2008

# Psychiatric Nurses' Association


## [PUBLIC CONSULTATION SUBMISSION TO THE REVIEW OF TRAINING AN GARDA SIOCHANA PNA]

## CONTENTS

## INTRODUCTION

More and more our society is becoming increasingly complex. Rapid and often unpredictable change is common within it. Technological innovation, complex ethical and legal challenges, new policy initiatives and increased public and professional expectations make the present age one of the most demanding and exigent that those in public service have ever faced. In this environment the Gardaí are required to have enhanced levels of analytical, critical, synthetic and practice abilities which enable them to strive towards and achieve standards of excellence.

The strategic planning of education and quality assurance of mental health services are of paramount importance to the work of the Psychiatric Nurses Association (PNA). As the professional representative body representing primarily psychiatric nurses, nurses working within intellectual disability services and general nurses working in specialist practice areas, we often submit and make representation on strategic developments which will have impact both for service users and our members. We welcome the opportunity to offer our submission to the review of An Garda Training and view this process as an opportunity for shared learning between the professions and to also highlight some of the mental health care needs of individuals, families, and groups to improve their access to, and attainment of quality care both in their communities and the services. It is recognised that for any academic programme to be successful it must respond to the existing and emerging needs of the population and have important consequences in the quality of workforce planning.

It is estimated that, at some point in their adult lives, one person in four will suffer from mental illness and that 25% of families are likely to have at least one member suffering from

mental illness. The incidence of depression in Ireland is estimated at 10% and schizophrenia at 1% (DoHC 2001a)[1].

"More than 27% of adult Europeans are estimated to experience at least one form of mental ill health during any one year" Wittchen HU & Jacobi F (2005)[2]

"The most common forms of mental ill health in the EU are anxiety disorders and depression. By the year 2020 depression is expected to be the highest ranking cause of disease in the developed world".WHO (2001)[3].

Both the United Nations (UN) and the World Health Organisation (WHO) consider suicide to be a significant threat to public health. From 1950 to 1995 the global rates of suicide have increased by 60% (World Health Organisation 2002)[4]. In 2002 suicide claimed an estimated 815,000 lives worldwide with an overall age – adjusted rate of 14.5 per 100,000 population globally and 19.1 per 100,000 in the European Region. While suicide was reported to be the

[1] Department of Health & Children (2001a) *Quality and Fairness – A Health System for You.* Stationary Office, Dublin.

[2] Wittchen HU, Jacobi F, (2005) *Size and burden of mental disorders in Europe: a critical review and appraisal of 27 studies.* European Neuropsychopharmacology, Volume 15, Number 4, pp. 357 – 376

[3] WHO World Health Report, (2001), p11. http://www.who.int/whr/2001

[4] World Health Organisation (2002) Krug EG et al eds. *World Report on violence and health.* Geneva, Switzerland.

thirteenth leading cause of death globally, it was the seventeenth leading cause of death in the European Region (World Health Organisation 2002). Moreover suicide rates among adolescences and young adults have increased considerably over the last few decades in a number of industrialised countries (Breton et al 2002).

There has been a ground swell of public concern about the problem of suicide in Ireland. The consistently high suicide toll in Ireland over the past 20 years particularly among young men has made the cause of death a major public health concern. Ireland experienced one of the fastest rising suicide rates in the world during the 1980's and 1990's, the overall suicide rate having doubled over that period.Whilst such statistic's make for stark reading, it is clear that the treatment of mental ill health and the promotion of mental health and wellness are key global and national issues. It follows therefore that professional autonomous Gardaí working in the community are important assets in the national mental health agenda.

A key theme of current community education and destigmatisation is to see mental health as "health" The more patients are managed well in general health settings and the more primary care teams promote mental health as a central aspect of their work , the more quickly community attitudes towards help- seeking for mental health problems will change It is clear that the main focus of care in mental health services is now in the community, with the focus of in-patient care being only for short term acute episodes or for chronically disturbed patients/clients who cannot function in lower support environments. This means that the Gardaí require a variety of skills in community settings when addressing the needs of those with individuals with mental health difficulties. This has implications for role development, and the Student/ Probationer Education/ Training and Development programme.

The PNA see the crucial role of Gardaí in responding and adapting to meet population based needs and the needs of particular at – risk groups. Increasingly the role of An Gardaí as

providers of signposting and access to health care has been referred to by all agencies. The PNA believe that working in partnership, the Gardaí can provide the gateway to mental health engagement but recognise the necessity to cultivate a closer collaborative relationship among the different partners involved.

Here to fore there has been a significant gap across all agencies, and the absence of a multi-sectoral, interagency framework that enables effective coordination, identifies useful practices and clarifies how different approaches to mental health promotion and psychosocial support complement one another in the greater community. In particular Gardaí have resources such as skills in problem solving, communication, and negotiation, all valuable assets when approaching mental health difficulties and illness in the wider community. It is our view (PNA) that the Gardaí can offer support mechanisms to persons with a mental health problem outside the health sector which could be mutually enhancing and complementary to the mental health services.

