighted gaps in service provision and resource deficits, and set out the parameters for future best practice. However, it is worth noting that references to children in both the 'Report of Joint Working Group on Mental Health Services and the Police' (2009), and 'The Future of Policing in Ireland' (2018) are fleeting and non-specific. Moreover, there is a void in information regarding the potential forensic MH needs of children or how they stand to benefit from inter-agency collaboration, professional training, or legislative clarification - all of which are particular points of interest for the present study and are addressed next.

Interagency linkage

The absence of efficient interagency working between government agencies has been cited as a significant barrier to the appropriate provision of child and adolescent MH care (Children's Mental Health Coalition, 2018). This section highlights some of the major gaps that exist within key policy documents designed to provide crucial guidance to the agencies involved in the crisis MH care pathway. Positive developments in this space will also be discussed.

In 2009, the 'Report of Joint Working Group on Mental Health Services and the Police' indicated the beginning of a collaborative relationship between the GS and the Mental Health Commission. Its primary recommendation was the "*ongoing development of a joint protocol between mental health services and An Garda Síochána and the development of formal liaison systems between the MH services and An Garda Síochána*"(p.20). It also recommended the establishment of specialist Crisis Intervention Teams (CITs) at Garda divisional level. CITs are heralded as a revolutionary and transformative intervention to bridge the gaps in community outreach services and practice (Ellis, 2014). Comprised of police officers, health professionals and social workers, CITs are available outside of traditional working hours and acquire specialist training in crisis management and harm reduction (Commission on the Future of Policing in Ireland, 2018; Ellis, 2014, Murphy at al., 2015). Twelve years on, CITs are still non-existent in Ireland, and information sharing, communication and collaboration between government agencies was identified, once again, as a significant barrier to the timely and appropriate provision of MH services (Commission on the Future of Policing in Ireland, 2018). These findings demonstrate that the key recommendations put forward by specialist committees and working groups

to enhance interagency working amongst professionals who encounter crisis MH events have not yet been fully Implemented (see Department of Justice, 2019; Commission on the Future of Policing in Ireland, 2018). Accordingly, further efforts are warranted to improve multi-agency collaboration as a means of promoting the rights of vulnerable individuals and the quality of care they receive.

Whilst preparing this report, the Minister for Justice, Heather Humphreys, was asked to comment on plans to situate a multi-agency MH crisis de-escalation team[7]. The Minister advised that a pilot CIT now renamed as CAST (Community Access Support Teams) is being established within the Limerick Garda Division. She also advised that the pilot project is in line with recommendations from 'The Future of Policing in Ireland' (2018) report. This report called for a collaborative crisis intervention team comprised of specialist uniformed officers and health professionals. It is hoped that the pilot programmes will be rolled out in early 2022 (Heather Humphreys, Dáil Debates, 150, 3 June 2021).

The 'Memorandum of Understanding between An Garda Síochána and the HSE on the Removal or Return of Persons to an Approved Centre in accordance with the Mental Health Act 2001' (An Garda Síochána and the HSE, 2001) was established as a joint initiative in 2010. The intention of the memorandum was to maximise interagency co-operation and communication for instances where Garda members are directly involved with individuals suspected to be suffering from a mental illness; or when a medical practitioner requests assistance with the removal or return of persons to an approved centre. While this protocol for joint working is undoubtedly a positive step in the right direction, these considerations are largely restricted to mental health governance and service provision for adults. At the time, similar recommendations were not proposed for children nor were they included in the Children Act 2001, which legislates for the lawful treatment of minors. Such an oversight highlights a lack of procedural guidance regarding the management of comparable situations involving children and suggests an important oversight, or neglect of matters relating to child and adolescent MH by the government.

In 2017, the 'Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991' (Shannon, 2017) revealed poor levels of interagency cooperation and coordination between the GS, Tusla, and other organisations following the invocation of section 12 of the Child Care Act 1991 (i.e. the removal of a child to a place of safety by the GS). In response to the shortfalls outlined in this report, Tusla and the GS worked together to create the 'Joint Working Protocol for An Garda Síochána/Tusla – Child and Family Agency Liaison' (2017). It outlines the importance of joint working between Tusla and the GS when managing child protection and welfare issues. More importantly, it set out the various roles, obligations, and procedures for Tusla Social Workers and Garda members for safeguarding children. Whilst the applicability of the procedures outlined in this document may not be of relevance to child and adolescent crisis MH management, it serves as a good example of effective and collaborative interagency policy designed to promote the welfare of children/children in the Irish context.

Overall, whilst it is evident that some work has been done to improve interagency working between the GS the HSE, and Tusla more work is needed. This gap is most evident in the management of crisis MH care pathways of children and children living in Ireland.

Garda Policy and Procedure

In conjunction with a disjointed and indistinct policy landscape, there is a lack of knowledge and understanding as to the practice of Garda members when faced with children experiencing a MH crisis event. 'In-house' protocols, known as Head Quarter [HQ] Directives, are issued on behalf of the Garda Commissioner to the Garda organisation to provide direction and advice on matters relating to policy, practice and procedure. Whilst some HQ directives are made available to the public, none relating to crisis MH events involving children were discoverable to the researchers at the time of this report. Therefore, it is not clear whether specific HQ

[7] Reply to PQ Ref 29840/21, Dáil Debates, 03 June 2021

Directives exist to guide practice in such scenarios. However, a range of protocols and procedures that are applicable to Garda member practice when managing a child/adolescent crisis MH event are available for public viewing on Garda.ie. A comprehensive review of these directives is beyond the scope of this report. Accordingly, a brief overview of relevant protocols is provided.

Hostage/Barricade/Suicide

Barricade incidents involve a person securing themselves at a location, with or without hostages (Garda Inspectorate, 2007). Public knowledge of such events in Ireland tends to be confined to a small number of incidents that receive significant media attention. However, the GS can respond to upwards of 90 barricade situations a year (An Garda Síochána, 2020) which they manage to resolve through negotiation within a short time and which do not attract significant public attention (An Garda Síochána, 2020; Garda Síochána Inspectorate, 2007).

The National Negotiation Unit (NNU) and the Armed Support Unit (ASU) are routinely deployed to resolve incidents involving persons with suicidal intentions. HQ Directive 75/2014, the Hostage/Barricade/Suicide Incident Command Policy, sets out the GS procedure on the use of force by Garda members as well as negotiation tactics for planned and spontaneous response to hostage, barricade, and suicide incidents. Speaking in the Dáil, Minister for Justice, Helen McEntee, explained that when a Hostage/Barricade/Suicide is declared, a trained 'Operational Commander' is deployed to oversee the incident. All Garda resources available to the Operational Commander will be used to resolve the situation safely (Helen McEntee, Dáil Debates, 606, 6 October 2020).

The (NNU) is a panel of trained Garda Negotiators who function as a national on call resource to all the GS districts (An Garda Síochána, 2020). Negotiators are deployed to assist with a range of incidents from hostage situations to barricade situations involving a person with mental illness. Between January and November of 2020, the NNU was deployed a total of 89 times, 38 of which involved some form of MH crisis event. Figures also showed that on three of these occasions MH Professionals provided assistance (Helen McEntee, Dáil Debates, 452, 15 December 2020).

The Garda Síochána Inspectorate is an independent statutory body, set up under the Garda Síochána Act 2005. Its purpose is to ensure that the resources available to the Garda Síochána are used efficiently and effectively. The Garda Síochána Inspectorate (2007, p.23) states that:

> *"The assistance of mental health professionals can be invaluable during a siege situation. The Inspectorate envisages mental health professionals being utilised during barricade incidents to support the Garda Negotiation Team and, in the case of those professionals who have treated the subject, as a source of advice on his/her medical condition"*

Moreover, the Inspectorate's 'Review of Practices and Procedures for Barricade Incidents' (2007, p.41) proposed a series of recommendations outlining the role of MH Professionals in barricade situations, specifically:

- Mental health professionals should accompany and advise negotiators, but should, as a rule, not engage directly with subjects.
- On-scene commanders and negotiators should attempt to identify medical doctors, mental health professionals or counsellors who have treated the subject and those individuals should be debriefed.

The 'Status Report on the Implementation of the Recommendations of the Second Report of the Garda Síochána Inspectorate - Review of Practices and procedures for barricade Incidents' (An Garda Síochána, 2009, p.11) states that both provisions had been implemented, in that they were Included in the 'On-Scene Commander Manual of Guidance'. Thus, figures to show that MH professionals provided assistance at only

three Hostage/Barricade/Suicide incidents in 2020 is a cause for concern. Further inquiry is needed to ascertain a full understanding of the issue at hand.

The Use of Force

In 2012, the GS introduced a policy on the use of force by Garda members. This policy is laid out in a set of Head Quarter (HQ) Directives, including an overarching policy on the use of force and individual directives concerning the use of batons, restraint and handcuffs, incapacitant spray, Taser, vehicle-stopping devices, method of entry equipment, and use of force by Garda dogs and horses. While the Overarching Use of Force Policy Document (HQ Directive 47/2012) is available to the public, there are internal Use of Force policies that are not publically available (The Garda Síochána Inspectorate, 2019). Accordingly, there is no way of knowing how such directives are intended for use with children/youth or persons with suspected mental illness.

The 'Overarching Use of Force Policy' (HQ Directive 47/2012) instructs the requirements for reporting the use of force by all Garda members. It states that use of force must be reported to a supervisor and recorded on PULSE. Further, the use of force figures are published on the Garda Síochána website and are provided to the Policing Authority monthly.

Children in Care of the GS

Policy document entitled 'Recording Procedures and Guidelines relating to children in the care of An Garda Síochána' (An Garda Síochána, 2021) outlines the rights and recording procedures for instances where a child is not arrested or detained but has come into the care of the GS. Specifically, this policy provides guidance concerning recording procedures, Tusla notification, conflict management, supervision, and the applicability of the European Convention on Human Rights Act 2003.

Training

The 'Report of Joint Working Group on Mental Health Services and the Police' (2009) and 'The Future of Policing in Ireland' (2018) called for the implementation of an education programme for training Garda members to recognise and respond appropriately to people with a mental illness in crisis. It also advised that such a program be included in the overall training programme for new recruits and rolled out as an ongoing professional development program for existing Garda members. Speaking at the Dáil on July 3rd 2018, in response to a question regarding the implementation of MH training of Garda members, Minister for Justice Charles Flanagan explained that the Garda Commissioner had informed him of the following:

- Mental health training is delivered to new recruits in a problem-based learning module called 'Mental Illness Awareness' (unit 5). This module covers different types of mental illness, Garda powers and procedures, transportation of persons with a medical illness and information about community and social services. Recruits also attend a 2 day internationally recognised ASIST suicide prevention programme, which is co-delivered with the HSE.

- In April 2014, as part of the Continuous Professional Development Core Programme, operational Garda members commenced training on 'Mental Illness Awareness' in keeping with the Mental Health Act 2001. They also received training surrounding types of mental illness, Garda powers and procedures and transportation of persons with a mental illness. This training was included in the Core Programme in 2018.

Ireland's Mental Health Policy

Over the past couple of decades, the Department of Health has released two Mental Health Strategies 'A Vision for Change' (AVFC) (HSE, 2006), and the more recent updated policy, 'Sharing the Vision: A Mental Health Policy for Everyone' (SV) (Department of Health, 2020). AVFC sought to be an innovative policy for the MH and well-being of the population, not just a policy for MH service provision. It introduced principles of recovery, citizenship and partnership; acknowledged the importance of involving service users and their families/carers at every service juncture; incorporated community support and primary care into its

framework; and shone a light on the significance of social inclusion for people with MH difficulties (Mental Health Reform, 2017).

On the one hand, AVFC initiated a great deal of MH reform during the 14 years it was in place. This was particularly evident within the area of Forensic Mental Health Services for both adults and children, with the establishment of the Prison In-reach and Court Liaison Service (PICLS), a multidisciplinary psychiatric service that assists the Courts in the identification of defendants with major mental illness and provides practical solutions to accessing appropriate MH care through liaison with community services. A new, state-of-the-art National Forensic Mental Health Service (NFMHS) facility was also developed in North County Dublin. Whilst services were due to move into the new facility in September 2020, unforeseen delays have meant that the opening date has been postponed but will be rescheduled in the near future (HSE, 2021). Eventually, this facility will provide care for 170 patients as well as community outreach and prison in-reach services and a 10-bed secure adolescent inpatient unit.

On the other hand, concerns were raised that many of the strategic goals set out in AVFC never reached fruition and those that did were implemented unevenly across the country (Mental Health Reform, 2017). This was particularly the case with regards to Child and Adolescent Mental Health Services (CAMHS). For instance, despite some increases in recommended levels, CAMHS is operating at 77.1% of the clinical staffing levels recommended in the AVFC, and access to 'out of hours' services is severely limited (HSE, 2019; McNicholas, 2018). Furthermore, the AVFC recommended that a total of 100 in-patient beds for 0–18-year-olds were established nationally. At the time of writing this quota had not yet been reached, with only 74 HSE funded child and adolescent inpatient beds operational across four specialist units (HSE, 2019a; Wayman, 2020).

Of particular relevance to the GS are difficulties associated with Forensic Mental Health Services as the AVFC recommended the establishment of two multidisciplinary Forensic Child and Adolescent Mental Health Services (F-CAMHS) – one based in a 10-bed secure unit and one to function as a community-based resource. Presently, only one F-CAMHS multidisciplinary team exists and continues to work with local MH services in every part of the country (Children's Mental Health Coalition, 2018; HSE, 2021). An unfortunate upshot of such deficits is that children in need of inpatient psychiatric treatment have had to be admitted to adult psychiatric units. Indeed, this was the case in 2019, with 14% of all child and adolescent inpatients being treated in adult approved centres (HSE, 2019b). Finally, the AVFC endorsed the need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents (Department of Health, 2006, p85). However, media reports and academic commentary released over the past 14 years indicates that this has not been the case, with CAMHS repeatedly being described as fragmented, over stretched, under resourced and understaffed (McNicholas, 2018). This has implications for staff wellbeing and service delivery, with research suggesting that CAMHS team leaders are experiencing high levels of occupational stress and reluctance to remain within services, and are unsure of government commitment to and effective management of services (McNicholas et al., 2020). Such concerns affect the HSE's ability to maintain the recommended staffing levels set by AVFC 14 years ago.

In 2020, the new national MH Policy, Sharing the Vision: A Mental Health Policy for Everyone (SV), was released by the Department of Health. Whilst there is a clear recognition of the AVFC shortcomings throughout the new policy, it does little to provide assurances to service providers that the strategic goals set out in AVFC will progress, with little reference to timelines for adequate provision and capacity of specialist services such as F-CAMHS and out-of-hours services. It has also received scrutiny from a number of professional associations such as the College of Psychiatrists of Ireland who criticised the new policy for "*recommending an acceptance of the need for admission of children to adult beds, rather than increasing capacity as needed for our current population of under 18-year-olds*" (College of Psychiatrists of Ireland, 2020, p.1). Additionally, the Irish Hospital Consultants Association commented that MH services "*simply do not have the resources and the number of consultant psychiatrists required to provide high quality, timely care and treatment to patients who need it*" and that the "*new mental health policy has failed to set out the urgent workforce requirements needed to staff*

a modern psychiatric service" (Irish Medical Times [Online], 2020). Overall, this review of the literature reveals that despite some progress in CAMHS and F-CAMHS provision, huge deficits in 'out of hours' specialist MH provisions exist for youth who experience acute MH crises, meaning that youth and families in crisis will continue to need the assistance of other emergency services, specifically the GS.

1.7 The Study

Objective One: Current Practice and Experience

To examine the current care pathways of Irish youth experiencing a crisis MH event from the commencement of the GS involvement through to the initiation of psychiatric care.

I. Exploring Garda members' perceptions and experiences of the systems in place to manage children experiencing a crisis MH event once under Garda Supervision.

Objective Two: Gathering Experience of Service Providers

I. Obtaining expert insight from interviews with key stakeholders (e.g. Child and Adolescent Psychiatrists, emergency department Doctors and Nurses, Tusla Social Workers) regarding their experiences of pathways to child and adolescent psychiatric care involving the GS.

II. Identify the opportunities and challenges associated with the pathways to child and adolescent psychiatric care via the criminal justice system from the perspective of the Garda members.

Objective Three: Producing Innovation

I. Conducting an international literature review identifying innovative practice in the area.

Conclusion

Children experiencing MH issues are an extremely vulnerable cohort. Their status as 'child' combined with their impaired mental state gives rise to a dual vulnerability that warrants a specialised professional approach. Given that a significant proportion of Irish adolescents experience MH difficulties (Cannon et al., 2013, Dooley et al., 2019), coupled with evidence of an increase in police involvement in crisis MH situations (Commission on the Future of Policing in Ireland, 2018), implies that Garda members (as first responders) are extremely likely to encounter a child experiencing a crisis MH event at some point in their careers. Henceforth, when it comes to managing such cases, it is of the utmost importance that Garda members of all ranks are provided with the appropriate training; are confident in and supported by the proficiency of the policy and protocols that are in place; and have access to the resources, supports and services that are necessary to ensure best practice. Whilst some policy and protocol exists to support the service with issues pertaining to MH crisis events, specific directives regarding the management of children in such scenarios are seriously lacking. Furthermore, there is a dearth of research documenting the extent of the GS involvement with youth with MH crisis, their experience of management of these crises and areas in which they feel are in need of additional support.

Chapter 2: Methodology

2.1. Introduction

This study adopted a qualitative research design incorporating two data collection phases. The study's focus on practitioners' experiences of child and adolescent pathways to MH assessment meant that an in-depth multidimensional approach to data collection was warranted. Qualitative methods were selected on the basis that:

i. They allow a focus on depth and meaning, rather than quantity and structure, and produce rich (often-verbal) data that elucidates participant perceptions of the world by making enquiries regarding thoughts, attitudes, opinions, and beliefs (Ivankova et al., 2007).

ii. They typically involve face-to-face contact with participants, making non-verbal participant cues accessible to the researcher as another source of data.

iii. They provide a front row seat to the lived experience of participants, thus allowing the collection of multidimensional experiential data regarding cultural, societal, and organisational norms (Ibid).

iv. They are suitable for use with small samples and in exploratory studies. The lack of quantitative data regarding the prevalence of the GS contact with children experiencing a crisis MH event and the subsequent number of children, who progress to various stages of the care pathway, necessitated the employment of a qualitative approach.

Expert Advisory Panel[8]

An Expert Advisory Panel (EAP) comprised of leading experts in the fields of Child and Adolescent Psychiatry, Youth Justice, Mental Health, Policing and Social Policy was convened. Panel members were invited to take part in two EAP meetings. The first meeting was held during the first data collection phase at the beginning of the study to present the project objectives, discuss academic research and policy in the field, and future directions. The second meeting was held at the beginning of the second phase of data collection to present pertinent themes that had emerged from interviews with Garda members, discuss how these themes could help inform interview schedules with stakeholders (Phase 2) and discuss any new literature to assist in the contextualisation of the project's results.

Ethical Approval

Ethical approval was granted by An Garda Síochána Ethics Review Board, Tusla, Children Health Ireland and University College Dublin's Human Research Ethics Committee.

2.2. Research Design[9]

Data collection was carried out in two phases:

Phase One

Semi-structured research interviews were conducted with a sample of Garda members (N= 18), of varying ranks across nine Garda Stations in the following districts: Dublin Metropolitan Region [DMR] East, DMR South Central, DMR North Central, Wicklow, Arklow, and Bray. The total interview time was 17hrs 1 min 16 sec and the average interview lasted 55 minutes.

[8] See Appendix 2 for List of Panel members

[9] See appendix 3 for a full outline of the research procedure

Table 1: Phase One-Sample Demographics

Sex	Age	Years of Service	Rank
Female: 4	Range: 26-44	Range: 2-23	Garda: 13
Male: 14	Mean: 35.5		Sergeant: 14

Phase Two:

Semi-structured research interviews were conducted with a sample of other professional stakeholders (N=11) involved in the care pathway under investigation; namely medical professionals working in a Paediatric Emergency Department that serves children aged 0-16 years in Leinster Province; and a Social Worker from Tusla Child and Family Agency (Leinster Province). Total interview time was 8hrs 50 min 36 sec and the average interview lasted 45 minutes.

Table 2: Phase Two Sample Demographics

Sex	Age	Years of Service	Profession
Female: 9	Range: 28-56	Range: 3-32	Consultant Child and Adolescent Psychiatrist: 2
Male: 2			Paediatric Emergency Department Doctor: 2
			Paediatric Emergency Department Nurse: 5
			Psychiatric Clinical Nurse Specialist: 1
			Senior Social Work Practitioner: 1

2.3. Methodology

Convenience Sampling

The present study involved a convenience sample of participants from government institutions across Counties Dublin and Wicklow. Convenience sampling has been referred to as "*a cheap and dirty way*" of conducting research because there is no way of knowing whether the findings generated are representative of the research population (Robson, 2002, p. 265). Thus, the results may be criticised for not being representative of the wider population and deemed ungeneralisable. This is a common issue faced by qualitative researchers within the social sciences. To mitigate this issue, the research team were mindful to recruit and assemble a diverse sample in terms of experience, with demographic characteristics that matched the research population as closely as possible.

Sample Composition

The research team had hoped to include two GPs in the Phase 2 sample and two Social Workers from the Tusla Child and Family Agency. However, attempts to include representation from the GPs who attend the station and more Social Workers was not successful due to unforeseen circumstances associated with the Covid-19. Finally, Phase 2 interviews were conducted with Medical Professionals from a Paediatric Emergency Department that works with children aged 0-16 years. This is the case in most Children's Hospitals across the country, with those aged 17 years and over attending adult Emergency Departments. The decision to collect data from professionals working in the Paediatric Emergency Department was not only informed by time constraints related to the project, but the commentary collected by Garda members in Phase 1 Interviews. Indeed, much of the testimony given by Garda members regarding their experiences of juvenile crisis MH

events concerned children aged 14-15-years. Thus, it is important to note that the findings from this study strictly apply to the experiences of professionals when managing crisis MH events involving children aged 16 years and under. Further research is needed to explore these issues with professionals involved in the crisis MH pathways of children aged 17 years.

2.4. Analysis[10]

All interviews were audio recorded and subsequently transcribed using Microsoft Word. The software package MaxQDA was then employed to systematically organise and code transcriptions.

Thematic Analysis, defined as "*a method for identifying, analysing and interpreting patterns of meaning ('themes') within qualitative data*", was conducted on transcribed interviews to capture frequently cited and meaningful information that was relevant to the overall research questions (Clarke and Braun, 2014, p.1). Braun and Clarke's (2006)[11] framework, which sets out six systematic phases that must be implemented when examining qualitative data, was used. This analytical process allowed the researcher to organise and describe the dataset in an informative and detailed manner. Salient themes were incorporated into a codebook that captured the key features of the textual material.

Reflections

Concern has been levelled with regard to a lack of structure and flexibility linked to qualitative research which has inadvertently led to the perception that researchers are guided by an 'anything goes' philosophy during analysis (Braun and Clarke, 2006, Robson, 2002). Strong opponents have opined that qualitative research is 'not real' research (Laubschagne, 2003). However, in recent years seasoned qualitative researchers have developed innovative methods for conducting qualitative analysis, which are decidedly structured and methodical. These scholars argue that when such frameworks are rigorously applied to qualitative data, they increase the objectivity and reliability of the findings produced (Madill et al., 2000).