The development of community and neighbourhood policing creates an opportunity for the Gardaí to take a more active role in identifying people at risk of more serious offending who may benefit from mental health care and other services. There is increasing interaction between Gardaí and persons with mental illness. Gardaí are, by default becoming the first point of access to mental health services for people with mental illness and often provide a path to emergency mental health care. Various reasons are put forward for the high contact between police and those with mental illness: deinstitutionalisation, changing police practices (community orientated) , and the association between mental illness and criminal victimisation studies estimate the prevalence of violent victimisation in adults with a mental illness to be between 2.5 (Hiday, Swartz, Swanson, Borum, & Wagner, 1999)[5] and 11 times

5 Hiday, V. A., Swartz, M. S., Swanson, J. W., Borum, R., & Wagner, H. R. (1999). Criminal victimization of persons with severe mental illness. Psychiatric Services, 50(1), 62-68.

(Teplin, McClelland, Abram, & Weiner, 2005)[6] the rate of the general population, with women being at greater risk than men (Goodman et al., 2001; Wood & Edwards, 2005)[7]. These factors and the general lack of understanding and awareness about mental illness result in some people with mental illness in crises coming into contact with An Gardaí Síochaná. It is also important to note few mental health services with the exception of the acute units, are staffed after office hours. Gardaí, being available 24 hours, 7 days a week can often find themselves "filling the gaps "or liaising with the services.

However there is some ambivalence among Gardaí about whether they should in fact be dealing with mental health issues. The police mandate is generally to ensure safety and to provide protection to the public. This ambivalence is reinforced if there is a lack of comprehensive, ongoing training of Gardaí in the recognition of mental illness and in mental health crisis intervention, and a lack of contact and support from mental health and emergency services. The results for persons with mental illness can be serious: long delays in receiving necessary diagnosis and treatment, unnecessary and damaging trauma, criminalisation of illness-induced behaviour. Family and friends of persons with mental illness experiences the trauma and frustrations of such interactions, as well as the impact of the criminalisation of mental illness. Moreover the procedures terminology and practices which characterize the criminal justice system are likely to be bewildering for individuals and their family members alike.

[6] Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime Victimisation in Adults With Severe Mental Illness: Comparison With the National Crime Victimisation Survey. Archives of General Psychiatry, 62(8), 911-921

[7] Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., et al. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. Journal of Traumatic Stress, 14(4), 615-632.

Mental illness labels evoke a set of stereotypes or beliefs about the group that influence how labelled individuals view themselves and how others respond to them8.Primary among these beliefs is that people with mental illness are dangerous and unpredictable9.

Although mental health problems occur in almost every family at some point, people who experience them still meet fear and prejudice from others and are made to feel ashamed and excluded. The stigma and discrimination associated with having a mental illness are often so devastating that they prevent people from seeking help for fear of being labelled. Effectively reducing stigma and discrimination requires concerted action by all interested parties – users, carers, professional groups and civil society. It is essential that all training policies recognise the impact of stigma and discrimination on people and their families, so that Gardaí can be equipped with strategies to redress the situation. This issue should be addressed in future Garda training programmes

We are taking the opportunity of commenting on the Student / Probationer Education/ Training and Development Programme as also an avenue to promote a community effort response to the difficulties surrounding mental illness enjoining the Gardaí, Mental Health/ Psychiatric Services and the community together for common goals of safety, understanding, and service to the mentally ill and their families, thus developing a more intelligent, understandable, and safe approach to mental crisis events.

[8] Scheff TJ: Users and non-users of a student psychiatric clinic. J Health Hum Behav 7:114 –21, 1966

Link BG, Cullen FT, Struening EL, et al: A modified labelling,theory approach to mental disorders: an empirical assessment. Am Sociol Rev 54:400 –23, 1989

Socall DW, Holtgraves T: Attitudes toward the mentally ill: the effects of label and beliefs. Sociol Q 33:435– 45, 1992

[9] Mental patients: understanding why labels matter. Am J Sociol 92:1461–500, 1987

Link BG, Phelan JC, Bresnahan M, et al: Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health 89:1328 –33, 1999

This submission will provide an overview with regard to aspects of the legislation which specifically refer to the Gardaí in their responses to dealing with mental illness, i.e. The Mental Health Act 2001 and the Criminal Justice Act 1984. It will then focus on two specific areas which we feel are vitally important and most topical in today's society, that of suicide prevention and the issue of dual diagnoses (substance misuse and mental illness). Both of these issues are easily the most frequent aspects of mental health care delivery discussed and debated by our members, we believe An Garda Síochaná encounter these issues on a frequent basis in the greater community also. We also offer a brief background into the developments in nurse education in Ireland in an effort to highlight those areas we feel worked well in the transition process of nursing becoming a degree programme. Finally our Deputy General Secretary offers a word with regard to escorts of people with a mental illness and some of the difficulties posed for An Garda Síochaná whilst examining some of the options within that regard.