The interview process allowed the research team to tune into the participants' emotions and frustrations in a way that would not have been possible using a quantitative methodology. Interviews allowed for the observation of body language and facial expressions, along with changes in speech patterns, volume and intonation. Finally, some participants noted that it felt good to be consulted about the issue at hand. They noted that it gave them the time and space to think about and reflect on a complex aspect of their job.

Covid-19 provided a range of unique challenges for the research team, specifically when it came to recruitment. The work demands on Phase 2 participants (Medical Professionals and Social Workers) meant that interviews were delayed for a number of months. Moreover, travel restrictions necessitated that the majority of Phase 2 interviews be conducted over the phone when participants managed to find some time to talk. Yet despite these unforeseen challenges, the research team was able to collect key insights from a range of key stakeholders.

[10] See Appendix 4 for a full description of the Research

[11] See Appendix 5 for outline of Thematic Analysis Process

Chapter 3: The Pathway

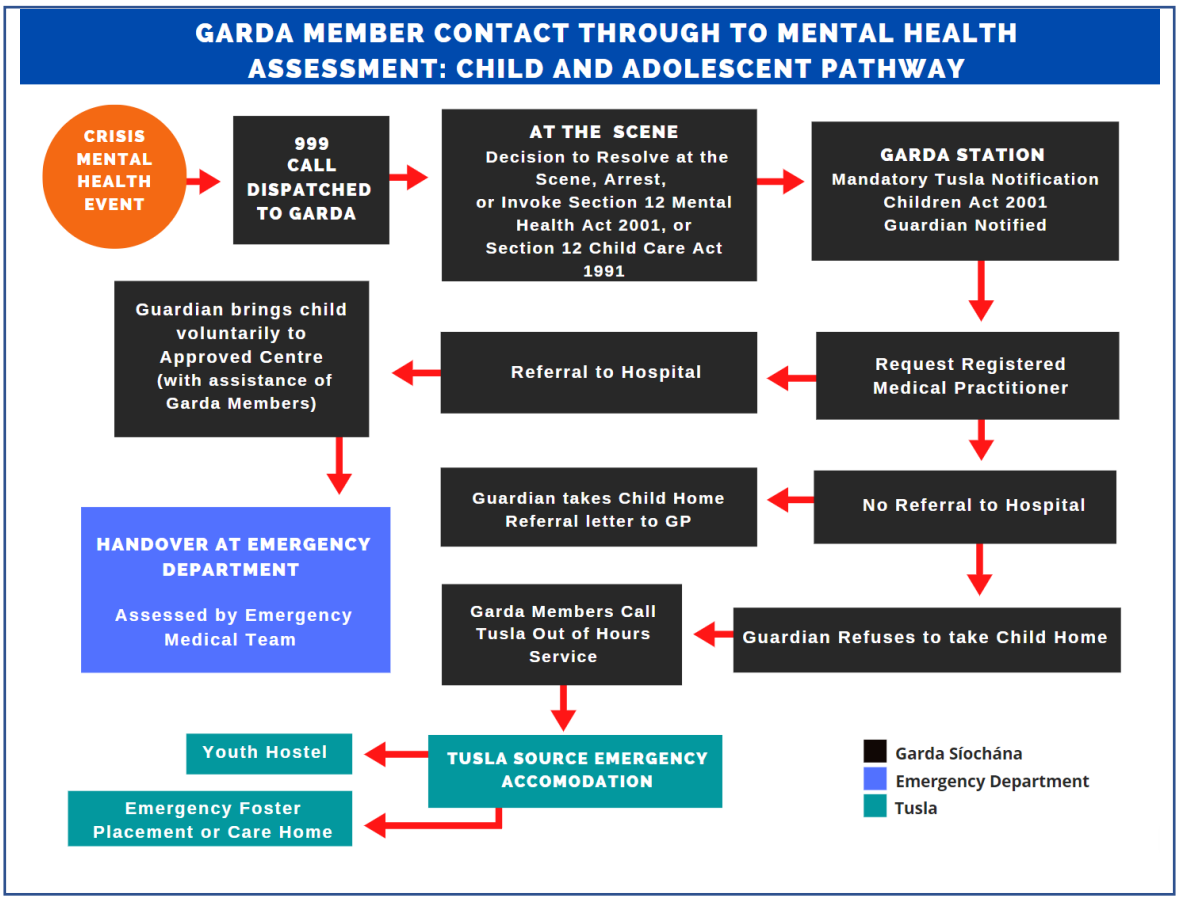
3.1. Introduction

A total of 18 Garda members were interviewed for this study, all of whom had been involved in at least one crisis MH call out concerning an adult. Almost the entire sample (n=17) had been directly involved in a crisis MH call concerning a child aged under 18 years. When asked about the frequency of such cases, participants commented that crisis MH calls were far more common amongst the adult population but felt there had been a marked increase of calls involving children over the past 5-10 years.

Garda members interviewed for this study were asked to provide a demographic profile of the children they encountered as a result of crisis MH events. In terms of age range, participants noted that call outs were most associated with children aged 14/15 years and older. However, a couple of participants noted encounters with children as young as nine and eleven years of age. Some participants noted more experience with girls; some felt they had more encounters with boys, whereas others felt that the gender ratio was equal. Finally, while participants explained that they had been called to assist children in crisis from very disadvantaged areas and very affluent areas, the vast majority felt that they had more experience with children from disadvantaged areas.

Juvenile crisis MH events are managed by the GS across three key settings: The Scene, the Garda Station, and the Emergency Department (see Figure 2). It is important to note that not all youth experiencing a crisis MH event are exposed to the full pathway. Sometimes the crisis incident is resolved in the home; other times it is resolved in the station once a GP assessment has been conducted; and occasionally further assessment in the Emergency Department is required. To provide an accurate chronological account of the care pathway, findings will be presented in relation to the three settings*: The Scene, The Garda Station*, and *The Paediatric Emergency Department.*

Figure 2: Garda member Contact through to Mental Health Assessment: Child and Adolescent Pathway



3.2. The Scene

An abundance of crisis MH case examples were given by participants. The most common setting for these cases was in the family home; however, some Garda members also recounted call outs to bridges, train stations and emergency departments. There was agreement amongst participants that the most frequent behavioural presentations on arrival to the scene of a youth crisis MH event were violence and aggression toward others, being armed with a weapon, property destruction, being barricaded in a room, self-harm, and threats of suicide. These behavioural disturbances were not only noted as the primary reason for the GS involvement, but were named by participants as key indicators for identifying a crisis MH event.

> *"A 16-year-old girl and she was on top of a bridge in (place name), when she was taken down off the bridge, she was taken back to the station, she said that she wanted to die" [GARDA 9]*

> *"A 14-year-old girl who locked herself into the bathroom in the family home with a knife saying that she wanted to kill herself" [GARDA 9].*

> *"Anger or violence. Straightaway, you go into the situation, it could be that the child has locked themselves into a bathroom or bedroom and you can hear them tossing stuff around breaking things in their room. Shouting threats of violence at us, parents, brothers, and sisters. Threatening to burn things down." [GARDA 20].*

"A juvenile, a very large, strong, fit young man…, who suddenly had a mental breakdown in [place name], and he suddenly, without warning, without any prior warning had some kind of an episode and he went absolutely insane, smashed windows…he had a [tool] from [the locality] and was smashing windows and, you know, I was dispatched to deal with that." [GARDA 2]

Garda members employed numerous skills and techniques while attending the scene of a juvenile MH crisis event. Some of these practices were formal, in that they were set out in legislation and policy; and some practices were informal, in that they were based on Garda member intuition, common sense, life experience, and knowledge acquired on-the-job. The findings presented below outline the formal and informal practices adopted by the GS attending the scene of a crisis juvenile MH event, along with the challenges they encounter at this stage of the pathway.

Formal Procedure and Response: Communication, Rapport Building, and Physical Intervention

The pathway begins when a 999 call is dispatched to Garda members at the station. Quite often, the information they are given regarding the situation is scant. Garda members explained they will assume there is a criminal aspect to the call and will not be expecting it to have a MH component unless that is conveyed to them, which is quite rare. Furthermore, participants noted that most of the call outs they attend involve members of the public that they have not encountered before. Thus, on arrival to the scene, the Garda member must urgently try to collect information from persons involved so that any threats to health and safety can be assessed and dealt with appropriately; specifically, identifying whether there are injured parties who require medical attention, whether there is a weapon involved, and whether the child is displaying physically aggressive behaviour. All participants noted that safety and preservation of life is their foremost concern, and they rely heavily on their communication skills to gather pertinent information from bystanders, parents/carers, the child, and their colleagues.

"And, you know, An Garda Síochána, we are the service of last resort. So, when people don't know what to do, generally that's when we, we are asked to come into play. So, as you can imagine, by the time that we are asked, or to deploy and to assist, generally the situation has gone, has gone, there's violence involved or there's a very immediate threat to the person. And so that's, so that's by and large what we are dealing with." [GARDA 2].

"I suppose the main thing is the preservation of life really, as in just try to get that child out of there safe and well, and everyone else in the house gets out safe and well, that I suppose would be the priority all the time. And then, of course, self-protection that the Guards are not put into a situation where they might become harmed as well." [GARDA 13]

"You get to the scene; we will always pull the parent to one side and get the full run down of what's after happening. Try and I suppose try and identify any medical issues that are there, any underlying issues that might be there…, what may have triggered the incident, how long the behaviour has lasted for, and why if it's lasted for two weeks, three weeks, what triggered it a month ago, and are those triggers the same as whatever triggered it today? Then ultimately we will go and speak to the child and try and get their point of view." [GARDA 8].

Participants stated that there is no 'one size fits all' response to MH crisis events. One of the most critical aspects of their role at the scene is to continually assess and reassess the situation and implement a response that promotes the safety and wellbeing of all persons involved. Crisis MH call outs were described as unpredictable with the propensity to "*go south quickly" [Garda 13].* Thus, being adaptable, resourceful, and decisive were deemed essential qualities in a Garda member. Participants outlined several formal procedural

tools and techniques that are typically implemented when managing a crisis MH event, namely the National Negotiation Unit, and the Armed Response Unit.

Negotiation and communication skills were described as the cornerstone of the GS toolkit. They were also described as the foundation for managing most crisis MH events. Negotiation is specifically the tool of choice when faced with a barricade situation or a threat of suicide (i.e. jumping from a bridge). Participants explained that unless the child is in serious danger, negotiation and rapport building is the best course of action no matter how long it takes. Some officers referred to trained negotiators who are on call to attend the scene if necessary. However, the majority of the sample felt that the negotiation skills they acquired as part of their formal training and what they had learned on-the-job were sufficient to manage these situations. Finally, participants believed that being patient and building rapport with a child typically led to a successful outcome without having to use force.

> *"You try talk to him through the door and if he's responding to you, or at least that you know he's not actively self-harming there. You know, I've done that before, it's mainly for adults, but you end up being there for ages, it could go over a couple of hours just trying to talk until eventually they come out and agree to chat to you." [GARDA 4]*

> *"If someone has locked themselves into an area like that and if there's a huge concern for their safety and welfare we would have to call out a negotiator in an instance like that, and our policy would say that as well that yeah we can sort of talk ourselves but if there's any sort of indication of them having a knife or anything like that, they're so obviously trained in that area compared to the regular unit, the first responders." [GARDA 7]*

Participants stated that great consideration is given to the use of force and/or restraint by Garda members who all agreed that it should only be used as a last resort, particularly with children. Participants were mindful of the impact that physical intervention could have on a distressed youth in terms of the potential to cause physical injury or further psychological distress. Accordingly, such a response is only adopted when negotiation tactics have failed, and the child poses significant risk to themselves or others. Finally, in situations where the juvenile is armed with a weapon, a request for assistance from the GS Armed Support Unit can be made. Staff in this unit are specially trained to disarm persons with a firearm, edged weapon, blunt object etc.

> *"We would have arrived at a place, and straight away we're going to be let in because she's rang us so the first thing then if the first thing then if that person has barricaded the door we'll find out first if he still has weapons if he has the hammer or whatever because if he does then it's a case that we might need to get an armed support unit or something like that you know unfortunately." [GARDA 11]*

Formal Pathways from the Scene: Removal to the Station

Not all crisis MH health events require the child to be brought to the station or the hospital. Indeed, Garda members believed that the best outcome for the child is to remain in the custody of their parents/carers and see their own GP at their earliest convenience. When this is not possible, there are two main pathways to MH assessment and treatment.

"Well typically we'd rather try and just calm the situation down, sometimes if it's you might find sometimes that the child has an issue with one parent maybe, and maybe if it's like, sometimes if you're dealing with a domestic incident where you try and just separate or take the person away from the situation, as in maybe the parent, if that parent was to just not be seen for a while, to calm the child down that's what I would prefer to leave the child in his home or her home I don't think that bringing the child to a Garda Station is the answer but if it's required of course it's required."[GARDA 7]

Removing a child from the home and bringing them to the station was described as a decision that is not taken lightly. The entire sample commented that the Garda Station is not the appropriate place for a child in distress. Thus, the only reason a child would ever be removed is when officers at the scene believe they pose a significant risk to themselves and it is deemed necessary to take them to a place of safety to be assessed by a GP, or when the parents/carers are unavailable/unwilling to have the child in their custody.

"I completely understand the need for the presence of Gardaí at some cases, completely understand that. But I'm a firm believer that a Garda Station isn't a place for a child to be brought back. Especially with mental health issues, you know?" [GARDA 9]

"If it's a thing that we believe he's around razor blades and there's just stuff like that we'd put the door in and we'd restrain him because unfortunately his needs require it like and then everything goes through the same protocol then you would restrain the person, establish whether, in that situation it's definitely safer to get him back to the Garda Station get a parent to accompany him." [GARDA 11]

Garda members cannot bring members of the public back to the station without due cause; there must be a lawful reason for detainment. Participants explained that three pieces of legislation are commonly adopted when they feel a juvenile experiencing a crisis MH event needs to be removed from the scene. The first is an arrest for a criminal offence. If a crime has been committed in the midst of a MH crisis (e.g. assault, affray, criminal damage) and the child is of an age where they can be held criminally responsible (12 years or older), a Garda member can make an arrest. This gives them the power to hold the child at the station for up to six hours. An arrest may be made if a complaint is made by the parent/carer but may also be made in the absence of a complaint if the GS deem it necessary. Moreover, if an incident results in a member of the public being victimised somehow, they may wish to make an official complaint. A quarter of the GS sample explained that the arrest route is sometimes employed as a means of getting the child to a place of safety so that an assessment by the GP can be carried out. While this sounds like a benign reason for arresting the child, such practice is a prime example of how the law can be used to criminalise children with mental illness (see Mulvey et al., 2017). More importantly, these findings provide evidence for the unintentional criminalisation of children experiencing a MH crisis within the Irish context.

"Obviously if they want to make a complaint there and then, then as a Guard we're obliged to arrest that child and bring them to the station, now when they're there obviously if they're arrested they are entitled to a doctor so we get a doctor to visit…if there wasn't a complaint made then you're talking about the Mental Health Act." [GARDA 15]

"I would say the first thing is, obviously you're going to get the child out of the house, you can make that reasonable grounds for an arrest, which is criminal damage – he's caused criminal damage in the home." [GARDA 1]

"You could arrest them, even if the parents said they're not making a complaint, if you're just not happy you arrest them for breaching the peace or something like that to, just to get them out of there like, do you know." [GARDA 4]

The second piece of legislation is removal under Section 12 of the Mental Health Act 2001, and the third is removal under Section 12 of the Child Care Act 1991[12]. These pieces of legislation allow Garda members to remove a child and bring them to a place of safety. The child can then be assessed by GP to ascertain whether they require referral to the Paediatric Emergency Department. Once again, Garda members do not require the permission of the parents.

"If we kind of make the decision that things are bad enough that we have to detain the youth under the mental health act, that's something we'll do, and the child will be brought back to the Garda station." [GARDA 9]

"But also, we have the Child Care legislation, Section 12 of the Child Care Act allows us to take the child to a place of safety if we believe there is an immediate risk to their safety. And arguably if, you know, if they are suffering from a mental health issue and they are in a home and their parents are unable to control them, arguably we can invoke that piece of the legislation" [GARDA 2].

"They are entitled to a Doctor so we get a Doctor to visit, which we would do in that situation, that would be the call from the Sergeant in charge of the station." [GARDA 3]

Although the outcome of both routes tends to be the same, the sample referred to adopting the criminal justice route the most. Analysis revealed that participants were more familiar with this procedural route and thus seemed more confident using it with children than the Mental Health Act 2001.

"I think a lot of Guards would tend to deal with the criminal act first and then deal with the mental health, and it should really be the other way around." [GARDA 15]

Informal Practice at the Scene

Formal procedure and protocol are not the only tools employed by Garda members when attending a crisis MH call out. Analysis revealed that participants adopted a wide range of informal approaches and techniques specifically intended to calm the situation down and mitigate negative consequences for the child and their guardians. This skillset was characterised as being informed by common sense and on-the-job experience. It was also attributed to the individual personalities of members. Four major informal practices adopted by Garda members at the scene were identified, namely, *Environmental Accommodations, Age-Appropriate Approach, Collaborative Resolution, and Follow-up*.

[12] See Chapter 1 pg. 17-19 for outline of Mental Health Act 2001 and the Child Care Act 1991.

Environmental Accommodations

Garda members were cognisant of the high level of distress experienced by children who are not only experiencing a crisis MH event, but must also contend with the presence of uniformed members in hats, high visibility jackets, and stab vests. They pointed out how intimidating and foreign their presence must be to a child that is unwell and highlighted the importance of making every possible effort to put the child and their guardians at ease. Such efforts included: asking the child if they have a favourite room in the house where they can sit and chat; bringing in a sibling/friend/family member that they trust to sit with them while they chat; suggesting the child sits with a favourite blanket or pillow; and requesting the Doctor comes to the house if possible.

> *"I would always try and find the source of comfort in the house. So that might be an older brother or an older sister. It might be so simple as an argument with a mother or a father and this sets off what is already underlying in the child, so there's no point putting that person back in the situation… We've a lot of young Guards here at the minute, I would always kind of tell them, find a comfort zone within the house and that may be the child's bedroom, that might be, and I have a child, it might be a particular toy, or it might be a particular item of clothing or a blanket or something, and then get the situation to where it's a relatively calm level and then try and talk the whole matter through. And like we don't receive any formal training in that, in this bit either, you're kind of going off incidents, you're learning as you go and what you think at that time, and ultimately, and I've been in situations where three of us went up, three Guards went up, and I'd tell one to stay in the car because three yellow uniforms can also be a trigger point and we've often been in situations where two might go in and you remove one from the situation." [GARDA 15]*

Age-Appropriate Approach

Participants highlighted a need to be mindful of the differences in cognitive and emotional functioning that apply across adults and children. Adolescents were deemed more vulnerable on account of having a lower level of emotional awareness and understanding of the behavioural disturbance they are experiencing. Accordingly, some members explained that they try to tailor their interaction with children and make it more age-appropriate. For instance, they described adopting a gentler tone when communicating with the child, avoiding the use of an authoritarian demeanour, explaining why the GS have been called in simple terms, keeping the child informed as to what is happening, offering to repeat the information in a different way, and reassuring the child that they are not in trouble.

> *"They are not emotionally developed enough and if they are suffering from some sort of mental breakdown they don't know how to control that and again seeing us is the worst-case scenario…But they don't understand your language either. If you are talking to a 13/14-year-old, no matter how mature they think they are their brains aren't developed enough, not even close." [GARDA 16]*

> *"It'd be like any incident when you're dealing with a juvenile it is a bit more sensitive, you kind of have to. You would be toning it back a bit as in you are speaking to a child as in like adults tend to know what they're doing children tend to sometimes not know what they're doing. Like you can't, if you're dealing with a child you can't really be going in kicking screaming and us roaring you just kind of have to take a bit of a laidback approach." [GARDA 14]*

"Like I suppose, approach it from the side of you know, 'what's going on how are you feeling that this incident might have happened?' You know I'd always kind of use, not harsh words in terms of kinda saying why did you do this, I'd be kinda saying, "can you give me any reason why this might have happened?" So, you know the child done it but you're not putting the blame straight on them." [GARDA 8]

Collaborative Resolution

Most of the sample believed that a lot of the time parents/carers really need somebody to talk to about the problem, somebody who can validate their concerns. Garda members recognised the value and importance of making themselves available to guardians for this kind of debrief, and felt it meant a great deal to them. In addition, some participants spoke of the importance of sitting down with the family over a cup of tea and trying to problem solve or reach a solution collectively. This approach was said to help empower the parents/carers amidst a situation where they feel they have no control.

"To be honest it comes down to giving them the time, so like what I try and get into lads' heads now is, don't be going out and taking details and legging it, take your time, and spend time with them, sit down with a cup of tea." [GARDA 15]

"I think the parents do need a bit more follow up from a Garda point of view, and although we mightn't be doing anything to help the child, there is an awful lot of people who rely on us to have a conversation, it's that kind of answer do you know? In that sort of, you know, we still have to be an avenue, some bit of a kind of a release for the parents to talk to about answers." [GARDA 8]

"You know with parents, it's just maybe sometimes, they need to talk as well and just to be reassured." [GARDA 7]

Follow-up

Finally, some participants noted that in crisis MH situations they sometimes provide the family with their name and number so that they may directly contact the Garda member who attended the scene should they have any follow-up questions or concerns. A couple of participants also noted that following these incidents they occasionally ask the Juvenile Liaison Officer to contact the guardians to check in and maybe offer a bit of advice. Participants felt that these means of follow-up help parents/carers to feel that they have a source of support.

"*The Community Sergeant sometimes calls me (Juvenile Liaison Officer), because I have training and dealing with victims of child sexual abuse and so on, I am used to talking to kids like this, maybe just to do the call out to see the family afterwards and then I can deal with them. I have absolutely no issue in doing that at all, happily that kind of thing." [GARDA 12]*

"There is a card we can hand over to the individual - regardless of whether they have been violent with us. We give them a card and tell them if it happens again, they can ring us, don't ring 999, just ring the station and ask for us and they will get us. It kind of gives them something, it's nothing to me it's just a card with my name on it, but to that person it could be the difference." [GARDA 16]

Challenges at the Scene

The GS must respond to all calls for assistance, 24 hours a day, 7 days a week. Garda members explained that they cannot be selective about which calls they respond to - making them a catchall service by default. The entire sample believed there is a collective expectation among the public and other government agencies that the GS will know what to do. On the contrary, most participants described feeling like imposters when attending these calls for assistance, in that they felt they were the wrong people to be overseeing a crisis MH situation. Overall, these findings demonstrate that Garda members not only feel occupationally misplaced in these situations but also extremely unsupported and isolated by their own organisation and other government agencies.

> *"So, any mental health is much much harder to deal with, because you're going to a house where straight away, you're of the belief that we're not the people that should be going here like we're the wrong people to be here and we could kick this off altogether. It is it's frightening we just we're massively under trained." [GARDA 11]*

> *"Or the other scenario that does happen then is outside of working hours, where maybe a child has some crisis event or some kind of a breakdown, some kind of serious incident. And again, there is nobody else to call then at that stage so again that's where we're going to have to intervene…. It takes a particular type of person to be willing to deal with something when nobody else will right and that's really what we have to do as Guards. No matter what we come across, no matter how violent the situation, we must deal with it. Like it's not an option for the Guards to say - oh no we can't, we can't deal with this." [GARDA 2]*

Legislation and Procedure

The entire sample believed there is considerably more clarity in terms of legislation, policy and protocol when managing adult crisis MH events. Garda members expressed more confidence in their approach to adult MH call outs, not just, because they are more frequent and participants have accrued more practical experience in the area, but because they felt that their role in terms of Garda powers and legislation is more distinct. Participants believed that the Mental Health Act 2001 provides the GS with very little guidance when it comes to managing children. For instance, participants informed researchers that there are no clear directives regarding when it is appropriate to bring a child to the station for an assessment or when to leave them in the custody of their parents/carers. Equally, participants felt there is a lack of clear guidance surrounding the use of restraint/physical intervention with children in these scenarios. As a result, Garda members demonstrated apprehension about invoking the Mental Health Act 2001 in this context.

Such uncertainty was compounded by the absence of a specific protocol, such as a HQ Directive, for managing these incidents. Accordingly, participants described their decision-making at the scene as being informed by common sense and gut feeling. Garda members acknowledged the fallibility of this instinctual approach and worried that they could inadvertently make the wrong call and aggravate the situation. Consequently, participants called for the development of youth-specific the GS protocol and improved legislation in the area. They felt strongly that such directives need to be clear and concise so that they can do right by the people they are called to assist.

> *"You wouldn't have any sort of doubt in mind on the procedure when it's an adult." [GARDA 7]*

> *"With this as well like a massive problem is legislation, it's missing or it's wrong or it's just not being, you know what I mean it's missing or it's wrong simple as that, and they'll never, ever, ever ask us. You're asking us now, which is fantastic, but literally it's the first time I've ever been asked these questions." [GARDA 15]*

"There wouldn't be protocol as such and if there is, I'm not aware of it" [GARDA 11]

"We need more training and support, in a situation like that we are going off our own experience. We are constantly assessing the situation and making judgement calls – using our common sense because we don't have a clear-cut procedure. For that reason, it puts us under a lot of pressure – we want to know we are doing the right thing and not making things worse." [GARDA 2]

Even though members framed themselves as competent negotiators within the context of a juvenile crisis MH event, they simultaneously expressed feeling that they were extremely undertrained when it came to interacting with children, crisis MH events, and neurodiversity[13].

Training

Participants who were relatively new to the organisation (qualified under 5 years) said they received some MH training at Garda College, which they found particularly useful when attending incidents involving neurodiverse individuals. Alternatively, Garda members with longer service (over 5 years) commented that they did not recall receiving any MH training outside of the Mental Health Act 2001 and Garda Powers connected with this legislation. They noted that any MH knowledge they possess was either picked up on-the-job or acquired outside the service. Such discrepancies in training may be attributed to the introduction of Unit 5 (Mental Illness Awareness Module) to the Garda Training College in 2015. Furthermore, none of the participants could recall attending any formal Continued Professional Development courses regarding MH, with the exception of Applied Suicide Intervention Skills Training (ASIST) program. Despite differences in the level of training received by newer members and long serving officers, all participants felt ill prepared to manage crisis MH call outs involving children and believed that further training in the area is warranted.

"I can't say yes or no, I'm sure there was but none of our training is significant… There is no training on-the-job; we just have to deal with it. We look at the Act and speak to people who have had experience themselves and we chat to the Doctors, but the Guards is all about learning on your feet, on-the-job." [GARDA 16]

"So, even just in Templemore, they've changed the training programme and I don't know what it's like for the majority of Guards who didn't go through this new programme, but it was decent. I mean we got a programme in trying to identify these mental health issues… So, you're trying to, if you get called to a specific incident, just not thinking that this person is definitely out of it, but that they may have Asperger's, or they may be on some sort of spectrum… So, rather than jumping the gun, and considering that first, say 'Right, what else might be going on here?' It wasn't child specific now, you know. "[GARDA 4]

Interestingly, Garda members expressed feeling more confident when dealing with a medical emergency such as cardiac arrest or a serious wound than a MH crisis. This was not just because they had received First Aid training, but because there is a distinct pathway for treatment i.e., calling the paramedics who will transport the person to hospital. Such certainty in terms of a pathway to treatment simply does not exist for crisis MH situations.

[13] "Neurodiversity" refers to Individuals who live with autism, are on the spectrum, or who have other developmental differences.

"Like If I get flagged down 'cause someone is having a heart attack, I know there is an AED somewhere I know an EMT will be there in 8 minutes I can do CPR. I know that everything can be done that is medically possible by the people who are trained to do it. When it comes to mental health, I can't get them to lie down on the couch and get them to look at Rorschach ink blot pictures and get them to tell me what it is and can't say see you next week same time same place, or prescribe them medication, I can't solve their parental issues etc. It's not us it's not a tool we have; it is out of our hands after they leave us." [GARDA 11]

Finally, the uncertainty experienced by parents/carers as to what they should do and where they should go means that they often look to the GS for answers that officers are not in a position to give. Many participants stated that 'their hands are tied' in these scenarios, in that they do not have a concrete answer to give parents/carers at a time when they need certitude and clarity the most. This not only led to participants feeling helpless and frustrated, but in some instances, it was described as severely undermining the ways in which officers understood their role as first responders. Participants believed that having more specialist knowledge at their disposal would enhance Garda member's abilities to collaboratively resolve crisis incidents with parents and caregivers.

"Just sort of helping them in that immediate moment, keep them safe for now but there's no long term I can't give any sort of long-term help. And that is, it is sort of disappointing, I always hate walking away from a house like that because, and then you feel will they ring you again because you were probably pretty useless to them in their eyes." [GARDA 7]

Restraint

The use of restraint/physical intervention with children was a contentious issue for participants on account of the perceived lack of clear protocol regarding its practice, and because of criticism, they have experienced from the public and other stakeholders (e.g. Social Care Workers, Medical Professionals) following the use of force at the scene. More importantly, fear regarding the use of restraint was also linked to potentially injuring the child and/or causing them further psychological distress. Despite this trepidation, interviewees stated that in some circumstances the use of force is necessary to keep people safe.

"I have been criticised. And I specifically remember a large, a large enough young lad violent in this situation who I had to physically restrain for quite an amount of time. And I remember being on top of this guy and restraining him, trying to get the handcuffs on trying to get, trying to calm him down, all of these things. And one of the, I'm not sure what her role there was, I know she was one of the HSE workers, one of the mental health professionals. At the same time as me trying to deal with this situation, was telling me that I was using too much force and that he couldn't breathe and to get off him and that she was going to report me to, to whoever it was." [GARDA 2]

"With an adult you can get physical with them when needs be, if you have to put your hands on them to protect yourself and it is accepted by them. If I was to grab a 12-year-old by the wrist, swing them around and put them in an arm lock, not only would the general public be upset but the parents would be upset as well." [GARDA 16]

Identifying a Behavioural Disturbance

Analysis revealed that the lack of training and subsequent lack of knowledge in the area of child and adolescent MH and neurodiversity was a catalyst for anxiety and unease among Garda members. Officers pointed out

that differentiating a behavioural disturbance from criminal behaviour is not always straightforward. Apprehension regarding the correct identification of behavioural disturbances was primarily associated with encounters with neurodiverse individuals. Interviewees cited a number of concerns in this regard.

Firstly, neurodiversity is often unapparent and indistinct. Consequently, Garda members are inclined to respond to a neurodiverse child as though they are neurotypical[14], which can lead to the individual becoming further agitated and distressed. This was said to be particularly problematic when faced with incidents involving serious violence and aggression, as children can end up being pepper sprayed or tasered. Participants believed that such outcomes could potentially be avoided if Garda members had a better understanding of neurodiversity and its presentation.

> *"I'll tell you now, I knew zero about autism up till, my nephews five now and about two years ago he was diagnosed with autism and it's all, what is it sensory? He's a big boy now and he's getting older and he's getting lively and this that and the other and like I knew zero about up until then." [GARDA 9]*

> *"Everyone in the station knew children on them (a family with the Autistic Spectrum) because we'd been out, like I'd been out one day and em one of them had what looked like a metal bar and it was about to kick off like, it was only then it was realised that it wasn't it was a piece of pipe, it was practically rubber, wouldn't have done much damage with it, but it was dark that night and I kept thinking I was convinced it was something… and only for talking and talking, a different Guard might not have given it that much talk , especially if they didn't know about the autism. Then all of a sudden you're tasering somebody and it can just go south on you so quickly." [GARDA 15]*

Secondly, even in instances where Garda members may know that a child is neurodiverse, the lack of training and protocol in the area means that they are still at a loss as to how the situation should be managed.

> *"Oh yeah especially in relation to autistic kids because I've been in that situation two or three times and trying to communicate and trying to get on an autistic child's level. Like there were certain things like touch, they can't bear being touched and stuff like that and trying to tell the child 'no look at you need to calm down' when that's the least thing that they are thinking of doing. Like you know and I was just lucky that the person that I was with had a home situation that he was more aware of what was what (to do). Bar that I was completely alien, well I was completely alien anyway do you know trying to use your good nature or your good will but it was completely the wrong thing for an autistic person…it's the unaware. You're completely unaware of what to do you're completely unaware of and there's so many different parts of it." [GARDA 11]*

Finally, resolving issues involving neurodiverse individuals who may have assaulted someone or caused criminal damage can be difficult. Victims can feel a strong sense of injustice and dissatisfaction with the fact that the child will unlikely be subject to any legal consequence.

[14] 'Neurotypical' refers to individuals of typical developmental, intellectual, and cognitive abilities.

"The neighbour was probably really pissed off, didn't understand what was going on and then it's like I can't believe he's after smashing my windscreen, I'm ringing the Guards, straight away it's like 'shit, what do we do here', you know? Because there has to be an outcome and then even at that like obviously due to the situation he wouldn't be prosecuted and stuff but then you have the other parts of them saying that's not good enough I had the Guards down and they done nothing about that fella coming over and putting in my windscreen, I don't care what he claims to have." [GARDA 9]

On a more positive note, in the absence of formal training and protocol, some Garda members took it upon themselves to promote knowledge and future proof against unnecessary adverse outcomes. Two officers spoke of bringing new recruits out to meet neurodiverse children who have frequent contact with the GS. This informal practice was described as extremely beneficial in that it not only ensured that new members would be able to identify the child should they encounter them in the future but helped them to increase their understanding of neurodiversity by talking to the child and their family.

"He is basically in a home Monday to Friday but then goes home for the weekend and he phones 999, he does this he does that, he robs things from outside shops, he's a grand chap but he's like an adult like and you're trying to deal with this and I will actually bring new recruits to actually meet him sometimes because you see him around the place and it's like what do we do with this, they don't know what to do you can't arrest him and he's robbing plain as day in front of everyone he's so vulnerable it's crazy like, and the family are so vulnerable."[GARDA 15]

Psychological Burden

Encounters with children were perceived as significantly more complex than those with the adult population. Participants felt that such complexity is exacerbated by the heightened level of accountability and responsibility that arises when dealing with children due to their increased vulnerability, particularly when suffering with mental illness. There was a consensus among the sample that 'doing the right thing' is not always obvious when managing a crisis MH event, due to a lack of appropriate training and a sparsity of legislative and procedural guidance. Consequently, Garda members described feeling anxious that something might go seriously wrong at the scene.

Such feelings were perceived to be linked to officer accountability in that Garda members strongly believed that the repercussions for mismanaging a child MH event would be far more serious than the mismanagement of an adult in a similar scenario. Finally, the majority of interviewees described being plagued by 'the what ifs' associated with a crisis MH call out. They mentioned second-guessing the decisions made at the scene for periods of time after they had left the scene. These findings reveal that Garda members have the potential to experience a significant level of psychological burden that could be alleviated with the implementation of a clear and concise operational directive.

"And again, if you make, if there's an error of judgement and there's no policy there, you're the one that made the mistake it's your fault you're going to be hauled over the coals" [GARDA 6]

"And if anything happens to, you know, an adult, you know as long as they've been getting the care, you've referred them, but children in particular, the repercussions for us would be even more serious." [GARDA 4]

"You know if we discuss the issues and agree 'yes you can see there is something wrong and you are happy to go to your GP in the morning and get a referral'. That is up to him then if he wants to do that, he could get up in the morning and decide he doesn't want to do that, then 2 weeks later we are called again and then this time he has took a knife to somebody or a knife to himself and then it comes back to us." [GARDA 16]

"There is a lot of pressure on Guards… you can't help but have a massive concern 'What if after I leave here something happens?' and so, that kind of has to be on everybody's mind in terms of motivating your decisions, well making sure that something is done and that things are done right and that, you know, it is a real pressure in those situations and I have definitely gone home from work sometimes before and been saying, you know, 'I hope to God nothing happens there' or you know? And so, that is definitely part of it in terms of personal anxieties and stuff that you'd have." [GARDA 4].

These findings suggest that concerns about accountability were significantly compounded by the perceived absence of both in-house instruction and interagency protocols, the lack of youth focused guidance in the Mental Health Act 2001, and the dearth of specialist training in child and adolescent MH, neurodiversity, and crisis intervention techniques.

Key Findings from the Scene

Testimony given by Garda members suggests that they try their utmost to protect the best interests of the child, whilst at the same time being mindful of the equal and at time conflicting rights of parents, or the public. At the height of any given crisis MH call out, the GS are tasked with maintaining safety, upholding rights, making judgement calls under immense pressure, and trying to manage the competing interests of all individuals involved (e.g. children/child, parents/carers, victim and extended family members). Moreover, these duties must be carried out in the absence of clear and distinct legislation and protocol, and formal crisis MH training. Finally, Garda members' apprehension about using the Mental Health Act 2001 for crisis MH events involving children is not only indicative of the unclear nature of the legislation itself, but a cause for concern given that some participants felt more comfortable using alternative legislative channels to bring a child back to the station for a GP assessment. Whilst this practice is certainly well intended, it raises concerns about the possible criminalisation of children who are mentally ill.

3.3. The Garda Station

Whilst participants referred to the Garda Station as a "*place of safety*" [Garda 15], they believed that it is not an appropriate environment for a child, particularly when they are experiencing significant psychological distress. However, in the absence of an emergency MH service, and the necessity to attend the station for the child to be assessed by a GP, the GS sometimes have no other choice but to remove the child to the station for assessment. This section presents the formal and informal practice adopted by participants when supervising a child in the station, along with the challenges they encounter at this stage of the pathway.

Formal Protocol and Procedure: Taking Young People to the Station

On arrival to the station, Garda members will explain the reasons why they are in custody, read them their rights, and tell them what is going to happen next. Garda members will also make enquiries regarding pre-existing medical issues, MH history, and whether the child requires any special accommodations while in the station. The case will also be entered into the custody record, which is updated every 15 minutes.

Participants explained that any time the GS manage a case involving a child, whether that be in the community or back at the station, a mandatory electronic notification is sent to Tusla outlining the situation. A social worker will then make the decision as to whether social work follow up is required. An appropriate adult must

also be present as an advocate for the child's best interests, and so the child can formally be given their rights. This is usually the child's parents, a carer, or family member. In instances where an appropriate adult is not available, the GS can call upon a peace commissioner to be present or they may ring Tusla's 'Out of Hours' service who will source somebody to attend the station.

> *"Like that's the situation, we wouldn't, obviously in the grand scheme of our role I suppose mental health is just something that kind of comes into our, nearly catch all category, so our process really has to go back to the Mental Health Act. It is a lengthy period that to be waiting in the station by the time a Doctor comes and everything else, like we wouldn't bring anyone back on a whim unless we thought, they need an intervention like that we wouldn't bring them back." [GARDA 15]*

> *"Every person that is detained in a Garda Station a custody record is filled out, just for their human rights like to say exactly what happened at this time and for a juvenile they're checked every, well a juvenile is checked all the time they're supervised all the time, but the custody record is filled out every fifteen minutes" [GARDA 10]*

> "*In the absence of a parent we're getting a peace commissioner, we're getting sometimes you have to get someone from DFB (Dublin Fire Brigade) or you ring Tusla and say have you got anyone spare but they're up to their eyeballs." [GARDA 9]*

Every single participant commented that the Garda Station is the wrong place for a child. Participants spoke about the importance of making the child feel safe and reminding them that they are not in trouble. They also explained that it would be very rare that a child brought to the station under these circumstances would be put in a cell. This would only happen if Garda members could not keep the child safe because of some kind of behavioural disturbance (aggression, violence, etc.). Instead, it is common practice to settle the child in the medical room, an interview room, or the canteen where they can be supervised without feeling like they are in trouble. Out of the nine Garda Stations visited, three of them had juvenile cells. However, when asked what the difference was between a juvenile cell and an adult cell, they explained that there was no difference other than sometimes they are in a separate part of the station.

> *"There is a juvenile cell here, but I've rarely seen it used. Usually they come in here, you know the interview room, and leave the door open until the parent or Guardian arrives." [GARDA 4]*

> *"In any situation with kids you have to like, you try never to handcuff a child you try never to put a child in a cell because we, there's certain stations that have juvenile cells we don't so it's awkward from a manpower point of view. So we would literally put them in here where we are, an interview room, and leave a Guard in to make sure they're safe." [GARDA 11]*

As mentioned above, the primary reason for bringing a child back to the station is to have the child assessed by a GP. The GP will then determine whether the child requires referral to the Emergency Department or can go home and see their own GP at their earliest convenience. If the GP feels the child needs to attend the Emergency Department to receive a psychiatric assessment, Garda members will then escort the child and their guardians to the nearest Paediatric Emergency Department.

"We as Guards aren't medical professionals so if we made a judgement call to bring someone back here under the Mental Health Act, it's because we think they are a danger to themselves or to others. That we think if we leave this person here, they could do something to themselves and it could be fatal so that's why I'm bringing them back… We call the Doctor, and of course the Doctor could talk with him and say look, that's grand. He's ok, there's no issues there, this, that and the other. I have to go with what the Doctor says then." [GARDA 17]

"I'd say 90% of people are just said oh yeah just give them a letter, a referral letter and they're let go." [GARDA 10]

In 2017, several panels of medical professionals were established to provide a call out GP service on a 24/7 basis to the GS. Each station now has a list of several 24-hour agencies that aim to have a GP attend a rural station within 45 minutes and an urban station within 30 minutes. Prior to this arrangement Garda Stations were dependent on local GPs, which sometimes led to long wait times for the GP to arrive. Some participants explained that there were still some teething issues with the new arrangement and that the response time can vary between 5 minutes to 2 hours. They noted that there does not appear to be a triage system or precedence given to a child in custody. Despite these issues however, the sample were in agreement that GP access has greatly improved since 2017.

"Like out of hours Doctor service has improved greatly in [place name] but again it's 24-hour Doc we use and yes they'll be there to you within the sort of hour or whatever." [GARDA 7]

"I think it's, it's fairly standard across the board whether if they're a child or an adult. Again, you could have the Doctor down in ten minutes and in other times you could be waiting two hours it just seems to depend on what, whether they're free or not." [GARDA 6]

"I personally find that a lot of Doctors once you're mentioning mental health won't break their neck getting to you. But I have seen Doctors come quicker for a drink driver than mental health." [GARDA 9]

Informal Practice: Mitigating Distress

Participants were very cognisant of how potentially traumatising and terrifying it must be for anyone, not just a child, to be brought to a Garda Station whilst experiencing a crisis MH event. Moreover, they believed that children in these scenarios must feel like they are in trouble or that they have done something wrong.

"Our mindset is, if you take them out of their home and bring them to a Garda station, or institution, I think ultimately they feel like they've done something wrong. And if you have a child with mental health difficulties, and they have that mindset then after having an episode, how are they supposed to understand it? That it's not because they've done something wrong, but it's because they might have a sickness or an illness, it's very hard for them." [GARDA 8]

"But I just picture if it was me going through something like that how I'd feel being brought into the Garda station. It's nearly pointing the finger at them saying you've done something wrong." [GARDA 9]

"Bringing a child, especially here, is just, just requires more, you know they're confused, they're wondering what's going… why are they in a Garda Station, they might associate the Guards only with 'I'm in trouble' or they mightn't like the Guards. They might have had horrible dealings with Guards before and with good reason they mightn't like the Guards." [GARDA 4]

Garda members expressed frustration and annoyance with how unfair the whole process is; and felt obliged to mitigate the child's distress as much as possible. Accordingly, they outlined several techniques they adopt to put the children at ease. For instance, three quarters of the sample explained that they would always try to find a room away from the cells and busy corridors for the child to sit and wait for the GP. They also explained that it is important to keep working on rapport and include the child in the decision-making process. Finally, a couple of Garda members felt it important to inform the child that they are not in any trouble and reinforce these sentiments by informally introducing them to everyone in the station or offering them something to eat or drink. These findings demonstrate that informal practices serve an important function both at the scene and in the Garda Station.

"They've been brought in they've been introduced to everyone that's in the station if someone's walking by the door they'll let them know, kind of make them more comfortable while they are here, if they need a cup of tea or a sandwich or something that's being given to them but like that maybe somewhere a bit more, I wouldn't say friendly, but you know what I mean?" [GARDA 14]

"They are not brought down to the cell or anything like that, it would be a room like this with a member with them at all times. You try to make them as comfortable as possible, offering them drinks, talking to them and stuff like that…You'll be talking about football and you'll be talking about loads of stuff." [GARDA 17]

Challenges at the Station

Resources and Logistics

Managing a youth crisis MH event can be quite taxing on the GS resources, especially when back at the station. Participants described these cases as time consuming due to the need to notify multiple parties i.e. parents/guardians, the GP, Tusla, and Emergency Department. Furthermore, because it is not deemed best practice to detain a child in a cell, significantly more manpower is required to monitor a child because they require constant supervision. Finally, the absence of an appropriate space to accommodate a child experiencing a crisis MH event means that Garda members often have to repurpose rooms at the station.

"The Garda Station is not the appropriate place for a child. Like we make do- we go to the kitchen, we will get the lads on break here to go and have a break in a different station and kind of use community Guards to entertain the child, you know it's not an ideal place, but it is the only place that is available." [GARDA 18]

"Like we don't even have a place to bring a juvenile that we do have to keep. Like say a juvenile does need to be kept or put in a secure place, where's that? There's nowhere to go." [GARDA 10]

"I suppose which is a fair statement, in a sense, but you see I think this is where the viewpoint is wrong because a child within a station, if you take a viewpoint like that, it does take more Guards to be with a child because ultimately, realistically for safety's sake, you've two officers with every child, you might have one officer with every adult." [GARDA 8]

Garda members explained, that for safety reasons, it is best practice to have two officers with a child while they are in the station. However, this is not always possible, especially at night-time in urban locations when the GS are at their busiest. Participants gave numerous examples of instances where the safety and wellbeing of a child has been compromised, not just because of workforce issues, but also because of the nature of the environment to which they are exposed. They described the station as a source of sensory overload, with prisoners screaming, shouting, and banging on cell doors; physical altercations between prisoners and Garda members; and prisoners being restrained. Finally, another consequence of a busy station is that the Garda members must sometimes step out to assist their colleagues, ultimately leaving the child unsupervised. Such instances can have potentially fatal consequences.