In preparation for this submission The Officer Board of the PNA would like to express their gratitude particularly to: Ms Imelda None Nurse Practice Development Co Ordinator North West Dublin Mental Health Services, Mr. Martin Farrell Director of Nursing North West Dublin Mental Health Services, Mr. James Lynch Nurse Tutor Centre of Nurse Education James Connolly Memorial Hospital Blanchardstown, Mr. Seamus Murphy Deputy General Secretary PNA, Ms Hanora Byrne Clinical Nurse Specialist Dual Diagnosis National Forensic Services Central Mental Hospital Dundrum, Ms Aisling Culhane Research & Development Advisor PNA

## POWERS OF THE GARDA SÍOCHANÁ - IRISH LAW

The following outlines aspects of Irish legislation which provides for the role of the Garda Síochaná in relation to mental illness Vis a vie the Mental Health Act 2001 and the Criminal Justice Act 1984.As described in this section there is significant powers scope and potential within the legislation for the Gardaí throughout the course of their duties to interface between people with mental illness and the criminal justice system.

Persons who may apply for involuntary admission

Section 9 (1) of the Mental Health Act 2001[10]makes provision for a member of the Garda Síochaná subject to *subsections (4)* and *(6)* and *section 12,* where it is proposed to have a person (other than a child) involuntarily admitted to an approved centre, to make an application for a recommendation that the person be so admitted to a registered medical practitioner.

Section 12 (1)[11] provides where a member of the Garda Síochaná has reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons, the member may either alone or with any other members of the Garda Síochaná –

(a) Take the person into custody, and

(b) Enter if need be by force any dwelling or other premises or any place if he or she has reasonable grounds for believing that the person is to be found there.

Section 12 (2) provides where a member of the Garda Síochaná takes a person into custody under subsection (1), he or she or any other member of the Garda Síochaná shall make an

[10] Mental Health Act 2001, s9

[11] Mental Health Act 2001, s.12

application forthwith in a form specified by the Commission to a registered medical practitioner for a recommendation.

Section 12 (5) states

*"Where following an application under this section, a recommendation is made in relation to a person; a member of the Garda Síochaná shall remove the person to the approved centre specified in the recommendation."*

Removal of persons to approved centres.

Section 13 (3) provides under the Act[12]. Where the clinical director of the approved centre or a consultant psychiatrist acting on his or her behalf and the registered medical practitioner who made the recommendation are of the opinion that there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, the clinical director or consultant psychiatrist acting o his or her behalf may, if necessary, request the Garda Síochaná to assist the members of the staff of the approved centre in the removal by the staff of the person to that centre and the Garda Síochaná shall comply with any such request.

Section 13(4) outlines. Where a request is made to the Garda Síochaná under *subsection (3*), a member or members of the Garda Síochaná may –

(a) Enter if need be by force any dwelling or other premises where he or she has reasonable cause to believe that the person concerned may be, and

[12] Mental Health Act 2001, s13

(b) Take all reasonable measures necessary for the removal of the person concerned to the approved centre including, where necessary, the detention or restraint of the person concerned.

The law regarding treatment of persons with mental disability in Garda custody is contained in the Criminal Justice Act 1984 (Treatment of Persons in Custody in Garda Síochaná Stations) regulations 1987[13]. The general rule with regard to treatment of persons in Garda custody is postulated in Regulation 3(1) which states that in carrying out their functions under the Regulations members of the Garda Síochaná shall act with due respect for the personal rights of persons in custody and their dignity as human persons and shall have regard 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 the protection and vindication of the personal rights of other persons.

The Psychiatric Nurses' Association see it as an imperative that the Gardaí receive adequate training in how to identify and deal appropriately and sensitively with people with mental illness. In 2002 the Report of the Inspector of Mental hospitals stated that:

*"Gardaí had no formal training in principles of mental health or on service availability or contactability."*

*It noted however that:*

*"Following discussions between the Department of Health and Children and An Garda Síochaná, a mental health module will be introduced into the student Garda training programme in 2003. Thereafter, it is hoped that there will be improved communication and mutuality between the mental health services and the Gardaí to replace the former distrust between the two. This is all the more important in the light of the proposed further development of forensic psychiatric services".*

[13] Criminal Justice Act 1984 (Treatment of Persons in Custody in Garda Síochaná Stations) Regulations 1987 (SI.No. 119 of 1987)