> *"I stepped out of the Doctor's room here in the station for a second and [a child] tried to hang themselves. The unfortunate thing is that if I were to write a book on the stuff that happens here people wouldn't believe it. When I stepped back in they had taken off [a piece of clothing] and wrapped it around their neck... We had to go and get a ligature knife to remove that, I remember when we were screaming for help and they were on the ground, their lips and nostrils were blue. I put my fingers under the noose and tried to stretch it as much as I could, I knew there was some stretch in it just to relieve it and get the knife in." [GARDA 16]*

> *"I completely understand the need for the presence of Gardaí at some cases, completely understand that. But I'm a firm believer that a Garda Station isn't a place for a child to be brought back. Especially with mental health issues, you know. Now the youth in particular wasn't in for mental health issues, but I was dealing with an incident in the interview room, 2 o'clock in the morning in, and a prisoner decided to attack my colleague. And the whole argument burst in through the door, and sitting across the table, faces drop, if you're looking at someone who is under severe distress in their head and see something like that, and to have prisoners kicking and screaming and down in the cells and just making noise… its very distressing." [GARDA 9]*

The fact that a parent/guardian must be present at the station makes dealing with youth crisis MH events more difficult. Quite often parents/carers are desperate for help, feel emotionally exhausted, and require a lot of support from Garda members. Moreover, matters can be complicated by tensions within the family network, which inadvertently requires Garda members to become mediators as well as safety providers. These relationships can be so fraught that parents/carers might refuse to accompany the child to the station or bring them home if the GP recommends that a referral to the Emergency Department is not required. Such scenarios are significantly more complex because the Garda member must then invoke the Child Care Act 1991, giving Garda members the power to take custody of the child and request Tusla involvement.

> *"You've got two additional interested parties – the parents of this person, as opposed to dealing with an adult. They may already, they may hate each other, they may… you know, there could be all sorts of different competing interests there" [GARDA 4]*

> *"Yeah, and I suppose like it could be a case that the mam doesn't want to go and you have a complete different set of issues at that point then you'd be ringing the Doctor, and you'd ring social worker to come as well to attend the station for the youth" [GARDA 9]*

"But with a juvenile, your care is much; your entire level of care is higher because you can't just let them walk out. You have to think about who you let them walk out with, if there's really serious issues and there's no support network you're thinking of going down section 12 of the Child Care Act, or Tusla and then you're also covering yourself you're following up with a welfare referral to Tusla saying to them listen this lad needs a bit of help" [GARDA 10]

Interagency Working with Tusla

The need to notify Tusla regarding all encounters involving a child meant that the entire sample had performed this mandatory procedure as part of their role. Many participants felt conflicted about mandatory Tusla notifications. On the one hand they believed that Tusla were the experts when it came to dealing with children and should be alerted when a child is believed to be at risk. On the other hand, they felt it was a 'tick the box exercise' to ensure accountability. Interestingly, Shannon (2017) reported a similar finding in his Audit of Section 12 of the Child Care Act, in that such notification measures were deemed by some members as a mechanism to uphold a culture of superficial accountability within the organisation.

Participants reasoned that the 'one size fits all' nature of mandatory alerts potentially diminishes the importance and urgency that should be associated with a notification. Additionally, some participants empathised with the number of notifications that Social Workers must have to sift through and screen. They described feeling a sense of guilt around the Tusla notification system, in that they believed, they were unnecessarily increasing the workloads of Social Workers who are already extremely busy and under resourced. Some Garda members commented that it would be more beneficial if they only alerted social workers about cases that involved potential risk to the child.

"Now everything's referred, which is wrong too to be honest some of the referrals…I know for a fact are landing over on [name]'s desk… and she is looking at it and going, the 'Guards just have to tick a box there' unfortunately. And we don't want to be doing that either because we hate when people send stuff to us" [GARDA 15]

"I don't agree with it every child that gets arrested for every offence. So, if my kids are in town and one of their friends or one of my children takes two euros' worth of something in Penneys, right they're going to get a Tusla notification. That's not good in my opinion; it should be on a case-by-case basis." [GARDA 2]

Participant experiences of Tusla 'Out of Hours' were mixed. Some felt the service was very accessible, whereas others said they found it difficult to reach. The main concerns voiced by Garda members referred to waiting times. Many examples were given describing instances when they had to wait a number of hours until a Social Worker became available. This inadvertently leads to Garda members being tasked with supervising a vulnerable child in the station, which is not only unfair on the child, but can cause a considerable strain on station resources in terms of staffing levels.

"Yeah, we ring them on the on-call number and they say 'yeah someone will be down to ya' and you ask how long they will be and they say '20 minutes' and 2 hours later you are ringing again and they say they are trying to organise somebody. Like what I meant to do with this 14-year-old here?" [GARDA 16]

Issues can also arise if the on-call GP recommends that a referral to the Emergency Department is not warranted and the parents/carers refuse to take the child home. This can happen if the relationship is very fraught between the child and their guardians or if parents/carers do not feel it is safe to have the child back

in the home environment. Garda members must then call Tusla 'Out of Hours service' to seek emergency accommodation. Given the huge deficit in emergency foster placements, the only option that is often available to Social Workers is to refer the child to a youth hostel in Dublin City. Garda members noted that there have also been occasions when youth hostels are at capacity and Social Workers have told Garda members that there is nowhere for the child to go. An upshot of this service deficit is that parents/carers end up taking the child home to face the same circumstances they were in prior to calling the GS – with no supports and no answers. Again, participants acknowledged that this was not the fault of Social Workers but a result of an overwhelming lack of government support services.

> *"Yeah, like the issue I have is, like we had a different case, we had a young male, a Saturday night; he'd gone missing for a week on, a bit of bother with drugs. And basically, we rang into the 24-hour line and were told, "[Youth Hostel] or nothing, that's all we have'. So, the mother had to come back in and collect him, that's not good enough you know." [GARDA 5]*

> *"They're all trying their best you know. I think Tusla especially they get such bad press, but I know from being with them at lots of meetings they just they don't have the manpower there they're absolutely drained themselves" [GARDA 7]*

> *"[A Youth Hostel] is basically a homeless hostel for children and it's where a lot of children we work with end up for yeah like a few nights, couple of weeks maybe yeah until we find somewhere long term for them. Do you feel there needs to be more put into services like that, I mean there's no psychology or mental health assistance there. There's no assistance there they're out at 10 o'clock in the morning they're not allowed back in until six o'clock at night, there's nowhere even for them to go in the day…like we've no placements full stop. We've no foster placements, we've no, we've very few residential placements and the privates really, I mean they're for profit, they have their pick of who they want and they're overrun by referrals. [Tusla 1]*

The vast majority of the interviewees said their working relationship with Tusla was positive. However, a third of this group also referred to the existence of an unspoken 'us and them' mentality between the two agencies that requires some work. Garda members believed that the cause of this friction was largely a result of unrealistic expectations regarding the powers of the other agency, a lack of understanding regarding the role of the other agency in crisis MH events, and a poor understanding of the constraints faced by each agency. The establishment of Tusla Liaison Officers within the GS was said to improve information sharing and rapport between both organisations. Overall, the majority of the sample believed that more face-to-face contact or interagency training with Tusla would significantly improve their interagency working.

> *"I felt, the few times I had to do it I found Tusla very good and actually very cooperative. I know you'll probably come across some Guards who are quite critical of Tusla but I think sometimes, people don't appreciate that they're two very different roles. And people have their own policies and procedures and limitations as to what we can and can't do. But again, personally I've actually found them very good the few times, and even like 2/3 o'clock in the morning. I've found them very good and come down as quick as they could like and dealt with it very well." [GARDA 6]*

"The relationship still has to be developed quite a bit in relation to the likes of these kind of things. I have a good relationship with the local social workers, but I know that there is an' us and them' a little bit between the Guards and the social workers…It's just their thresholds like they'd love to be able to assign social workers to every case that comes in but they can't. So, I think maybe something like that you know, joint sort of training or even if it was just with a few people and then passing it on like through like training in the stations. I think it is the lack of understanding and everyone's sort of pushing it off 'it's not my problem it's someone else's'." [GARDA 12]

Garda members' Experiences with GPs at the Station

On the surface, most Garda members believed they had a good professional relationship with GPs. Many recalled positive experiences where they felt the GP put the child at ease, listened to the concerns of guardians, and liaised with Garda members. However, they were also able to recount times when this was not the case. One of the downsides of the new out of hours GP services is the tendency for a different GP to attend the station each time the GS call. Thus, Garda members do not get a chance to build up a good working relationship with the GPs they encounter. Before the 'out of hours' system was established, participants noted that, whilst it could take much longer to get a GP to the station, they knew the local GPs well and felt there was more collaboration when it came to decision-making.

"They'll be there to you within the sort of hour or whatever. We don't have the same doc the whole time that's an issue, yeah you've really good Doctors, we all have our strengths and weaknesses, some are really good with children and some aren't" [GARDA 7]

"I'd rather use local lads if we could because we've more of a relationship with them, and now that's gone, it goes to [Service Name] who are supposed to be there in the contract within the hour and they're not. And we're reporting up that they're not and they're not taking the contract off them, because they're probably the cheapest" [GARDA 15]

When asked about the 'typical outcome' of a GP assessment, over half of the Garda members interviewed felt that there can be a reluctance among some GPs to refer the child to the Emergency Department. More often than not, children experiencing a crisis MH event were said to be sent home with a referral letter to see their own GP. Alternatively, a few participants believed that children are more likely to be referred to the Emergency Department than adults. They attributed this to the GP possibly being a little more cautious when it comes to assessing children.

"There attitude is, we can give them a letter and they can go and see their GP next week, then I've done my job. That happens in 90% of cases." [GARDA 16]

"Doctors would kind of take the side of the Guard and listen to what the Guard was saying and listen to the mother's concerns, they would also err on the side of caution, make the referral and leave the final decision for the psychiatric team as opposed to saying this guy is presenting as well and we can let him go." [GARDA 18]

"Juveniles it's probably a little bit different I can't think off the top of my head where I've had, I can't think off the top of my head where I've had a Doctor not do, like section for want of a better word, a juvenile." [GARDA 10]

Garda members explained that they are not in a professional position to question the outcome of a GP's assessment. Nevertheless, some participants explained that there have been times when they have strongly disagreed with the GP's decision not to send a child to the Emergency Department. However, a couple of participants empathised with some of the difficulties GPs face when attending these complex scenarios, noting that they do not have the benefit of observing the child at the scene when they are at the peak of their behavioural disturbance. Additionally, they pointed out that by the time the GP arrives at the station the child will usually have calmed down a great deal and appear perfectly fine. Other times the child and the parents/carers may play down the severity of the incident. In such cases there is nothing that can be done as the GP must make an assessment on the basis of the information presented to them, even if that information is not accurate.

> *"Yeah, and I suppose it might be hard for the GP to understand in some ways if they weren't in that situation and they didn't see how severe it was, how dangerous it was for the other siblings, you've to think of them as well and their safety and some GPs may feel that the child is better off always in the home, sometimes that just isn't the case, I know it's sad but…" [GARDA 7]*

> *"So, when we do like that situation, her standing on top of the bridge and expressing to Guards that she wanted to kill herself, and then she was seen by the Doctor and the Doctor 'nope, she's fine to go home' like my jaw nearly hit the floor I was like 'we're going to be back up to that bridge in half an hours' time. Now thank god we weren't but." [GARDA 9]*

> *"But then sometimes, when you bring them back to the Doctor, they won't tell the Doctor what they told you. They'll say 'Oh, I'm fine. I don't why I'm here' and the Doctor will say that there's nothing wrong with this person and sign them off or gone, that's the end of it. We talk about this a lot actually because sometimes you feel like it's helpless." [GARDA 17]*

Key Findings from the Station Setting

Having a child come back to the station amid a crisis MH health event was not only characterised by participants as a massive strain on Garda resources, but a source of further distress for the child. Participants believed supervising a child in this setting whilst waiting for a GP was associated with a great deal of risk for Garda members, in terms of accountability, responsibility, and the availability of personnel, and for the child, in terms of physical safety and psychological distress. Such verdicts call into question whether the Garda Station really is a place of safety for a child in these circumstances. Moreover, the need to return to the station for a GP assessment was deemed a superfluous step in the process necessitated by a significant deficit in emergency MH service provision. Finally, such difficulties were compounded by the involvement of various other agencies and professionals who are perceived to be under similar amounts of pressure. Thus, it may be argued, that in many ways, the station is a more complex setting to manage these kinds of incidents than the scene.

3.4. The Paediatric Emergency Department

The emergency department represents the final stage of the pathway for Garda members. This section presents insights from Garda members and Medical Professionals regarding their experiences of managing crisis MH presentations in the Paediatric Emergency Department.

Formal Protocol and Procedure: Garda member Handover

Once a referral to the Emergency Department is made by the GP at the station, Garda members are then responsible for making sure the child is safely transported to the nearest hospital. The nature of that transportation is dependent on several variables. For instance, if the child is calm and the Garda member feels

they can transport them and their guardian safely in a Garda car they will do so. Alternatively, if the child is engaging in high-risk behaviour, such as violence or aggression, Garda members may decide to transport them in a Garda van and make arrangements for their guardian to meet them at the Emergency Department. If there is an underlying health condition or the child has become injured, the Garda member will escort the paramedics to the hospital via ambulance. In any situation, a minimum of two officers are required for transportation. Garda members were not aware of any formal handover protocol when arriving at the emergency department. However, a couple of Garda members noted that sometimes the GP who attends the station will ring ahead and let the hospital know of their impending arrival. Whilst they felt that this pre-alert made the process a bit smoother, it is not standard practice.

> *"There's no specific protocol that I'm aware of but often they would just ring, look we're on the way with such and such a child, X, Y and Z has happened and they might just let us know so that we can prepare a space, then it's down to the, they'd have to check the child in, bring the child through to, now more often than not it's the Guard that brings the child through directly to us and we'll kind of, one of us triage nurses or whoever will kind of handle the registration process." [Nurse 4]*

> *"It's better when the GP rings directly so whoever is in the hospital is they're not hearing it from a Guard and they're thinking 'okay but like what, what you're not a medical professional you're a Guard what the hell do you know?" [GARDA 6]*

Informal Procedure: the GS Assistance in the Paediatric Emergency Department

Both Garda members and Medical Professionals noted that there is no formal protocol outlining the need for the GS to remain in the Emergency Department following a Garda escort. They explained that in instances when a child poses a risk to themselves and others, Medical Professionals will ask Garda members to stay and help maintain the safety of the Emergency Department (patients, staff, and family members). Medical professionals commented that Garda members are always very accommodating and stay as long as they are required, or until they are called back to the station.

> *"Sometimes they just go, but if they have been very aggressive at home or if the Guards have built up a good rapport with the kid they will stay. And you know sometimes the Guards are called and told to come back to the station so they don't have a choice, even if they did wish to stay, often times they will be called back." [Doctor 2]*

> *"It's good, usually before we meet the child, they let us know how they think it might be best to approach the child you know in case they think they might become violent. They will usually come with us when we take the child to the room where they will be assessed". [Nurse 2]*

Interagency Rapport

Interactions between the GS and Medical Professionals in the context of the Emergency Department were described by Garda members as being mostly positive. Fourteen of the GS participants who had experience going to hospitals with children following a crisis MH event said that the handover to medical staff usually goes well. Compared to adult Emergency Departments, most participants believed that Paediatric Emergency Departments deal with these types of patients with greater urgency.

> *"I think in fairness, if you brought a child up almost in handcuffs, or certainly chaperoned by the Guards, that they'll do their best" [GARDA 11]*

"Bringing adult patients maybe to the hospital on an ongoing basis, they're so sick of it, they'd just be looking at you, you could be sitting there for hours. But for children in [Hospital Name], that service would try and expedite you as quickly as possible." [GARDA 1]

Similarly, Medical Professionals found the GS to be supportive, obliging, and empathetic when providing assistance in the Emergency Department. They were mindful of the constraints that Garda members are working under, specifically that they are understaffed, overworked, and undertrained with regard to MH. Medical Professionals recognised that the GS are called out to assist crisis MH events because there is no other service available. In addition, they understood how difficult it can be when it comes to managing the expectations of the parents/carers in these scenarios, who often believe that the GS and medical staff have a quick fix for resolving crisis situations. Medical Professionals recalled situations where they were very grateful for the GS assistance, and commended them for their conduct in such volatile circumstances.

"I suppose in a hospital setting there are lot of expectations you know for there to be a quick fix, as if there is an algorithm that we go to, you know like this is what we know, and this is how we resolve it. But in truth it doesn't necessarily change the consequences... You know when it comes to MH and psychosocial stressors there is an overlap, and they are really difficult expectations to place members of the police force you know people kind of expect them to be able to manage or expect them to be able to determine the differences between psychosocial stressors and acute MH presentations but it's not their job." [Psychiatrist 2]

"I think they are very good in terms of trying to de-escalate the situation, you know bearing in mind that some of these children would have assaulted members of the Guards and they are still there, still present and trying to de-escalate the situation with a great deal of grace that I don't think I would have if somebody had just tried to bite me or whatever the case may be. I do think the way they manage it is very good." [Psychiatrist 1]

However, a positive response from Medical Professionals was not the experience of all Garda members interviewed. Four members noted a lack of urgency from Medical Professionals when presenting at some children's hospitals. Whilst they found this frustrating, two of these interviewees commented that medical professionals are very busy and long wait times are a result of resource issues.

"I've often been in a situation where we've brought a child to [place name] hospital into care and it's just kind of, it's monotone does that make sense? You bring a child in, they're processed in, and they're then told to just sit there. So, there is no immediate engagement and it's probably impossible to have immediate engagement but it's almost like going into A&E departments for four hours, do you know that kind of way? There's no sense of urgency" [GARDA 8]

Challenges in the Paediatric Emergency Department

Clinical Environment

There was a shared perspective among the Medical Professionals and the GS with regard to the challenges associated with managing crisis MH events in children. Both professional groups emphasised their view of the Emergency Department as a clinical environment, not well-equipped to deal with children in distress, with medical machinery, tubing, and trolleys positioned in each of the assessment cubicles and throughout the corridors. There was a sense of generally high activity levels and workload, staff being busy with both routine and urgent cases, with patients ranging in age from neonates to under 16. A calm clinical interaction can suddenly change into an urgent emergency assessment. The reality of constant unpredictability contributes

to a state of constant alertness among staff who have to manage their own raised emotions to engage in competent and skilled urgent care while at the same time interacting with and managing the heightened emotions of parents/carers. Medical professionals explained that the vast majority of children who are escorted to the Emergency Department by the GS present in an extremely heightened and distressed state. Young people may be unpredictable both in clinical and behavioural presentation, and pose a substantial risk of physical harm to themselves and/or others. They also pose a flight risk. This poses legitimate concerns for Medical professionals and the GS regarding the health and safety of the child, and other Emergency Department attendees, and staff. Furthermore, there is often a need to de-escalate tensions between parents and children while simultaneously trying to gather important background information. All participants (Garda members and Medical professionals) commented that these cases are both time consuming, and require a significant number of personnel to ensure the patient receives the treatment they require and to maintain the safety of the department as whole.

> *"You know we have to think of the safety of the whole department as well so, whether these kids are going to be aggressive towards staff members or more importantly there are often much younger children here, you know it could spill out into the corridor. You know are they going to be a potential risk to other families and other children in the department. So, they are the types of things that we have to consider. So, trying to manage these kinds of children in the department can often be very tricky for us. I suppose then the other thing is that if there is a significant mental health concern, you know if there is a genuine concern that they may harm themselves, then its wondering are they a flight risk and we have to try and manage that appropriately within the department so that they don't scarper out the front door, which is what happens all too frequently unfortunately." [Doctor 2]*

> *"I find that the Gardaí are quite helpful, they tend to stand back by the door, we would often ask our security Guards to come in as well, for the safety of the staff. Usually, one Doctor would review the child and there would be two nurses and a shift leader would be present as well. It does tend to require quite a lot of staff." [Doctor 1]*

As noted above, the Paediatric Emergency Department is a clinical environment. It is not equipped to manage a behaviourally volatile child. Medical Professionals stated that there is no designated area or 'safe space' to assess and treat patients who do not require any medical treatment (for physical illness or injury) but are experiencing a crisis MH event. Often, they will have to use the 'family room' purposed for parents of very unwell children, or the resuscitation bay. Sometimes the department is so busy that a room cannot be found, and Medical Professionals may have to assess children in the corridors.

> *"And they also might arrive when we're extremely busy and sometimes it might be hard to even find a single room space for them to have a chat, and they often end up in shared rooms or on corridors and I suppose yeah in the best of times our environment isn't suitable to see these children." [Nurse 3]*

> *"So, it tends to be the resuss bay that they are brought into, so the resuss bay has kind of three spaces, so two trolley spaces and care space for small babies. So, it could happen that there would be parents in there with a small baby in that area and then a child is brought in by the Gardaí." [Doctor 2]*

Legislation, Protocol and Training

Garda members and Medical Professionals felt that the legislation surrounding the management of children experiencing a crisis MH event is both scant and unclear. This not only makes their jobs more difficult but can be a source of worry in terms of accountability. Furthermore, the absence of formal protocol outlining the role of the GS in the Emergency Department caused a great deal of frustration for all of the professionals involved.

> *"But you know it can be such a messy situation because nobody wants to do anything that is illegal or outside of their powers. It seems that things are just clearer cut for dealing with adults." [Doctor 2]*

> *"I have experienced a kind of a deer in the headlights effect where you can see that they don't know what to do, you know they are standing there, and they feel totally superfluous when the assessment is being done." [Doctor 2]*

> *"I need to know where my role begins and ends. I also need to know where and when it gets to the point where another professional is obliged to take over and is in charge. Currently, that is not clear, it needs to be in black and white." [GARDA 1]*

Finally, four Medical Professionals commented that they felt more training was needed regarding the legislation for everyone involved in the care pathway. They noted that there can be confusion among Medical Professionals and Garda members as to how the Mental Health Act 2001 specifically applies to child and adolescent crisis MH events. Such sentiments are very much in line with commentary given by Garda members who also pointed out that their knowledge in the area is sometimes lacking.

> *"I think there's a lack of knowledge and the, what's a section 12 is that what they call it when they have to, like I wouldn't know if that applies to a child I very much have a legal gap in my knowledge that I feel could be filled if that was possible and it would be great if there was a liaison with the actual Gardaí so we could kind of advance knowledge on that for both then, specialties then yeah definitely." [Nurse 3]*

> *"I have found that sometimes the Gardaí can be unfamiliar with the protocol, there have been times when they are not entirely clear about the legislation. Like I have had cases where they are saying "oh we are sending children over to be sectioned' you know so they are not entirely clear on the mental health act nor are they clear about section 12 you know with regards to a place of safety. I suppose because they are not entirely familiar with it then that can cause a bit of confusion." [Doctor 2]*

Six of the Medical Professionals interviewed stated that Garda members can sometimes be quite intolerant when managing teenagers in the Emergency Department, particularly if they are giving them cheek or acting out. Some Garda members were perceived to adopt a very authoritarian approach, which was described by Medical Professionals as an inappropriate way to interact with a behaviourally disturbed child and tended to exacerbate the situation. Findings reveal that Medical Professionals tried to be as diplomatic as possible when discussing Garda member's interactions with children. They wanted to be clear that their commentary was not a criticism but an acknowledgement of the fact that the GS are both unfamiliar and undertrained when it comes to these types of situations. Once again, the findings presented above demonstrate that Garda members agree with such sentiments, in that they note feeling undertrained and ill-equipped to deal with children, particularly during crisis MH events.

"I actually find, just in general now and most of them are actually lovely, I do find a lot of them nearly wind up the children, as in they're so no nonsense with them that it aggravates the child whereas we might have a kind of softly, softly, approach. If a child was cursing a Guard might give out to them, whereas a nurse just might ignore that you know and then they calm over time does that make sense? I do find in general though sometimes they can aggravate the behaviour, but I don't think it's on purpose I think it's a lack of training or insight maybe? And then obviously confusion between the way you usually deal with an adult and the way you deal with a teenager. And I'd say it's much more rare for them as well to deal with kids." [Nurse 3]

"And sometimes I find that that's what happens that they come from a house or a situation, or even the ones that we've called them into us, five minutes in I'm regretting calling them in to help me because they've actually made it worse and I don't mean that in a bad way…When we're looking for their back up with stuff with a younger adult it's not the same as it is responding to a chronic drug abuser that's chronically aggressive that's known to the Guards and known to an adult setting which is probably what they're more used to" [Nurse 4]

"It's hard because you just don't know what to do in that because we're massively undertrained like." [GARDA 11]

Restraint

A major issue that came to light for both Garda members and Medical Professionals was uncertainty surrounding the use of force/restraint when managing crisis scenarios. While the Emergency Department has its own security staff, they are not permitted to restrain a child, or prohibit them from leaving the building. Doctors and Nurses are also subject to the same regulations. Thus, the responsibility of physical intervention falls solely on the GS. However, data collected from both Medical Professionals and Garda members indicates that there is quite a bit of confusion as to when physical restraint/intervention should be used. Once again, this issue is rooted in a lack of procedural guidance and training regarding the management of children by the GS in the Emergency Department.

Medical Professionals felt at times that Garda members can be too heavy handed with adolescents. They also noted that Garda members can be untimely in their use of restraint, in that they respond with physical intervention too quickly. Interestingly, they also noted times when Garda members were too hesitant and had to be asked to physically intervene. Medical Professionals explained that the management of crisis MH events in adult Emergency Departments is very different to the approach adopted in Paediatrics Hospitals. They reasoned that Garda members have considerably more experience attending adult Emergency Departments with these types of cases. Thus, in the absence of specialist training and protocol, Medical Professionals believed that Garda members can be conflicted as to whether they should employ the same tactics they employ in an adult Emergency Department when managing a similar situation in a paediatric setting. Finally, it is also a possibility that Garda members become apprehensive about restraint if they have been previously reprimanded for being heavy handed.

"Again, I don't think they really know the difference between…you know it is very different for them if they are bringing an adult to an emergency department if they are being aggressive because they know that they can restrain them, they know the limits as to what they can do. Whereas if they bring a kid in who is being aggressive here, sometimes it can go either way. You know sometimes they stand back and don't do anything at all which isn't very helpful. But then sometimes they can also be a little bit heavy handed and there have been times where we would have to say to them to lay off. I think the older kids they are maybe a little bit harsh on them, you know they don't give them the level of understanding that perhaps they should. And then there are time where they are maybe a little bit too understanding, like I said they are being aggressive toward staff or aggressive towards their parents you know and if they are being particularly violent sometimes the GS have to be asked to restrain them which can be difficult." [Doctor 2]

"I suppose because I would have had a lot of experience with Gardaí bringing in adult patients, I think their approach is similar and that is obviously an approach that they have learnt and it's possibly not best tailored to a child. You know they are in a vulnerable position because they are not sure how to manage the situation and there is almost a reluctance, or a hesitancy is a better word. You know they are not sure how to manage the situation and I think they would be far more comfortable dealing with a 30-year-old who is lashing out as opposed to a child that is lashing out. And in the paediatric ED, the way that we would manage children and the way that we would de-escalate a situation is different than the way it is managed in an adult setting. You know in an adult setting you would be far more likely to sedate them, far more likely to administer antipsychotics and get security to help if a patient needed to be restrained. So, none of that happens in paediatrics and that's not what the Gardaí are used to. You know I think any training or protocol needs to emphasise that these children are typically not sedated or restrained, that that is not what happens to children. And I think they have seen that with adults and that is where that comes from, so you can't blame them for that. But it's definitely not the approach taken in paediatrics." [Doctor 1]

Garda members were very clear about feeling apprehensive when managing a youth MH crisis event. This was linked to concerns about accountability and the potential for the child to be physically and/or psychologically harmed. Findings indicate that while physical intervention is a measure of last resort, there are circumstances that sometimes necessitate it. Specifically, when the child's behaviour poses a significant risk to their own safety or the safety of others, Garda members felt that there is an expectation among the public and other professionals (Doctors, Nurses, Social Care workers) to restrain a physically violent child. Yet, they have often experienced criticism for the use of force by the very people who ask them to intervene, illustrating the difficult balancing act involved.

Finally, data collected from Garda members confirms the perceptions of Medical Professionals concerning their rate of exposure to crisis MH events in adults and children. Indeed, Garda members not only spoke at length about their familiarity with adult MH calls, but about the certainty that such exposure provides. Collective consideration of the insights put forward by Garda members and Medical Professionals indicates the need for greater procedural clarity for the GS conduct in the paediatric Emergency Department.

"So, that just makes things extra, extra difficult, you know, you are, it's, when you are dealing with a situation where force has to be employed, it's difficult enough without somebody telling you that you are doing it wrong who may not necessarily know what they're talking about, and to untrained people who are not used to physical altercations, it can sometimes look like 'well this is wrong'…It's really a no-win situation for the Guards because any time you use force there's always somebody that's going to say 'Well you probably used too much force'… there will be armchair quarterbacking of it afterwards and especially when you're dealing with a juvenile." [GARDA 2]

"And you know like you try not to be heavy handed with them but like, some of these young lads, they're bigger than me like. So, I find that our hands are tied in a big way." [GARDA 15]

"Yeah, it's remarkably rare but that option is available to us and it's not something that's available to other people… and nor should it be but, nor do they have the training which, which is a very, it takes a long time and it's not just training, it's experience in all of these things, to know when a situation has gone so far out of control that it now requires a particular response. And that's, it's a difficult skill to learn and it's not for everybody and it's unpalatable to a lot of people." [GARDA 1]

Key findings from the Emergency Department

The findings presented in this section reveal that both Medical Professionals and Garda members experience very similar challenges when dealing with child and adolescent crisis MH events. Specifically, the necessity to manage these situations in inappropriate environments, an absence of protocol and youth focused legislation, interagency tensions, and an overwhelming sense that their involvement in these crisis presentations is a result of resource deficits in other areas (i.e. primary care, a lack of emergency MH services). Overall, the results show that these groups of professionals generally work very well together throughout every stage of the care pathway. However, participants suggested a number of ways in which interagency rapport, communication, and information sharing may be improved. Such suggestions are outlined in Chapter 4.

Chapter 4: Opportunities and Challenges

As noted in the previous chapter, professionals involved in the child and adolescent crisis MH care pathway experienced many of the same challenges. This chapter presents opportunities and barriers identified by the sample, along with key participant insights and recommendations as to how these issues may be remedied. These recommendations varied from national level organisation change (macro) to small departmental changes (micro). Once again, it is important to note that both the small sample size and exploratory nature of the present study means that the findings presented should be taken tentatively, and are worthy of further research inquiry.

The Wrong Place and the Wrong People

Participants noted that the Garda Station and the Emergency Department are not suitable environments for children in crisis. Moreover, all participants – including Garda members – believed that the GS are the 'wrong people' to be tasked with managing these crisis situations. However, a lack of a crisis MH services means that both the Garda Station and the Emergency Department have become a catchall service for all emergencies despite their environmental unsuitability. Additionally, the multiple settings and professional bodies involved means that children and their guardians often endure a disjointed and drawn-out care pathway that has the potential to exacerbate their distress.

Participants argued there is a significant need for 24-hour facilities, staffed with multi-disciplinary teams, specifically designed to allow safe assessment and treatment for the child and their family – a type of dedicated Emergency Mental Health Service. Psychiatric emergency departments/services have been established in other jurisdictions, such as the U.S. (MountSinai.org, 2021), and England (NHS, 2021). These services have one crucial goal in common, that is to stabilize acute symptoms and if possible avoid inpatient admissions that result in long-term hospital stays (Zeller et al., 2014). In the U.S. dedicated psychiatric emergency services are typically affiliated with an adjacent medical Emergency Department (Zeller, 2010). For example, Mount Sinai hospital in New York has established a psychiatric emergency service that is linked with an Emergency Department. This service has a dedicated 24-hour psychiatric emergency team that treats patients from 13 years and above (MountSinai.org, 2021). Similarly, the National Health Service (NHS) in England has recently drafted a long-term plan that aims to facilitate comprehensive crisis care pathways in the community, Emergency Departments, and inpatient services. It proposes that by the end of 2021, every area of England will have a fully funded plan to establish 24-hour mental health crisis services for Adults. In addition, 24-hour age-appropriate crisis MH services for children and children will be established nationwide by 2023/2024 (NHS, 2021). The psychiatric emergency service model is hailed as an important method of reducing attendance at the Emergency Department by persons experiencing a crisis mental health event (Alakeson et al., 2010). This model has not only been found to enhance patient experience of care (Korn et al., 2010; Lindstrom et al, 2020), but is associated with more timely psychiatric emergency assessment and treatment, and increased patient safety (Woo et al., 2007).

Indeed, study participants recognised that organisational and structural change across the health service is a 'big ask' that requires a great deal of time and money. Accordingly, they felt that the development of a designated area for the safe management of distressed child within the Garda Station and Paediatric Emergency Department would be an initial step, extremely beneficial and realistic.

> *"I'd love to see somewhere that we can just bring people whether it's at a hospital or a clinic it's there the whole time and that there's some place for us to advise people to go." [GARDA 7]*

> *"I think having a separate area like a separate adolescent area to see these kids would be really helpful, you know so they don't have to be seen in the main department." [Doctor 2]*

Garda members framed their role within crisis MH events as 'transporters' who bring unwell individuals to access treatment, and 'safety providers' who assess risk and protect the public. They believed that when it comes to MH call outs, they should provide a supplementary support service to specialist professionals who are trained to manage crisis MH scenarios. This collaborative approach outlined by Garda members resembles that of the Crisis Intervention Team (CIT) model outlined in Chapter One. Medical Professionals were also of the opinion that CITs would be an extremely useful resource for crisis MH call outs. They felt that this kind of collaborative approach could significantly improve the patients' experience, promote interagency working, and allow for skills to transfer across different groups of professionals.

> *"Just thinking about the U.S. template around MH they have CITs so they would have access, maybe not to an emergency department, but access to community-based teams. Maybe that would be ideal, in my head." [Psychiatrist 2]*

> *"The ideal pathway would be that you would attend mental health calls with a mental health professional, I suppose in the ideal world." [GARDA 9]*

Bringing a child in crisis back to the station was associated with a myriad of challenges specifically related to health and safety, the level of distress caused by the environment, the lack of an appropriate space/room, and difficulties with manpower. Garda members believed that the situation could be improved by requesting that the GP attends the child's home. They also suggested the establishment of a collaborative risk assessment that could be conducted by Garda members and the National Ambulance Service to ascertain whether the assessment and intervention at the Emergency Department is required. Two Garda members also referred to the roll out of a MH Ambulance service as operates in Sweden and commented that Ireland could really benefit from a similar programme. Overall, Garda members felt that taking the Garda Station out of the equation would be a far more humane way to deal with these delicate situations.

> *"That's where the delay starts. It's a cog that… it's an unnecessary step. Yeah, ideally, you'd be bringing them straight from the house to, or bringing the GP, whoever has to make that decision, to the house and then off to the hospital." [GARDA 4]*

Legislative and Procedural Clarity

The Mental Health Act 2001 was highlighted as a cause for concern by participants when it came to managing child and adolescent crisis MH events. Garda members and Medical Professionals described it as being unclear and wanting in terms of youth specific provisions. On a more tertiary level, this study also revealed that procedural guidance for frontline staff is also lacking. Accordingly, participants suggested that an interagency protocol is required to guide professional practice throughout the care pathway. Such a protocol should include:

1. Information regarding the roles and responsibilities of various professionals, which agency is in charge at each pathway juncture, along with clear and concise guidance surrounding each professional's role and jurisdiction.
2. A mandatory pre-alert provided by the GS to the Emergency Department and a set of criteria outlining what information should be communicated as part of the pre-alert.
3. A point of contact within the Emergency Department (such as a Triage Nurse) for the GS to provide a formal handover to on their arrival. This information could be provided as part of the mandatory pre-alert procedure.
4. Clarity on when and how to use physical interventions and restraints with children.

Participants argued that an interagency protocol would provide increased understanding of what is expected of each agency. It would also help to identify where and when something has gone wrong, which would not only be useful in terms of improving future practice but could potentially enhance professional accountability and responsibility.

> *"I think the idea of uncertainty from a legal point of view you know a medical legal approach, it needs to be improved so that Guards and clinicians feel supported and know exactly where their powers lie when managing an adolescent who is presenting and isn't under an involuntary order, because you know they don't have a whole lot of power there." [Psychiatrist 2]*

> *"We need to understand their role (other agencies) and they need to understand ours. That might help us communicate better, people would be a lot more, not confident, but you know you (unclear) and even from a multi-agency perspective too, everybody knows what they're meant to do and again if you can stand over that 'this was a policy procedure, I followed that, and this is the information I had available at that point in time, that's why I made the decision' you know?" [GARDA 2]*

> *"The only joint protocol I know of is the 'Missing from Care' between Tusla and the Guards, and then there is a protocol for collaboration between the HSE and Disability Services but mental health no." [Tusla 1]*

Finally, analysis indicated that Garda members feel they lack a voice when it comes to organisational decision-making and policy development. They felt that all Garda members, particularly those working on the frontline should be given the opportunity to contribute to changes in policy and practice, not just because it impacts them directly, but because they believe they can provide valuable insights regarding the issues they confront daily.

> *"Stop listening to people at the top because they haven't dealt with it. The upper management haven't dealt with it. They only go on what is written in reports. What's written in reports is not what actually happens, there is always a lot more to it. Nobody listens to us. There is no panel for the Guards, legislation has never changed because a Guard has sat on the panel and had a discussion." [GARDA 15]*

Providing Information

Garda members and Medical Professionals commented that they are largely unaware of the MH support services that child and their families can avail of. As a result, both professional groups felt ill-equipped to advise parents/carers about follow up MH supports once contact with emergency services came to an end. Both cohorts of professionals noted that parents/carers can often feel very isolated and anxious when returning to 'normality' after a crisis MH health event and look to frontline staff to advise them about support services they can source in their community. Accordingly, they suggested that an information leaflet outlining a list of resources and services that are available (free of charge) to parents/carers and children would be extremely beneficial. They believed that having more specialist knowledge at their disposal would enhance Garda members' ability to collaboratively resolve crisis incidents with parents/guardians and signpost useful and appropriate support services.

"I don't think we have any formal list of resources in the ED regarding what could be beneficial for these kids going home. You know just even a list of supports for the parents, you know things like how to talk to your child about substance misuse or whatever it is. I think that could be quite reassuring for the parents." [Doctor2]

"Poor Mam and Dad are trying to deal with it and just try and give them the best advice you can about that State or NGO support that does exist like, you know? But again, not every Guard is aware of those supports either and it's again just based on personal experience, you know?" [GARDA 6]

Enhancing Garda members' Knowledge

Garda members with less than 5 years' service said they received some MH training at Garda College (i.e., Unit 5: Mental Illness Awareness) which they found particularly useful. However, those members with longer service (over 5 years) commented that they did not recall receiving any MH training outside of the Mental Health Act 2001 and Garda Powers connected with this legislation. 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). On a more positive note, all Garda members, with the exception of one who stated they were not interested, expressed an openness to further training and felt it would be of great value to them, specifically in the areas of neurodiversity and child and adolescent MH. Finally, both Garda members and Medical Professionals agreed that MH professionals have an important role to play in upskilling first responders and should be involved in the development and delivery of future training in the area.

"I suppose so education sessions with the Guards around acute behavioural disturbances and mental illness on a very tertiary level." [Psychiatrist 2]

"Absolutely, it couldn't do anything but help the organisation and the members concerned, you can never have too much knowledge in relation to human behaviour." [GARDA 2]

"It's definitely something we need to look at because it's through all walks of life and without training we're assessing those situations…without knowing what to look for." [GARDA 10]

Enhancing Interagency Relationships

Findings identified a shared understanding across professional groups that everyone is doing their best within the confines of a system plagued by departmental deficits. In turn, this solidarity propagated a level of mutual respect and comradery across agencies. Yet, findings also indicate that, on occasion, interagency working can

be a source of tension and conflict for professionals, specifically in the context of a youth crisis MH event. Whilst such grievances were by no means personal, their occurrence was perceived as a significant threat to the health of ongoing interagency relationships and the quality of the services being provided. Thus, participants noted that a concerted effort to improve interagency relationships is required.

A lack of detailed understanding regarding the nature of each organisation's role, along with the legislative and bureaucratic parameters in which each professional works, were highlighted as the major instigators of interagency tension and conflict. Participants explained that a consequence of poor interagency insights was the development of unrealistic expectations as to what other agencies can and should do when faced with a juvenile crisis MH event. Similar findings regarding interagency relations between the GS and Tusla were revealed in the 'Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991' (Shannon, 2017). For Instance, poor interagency communication between the GS and Tusla was not only a cause for frustration for Garda members but compounded their uncertainty regarding Tusla practice and procedure.

The vast majority of the sample believed that increased interagency training could be a game changer in terms of strengthening interagency rapport, which would in turn enhance collaborative working, information sharing, and communication. Such sentiments were informed by past experiences of joint training (mostly involving the GS and Tusla) which participants characterised as eye-opening as regards to learning about the other organisations, the different perspectives of professionals who work within them, and the challenges they face. Finally, participants believed that the development and subsequent roll out of an interagency protocol for youth crisis MH events would be an ideal opportunity to gather Health Professionals, Garda members, and Social Workers for joint training and rapport building.

> *"I think we could do with more training as well, we should, it would be great for us to see where they're coming from with it you know what I mean and like it would be great if we could all do something together. Because like it's very much like a multi-pronged approach if that makes sense." [Nurse 4]*

> *"Yeah, and everybody does genuinely want to do their best like, and it is frustrating." [GARDA 7]*

> *"I remember doing a training, a joint training between the Guards and the Social Work Department on domestic violence and it was amazing, and we were all kind of sitting there going 'Jesus, I didn't know that's what you had to do' and they were saying 'oh we didn't know that's what you had to do and needed from us' as a follow up." [Tusla 1]*

> *"...it really opened your eyes to go 'God, yeah I didn't think that they'd be doing that, or I didn't think that they'd thought that' and…get a little bit more insight on how they do their job and the struggles they have as well." [GARDA 12]*

Creating a Reliable Evidence Base

PULSE (Police Using Leading Systems Effectively) is a data consolidation and repository computer software program used by the GS to collect valuable information about reported incidents. Garda Personnel stationed at the Garda Information Services Centre (GISC) are responsible for updating and maintaining the PULSE system. The GISC is a contact centre for operational members of the GS. Following an incident, Garda members can contact the GISC on mobile phones instead of returning to their station to record the case details. They pass on information to trained call-takers who enter the details into the PULSE system (Garda.ie, 2021). Pulse represents the primary data collection tool used by the GS and the CSO to collate information regarding

criminality; victimisation; Garda member response; case management, progression, and outcomes. This information subsequently plays an important role in informing policy and practice within the organisation.

Findings revealed considerable variability in the ways in which MH call outs are recorded on PULSE by study respondents. For example, when called out to manage a crisis MH situation where no crime has been committed and the Mental Health Act 2001 has not been invoked, some participants explained that the incident is recorded on PULSE under the category 'Attention and Complaints'. Others stated that this type of incident is recorded under the category 'Domestic Dispute'. Interview data suggests that inconsistencies in recording this type of call out may be due to limitations with PULSE functionality. Participants explained that while PULSE has the capacity to record incidents where Section 12 of the Mental Health Act 2001 is invoked, it does not have functionality to record MH call outs where this legislation is not employed. As a result, Garda members must input information about such incidents under the PULSE category they feel is most suitable (i.e. Attention and Complaints or Domestic Dispute). Approximately one third of the GS sample suggested that a category for recording MH call outs that do not require invocation of the Mental Health Act 2001 would be useful. This would allow the system to capture a broad range of Garda involvement in MH call outs (i.e. both MH incidents when the Mental Health Act 2001 has been invoked and incidents when it has not).

> *"You'd love to see one in relation to mental health on that as well to be able to capture it but it's not there. And then again it comes down to the individual Guard and the way they refer, the way they tell the story as such." [GARDA 7]*

Further issues regarding PULSE emerged when discussing how incidents are recorded when both a crime has been committed and the Mental Health Act 2001 is invoked. Some participants stated that PULSE currently does not have functionality to capture the dual aspect of such of call outs (e.g. arrest for an assault and invocation of the Mental Health Act 2001). Participants explained that when such cases arise, information regarding the criminal aspect of the case takes precedence over the invocation of the Mental Health Act 2001 and it is this information that is subsequently entered into PULSE. Three participants suggested that modifications to the PULSE system to enable the recording of incidents of this nature, in a more nuanced and multifaceted way, would be useful.

These findings suggest that data regarding MH call outs may be being recorded in multiple locations on PULSE. They also imply that there are instances where important information regarding call outs that have a MH component are not being captured at all. Such verdicts are in line with findings reported in the 'Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991' (2017), which noted shortfalls in the operation of PULSE and ambiguities in Garda member practice when recording information onto the system (Shannon, 2017). Shannon (2017, p xiii) notes that "*consistent, comprehensive and accurate data collection"* is a vital part of evidence-based policing policy and best practice, in that it not only facilitates reflexive policing practice but promotes full transparency and accountability of the GS Accordingly, it is recommended that further investigation into the reporting mechanisms surrounding MH call outs are explored to ensure key data is being captured in a way that is meaningful and useful to the GS.

Concluding Comments

Overall, the findings outlined in this chapter call attention to a series of key opportunities and challenges associated with this pathway to crisis MH assessment and treatment. Participants suggested numerous ways in which the care pathway may be improved – some suggestions involved macro-level organisational and system changes, while others referred to micro-level modifications that may be implemented departmentally. This small explorative study is the first of its kind in Ireland; further research inquiry is needed on a national level to develop a comprehensive understanding of the issue at hand and how it may be improved. However, despite its small size, it provides useful insights into practice that inform recommendations in the next chapter.

Chapter 5: Discussion, Conclusions and Recommendations

5.1. Introduction

The crisis MH pathway travelled by children from contact with the GS through to psychiatric assessment is best described as fragmented and convoluted. It often involves numerous professionals, from multiple agencies, across three very different settings (the Scene, the Station, and the Emergency Department). The complex nature of the pathway can make it difficult for Garda members, Medical Professionals, and Social Workers to effectively navigate their way to an outcome that best meets the needs of the child. Each juncture is associated with a unique set of challenges that must be managed collaboratively by a range of stakeholders with competing interests and different expectations while also serving the needs of the child and their families. Despite the difficulties already alluded to, this study is testament to the fact that the child's best interests seem to be at the forefront of each of the stakeholder's minds.