Commenting on the expertise of the Irish Gardaí in relation to mental health issues Amnesty International has observed that other jurisdictions[14]' have employed specially trained officers to supply on- scene expertise, determine whether mental illness is a factor in a criminal incident and ensure the safety of all involved parties and has advocated that such schemes should be considered in Ireland[15].In preparation for this submission we have examined these models and others (Building Capacity: Mental Health and Police Project (BC:MHAPP) is a project of the Canadian Mental Health Association's BC Division, with a goal of improving interactions between police, emergency services, and people with mental illness[16]. Queensland Police Service, Mental Health Intervention Project Mental Health First aid (MHFA)17 ) and recognise like most initiatives there is a cost and human resource implication, however whilst that may be the case we are supportive of such initiatives but in the context of this submission we recognise that the Student / Probationer Education/ Training and Development Programme has included Suicide and Mental Illness in Phase 1 – Primary Orientation Phase. As an organisation with obviously a wealth of experience and education backgrounds we would welcome the opportunity to contribute to such studies and indeed would go one step further and suggest as part of the training programme Phase

[14] It notes that the Memphis Police Department adopts a Crisis intervention Team approach whereby uniformed officers specially trained in mental health issues act as primary or secondary responders in every call involving people with mental illnesses. Such an approach is also adopted in Albuquerque, New Mexico, Police Department; The Roanoke, Virginia Police Department and the Houston, Texas, Police Department. A Comprehensive Advanced Approach involving every officer attending advanced 40 hour crisis intervention training to be able to respond appropriately to call for service involving people with mental illness has been adopted by the Athens- Clarke County Police Department. A system involving mental health professionals who respond has been adopted by the Birmingham Police department. Under this system a community Service Officer Unit is attached to each Patrol Division. The unit is composed of social workers who respond directly to an incident location when requested by an officer. They service a variety of populations including people with mental illness.

[15] See *Mental illness The Neglected Quarter ; Marginalised Groups* Report November 2003 at p.58

[16] *For a more complete analysis of these issues, please see Study in Blue and Grey: Police Interventions with People with Mental Illness (2003) on www.cmha-bc.org/research.*

[1717] Mental Health First Aid http://mentalhealthfirstaid.csip.org.uk

II – Module 2 that students should complete a placement in the psychiatric / mental health services in a supernummery / observational capacity to contextualise and copperfast any theoretical input at Phase 1.

**The inclusion/ provision of Gardaí /mental health linked programmes**

We (PNA) submit that the inclusion/ provision of Garda /mental health linked programmes has a chronological logic in that Gardaí are often the first to have contact with the mentally ill.

Regarding the programme content we suggest it would be worth considering exploring ways in which the Social and Psychological Studies could be expanded to assist in preparing the student Garda to deal with in particular the many and varied psychological states of the general public. In particular it is worth considering creative and innovative ways in which the Garda's practical skills can be enhanced. It is considered that skills training on various different communication techniques would be of great value in assisting the Gardaí to engage in a meaningful and productive manner with distressed individuals. Examples of these types of training include solution-focused training and ASSIST (Applied Suicide Intervention Skills Training) training.

Communicating in a solution-focused way would help the Garda to engage with people about their strengths and resources and leads to the person being more hopeful about their current situation. It is an empowering way to communicate as it results in people feeling listened to & understood. ASSIST is suicide first aid training for helpers who engage with people who are at risk of harming themselves. It is recommended by the National Office for Suicide Prevention. This intervention training prepares these helpers to see, hear and respond to people who are suicidal. It also enables the helper to work with these vulnerable people by increasing their immediate safety and getting further help.

Such programmes could emphasize the ways in which Gardaí can best approach awareness training in suicide prevention, problems of, anti social behaviour, violence & substance / alcohol abuse when dealing with the mentally ill population. Importantly they would also

recognize the high levels of stress for Gardaí who do this work and help them deal with their own responses. Gardaí are major contributors to the prevention of criminalising people with mental illness by linking the individual to appropriate treatment where possible.

## Suicide

International evidence suggests that the training of police forces in basic suicide awareness is an effective intervention element in reducing suicide rates. Moreover, such training has been shown to be effective in increasing the confidence levels of police officers in dealing with individuals who are high risk of suicide and in improving their knowledge and referral rates to mental health services.

In 2005, Reach Out – A National Strategy for Action on Suicide Prevention[18] was launched it recommended key actions which could be monitored over the 10 year span of the strategy. One of the elements to the implementation of the strategy is the establishment of formal partnerships that link suicide prevention services and a range of voluntary and statutory agencies.

One of the key goals of the approach to suicide prevention within the strategy is to reduce the risk of suicidal behaviour among high risk groups and vulnerable people. As part of this approach An Garda Síochaná has been identified as a key group in the implementation of this goal. Action 17 of the strategy states the clear need to support An Garda Síochaná in all aspects of their work related to suicidal behaviour. Indeed one of the key recommendations of'Reach Out' is to prioritise the delivery of a structured, coordinated, national training and support programme, drawing on the training resources on suicide related issues for established members of the Garda force and for probationary Gardaí.