There is currently an absence of domestic research investigating the role of the GS as first responders in crisis MH health scenarios involving children. Other than anecdotal commentary published by the press, there is also a dearth of national data outlining the frequency of Garda escorts to Paediatric Emergency Departments with children who require MH assessment and treatment. This study set about exploring the current care pathways of Irish youths experiencing a crisis mental health event from the time the GS become involved, through to the initiation of psychiatric assessment. It also sought to identify the major opportunities and challenges experienced by key stakeholders involved and suggested a practical set of recommendations for streamlining this pathway to care. Before drawing conclusions and discussing future directions, this chapter will contextualise the findings from the present study within the current knowledge base under the four thematic headings identified from the qualitative data analysis: *Accountability, Informal Practice, Service Development and Burden.*

Accountability and Responsibility

Interviews conducted with Garda members revealed that they had an increased sense of responsibility and accountability when dealing with children, not just in the context of crisis MH events but right across the board. Garda members identified children as an extremely vulnerable cohort and believed that the repercussions they, as members of the GS, would be subjected to if they made a mistake whilst dealing with a child in custody would be extremely serious. These findings are in line with existing research to show that police officers perceive MH call outs as particularly 'high risk' and worry that their lack of expertise in the area could potentially lead to a worsening of the situation for everyone involved (Ruiz and Miller, 2004). The present study identified an undercurrent of fear and dread among Garda members when dealing with individuals under 18 years, particularly in the content of a crisis MH event. These negative emotions were linked, in part, to concerns about being held to a higher level of account when managing situations they felt professionally ill-equipped to deal with.

The past couple of decades has witnessed a series of events that increased awareness of the need for better governance of policing conduct in the Republic of Ireland. Such shifts perhaps help to provide some insight as to why accountability was such a significant talking point for Garda members who participated in the study; for instance, the deaths of several young males while in Garda custody or following contact with Garda members, namely, Brian Rossiter (aged 15 years) in 2002, John Maloney (aged 18 years) in 2003, and Terence Wheelock (aged 20 years) in 2005 (Conway, 2016). Additionally, allegations of collusion between Garda members and a known drug dealer (GSOC, 2013); the vanishing of money from an evidence storeroom (Anon, 2013); apparent discrepancies in breath test results, and the discretionary wiping of penalty points (Conway, 2010) which led to the Morris Tribunal (Department of Justice, 2021), and the ongoing Charleton Tribunal (Department of Justice 2021) have placed members of the GS under very public scrutiny. The Morris Tribunal was one of the longest and most comprehensive inquiries into policing conduct in modern times (Brady 2014). It investigated the policing practice of one district of the GS and identified high levels of police misconduct,

abuses of power, and a "*blue wall of silence*" that not only shocked the Irish public, but called the occupational culture of the whole police service into question (Conway, 2010, p.1; Charman and Corcoran, 2015). The Morris Tribunal prompted the establishment of the Garda Síochána Act 2005, which set out a new framework of governance and accountability for the GS (Conway and Walshe, 2011), specifically, the reform of the complaints procedure, the launch of local police-community consultation committees, and the establishment of the Garda Inspectorate[15] in 2006, the Garda Síochána Ombudsman Commission (GSOC)[16] in 2007, the Policing Authority[17] in 2016, and the Commission on the Future of Policing in Ireland[18]in 2018.

Unsurprisingly, domestic research indicates that increased governance and accountability within the GS has instigated a significant shift in policing culture. Several recent studies conducted with the GS suggest that the traditional blue code of silence that came to light over via the Morris Tribunal inquiries has been replaced by a hyper-awareness concerning accountability. Such sentiments are evidenced by a culture of "*accountability avoidance*" (Shannon, 2017 p.205), which involves members limiting the scope of information formally recorded regarding their involvement in a case, and a "*cover your ass*" mentality (Marsh, 2020, p.7; Charman and Corcoran, 2015; An Garda Síochána, 2018; O'Brien-Olinger, 2016). Moreover, the establishment of GSOC has given rise to a culture of blame and fear within the organisation, in that Garda members have described feeling afraid to speak up about poor conduct, take risks, or make mistakes for fear that they will be blamed and reprimanded (An Garda Síochána, 2018; Barry, 2014; Corcoran, 2012).

Results from the present study regarding police responsibility and accountability echo findings outlined in existing scholarship. They also contribute to current knowledge by identifying a hyper-awareness amongst Garda members of the vulnerability experienced by children, and how this vulnerability stands to amplify and accelerate public scrutiny and formal repercussions if a mistake is made. Concerns about accountability were significantly compounded by three major factors: firstly, the perception that both in-house instruction (HQ Directives) and interagency protocols/procedures for managing child and adolescent crisis MH events are seriously lacking; secondly, the understanding that Mental Health legislation is both limited and indistinct in relation to youth-specific directives, and; thirdly, the absence of specialist training in child and adolescent mental health, neurodiversity, and youth-specific crisis intervention techniques.

To mitigate these concerns, findings from the present study revealed that Garda members believed that the introduction of specialist training and protocol, along with enhanced legislation in the area would serve to mitigate anxieties associated with responsibility and accountability, and improve their capacity to appropriately manage youth crisis MH events. More importantly, participants felt that the introduction of such measures would significantly improve how children and their guardians experience these crisis scenarios.

Pressure, Dread and Anxiety

Accountability was something Garda members spoke about a lot, not only in relation to the repercussions they may be subjected to following erroneous management of youth crisis MH event, but their recognition of the vulnerable status of the child and the personal pressure they put themselves under to protect and accommodate it. Such pressure was compounded by criticism some Garda members had been subject to in the past from the public and other stakeholders, and the belief that they are the wrong professionals to be dealing with the issue. Such findings are in line with international research to show that police officers worry that their lack of expertise in the area could potentially lead to a worsening of the situation for everyone involved (Ruiz and Miller, 2004; Watson et al, 2012). Moreover, Garda members communicated a sense of

[15] The Garda Inspectorate: is responsible for inspections and/or enquiries on particular aspects of the operation and administration of the Garda.

[16] Garda Síochána Ombudsman Commission (GSOC): Is responsible for dealing with complaints made by members of the public concerning the conduct of members of the Garda Síochána.

[17] The Policing Authority: established to oversee the performance of the Garda Síochána in relation to policing services in Ireland.

[18] Commission on the Future of Policing in Ireland: set up to provide a roadmap for strengthening An Garda Síochána and the broader national framework for policing, security, and community safety.

injustice about being held accountable for the management of an incident that they felt was well beyond their scope of practice given the absence of specialist MH procedure and adequate training. Finally, the anxiety associated with these call outs tended to linger for a period of time following the event, as Garda members described being plagued by intrusive thoughts regarding the 'what ifs' of the situation.

Informal Practice

Garda members adopted a variety of informal practices when managing crisis MH events to help put the child and their guardians at ease. Specifically, making environmental accommodations at the scene, offering to have a follow-up call with parents/carers, adopting an age-appropriate interaction style, and involving child and their guardians in the decision-making process. The adoption of informal practices by police officers is by no means a new phenomenon. Research from the 1960s onwards highlights the adoption of a variety of informal measures by law enforcement to navigate incidents on the frontlines (see Banton, 1964; Bittner, 1990; Skolnick and Fyfe, 1993; Wood and Watson, 2017). A review of existing research in the field reveals a tendency toward the exploration of police encounters with adults while similar inquiries with children have been largely overlooked (Doulas et al., 2014). Consequently, there is no way of knowing whether the informal practices adopted by the GS to manage child and adolescent MH crisis events emulate those adopted by police officers in other jurisdictions and with adults. That said, literature surrounding informal policing practices adopted in crisis MH incidents with adults demonstrates some resemblance to the findings outlined in this study. For instance, police officers reportedly exercise a great deal of discretion when it comes to crisis MH call outs which is evidenced by their propensity to divert people away from the police station where possible (Green, 1997; Teller, 2000). In many cases, officers adopt informal tactics to try to calm the individual down and make sure they get home safely (Lamb et al., 2002; Teller et al., 2000). Indeed, this was the general approach described by the Garda members interviewed in the present study with regards to the management of youth MH crisis.

Informal practices were adopted by Garda members both at the scene and at the Garda Station. These informal techniques are specifically intended to mitigate the distress experienced by both the children and their guardians. Garda members described these skills as being informed by common sense or learned on-the-job. These findings echo those of Shannon (2017, p.167) who reported a "deep-seated culture within An Garda Síochána privileging 'on-the-job' training and learning". While participants believed that such practices were important, they gave themselves no praise for going over and above their formal role (as safety providers and transporters) when they believed it necessary. To put it another way, participants were self-deprecating when describing informal tactics. They believed that any individual in a similar situation would do the same thing, thus, running the risk of undermining their input and skill set. Analysis also revealed that two key factors necessitated the adoption of informal practices. The first was the recognition of the child's increased level of vulnerability and the importance of mitigating undue distress. The second was the lack of formal procedure and knowledge available to officers when managing these crisis scenarios, coupled with the overwhelming sense that they must utilise all their skills (both formal and informal) to manage the situation safely and humanely. Whilst such conduct was framed by Garda members as essential, the need to trust their instincts was also a source of anxiety and worry, in that they described feeling uncertain as to whether they were in fact doing the 'right thing'. There were significant post-event ruminations reported by Garda participants, which subsequently impacted on their own wellbeing and ability to manage everyday work.

Service Development

Both the incidence of child and adolescent mental illness and the services in place to manage it are a serious cause for concern within the Irish context. This is evidenced by domestic research which shows that the number of children experiencing mental illness is on the rise (Dooley et al., 2019). Research also indicates a rise of 526% in crisis MH presentations to Paediatric Emergency departments between 2006 and 2017 (Fitzgerald et al., 2020). Moreover, these issues are compounded further by resource deficits in primary care resulting in long waiting lists for out-patient appointments (Coyne et al., 2015; Fitzgerald et al., 2020;

McNicholas et al., 2020). For instance, the most recent HSE figures (months April-June 2020) reveal that 2,315 children were waiting to be seen by CAMHS, of which 224 had been waiting for over a year (HSE, 2020). Delayed access to primary care, psychiatry and psychology services means that symptoms can worsen significantly whilst waiting for an appointment. In some instances, this deterioration can result in a crisis that requires intervention by the GS and urgent assessment by Emergency Medical Professionals (Fitzgerald et al, 2020). Findings from the present study reiterate just how pervasive these issues are from the standpoint of frontline professionals. All participants (Garda members, Tusla, Hospital Staff) felt strongly that primary care services require more funding so that staffing levels within primary care may be increased. Participants believed that such a measure could potentially help to curtail patient wait times, increase service accessibility, and potentially decrease the number of children who require crisis MH intervention from the GS. It would also allow the GS to be more confident that the child was being offered appropriate assessment and subsequent intervention if required. Further research is needed to explore the potential impact of primary care service development on the prevalence of child and adolescent crisis events within the Irish context.

Finally, the most salient theme that emerged throughout discussions regarding service provision was the desperate need for an appropriate facility/community-based clinic service for crisis patients, particularly outside of normal working hours (9am-5pm and at weekends). Previous research indicates that three quarters of all MH presentations to the Paediatric Emergency Department occur between 8pm and 3am (McNicholas, 2010). Indeed, accounts given by participants in this study regarding the 'typical' time of day that that the GS are dispatched to MH calls align with these findings. Thus, interviewees agreed there is a desperate need for the national roll out of 24-hour MH emergency facilities/community-based clinics where children (and adults) in crisis can receive urgent assessment and treatment. Garda members and Medical Professionals argued that the establishment of such a service would increase patient safety; expedite psychiatric assessment, treatment, and referral; and improve the experience of professionals, patients, and their families. Advice from these services to the GS post engagement would allow ongoing the GS training, confidence in their case management, and recognition of, and intervention in, areas in need of further development.

Crisis Intervention

Until now, the role of the GS in youth crisis MH events within the Irish context has been drastically under researched, resulting in a lacuna of knowledge in terms of frontline practice. The present study not only provides novel insights as to the challenges faced by the GS but creates the background necessary to consider improvements. A major concern communicated by Garda members was that they believed they were 'the wrong people' to be tasked with crisis MH events. Yet, they also recognised why their involvement in such incidents is necessary i.e. to maintain the safety of the child/child, family and public and provide transport when needed. They framed their 'ideal role' within MH crises as one of support to other specialist professionals who are trained to manage these complex scenarios. They also believed that the adoption of a collaborative crisis intervention model would increase interagency rapport, promote the knowledge and skills transfer across professionals, and mitigate undue distress experienced by children/children and their families/carers.

International research testifies to the benefits of implementing a multi-agency response when dealing with members of the public with suspected mental illness. Such approaches have been found to be associated with lower rates of arrest and reduced referrals to acute psychiatric services (Patron et al., 2016), less time spent at the scene, and the employment of positive engagement and negotiation skills by law enforcement (Kane et al., 2017, 2018; Patron et al., 2016). Moreover, it is clear that domestic policy makers are aware of these benefits as the establishment of Crisis Intervention Teams has been recommended numerous times in mental health and policing policy here in Ireland i.e. A Vision for Change (2006), 'Report of Joint Working Group on Mental Health Services and the Police' (2009), 'The future of Policing in Ireland' (2018).

As noted in Chapter 1, the roll out of a CIT/CAST pilot programme in line with the recommendations put forward in the report by the Commission on the Future of Policing in Ireland (2018), is expected to commence

in early 2022. Whilst such developments are extremely positive, it is important to note that recommendations outlined in this report were adult-centred and the crisis MH needs of children were largely overlooked. Accordingly, it is recommended that careful consideration is given to the pilot program's applicability to youth crisis MH events. Consultations with child and adolescent MH professionals, frontline Garda members, youth MH advocacy groups, and Public and Patient Involvement panels should be conducted to gather practical insights into the issue at hand. Key learnings from consultations should be used to inform each phase of program development (e.g. protocol and procedure, staff training, implementation, evaluation, and scale up). Such an approach would not only provide Garda members with the skills to manage youth MH crises, but would work toward ensuring access to age appropriate crisis intervention for adults and children.

Burden and Wellbeing

Whilst the term 'burden' was not directly used by Garda members during the interview process, the notion of 'Garda burden' emerged as both an unexpected and prominent theme throughout the commentary given by all Garda members. Garda burden was characterised by feelings of anxiety and dread, sleepless nights, and prolonged periods of feeling worried. The manifestation of Garda burden was both multidimensional and far-reaching, in that it was not only apparent throughout the narrative offered about youth crisis MH events, but throughout other commentary regarding different aspects of their job. The GS members referred to other trauma provoking incidents they encountered as part of their day-to-day work, such as involvement in body identification, completed suicides, road traffic accidents, sexual violence, child abuse and neglect. While discussion of all the data that fell under this umbrella code is beyond the scope of this report, 'Garda Burden' as it pertains to Youth MH crisis events is outlined below.

Useless, Frustrated and Unheard

Garda members referenced feeling useless, frustrated, and unheard. For instance, they recalled feeling useless when parents/carers asked them for advice that they simply did not have the expertise to give. Even though they acknowledged that it was impossible to know everything, they commented that it is extremely difficult to tell a parent/carer that they do not have the answers they so desperately seek. Furthermore, feelings of being useless and unheard were discussed in the context of frontline policing and at an organisational level. Garda members expressed frustration with some of the assessments made by GPs who attend the station. They noted times when they strongly disagreed with the GP's decision not to refer a child to the Emergency Department when they felt sure that the situation would worsen considerably for the child and their guardian without emergency intervention. Whilst they acknowledged that they were not medically trained and had no right to disagree with the GP, they noted that they are the first people at the scene and observe the child at the height of their distress. Accordingly, they felt that their insights should count for something. Finally, analysis revealed a general sense among Garda members that their opinions and insights are largely overlooked by decision-makers. These findings indicate that they not only feel unheard but undervalued. Such sentiments are not unique to the GS with a growing body of research to show that frontline officers are rarely consulted about policy and practice reforms (Hail, 2020; Bayley, 2008). Moreover, Garda members argued that their experience on the frontlines should earn them the right to actively participate in policy and reforms that directly impact first responder practice. They believed that directives developed using a top-down approach are seldom applicable in the field.

Burnout

Occupational stress is a phenomenon of growing importance. Job burnout is a psychological syndrome that involves a prolonged response to chronic on-the-job stressors. Six major factors have been shown to precipitate occupational stress and burnout: workload, degree of personal control, personal reward, community or working environment, fairness, and value system (Maslach and Leiter 2017). Research indicates that individuals who feel overworked and undervalued, believe they have no control or decision-making power, feel unfairly treated, and have poor quality relationships with colleagues, are at risk of experiencing work related stress and/or burnout (Ibid). Indeed, some Garda members who participated in this study

described experiencing several of these precipitating factors. Several members felt that their opinions were not only unheard but that they were not valued, both on a practice level when liaising with other professionals and on an organizational level in terms of policy development and decision-making. They also expressed feeling conflicted about the appropriateness of their role within crisis MH events in that they described feeling occupationally misplaced, unsupported, and undertrained.

International research indicates that occupational stress amongst police officers has increased significantly over the past decade (Queiras et al., 2020). Moreover, the augmentation of such occupational stress has been found to negatively impact officers, their families, and the organisation as a whole (Baldwin et al., 2019; Pines and Keinan, 2005). Occupational stress amongst the police service is a significant concern for government agencies, police force administrators, and the community because of its wider impact on police officer health, service provision, and job performance (McCarty et al., 2019). Overall, findings show that Garda member involvement in crisis MH events has the potential to precipitate and contribute to psychological burden, occupational stress, and burnout, which begs the question: how does the GS as an organisation safeguard the psychological wellbeing of its members?

Promoting Wellbeing Throughout the Service

In conjunction with the experiences of burden, as discussed above, research indicates that police officers are exposed to a range of traumatic events and are frequently faced with potentially life-threatening situations (Bartol and Bartol, 2008; Toch, 2002). Consequently, police work is associated with serious challenges to mental and emotional wellbeing (Violanti and Paton, 1999; Liberman et al., 2002). Repeated exposure to such a range of stressors can have a significant negative impact on officers' lives, such as problematic alcohol misuse, divorce, anxiety and depression, suicide, and burnout (Violanti and Paton, 1999; Tanigoshi, et al, 2008). The 'Garda Representative Association Wellbeing Survey' (Fallon, 2018) suggests that "An Garda Síochána is a cauldron for adversity in relation to trauma and wellbeing", with 1 in 6 officers potentially meeting criteria for Post-Traumatic Stress Disorder, 1 in 4 experiencing significant levels of trauma-induced distress, and a high rate of completed suicide amongst members. Findings also showed that Garda members perceived the services in place to help them to manage occupational distress were more of a 'box ticking' exercise than a meaningful source of support (ibid, p.111). These findings, in conjunction with those presented by the present study regarding Garda burden, are a cause for concern. Not only do the members of the GS experience a heightened level of trauma and occupational stress, but they believe these occupational health issues are not being appropriately addressed by their organisation.

In recent years, the GS has enhanced its psychological support services. In 1994 the Peer Support Program was established, which activates the deployment of a trained Peer Supporter to assist officers following a traumatic event. This was followed by the introduction of a confidential 24-hour counselling service in 2016 (Charles Flanagan, Dáil Debates 252, 3 July 2018) In 2020, the GS conducted research investigating the health needs of its personnel (both Garda members and Civilian Staff). Findings revealed that over 68% of Garda members reported 'occasionally' experiencing trauma at work, and over 70% were aware of the support services available within the organisation (An Garda Síochána, 2020). In addition, a significant proportion of the sample reported perceptions of stigma associated with seeking out MH and emotional supports, and many felt that such help-seeking would negatively impact career progression (ibid). In response to these findings, Garda Commissioner, Drew Harris, stated that the organisation has enhanced its independent 24/7 counselling service and intended to launch a health and wellbeing app in December 2020. He also commented that further measures to support personnel will be outlined in the forthcoming 'Health and Wellness Strategy, and Implementation Plan' (An Garda Síochána, 2021).

5.2. Conclusion and Recommendations

This study reveals that children and adolescents who experience acute episodes of mental illness in Ireland represent a "*neglected cohort*", with poor access to urgent psychiatry care (McNicholas, 2018, p.1). It also

suggests that the resource needs of frontline personnel responsible for providing both emergency and primary care services to this vulnerable group are similarly overlooked. The dearth in international and domestic research surrounding police encounters with children and adolescents experiencing a crisis MH event means that very little is known about the formal and informal tactics employed by officers when managing these incidents. The findings outlined in this report shed some light on this and help inform the following key recommendations.

Specialist Education and Training

In the absence of specialist training and formal procedure, the research suggests that members seem to be industrious and dynamic in their approach to youth crisis MH events. This is evidenced by the ability to supplement formal procedure with informal practices which they have developed via their on-the-job experience, gut instinct and common sense. Garda members also demonstrated a high level of insight regarding the vulnerable status of the child, which in turn precipitated a shift in their approach styles when managing crisis events from authoritarian to authoritative, age-appropriate and youth-centred. Garda members accepted that their conduct with children in crisis scenarios was not perfect, and this was corroborated by Medical Professionals. Moreover, they recognised their need to upskill and demonstrated an openness to engage in further training to achieve this end. Thus, it is recommended that policymakers within the GS give serious consideration to the development and implementation of a new curriculum for new recruits and qualified members that specifically focuses on youth-officer interaction and positive engagement, child and adolescent crisis MH presentations, and Neurodiversity. Teaching needs should be informed by frontline Garda members with experiences in the field, and mental health experts should be directly involved in selecting and delivering content. Such a program has the potential to enhance the experiences of all those involved in this complex pathway to care, specifically the children in crisis.

Providing Information

Garda members and Medical Professionals commented that they are largely unaware of the MH support services that children and their families can avail of. As a result, both professional groups felt ill-equipped to advise parents/carers about follow up MH supports once contact with emergency services came to an end. It is recommended that an information leaflet is developed outlining a list of MH resources and services that are available to parents/carers and children. This resource should be made available for distribution by professionals working on the frontlines of youth crisis MH events.

Youth Focused Protocol and Procedure

Legislative ambiguity and a lack of procedural guidance emerged as a significant challenge for all of the participants interviewed for this study. Garda members, in particular, felt that they were stumbling around in the dark when faced with crisis MH calls outs which left them feeling fearful and unsure about the validity of their decision-making. Furthermore, the absence of clear-cut protocol precipitated a hyper-awareness surrounding professional accountability, further compounding the uncertainty they felt when deliberating a course of action. Additionally, Medical Professionals and Garda members agreed that they could all use further training concerning the Mental Health Act 2001, specifically concerning its application to children. There was also a consensus amongst the sample that the development of a formal interagency protocol would be extremely beneficial to all stakeholders involved in this care pathway. Accordingly, a concerted effort should be made to establish an interagency protocol that maps out the care pathway and provides a clear definition of the roles, jurisdiction, and responsibilities of each professional/agency.

Developing Interagency Relationships

A great deal of respect was communicated by Garda participants for professionals from other agencies involved in the care pathway. Indeed, interviewees admitted that there are times when tensions can run high, but such conflict was attributed to resource issues as opposed to the conduct of individual professionals. There was a consensus amongst participants that frictions between agencies are enhanced by a lack of understanding regarding each stakeholder's role within the care pathway, the procedural parameters they

must adhere to, and the subsequent restraints they experience. Accordingly, participants suggested that increased contact via structured interagency engagement (e.g. joint training) could go a long way toward improving interagency rapport, communication, and information sharing. Thus, it is recommended that the Department of Justice, the Department of Health, and the Child and Family Agency take heed of these suggestions in their future efforts to promote effective interagency working across these stakeholder groups.

Crisis Intervention

International policy and research indicates that Crisis MH Intervention Models are increasingly becoming a social policy feature in many jurisdictions. Findings from this study, in conjunction with numerous recommendations regarding domestic policy, indicate that Ireland is long overdue in its efforts to follow suit. Garda members and Medical Professionals both agreed that one of the major benefits of rolling out specialist training and protocols regarding youth crisis intervention was its potential to ease the uncertainty experienced by the professionals involved in the care pathway. Whilst recent news of the CIT/CAST pilot programme is indicative of a positive step in the right direction, whether or not it is intended for use in youth crisis MH scenarios is unknown at this time. Based on the findings generated by the present study, is recommended that careful consideration is given to the CIT/CAST pilot programs applicability to youth crisis MH events. Consultations should be held with key stakeholders to inform youth-focused protocol within the pilot programme; namely, child and adolescent MH professionals, frontline Garda members, youth MH advocacy groups, and Public and Patient Involvement panels. Such an approach could go a long way toward ensuring the availability of crisis intervention supports to all members of the public, regardless of age.