The National Office for Suicide Prevention currently coordinates the ASIST (Applied Suicide Intervention Skills Training). Since 2005, many members of An Garda Síochaná including employees from the Garda Síochaná's employee assistance programme have completed the ASIST programme. However there is allocated funding provided through the National Office for Suicide Prevention (NOSP) to target suicide awareness training and prevention in the

[18] Health Services Executive (2005) *Reach Out, National Strategy for Action on Suicide Prevention 2005-2014.* Dublin: Health Services Executive Publication.

force. We propose a multi agency partnership approach to examine studies in the current Garda training programme relating to mental health / illness and suicide prevention and suggest with the assistance of ourselves (PNA) and other key stakeholders such as the NOSP we form alliances with the Garda College and existing training structures within An Garda Síochaná to address these components of the Garda programme.

**Dual Diagnosis**

Mental illness and addiction frequently occur together but have traditionally been treated separately, often in isolation and with an unsuccessful history (MacGabhann et al 2004)[19].Complex interactions between the two can have serious consequences for the health and well being of the individual patient. Successful treatment of either substance disorders or mental illness is extremely challenging if treated separately. Both disorders are chronic, relapsing, stigmatising and potentially disabling. Mental health and substance misuse problems generally require the use of long-term management approaches by the relevant treatment services.

Dual diagnosis is a relatively new phenomenon with service providers only in the last two decades accepting its existence as a condition requiring treatment. With this in mind it is worth mentioning that there is little research or development in relation to dual diagnosis specifically in Ireland. It is also a fact that the term dual diagnosis only appeared for the first time in "A Vision for Change 2006"[20]. This was the first government published document to recognise the term Dual diagnosis.

[19] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., Philbin, M., (2004). Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland. National Advisory Committee on Drugs, Dublin, Government Public Sales Office

[20] Department of Health and Children (2006). A Vision for Change Report of the Expert Group on Mental Health Policy. Dublin: Stationary Office.

A Vision for Change" showed that there are up to 12,000 committals made yearly to the 14 prisons in Ireland. Of these it stated that 2.6% of all sentenced prisoners suffered from a severe mental illness. This figure went up to 7.6% among the remand prisoners.

This research is further supported by Duffy et al.'s (2006)[21] study which investigated the Psychiatric morbidity in the male sentenced Irish prisons population. Their findings suggested that "the prevalence of drugs and alcohol problems was high among fixed and life-sentences prisoners. Dual diagnosis was common with 2.4% prevalence of psychosis for fixed sentenced prisoners and 7.1% for lifers." In this study, all those with a lifetime diagnosis of a mental illness were known to the community mental health services, as were 23% of all fixed sentence prisoners.

Further evidence to support the prevalence of dual diagnosis in forensic mental health comes from a study by Wright et al. 2006[22] which addressed the psychiatric morbidity among women prisoners newly committed and amongst remand and sentenced women in the Irish prison system. The findings from this study showed that "5.4% of the committals and 5.4% of the cross-sectional sample had a psychotic illness within the previous six months. 8.5% of the committals and 16.3% of the women in the cross-sectional sample had a major depressive disorder in the last six months. 8.6% of committals and 15.2% in the cross-sectional sample had an anxiety disorder in the past six months. 65.6% of the women interviewed at committal and 65.2% of the cross-sectional sample had a substance misuse problem in the last six months (94 newly committed prisoners representing 9% of

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[21] Duffy, D., Linehan, S., Kennedy, H.G. (2006) Psychiatric Morbidity in the Male Sentences Irish prison population. *Irish Journal of Psychiatric Medicine*, vol.23 (2), 54-62

[22] Wright, B., Duffy, D., Curtin, K., Linehan, S., Monks, S., Kennedy, H.G. (2006) Psychiatric Morbidity among Women Prisoners Newly Committed and amongst Remanded and Sentenced Women in the Irish Prison System. Irish Journal of Psychiatric Medicine vol. 23 (2), 47-53.

committals per year and a cross- sectional sample of 92 women representing 90% of women already in custody were used for in this study).

People with a dual diagnoses are more likely to come to the attention of the Gardaí because of poverty, homelessness and behavioural issues. The substance abuse is often much more visible and identifiable, and may mask the presence of mental illness. Increased awareness about dual diagnoses and the unique challenges in recognizing, diagnosing and treating them – as well as the multitude of problems faced by those suffering from them – is a first step to better and more appropriate responses and support. In light of the evidence presented and anecdotal evidence coming from members of An Garda Síochaná and indeed members of this union who are working at the coal face of acute psychiatric services, we (PNA) suggest the inclusion of a module on Dual Diagnosis be included in the current Student / Probationer Education/ Training and Development Programme. A pilot module has been developed with the assistance of the clinical nurse specialist in dual diagnosis in the National Forensic Services in Central Mental Hospital Dundrum. This programme has been piloted in a specific community area in Dublin across all disciplines and professionals who interface on a regular basis with those individuals with a dual diagnosis of substance abuse and mental illness. It would be particularly useful to adapt this programme for the purposes of informing and education new recruits and probationer Gardaí.

## BRIEF BACKGROUND TO NURSE EDUCATION IN IRELAND.

In an effort contextualise some of the proposals we suggest in terms of the review of Garda training and indeed from some discussions we have had with members of An Garda Síochaná, we felt it might be useful to provide a Brief Background to Nurse Education in Ireland. Our reasons for this are twofold

1. Nurse education has in recent years been reviewed and transferred into a third level programme having come from at not too dissimilar approach currently provided to new Grad recruits
2. Secondly by providing the context and history of this transition we hope to highlight the areas of success we have encountered on this journey whilst perhaps cautioning against those aspects we as a profession are struggling with and which may require revisiting.

The education and training of nurses in the Republic of Ireland has under gone a period of radical change in response to the recommendations of the Report of the Commission of Nursing A Blueprint for the Future, (1988)[23], The Nursing Education Forum (2000)[24]. Prior to the Introduction of the General Nurse registration/diploma programme which began as a pilot project in Galway in 1994, the training and education was an "Apprenticeship Model" where students attended a Central School of Nursing for forty weeks (over three years) and completed 97 weeks (over three years) in clinical placements. Today, successful completion of an education and Training Programme in General, Psychiatric or Intellectual Disability, results in registration as a nurse and the award of a primary honours degree (Level 8 Honours Degree). The registration/degree programme is a four year degree programme which takes place between third level institutions and allied Health Care Institutions Hospitals/Community Services) throughout the country.

[23] Government of Ireland (1998) *Report of the Commission on Nursing. A Blueprint for the Future*. Dublin: The Stationery Office.

[24] Government of Ireland (2000) *A Strategy for the Pre-Registration Nursing Education Degree Programme.* The Report of the Nurse Education Forum: The Stationery Office.

Associated with the change to Diploma Programme, the Department of Health and Children established two new clinically based nursing posts to support programme introduction and implementation Nurse Practice Development Co-ordinator (NPDC) and Clinical Placement Co Ordinator (CPC). As well as managing the clinical component of the BSc in Nursing programme, these new roles / posts also evaluate, develop and monitor nursing practice, manage Nursing Quality Assurance programmes and promote change and research throughout the nursing workforce.

The theoretical component of the BSc programme is delivered by University staff commencing in September of each year. The student commences practice/clinical placements 4 weeks later with a 2 week "Orientation" Placement in October. Practice/clinical placements continue throughout the four years at pre designated times which fits in with the Universities yearly calendar. The final year is the "Internship" where the student works as part of the clinical team and is a paid employee.

All theory, supernumery placements and specialist placements must be completed prior to students undertaking the 36 week Internship which is meant to consolidate the completed theoretical learning and supports the achievement of clinical competence within the learning environment.

**Internship**

As already stated the Internship takes place in the 4$^{th}$ year of the programme where the student is paid 80% of a first year staff nurses pay. During this time the NPDU strives to ensure that clinical areas take cognisance of the student's transition from student to registered nurse. This is facilitated by workshops for registered nurses (in addition to Preceptorship training). The students are also actively involved with the Clinical Nurse Managers in the managing/overseeing all aspects of the unit/area. This approach provides the student (soon to be registered nurse) with the opportunity to utilise the skills of critical analysis, problem solving, decision-making, reflective skills and the abilities essential to the art and science of nursing, while managing quality patient care. During Internship the

student is entitled to four hours protected time for Self Directed Learning each week. This is usually given in block periods and managed over the four years by the NPDU with specific time allocated for Formal Continuing Education Programmes and a number of hours for personal study.

**Quality Structures in place to Monitor BSc in Nursing Programme**

**Requirements and Standards for the programme**

The overseeing and monitoring of the BSc programme is carried out by our governing body An Bord Altranais (ABA). The responsibilities and functions of An Bord Altranais are defined by the provisions of the Nurses Act, 1985. The four year degree programme is governed by the Requirements and Standards (2005)[25]. The standards identified by ABA are in relation to the following:

1. The approval process of the Third Level Institution
2. The approval process of the Third Level Institution and the Health Care Institution(S)
3. Approval of the programme/Curriculum design and Development
4. Provision of Annual Reports
5. Clinical Practice Experience and the Clinical Learning Environment
6. The Assessment process
7. External Examiners

The purpose of the BSc in Nursing programme is to ensure that on successful completion the student is equipped with the knowledge and skills necessary to practice as a competent and professional nurse.