Garda Wellbeing

Efforts to enhance psychological support services for Garda members by the GS in recent years are extremely positive. Such developments demonstrate that decision-makers recognise the propensity for psychological distress within the GS and plan to improve the supports available to all the organisation's personnel. However, in conjunction with these measures, decision-makers must also consider how current systems and procedures may be improved to alleviate Garda member stress and burden. This may be achieved by locating gaps in knowledge and procedure, and adopting a collaborative bottom-up approach involving key stakeholders (e.g. first responders) to update policy and procedure in a way that is beneficial for the organisation, its members and the public. The adoption of such an approach is of particular importance because "*policy and procedure does not implement itself*" and bottom-up reform has been shown to promote stakeholder buy-in and policy roll out (Barrett and Fudge, 1981 p. 9; Quinlan et al, 2016). With regard to the GS management of MH crisis in young individuals, this study outlining the lived experience of Garda members goes some way to provide insight into these challenges.

Future Research

Research investigating police involvement in child and adolescent crisis MH events remains in its infancy. This gap contributes to a void in knowledge and understanding as to how the police respond to these complex scenarios and the systems in place to guide frontline practice. The insights generated by this study make a sizable contribution to the current knowledge base. However, these findings are only a starting point. Further inquiry is needed to understand the intricacies of these complex encounters between the police and juveniles in crisis. The present study with a small sample size of participants working in Leinster province fails to capture the experience of professionals working in other parts of the country. Further interrogation of this issue, with a larger and representative sample of Garda members, General Practitioners, Emergency Department Medics, and Social Workers will help provide a comprehensive understanding of the issue at hand.

The professional group and stakeholders interviewed were from the emergency departments of paediatric hospitals. As such the views might pertain more to youth aged under 16, leaving the crisis MH pathways travelled by 17 year olds unexplored. Such information is necessary. This is of particular importance given that this cohort of children have aged-out of the Paediatric Emergency Department and must attend an adult facility for emergency assessment and treatment. An inquiry of this nature would not only provide a more

detailed understanding of the care pathways travelled by children and adolescents, but the experiences of the professionals who assist them along the way.

Findings suggest that data regarding MH call outs for all age groups are at risk of being recorded in multiple locations on PULSE. Study respondents also expressed a fear that important information regarding call outs with a MH component might not be captured at all. Accordingly, it is recommended that the recording of MH call outs on PULSE are reviewed to ensure consistency and clarity of data entry, allowing key data on MH events be captured in a way that is meaningful and useful to the GS.

Finally, a comprehensive understanding of the issue at hand will not be complete without gathering the perspectives of the children/children and their families who are embroiled in this crisis care pathway. Such insights are key for the development of child focused policy and practice that directly caters for the needs of this vulnerable group during a crisis MH event.

References

Adamis, D., Tatlow-Golden, M., Gavin, B. and McNicholas, F., 2019. General practitioners'attitudes and knowledge about attention deficit hyperactivity disorder (ADHD) in Ireland. *Irish Journal of Medical Science (1971-)*, *188*(1), pp.231-239.

Alakeson, V., Pande, N. and Ludwig, M., 2010. A plan to reduce emergency room 'boarding'of psychiatric patients. *Health Affairs*, *29*(9), pp.1637-1642.

An Garda Síochána and the HSE, 2010. Memorandum of Understanding between An Garda Síochána and the HSE on the Removal or Return of Persons to an Approved Centre in accordance with the Mental Health Act 2001. Available at: https://www.hse.ie/eng/services/publications/mentalhealth/memo-of-understanding-between-hse-and-garda-.pdf (Accessed 10 April, 2021).

An Garda Síochána and Tusla – Child and Family Agency, 2017. Joint Working Protocol for An Garda Síochána/Tusla – Child and Family Agency Liaison. Available at: https://www.tusla.ie/uploads/content/CF_Joint_Protocol.pdf (Accessed 17 April 2021).

An Garda Síochána, 2009. Status Report on the Implementation of the Recommendations of the Second Report of the Garda Síochána Inspectorate - Review of Practices and procedures for barricade Incidents. Available at: https://www.garda.ie/en/about-us/publications/reviews-and-evaluations/internal-audit-reports/recommendation-matrix-%E2%80%93-report-2-barricade-incidents.pdf (Accessed 16 April, 2021).

An Garda Síochána, 2019. Play Your Part: Cultural Audit of An Garda Síochána. Available at: https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/news-media/ags-cultural-audit-2018.pdf (Accessed 28 March 2021).

An Garda Síochána, 2020. An Garda Síochána Outlines Measures to Support Health and Wellbeing of Garda Personnel - 5/11/20 Available at: https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/press-releases/2020/november/an-garda-siochana-outlines-measures-to-support-health-and-wellbeing-of-garda-personnel-5-11-20.html (Accessed 10 January 2021).

An Garda Síochána, 2020. Annual Report 2019. Available at: https://www.garda.ie/en/about-us/publications/annual%20reports/an-garda-siochana-annual-reports/an-garda-sochna-annual-report-2019.pdf (Accessed 15 March 2021).

An Garda Síochána, 2021. An Garda Síochána Outlines Measures to Support Health and Wellbeing of Garda Personnel - 5/11/20. Available at: An Garda Síochána Outlines Measures to Support Health and Wellbeing of Garda Personnel - 5/11/20 - Garda (Accessed 16 April, 2021).

An Garda Síochána, 2021. Recording Procedures and Guidelines relating to children in the care of An Garda Síochána. Available at: https://www.garda.ie/en/about-us/publications/policy-documents/policy-for-recording-children-in-care-of-an-garda-siochana-.pdf. (Accessed 16 April, 2021).

Apolitical, 2017. The world's first mental health ambulance arrives in Sweden. Available at: https://apolitical.co/en/solution_article/worlds-first-mental-health-ambulance-arrives-sweden (Accessed 22 January 2020).

Baldwin, S., Bennell, C., Andersen, J.P., Semple, T. and Jenkins, B., 2019. Stress-activity mapping: physiological responses during general duty police encounters. *Frontiers in psychology, 10,* p.2216.

Banton, M.P., 1964. The policeman in the community. New York: Basic Books.

Barnardos, 2019. Strategy 2019-2021. Available at: https://www.barnardos.ie/about-us/funding-governance/strategy (Accessed 10 January 2021).

Barrett, S. and Fudge, C., 1981. Policy and Action: Essays on the Implementation of Public Policy. London: Methuen.

Barry, N., 2014. Policing the police: How is the operation of the Garda Síochána Ombudsman Commission perceived by frontline members of An Garda Síochána (Unpublished). Masters Dissertation. Dublin Institute of Technology.

Bartol, CR, and Bartol, A.M., 2008. *Introduction to Forensic Psychology*, 2nd ed., Thousand Oaks, CA: SAGE.

Bayley, D.H., 2008. Police reform: Who done it?. Policing & Society, 18(1), pp.7-17.

Bittner, E., 1967. Police discretion in emergency apprehension of mentally ill persons. *Social problems, 14*(3), pp.278-292.

Bittner, E., 1990. Aspects of police work. Boston, MD: Northeastern University Press.

Booth, A., Scantlebury, A., Hughes-Morley, A., Mitchell, N., Wright, K., Scott, W. and McDaid, C., 2017. Mental health training programmes for non-mental health trained professionals coming into contact with people with mental ill health: a systematic review of effectiveness. BMC psychiatry, 17(1), pp.1-24.

Bouveng, O., Bengtsson, F. A., & Carlborg, A. (2017). First-Year follow-up of the psychiatric emergency response team (PAM) in Stockholm County, Sweden: a descriptive study. *International Journal of Mental Health, 46*(2), 65-73.

Brady, C. 2012, 'Trust an issue as Garda fortress shut to outsiders', *Irish Times*, 23 May. Available at: https://paddoconnell.blogspot.com/2012/05/trust-issue-as-garda-fortress-shut-to.html (Accessed 20 January 2021).

Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), pp.77-101.

Cannon, M., Coughlan, H., Clarke, M., Harley, M. and Kelleher, I., 2013. The Mental Health of Young People in Ireland: A report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group.

Central Statistics Office, 2016. Census 2016 Results. Available at: https://www.cso.ie/en/csolatestnews/presspages/2017/census2016profile9-healthdisabilityandcarers/ (Accessed 27 June 2020).

Charman, S. and Corcoran, D., 2015. Adjusting the police occupational cultural landscape: The case of An Garda Síochána. *Policing and society, 25*(5), pp.484-503.

Children's Mental Health Coalition, 2018. Children's Mental Health Coalition submission to the Independent Monitoring Group on *A Vision for Change.* Available at: https://www.mentalhealthreform.ie/wp-content/uploads/2018/08/FINAL_IMG_submission_2012_Childrens_Mental_Health_Coalition.pdf (Accessed 20 December 2020).

Clarke, V. and Braun, V., 2014. Thematic analysis. In *Encyclopedia of critical psychology* (pp. 1947-1952). Springer, New York, NY.

College of Psychiatrists of Ireland, 2020. Summary Response to Sharing the Vision: A Mental Health Policy for Everyone. Available at: https://www.irishpsychiatry.ie/external-affairs-policy/college-papers-submissions-publications/submissions/summary-response-to-sharing-the-vision-a-mental-health-policy-for-everyone/ (Accessed 10 January 2021).

Commission on the Future of Policing in Ireland, 2018. The future of Policing in Ireland. Available at: http://www.policereform.ie/ (Accessed 11 March 2019).

Compton, M., Bakeman, R., Broussard, B., D'Orio, B. and C. Watson, A., 2017. Police officers' volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) training: Evidence for a beneficial self-selection effect. *Behavioral sciences & the law, 35*(5-6), pp.470-479.

Conradi, L., Wherry, J. and Kisiel, C., 2011. Linking child welfare and mental health using trauma-informed screening and assessment practices. *Child Welfare, 90*(6), pp.129-147.

Conway, V. 2010. The Blue Wall of Silence. The Morris Tribunal and Police Accountability in Ireland. Irish Academic Press.

Conway, V., & Walsh, D. P. J. 2011. Current developments in police governance and accountability in Ireland. *Crime, Law and Social Change, 55*(2–3), 241–257.

Conway, V., 2016. All that shimmers is not gold: The Garda Síochána Ombudsman Commission and Garda accountability. In Defining events. Manchester University Press.

Cooper, V.G., Mclearen, A.M. and Zapf, P.A., 2004. Dispositional decisions with the mentally ill: police perceptions and characteristics. *Police Quarterly, 7*(3), pp.295-310.

Corcoran, D. (2012). Responding to change? A cultural analysis of Garda perceptions of police reform agendas within the Republic of Ireland (PhD). University of Portsmouth.

Courtois, C.A. and Gold, S.N., 2009. The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy*, *1*(1), p.3.

Coyne, I., McNamara, N., Healy, M., Gower, C., Sarkar, M. and McNicholas, F., 2015. Adolescents' and parents' views of Child and Adolescent Mental Health Services (CAMHS) in Ireland. *Journal of psychiatric and mental health nursing, 22*(8), pp.561-569.

Crosby, S.D., 2016. Trauma-informed approaches to juvenile justice: A critical race perspective. Juvenile and *Family Court Journal, 67*(1), pp.5-18.

CSO, 2016. Census 2016 Profile 9 - Health, Disability and Carers Available at: https://www.cso.ie/en/csolatestnews/presspages/2017/census2016profile9-healthdisabilityandcarers/ (Accessed 15 November 2019).

Curran S., & Fitzgerald M., 1999. Attention deficit hyperactivity disorder in the prison population. *American Journal of Psychiatry, 156*(10), pp. 1664.

Curtin, K., Monks, S., Wright, B., Duffy, D., Linehan, S. and Kennedy, H.G., 2009. Psychiatric morbidity in male remanded and sentenced committals to Irish prisons. *Irish journal of psychological medicine*, *26*(4), pp.169-173.

Dáil Debates, 2018. Charles Flannigan, Question 252, 3 July 2018. Available at: https://www.oireachtas.ie/en/debates/debate/joint_committee_on_future_of_mental_health_care/2018-05-23/3/ (Accessed 17 November, 2020).

Dáil Debates, 2020. Helen McEntee, Question 452, Tuesday, 15 December 2020. Available at: https://www.oireachtas.ie/en/debates/question/2020-12-15/453/ (Accessed 20 April 2021).

Dáil Debates, 2020. Helen McEntee, Question 606, Tuesday, 6 October 2020. Available at: Garda Training – Tuesday, 6 Oct 2020 – Parliamentary Questions (33rd Dáil) – Houses of the Oireachtas (Accessed 20 April 2021).

Dáil Debates, 2020. Heather Humphreys, Question 150, Thursday, June 2021. Available at: https://www.oireachtas.ie/en/debates/question/2021-06-03/150/ (Accessed 30 junel 2021).

Day, A.G., Somers, C.L., Baroni, B.A., West, S.D., Sanders, L. and Peterson, C.D., 2015. Evaluation of a trauma-informed school intervention with girls in a residential facility school: Student perceptions of school environment. *Journal of Aggression, Maltreatment & Trauma, 24*(10), pp.1086-1105.

De Lucca, D.W., 2017. Implementing all aspects of officer safety and wellness. *Police Chief,* 84, pp.1-3.

Deirdre Malone, Dáil Debates, 23 May 2018. Available at: https://www.oireachtas.ie/en/debates/debate/joint_committee_on_future_of_mental_health_care/2018-05-23/3/ (Accessed 11 March 2021).

Department of Health, 2015. Report of the Expert Group Review of the Mental Health Act, 2001. Available at: https://www.gov.ie/en/publication/637ccf-report-of-the-expert-group-review-of-the-mental-health-act-2001/ (Accessed 20 March 2021).

Department of Health, 2020. Sharing the Vision: a Mental Health Policy for Everyone. Available at: https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/ (Accessed 11 March 2019).

Department of Justice, 2019. A Policing Service for the Future. Available at: http://www.justice.ie/en/JELR/Pages/Commission_on%20the_Future_of-Policing_in_Ireland (Accessed 25 April 2021).

Department of Justice, 2021. Morris Tribunal. Available at: http://www.justice.ie/en/JELR/Pages/MorrisTribunal (Accessed 16 April, 2021).

Department of Justice, 2021. Establishment of a High Level Taskforce to consider the mental health and addition challenges of persons interacting with the criminal justice system. Available at: http://www.justice.ie/en/JELR/Pages/PR21000071 (Accessed 23 September 2021).

Dierkhising, C.B., Ko, S.J., Woods-Jaeger, B., Briggs, E.C., Lee, R. and Pynoos, R.S., 2013. Trauma histories among justice-involved youth: Findings from the National Child Traumatic Stress Network. *European journal of psychotraumatology*, *4*(1), p.20274.

Disley, E., Taylor, C., Kruithof, K., Winpenny, E., Liddle, M., Sutherland, A., Lilford, R., Wright, S., McAteer, L. and Francis, V., 2016. Evaluation of the offender liaison and diversion trial schemes. London.

Dooley, B, O'Connor, C, Fitzgerald, A, and O'Reilly, A (2019). My world survey 2. National Study of Youth Mental Health in Ireland.

Douglas, A.V. and Lurigio, A.J., 2010. Youth crisis intervention teams (CITs): A response to the fragmentation of the educational, mental health, and juvenile justice systems. *Journal of Police Crisis Negotiations, 10*(1-2), pp.241-263.

Douglas, A.V. and Lurigio, A.J., 2014. Juvenile Crisis Intervention Teams (CITs): A Qualitative Description of Current Programs. Police Journal: Theory, Practice, and Principles, 87(2).

Dupont, R. and Cochran, S., 2000. Police response to mental health emergencies—Barriers to change. *Journal of the American Academy of Psychiatry and the Law*, *28*(3), pp. 338–344.

Ellis, H.A., 2014. Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. *Archives of psychiatric nursing*, *28*(1), pp.10-16.

Fakhoury, W. and Priebe, S., 2007. Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare. *Psychiatry*, *6*(8), pp.313-316.

Fallon, F., 2018. Garda Representative Association Wellbeing Survey 2018. Garda Representative.

Fitzgerald, E., Foley, D., McNamara, R., Barrett, E., Boylan, C., Butler, J., Morgan, S. and Okafor, I., 2020. Trends in mental health presentations to a paediatric emergency department. *Irish Medical Journal*, *113*(2), pp.20-20.

Forrester, D., Holland, S., Williams, A. and Copello, A., 2016. Helping families where parents misuse drugs or alcohol: A mixed methods comparative evaluation of an intensive family preservation service. *Child & Family Social Work, 21*(1), pp.65-75.

Gavin, A., Keane, E., Callaghan, M., Kelly, C., Molcho, M. and Nic Gabhainn, S., 2015. The Irish health behaviour in school-aged children (HBSC) study 2014.

Gov.ie (2021) Draft Heads of a bill to amend the Mental Health Act 2001. Available at: https://www.gov.ie/en/publication/47068-draft-heads-of-a-bill-to-amend-the-mental-health-act-2001/ (Accessed 23 September 2021).

Green, T.M., 1997. Police as frontline mental health workers. The decision to arrest or refer to mental health agencies. *International journal of law and psychiatry*, *20*(4), pp.469-486.

Griffin, E., McMahon, E., McNicholas, F., Corcoran, P., Perry, I.J. and Arensman, E., 2018. Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016. *Social psychiatry and psychiatric epidemiology, 53(*7), pp.663-671.

GSOC, 2013. Report into allegations of collusion by members of the Garda Síochána with an individual in the movement and supply of controlled drugs, and the nature and extent of any relationship/s between members of the Garda Síochána and that individual, Dublin: GSOC.

Gov.ie, 2021. Press release: Garda powers to be modernised and updated under new Bill from Minister Humphreys. Department of Justice, 14 June 2021. Available at: https://www.gov.ie/en/press-release/6ed9f-garda-powers-to-be-modernised-and-updated-under-new-bill-from-minister-humphreys/

Health Service Executive (HSE), 2019a. CAMHS Operational Guideline 2019. Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/operational-guideline/ (Accessed 10 January 2021).

Health Service Executive (HSE), 2019b. Delivering Specialist Mental Health Services 2019 Available at: https://www.hse.ie/eng/services/publications/mentalhealth/hse-mental-health-division-delivering-specialist-mental-health-services.pdf (Accessed 10 January 2021).

Health Service Executive (HSE), 2006. A vision for Change. Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/visionforchange/ (Accessed 11 March 2020).

Health Service Executive (HSE), 2020.Performance profile April-June 2020.Available at:https://www.hse.ie/eng/services/publications/performancereports/2020-performance-reports.html (Accessed 10 January 2021).

Health Service Executive (HSE), 2021. National Forensic Mental Health Service. Available at: https://www.hse.ie/eng/national-forensic-mental-health-service (Accessed 20 April, 2021).

Hill, M. and Hupe, P., 2014. Implementing public policy: An introduction to the study of operational governance. Sage.

Hollandare, F., Tillfors, M., Nordenskjad, A., & Sellin, T., 2020. Are quantity and content of psychiatric interventions associated with suicide: A case-control study of a Swedish sample. *BMC psychiatry, 20*(1), 1-11.

Hummer, V.L., Dollard, N., Robst, J. and Armstrong, M.I., 2010. Innovations in implementation of trauma-informed care practices in youth residential treatment: A curriculum for organizational change. *Child welfare, 89*(2), p.79.

IPRT, 2014. Children's Rights Behind Bars: Report. Available at: https://www.iprt.ie/latest-news/childrens-rights-behind-bars-report/ (Accessed 2 December 2020).

Irish Medical Times, 2020. New mental health policy fails to set out medical workforce requirements. *Irish Medical Times,* 2 July. Available at: https://www.imt.ie/news/new-mental-health-policy-fails-set-medical-workforce-requirements-02-07-2020/ (Accessed 10 January 2021).

ISB (2021) S.I. No. 119/1987 – Criminal Justice Act, 1984 (Treatment of Persons in Custody in Garda Síochána Stations) Regulations, 1987. Available at: http://www.irishstatutebook.ie/eli/1987/si/119/made/en/print (Accessed 23 September 2021).

Ivankova, N.V., Creswell, J.W. and Plano Clark, V.L., 2007. Foundations and approaches to mixed methods research. *First steps in research. Pretoria: Van Schaik*, pp.253-282.

Jacob, N., Evans, R. and Scourfield, J., 2017. The influence of online images on self-harm: A qualitative study of children aged 16–24. *Journal of adolescence*, *60*, pp.140-147.

Kane, E., Evans, E. and Shokraneh, F., 2017. Effectiveness of current policing-related mental health interventions in England and Wales and Crisis Intervention Teams as a future potential model: a systematic review. *Systematic reviews*, *6*(1), pp.1-7.

Kane, E., Evans, E. and Shokraneh, F., 2018. Effectiveness of current policing-related mental health interventions: A systematic review. *Criminal behaviour and mental health*, *28*(2), pp.108-119.

Kelly, B.D., 2007. Penrose's Law in Ireland: an ecological analysis of psychiatric inpatients and prisoners. *Irish Medical Journal*, *100*(2), pp.373-374.

Kessler, R.C., Chiu, W.T., Demler, O. and Walters, E.E., 2005. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), pp.617-627.

Kilkelly, U. and Forde, L., 2021. Children's Rights and Police Questioning: A Qualitative Study of Children's Experiences of being interviewed by the Garda Síochána. Available at: Experiences_of_being_interviewed_by_the_Garda_S%C3%ADoch%C3%A1na.pdf (Accessed 27 September 2021)

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M., Brymer, M.J. and Layne, C.M., 2008. Creating trauma-informed systems: child welfare, education, first responders, health care, juvenile justice. *Professional psychology: Research and practice, 39*(4), p.396.

Korn, C.S., Currier, G.W. and Henderson, S.O., 2000. "Medical clearance" of psychiatric patients without medical complaints in the emergency department. *The Journal of emergency medicine*, *18*(2), pp.173-176.

Kubiak, S., Comartin, E., Milanovic, E., Bybee, D., Tillander, E., Rabaut, C., Bisson, H., Dunn, L.M., Bouchard, M.J., Hill, T. and Schneider, S., 2017. Countywide implementation of crisis intervention teams: Multiple methods, measures and sustained outcomes. *Behavioral sciences & the law*, *35*(5-6), pp.456-469.

Kubiak, S., Shamrova, D. and Comartin, E., 2019. Enhancing knowledge of adolescent mental health among law enforcement: Implementing youth-focused crisis intervention team training. *Evaluation and program planning, 73*, pp.44-52.

Lamb, H.R., Weinberger, L.E., and DeCuir, W.J., 2002. The police and mental health. *Psychiatric services, 53* (10), 1266–1271.

Laubschagne, A., 2003. Qualitative research - Airy fairy or fundamental? *The Qualitative Report*, 8(1), pp. 100-103.

Lawrence, R.G., 2000. The politics of force: Media and the construction of police brutality. University of California Press.

Lee, F.S., Heimer, H., Giedd, J.N., Lein, E.S., Šestan, N., Weinberger, D.R. and Casey, B.J., 2014. Adolescent mental health—opportunity and obligation. *Science*, *346*(6209), pp.547-549.

Liberman, A.M., Best, S.R., Metzler, T.J., Fagan, J.A., Weiss, D.S. and Marmar, C.R., 2002. Routine occupational stress and psychological distress in police. *Policing: An International Journal of Police Strategies & Management*, *25*(2), ISSN: 1363-951X.

Lindstrom, V., Sturesson, L. and Carlborg, A., 2020. Patients' experiences of the caring encounter with the psychiatric emergency response team in the emergency medical service—A qualitative interview study. *Health Expectations*, *23*(2), pp.442-449.

Lynch, F., Mills, C., Daly, I. and Fitzpatrick, C., 2006. Challenging times: prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents. *Journal of adolescence, 29*(4), pp.555-573.

Madill, A., Jordan, A. and Shirley, C., 2000. Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), pp.1-20.

Marchant, A., Hawton, K., Stewart, A., Montgomery, P., Singaravelu, V., Lloyd, K., Purdy, N., Daine, K. and John, A., 2017. A systematic review of the relationship between internet use, self-harm and suicidal behaviour in children: The good, the bad and the unknown. *PLoS one, 12*(8), p. e0181722.

Markowitz, F.E., 2011. Mental illness, crime, and violence: Risk, context, and social control. *Aggression and violent behavior*, *16*(1), pp.36-44.

Marsh, C., 2020. *An Garda Síochána: Culture, challenges, and change* (Doctoral dissertation, School of Social Work and Social Policy, Trinity College Dublin).

Maslach, C., & Leiter, M. P. 2017. New insights into burnout and health care: Strategies for improving civility and alleviating burnout. *Medical Teacher, 39*(2), pp.160-163.

McCarty, W.P., Aldirawi, H., Dewald, S. and Palacios, M., 2019. Burnout in blue: An analysis of the extent and primary predictors of burnout among law enforcement officers in the United States. Police quarterly, 22(3), pp.278-304.

McKenna, D., Murphy, H., Rosenbrier, C., Soulsby, A., Lyall, A., Keown, P., Reid, K. and McKinnon, I., 2019. Referrals to a mental health criminal justice Liaison and diversion team in the North East of England. *The Journal of Forensic Psychiatry & Psychology, 30*(2), pp.301-321.

McMahon, E.M., Reulbach, U., Corcoran, P., Keeley, H.S., Perry, I.J. and Arensman, E., 2010. Factors associated with deliberate self-harm among Irish adolescents. *Psychological medicine, 40*(11), pp.1811-1819.

McNicholas, F. 2018. Child & adolescent emergency mental health crisis: a neglected cohort. *Irish Medical Journal 111*, pp. 841.

McNicholas, F., O'Sullivan, M., Lennon, R., Doherty, M. and Adamson, N., 2010. Deliberate self-harm (DSH) out of hour's presentations. *Irish journal of psychological medicine*, *27*(1), p.11.

McNicholas, F., Rooney, L. and Holme, I., 2019. PC/DC: Police Contact with Distressed Children. *Irish Medical Journal, 112*(8), pp.989-989.

McNicholas, F., Sharma, S., Oconnor, C. and Barrett, E., 2020. Burnout in consultants in child and adolescent mental health services (CAMHS) in Ireland: a cross-sectional study. *BMJ open*, *10*(1), p. e030354.

Mental Health Commission & An Garda Síochána, 2009. Report of Joint Working Group on Mental Health Services and the Police 2009. Available at: https://www.mhcirl.ie/File/Rpt_JWG_MHS_Police.pdf (Accessed 10 March 2020).

Mental Health Commission 2001. Reference Guide: Mental Health Act 2001. Part 2: Children. Available at: https://www.mhcirl.ie/File/refguidmha2001p2.pdf (Accessed 17 May 2020).

Mental Health Commission, 2001. Guidance Document for Application for the Examination, Admission or Treatment of a Child under the Mental Health Act 2001. Available at http://www.tipperaryinfo.ie/sites/default/files/Guidance%20for%20Mental%20Health%20Act2001-Children.pdf (Accessed 16 April, 2021).

Mental Health Commission, 2016. Mental Health Commission: Annual Report 2016. Including Report of the Inspector of Mental Health Services. Available at: https://www.mhcirl.ie/sites/default/files/2021-01/2016_AR_Incl_OIMS.pdf (Accessed14 September 2020)

Mental Health Commission, 2017. Mental Health Commission: Annual Report 2017. Including Report of the Inspector of Mental Health Services Available at: 2017_AR_Incl_OIMS.pdf (mhcirl.ie) (Accessed 14 September 2020)

Mental Health Commission, 2021. Mental Health Commission: Annual Report 2020. Including Report of the Inspector of Mental Health Services. Available at: https://www.mhcirl.ie/sites/default/files/2021-06/MHC-Annual-Report-2020.pdf (Accessed 9 August 2021)

Mental Health Ireland, 2018. Stigma. Available at: http://www.mentalhealthireland.ie/a-to-z/stigma/ (Accessed 6 February 2020).

Mental Health Reform, 2017. Mental Health Reform submission on review of A Vision for Change. Available at: https://www.mentalhealthreform.ie/wp-content/uploads/2017/09/Submission-on-review-of-A-Vision-for-Change.pdf (Accessed 14 September 2020).

Mental Health Reform, 2019. Briefing note on reform of the Mental Health Act, 2001. Available at: https://www.mentalhealthreform.ie/news/briefing-note-on-reform-of-the-mental-health-act-2001/ (Accessed 12 December 2020).

Miles, M., & Huberman, M., 1994. *Qualitative Data Analysis*: *A methods Sourcebook.* London: Sage

Mount Sinai, 2021. Emergency Behavioural Services. Available at: https://www.mountsinai.org/care/behavioral-health/treatment-programs/emergency (Accessed 20 April 2021)

Mulvey, E.P. and Schubert, C.A., 2017. Mentally ill individuals in jails and prisons. *Crime and justice*, *46*(1), pp.231-277.

Murphy, S.M., Irving, C.B., Adams, C.E. and Waqar, M., 2015. Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*, (12).

NHS Education for Scotland, 2017. Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce' Available at: https://transformingpsychologicaltrauma.scot/media/x54hw43l/nationaltraumatrainingframework.pdf. (Accessed 10 January 2021).

NHS, 2020. Crisis and acute mental health services Available at: Crisis and acute mental health services https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/ (Accessed 10 January 2021).

NHS, 2021. Crisis and acute mental health services. Available at: https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/ (Accessed 20 April 2021).

O'Brien-Olinger, S., 2016. Police, race and culture in the 'New Ireland': An ethnography. Palgrave Macmillan.

O'Keefe, C., 2016. Gardaí want training for mental illness cases: The Irish Examiner, 3 August. Available at: https://www.irishexaminer.com/ireland/gardai-want-training-for-mental-illness-cases-413839.html (Accessed 17 November 2020).

O'Regan, E., 2016. 'More mental-health patients now being committed by their families and Gardaí, *The Irish Independent* 21 June. Available at: https://www.independent.ie/irish-news/health/more-mental-health-patients-now-being-committed-by-their-families-and-gardai-34818847.html (Accessed 26 November 2020).

O'Sullivan, E. and O'Donnell, I., 2007. Coercive confinement in the Republic of Ireland: The waning of a culture of control. *Punishment & Society*, *9*(1), pp.27-48.

Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Simpson, A., Webber, M. and Meader, N., 2016. Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. *Health Technology Assessment*, 20(3).

Penrose LS., 1939. Mental disease and crime: outlines of a comparative study of European statistics. British *Journal of Medical Psychology 1939*(18), pp. 1-15.

Pines, A.M. and Keinan, G., 2005. Stress and burnout: The significant difference. *Personality and individual differences*, *39*(3), pp.625-635.

Punch, M., 1979. Policing the inner city: A study of Amsterdam's Warmoesstraat. Springer.

Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E. and Molodynski, A., 2018. A systematic review of co-responder models of police mental health 'street' triage. *BMC psychiatry, 18*(1), pp.1-11.

Queiras, C., Passos, F., Baįrtolo, A., Marques, A.J., da Silva, C.F. and Pereira, A., 2020. Burnout and stress measurement in police officers: Literature review and a study with the operational police stress questionnaire. *Frontiers in psychology, 11*.

Quinlan, M. 2016. Implementing change in healthcare – lessons in best practice from the movement towards integrated care in the US. Applied Research for Connected Health (ARCH): Report. Available at http://www.arch.ie/wp-content/uploads/2015/08/Implementing-change-within-healthcare_Executive-Summary.pdf (Accessed 10 January 2021).

Robson, C., 2002. Real world research: A resource for social scientists and practitioner-researchers (Vol. 2). Oxford: Blackwell.

Ruiz, J. and Miller, C., 2004. An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. *Police quarterly, 7*(3), pp.359-371.

SAMSHA. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf (Accessed 10 January 2021).

Schwalbe, C.S. and Maschi, T.M., 2012. Probation officers' perspectives on interagency collaboration for juvenile offenders with mental health problems. *Psychiatric services, 63*(8), pp.830-833.

Scottish Police Authority, 2019. Trauma Informed Policing https://www.spa.police.uk/spa-media/p2jhy1m1/rep-b-20190124-item-4-trauma-informed-policing.pdf (Accessed 10 January 2021).

Shannon, G. 2017. Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991. Available at: https://www.drugsandalcohol.ie/27362/1/Audit%20of%20Section%2012%20Child%20Care%20Act%201991.pdf (Accessed 22 March 2021).

Skolnick, J.H. and Fyfe, J.J., 1993. Above the law: police and the excessive use of force. New York, NY: Free Press.

St Michaels Hospital, 2021. Mental Health and Addiction Service. Available at: https://www.stmichaelshospital.com/programs/mentalhealth/emergency.php (Accessed 20 April 2021)

Taheri, S.A., 2016. Do crisis intervention teams reduce arrests and improve officer safety: A systematic review and meta-analysis. *Criminal Justice Policy Review, 27*(1), pp.76-96.

Tanigoshi, H., Kontos, A.P. and Remley Jr, T.P., 2008. The effectiveness of individual wellness counselling on the wellness of law enforcement officers. *Journal of Counselling & Development*, *86*(1), pp.64-74.

Teller, J.L., Munetz, M.R., Gil, K.M. and Ritter, C., 2006. Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric services*, *57*(2), pp.232-237.

Teplin, L.A., 2000. Keeping the peace: police discretion and mentally ill persons. National institute of justice journal, July, pp.9–15.

The Department of Justice, 2021. The disclosures Tribunal Available at: http://www.justice.ie/en/JELR/Pages/The_Disclosures_Tribunal (Accessed 16 April 2021).

The Garda Síochána Inspectorate, 2007. Review of Practices and Procedures for Barricade Incidents. Available at: Review-of-Practices-and-Procedures-for-Barricade-Incidents.pdf (gsinsp.ie) (Accessed 12 April 2021).

The Garda Síochána Inspectorate, 2019. Public Order Policing A Review of Practices in the Garda Síochána. Available at: https://www.gsinsp.ie/wp-content/uploads/2019/07/Public-Order-Policing.pdf (Accessed 1 May 2021)

Toch, H. 2002. *Stress in policing*. American Psychological Association.

Vermette, H.S., Pinals, D.A. and Appelbaum, P.S., 2005. Mental health training for law enforcement professionals. Journal of the American Academy of Psychiatry and the Law.

Violanti, J.M. and Paton, D., 1999. *Police trauma: Psychological aftermath of civilian combat*. Charles C Thomas Publisher.

Walther, J., Sochacka, N.W. and Kellam, N.N., 2013. Quality in interpretive engineering education research: Reflections on an example study. *Journal of Engineering Education*, *102*(4), pp.626-659.

Watson, A.C. and Fulambarker, A.J., 2012. The crisis intervention team model of police response to mental health crises: a primer for mental health practitioners. *Best practices in mental health, 8*(2), p.71.

Watson, A.C., Compton, M.T. and Draine, J.N., 2017. The crisis intervention team (CIT) model: An evidence-based policing practice?. *Behavioural Sciences & the Law*, *35*(5-6), pp.431-441.

Wayman, S., 2020. Inpatient psychiatric care for under-18s exposes health system flaws*, The Irish Times* 13 August. Available at: https://www.irishtimes.com/life-and-style/health-family/parenting/inpatient-

psychiatric-care-for-under-18s-exposes-health-system-flaws-1.4321821 (Accessed 19 December 2020).

Wells, W. and Schafer, J.A., 2006. Officer perceptions of police responses to persons with a mental illness. *Policing: An International Journal of Police Strategies & Management*.

WHO, 2014. Mental health: a state of well-being. Available at: http://www.who.int/features/factfiles/mental_health/en/ (Accessed 21 January 2020).

WHO, 2020. Improving the mental and brain health of children and adolescents. Available at: https://www.who.int/activities/Improving-the-mental-and-brain-health-of-children-and-adolescents (Accessed 12 January 2021).

WHO, 2020. Mental Health in Emergencies Available at https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies (Accessed 17 April 2020).

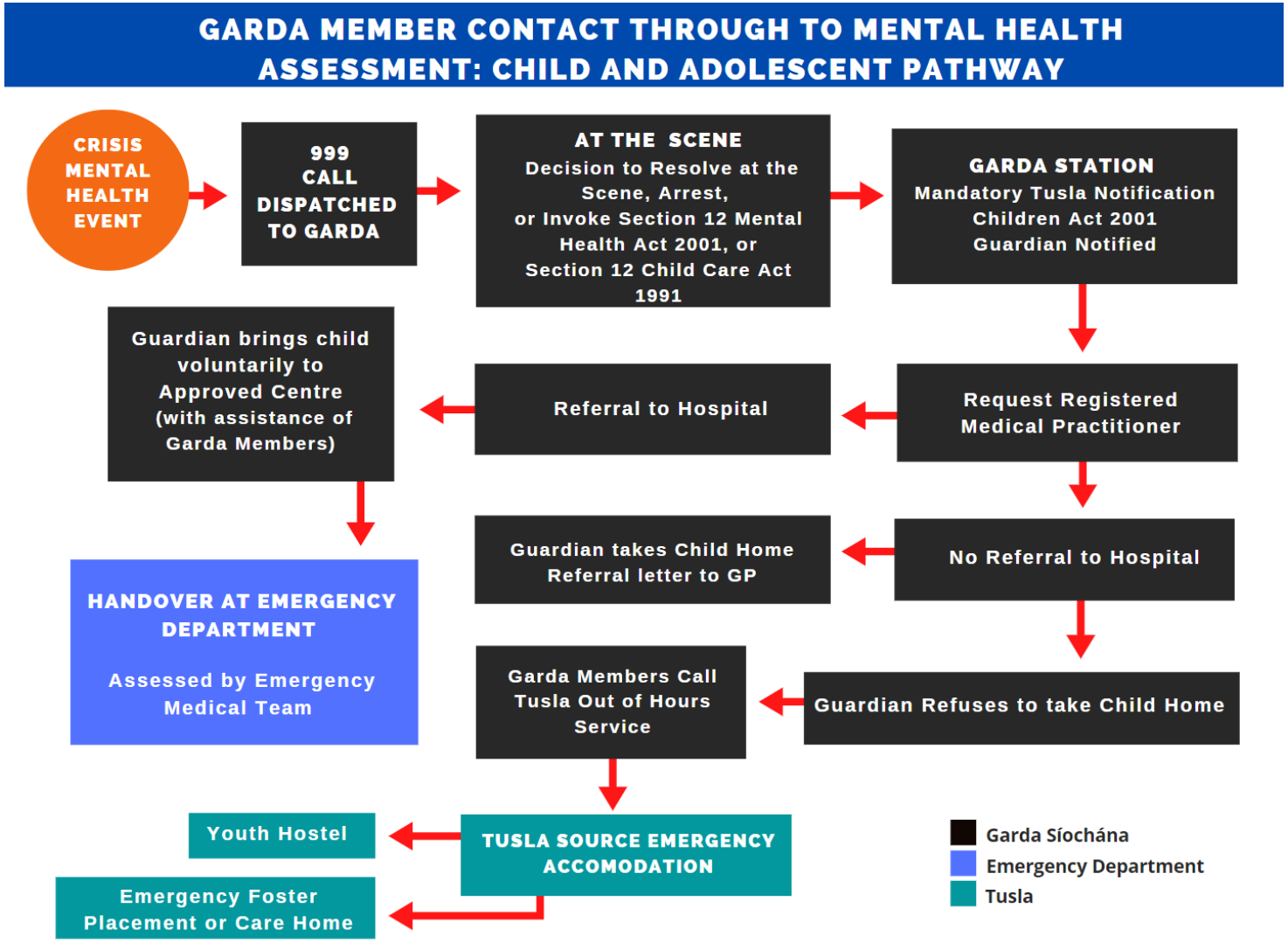
Woo, B.K., Chan, V.T., Ghobrial, N. and Sevilla, C.C., 2007. Comparison of two models for delivery of services in psychiatric emergencies. *General hospital psychiatry*, *29*(6), pp.489-491.

Wood, J.D. and Watson, A.C., 2017. Improving police interventions during mental health-related encounters: past, present and future. Policing and society, 27(3), pp.289-299.

Zeller, S.L, Calma, N. and Stone, A., 2014. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *Western Journal of Emergency Medicine*, *15*(1), p.1.

Zeller, S.L., 2010. Treatment of psychiatric patients in emergency settings. *Primary Psychiatry*, *17*(6), pp.35-41.

Appendix 1: Pathway



Appendix 2: Expert Advisory Panel

Expert Advisory Panel		
Name	**Affiliation**	**Experience**
Dr Blánaid Gavin	Child and Adolescent Psychiatry, UCD School of Medicine, University College Dublin	Associate Professor, Consultant Psychiatrist
Dr Ingrid Holme	School of Sociology, University College Dublin	Lecturer and Research Fellow. Expert in medical sociology
Ms Kate Mitchel	Mental Health Reform Trust	Expert in Mental Health Policy
Dr Aogan Mulcahy	School of Sociology, University College Dublin	Lecturer in Sociology, expert in policing culture and social policy.
Dr Etain Quigley	Department of Law, Maynooth University. HSE Mental Health Tribunals	Lecturer in Law, expert in mental health and the youth justice system.
Dr Mairead Seymore	School of Languages, Law and Social Sciences, Dublin Institute of Technology	Lecturer in Law, expert in mental health and the youth justice system.

Appendix 3: Research Design

Phase 1: First Responder Interviews

Sample

A convenience sample of 18 Garda members (n=4 females, n=14 males) took part in Phase 1 semi-structured interviews. Data collection took place across nine Garda Stations in the following districts: Dublin Metropolitan Region [DMR] East, DMR South Central, DMR North Central, Wicklow, Arklow and Bray. The sample consisted of Garda members of three ranks: Garda (n=13), Sergeant (n=15), and Juvenile Liaison Officer (n=3). Participants' ages ranged from 26-44 years old with an average age of 35.5 years. The sample varied somewhat in terms of their years of service, from 2-23 years. Total interview time was 17hrs 1 minute and 16 seconds; the average interview lasted 55 minutes.

Procedure

All participants were recruited via an 'invitation to participate' email sent out by the Garda Research Unit. Participants contacted the research team by phone/email to express interest and were subsequently sent an information sheet and consent form. After 48 hours, the researcher re-established contact to arrange prospective interviews. A total of 15 interviews were conducted in person and 3 Interviews were conducted over the phone.

Measures

Semi-structured interviews were conducted with participants to collect rich experiential data regarding thoughts, attitudes, opinions, and belief systems. Interview themes included: Garda member experience, contact and knowledge in youth justice and MH; practicalities of policy in practice; inter-agency linkage and communication (Tusla, Emergency Department, GP's, etc.), training and support; opportunities and challenges.

Phase 2: Stakeholder Interviews

Sample

Clinicians with regular exposure to youth presenting with MH crisis were considered essential participants. A convenience sample of 11 stakeholders (n=9 females, n=2 males) took part in phase 2 semi-structured interviews. The sample consisted of medical professionals (n=2 Consultant Child and Adolescent Psychiatrists, n=2 Paediatric Emergency Department Doctors, n=4 Paediatric Emergency Department Nurses, n=1 Child and Adolescent Psychiatry Clinical Nurse Specialist) from a Paediatric Emergency Department that serves children aged 0-16 years in the Leinster Province. A Senior Social Work Practitioner (n=1) from Tusla Child and Family Agency (Leinster Province) was also interviewed. Stakeholders varied between the ages of 28-56 years. Phase 2 Participants ranged in their years of service from 3-32 years. Total interview time was 8hrs 50 minutes 36 seconds; the average interview lasted 45 minutes.

Procedure

All participants were recruited via an 'invitation to participate' email sent out by Children's Health Ireland and Tusla Child and Family Agency. Participants contacted the research team by phone/email to express interest and were subsequently sent an information sheet and consent form. After 48 hours, the researcher re-established contact to arrange prospective interviews. One interview was conducted in person and ten were conducted over the phone. Phone interviews were necessary due to Covid-19 lockdown restrictions that were in place at the time (September- December 2020).

Measures

Semi-structured interviews were conducted with key stakeholders to collect rich experiential data regarding thoughts, attitudes, opinions, and belief systems. Interview questions were informed by the data collected in Phase 1 of the project and guidance given by the Expert Advisory Panel. Themes included: experience of Garda Escorts to the Emergency Department, inter-agency linkage and communication (Tusla, Garda members, GP's, etc.), and opportunities and challenges associated with child pathways to MH care.

Appendix 4: Research Analysis

Preliminary Analysis was conducted on both Phase 1 and Phase 2 datasets individually, before being amalgamated and undergoing three final intensive cycles of thematic analysis by the research team (see Table A). The cycle generated 18 Umbrella Themes (see Table B) and 98 subthemes.

Table A: Cycles of Analysis

1st Cycle		2nd Cycle		3rd Cycle	
Umbrella Themes	28	Umbrella Themes	22	Umbrella Themes	18
Subthemes	114	Subthemes	102	Subthemes	97
Participant Quotations	2004	Participant Quotations	1887	Participant Quotations	1712

Table B: Final Umbrella Themes

Umbrella Themes
1. Garda Experience of MH
2. "Typical" Crisis Case
3. Our Role (Garda members)
4. Service Deficit
5. Formal Response
6. Informal Practice
7. Responsibility and Accountability
8. Juvenile Complexity
9. Liaising with Parents/Carers
10. The Young Persons Experience
11. Interagency working
12. Training
13. Legislation
14. Recording (Pulse/Referrals/IT Systems)
15. Opportunities
16. Challenges
17. Ideal Pathway
18. Burden

Appendix 5: Process of Thematic Analysis (Braun and Clarke, 2006)

Stages	Analytical Process
1. Data Familiarisation	- Transcribing data - Reading and familiarising oneself with the data - Making notes of ideas
2. Code Generation	- Systematic coding of interesting and relevant information - Categorising data per code
3. Locating Potential Themes	- Categorising codes into prospective themes - Collating all the pertinent information to each prospective theme
4. Thematic Review	- Review prospective themes to ensure no data overlap - Review prospective themes to ensure they make sense in relation to the data set and the research question(s) - Check data for additional themes that may have been missed
5. Theme Definition	- Name each theme - Refine each theme so that only the specifics are included - Develop clear definitions pertaining to the meaning of each theme
6. Report Generation	- Select information rich extracts for examples - Review extracts - Discuss findings in relation to research questions - Situate findings within the current knowledge base