[25] An Bord Altranais (2000) *Requirements and Standards for Nurse Education Programme*. 2nd Ed.Dublin: An Bord Altranais

**Clinical Practice**

As already stated, the NPDC is responsible for the co-ordination of the clinical component of the BSc programme and constantly monitors the quality of the clinical learning environment that the student is exposed to during a practice placement. There are a number of other support structures that ensure the student is achieving aims and learning outcomes for each practice placement.

**Supernumery Status**

Students undertaking the BSc in Nursing have supernumery status during the programme with the exception of the final placement of 36 weeks internship, which consolidates the completed theoretical component of the programme. The key features of supernumery status are:

1. Allocation to a clinical practice placement is driven by educational needs enabling the student achieve stated learning outcomes.
2. The student actively participates in giving care appropriate to the student's knowledge and practical experience, with the supervision and direction of a registered nurse.
3. The student is surplus to the rostered complement of nurses.
4. The clinical placement allows for purposeful/focused learning where the student applies the theoretical knowledge to health care practice and develops the integrated knowledge and skills essential to a professional practitioner.
5. The student takes and active role in achieving the learning outcomes whilst acknowledging and respecting the interests of the patient/client.

There is currently a 2:1 replacement ratio (2 students to replace 1 staff nurse) system in place.

**Preceptor**

Each student is required to have a named Preceptor (registered Nurse) who will provide ongoing support on practice placement. They support the student on a day-to-day basis and are also involved in their final assessment. The Preceptor helps the student identify their specific learning needs and plan learning experiences, as well as acting as an effective role model. The preceptor is responsible for reviewing achievement of learning outcomes and to make an informed professional decision regarding the student's achievement of competency of each domain.

**Preceptorship Training**

Prior to the commencement of the BSc in nursing programme a three day Preceptorship training programme was developed and carried out on a continuous basis. This programme included aspects of the following:

1. Overview of the BSC in Nursing
2. Teaching Skills
3. Assessment process/Learning plans/Portfolio development
4. Providing constructive feedback
5. Reflective Practice

It is a prerequisite of the BSc in Nursing programme that all Preceptors must have the course completed and that they would have at least 2 years post registration experience.

**Practice Placements**

It is essential that nurses who care for people with complex health problems and needs are competent in the delivery of care. Each practice placement will have Aims and Learning Outcomes that need to be achieved on each placement. The student alongside their identified Preceptor must identify a learning plan, utilising specific learning opportunities

relating to that placement. This guides the student and the Preceptor on the required skills and experiences that need to be focused on at this particular time. The CPC also actively supports this process

We have highlighted key aspects /provisions incorporated in order to provide for a smooth transition in making nursing a degree programme. Central to this process and key drivers in indoctrinating confidence in the clinical environments and amongst qualified existing staff were the NPDC's and the CPC's. Crucial also was the whole preceptorship process and the supernumery status of the students. The whole process required a greater emphasis on collaborative working. On the negative side a limited number of staff spoke about the dangers of removing nurses from the bedside. Medical consultants in particular were concerned at some aspects of these developments referring to the danger of producing a theoretical nurse and not a practical nurse questioning as to whether the new order had gone too academic[26].

However the vast majority of staff sees the move to a baccalaureate pre – registration education programme as very positive. The move is viewed as giving nursing an equal footing with other professions, enhancing their knowledge and understanding and helping them to become more confident in asking questions and demanding standards in the system. Nurses emerging from a degree programme are considered to have higher expectations of their role, its positioning within the system and their own professional identity[27].

Currently the undergraduate programme completed by student Gardaí is a two year National Diploma in Police Studies. The programme is validated by the Higher Education

[26] O' Shea Y ( 2008) Nursing and Midwifery in Ireland – A Strategy for Professional Development in a Changing Health Service pp 197- 198.

[27] O' Shea Y ( 2008) Nursing and Midwifery in Ireland – A Strategy for Professional Development in a Changing Health Service pp 196

and Training Awards Council (HETAC) and is at Level 7 on the National Framework of Qualifications. HETAC validation of this programme guarantees a standard of excellence and quality in terms of ifs educational value for the Gardaí graduating from it. It would be worth considering upgrading the programme to Level 8 on the National Framework of Qualifications. This would result in graduates from the programme been awarded an Honours Bachelor Degree or a Higher Diploma. Accordingly Gardaí would graduate with a higher level of knowledge, skills and competence. This higher level of education would have many benefits for Gardaí including the move towards a greater level of professionalism and the ability to be creative, innovative and highly capable of dealing with the many changes of modern police work. It would also be of benefit to Gardaí in terms of career advancement and conditions of pay and remuneration.

In line with a move towards the delivery of this higher level of education; academic staff delivering the programme should be educated to a minimum of Masters Degree (Level 9, National Framework of Qualifications). This will guarantee that the standards for the specific fields of learning on the programme will be delivered by experts in the various fields thus ensuring the achievement of learning outcomes at Level 8 by the participants. Obviously this will require expansion of the programme both in terms of theoretical components and actual weeks within the five phase's s and modules. In this submission we propose additional programme content which we suggest would have obvious benefits for the Student / Probationer Education/ Training and Development Programme and the larger Garda workforce, we have provided some specific examples in the previous section whilst also referring broadly to Garda/mental health linked programmes at the start of this submission.

## A WORD FROM THE DEPUTY GENERAL SECRETARY PNA MR SEAMUS MURPHY WITH REGARD TO GARDA ESCORTS IN THE MENTAL HEALTH SERVICES

It has to be said however that regardless of what the law says and regardless of what garda students learn in training there are operational difficulties particularly relating to injuries to Gardaí while escorting psychiatric patients. It appears that there have been some cases recently under the Garda compensation scheme that have been disallowed on the basis, as we understand it of the injuries not having been criminally inflicted based on, it appears, the psychiatric patients "Men's Rea" of capacity and intent.

Any "reluctance" on the part of gardai in situations relating to psychiatric patients in that if they informed they are unlikely to receive compensation can be easily understood in Industrial Relations Terms. Psychiatric nurses were without a compensation scheme until a dispute earlier in the year persuaded the government to put in place a scheme the formal circular giving effect to the scheme only issued on 26th November 08. These circulars can be accessed on www.PNA.ie. The PNA would have to urge that these matters are resolved since Gardaí assistance is being required more and more in the admission of involuntary patients of psychiatric facilities and it must be understood that nurses can never assure that role since nurses have no legal powers to arrest, forcible entry or detention except some limited right to detain a patient in an inpatient psychiatric facility pending examination by a psychiatrist but not outside of this either in public or in the persons own home nor do we seek those powers.

## CONCLUSION

It is clear that a significant proportion of Garda time and resources is spent engaging with individuals with mental health problems; further research is needed to determine the cost of mental health upon policing and the potential savings and efficiencies which could be obtained from earlier intervention and diversion initiatives.

Community commitment and providing protection to the public is the mission of An Garda Síochaná, we (PNA) view promoting a protective environment as an integral part of psychosocial support. Legal protection promotes mental health and psychosocial well- being by shielding people from harm, promoting a sense of dignity, self worth and safety.

Improving Garda training in mental illness should not be seen as a means of addressing the problems associated with Ireland's inadequate mental health system. The role of An Gardaí should be to act as a flag raising and directional service providing links to other agencies, GP's Community Mental Health Services, Community Care Services etc. However health services need to be available for the Gardaí to access and approach. Also the boundaries of the Garda services are not co- terminous with mental health catchment areas, the challenge of crossing boundaries both at operational and at a strategic level needs to be responded to. The Gardaí should not be relied upon as a 24hour social service. While ensuring that Gardaí are equipped with the appropriate knowledge and skills to manage situations involving individuals with mental illness is a high priority, the provision of training should not come at the expense of developing partnerships with mental health service providers. Consideration must also be given to the need for training mental health service providers in the Gardai role and functions.

It is our view (PNA) that the Gardaí can offer support mechanisms to persons with a mental health problem outside the health sector which could be mutually enhancing and complementary to the wider mental health services.

We have taken this opportunity to outline the potential relationship between Garda mental health training, law enforcement, crisis intervention with mental health services and professionals in a manner that is diverse and challenging to all parties.

It is vitally important for all those key stakeholders involved and interfacing with those individuals with mental health difficulties consider how best to continue to achieve a productive inter agency working relationship.

## RECOMMENDATIONS

**Mobile teams of Gardaí and mental health professionals to respond to mental health crises**

**Police 'reception centre' where police can take persons suspected of having a mental illness for further assessment and referral by specially trained Gardaí**

**Crisis intervention teams' located in designated areas to respond to mental health crises**

**Special trained officers to respond immediately to crisis calls and have the lead role of strengthening responses in relation to mental health and policing.**

**Establishments of partnerships of Gardaí, carers, mental health providers, and mental health consumers. It is recommended to cultivate a close collaborative relationship among the different partners involved through these collaborations, comprehensive and sustainable networks can be developed to address the needs of persons with mental illness in the community to prevent and to provide appropriate help in times of crisis.**

**Joint protocols between Gardaí and a mental health approved centre or service, with continued joint assessment and problem-solving**

**A dispute resolution mechanism to resolve issues as they arise between collaborating parties**

**It would be worth considering upgrading the two year National Diploma in Police Studies programme to Level 8 on the National Framework of Qualifications. This would result in graduates from the programme been awarded an Honours Bachelor Degree or a Higher Diploma**

**Student Gardaí should complete a placement in the psychiatric / mental health services in a supernummery / observational capacity to contextualise and copperfast any theoretical input at Phase 1 of their training.**

**The provision of training by staff from mental health services to front – line Gardaí represents an ideal means of developing a comprehensive approach in local areas.**