**CJ/S6/25/1/1**

**Criminal Justice Committee**
**Wednesday 8 January 2025**
**1st Meeting, 2025 (Session 6)**

# Update on progress to reduce the burden on Police Scotland from the policing of vulnerable people

## Note by the clerk

### Introduction

1. In session 6, one of the priorities for the Criminal Justice has been to improve the way in which Police Scotland is able to police incidents involving vulnerable members of the community. Although understandably the police have a role as first responders when called to an incident, the Committee has previously heard evidence that there are challenges for the police after the initial call out in terms of passing on to other appropriate services.

2. In a recent report, His Majesty's Inspectorate of Constabulary in Scotland (HMICS) - Thematic Review of the servicing of mental health demand on policing (published on 18 October 2023) – stated:

> "Currently, it seems that Police Scotland (along with most other UK police forces) is in a situation where the impact of mental health demand is limiting its effectiveness and efficiency in performing its traditional role - that of keeping the peace and preventing and detecting crime. Police Scotland is filling gaps in the health and social care system in Scotland, and there appears to be consensus in the benefit of establishing a whole-system review of mental health in Scotland"

3. As part of its work, the Committee has been pressing for improvements to be made in this respect.

4. In response to a request for a progress report, the Cabinet Secretary for Justice and Home Affairs has written to the Committee providing an update on the various strands of work the Scottish Government is undertaking on policing vulnerable people in the community.

5. The Scottish Government have committed to act on the findings of the above-mentioned HMICS report although, as noted by Craig Naylor, HMICS Inspector of Constabulary in Scotland "none of the recommendations made in [his] report have been discharged" but he does note that a "considerable amount of progress [has been] made" in some areas.

## Evidence

6. At today's meeting, the Committee will take evidence from—

**Panel 1**

- Dr Inga Heyman, Associate Professor, Edinburgh Napier University
- Chief Superintendent Matt Paden, Police Scotland
- Dr David Hamilton, Mental Health Manager, The State Hospital
- Dr Robby Steel, Consultant Liaison Psychiatrist, NHS

**Panel 2**

- Angela Constance MSP, Cabinet Secretary for Justice and Home Affairs
- Lynsey McKean, Police Policy Team Leader, Police Division
- Alastair Cook, Principal Medical Advisor, Mental Health Division, Scottish Government

7. The following individuals and organisations have provided written evidence—

- Dr Inga Heyman
- Police Scotland
- HM Inspectorate of Constabulary in Scotland
- Scottish Police Federation
- The Association of Scottish Police Superintendents
- Social Work Scotland
- Scottish Government, Mental Health Primary and Unscheduled Care Team

8. Please see **Annex** for details of the written evidence.

## Actions

9. Members are invited to discuss issues related to the policing of vulnerable people in the community with the witnesses at today's meeting.

10. Following the evidence session, Members will review the evidence heard and consider what further action to take.

**Clerks to the Committee**
**January 2025**

# Annex: Written Evidence

**Dr Inga Heyman**

INTRODUCTION

The Scottish Government Criminal Justice Committee, prior to a roundtable evidence session on Policing and vulnerable people on the 8th of January 2025, have asked for a brief written submission on evolving evidence and practice in policing with vulnerable people.

Two key reviews have influenced the potential for redesign of mental health pathways for people coming to the attention of the police. These are His Majesty's Inspectorate of Constabulary in Scotland (HMICS) HMICS Thematic review of policing mental health in Scotland (published January 2023) and The Scottish Mental Health Law Review, (published in September2022)

In my view, the most pressing consideration from both reports must be for the implementation of additional safe spaces as an alternative to taking people in crisis to an Emergency Department (ED). This is particularly urgent to support people coming to the attention of the police in mental distress who are intoxicated. Current emergency services operate to a much narrower medicalised model and are not set up to meet the needs of people experiencing acute distress in the absence of a "diagnosable" mental illness.

A comprehensive redesign of "front door" mental health provision could go some way to support people whose needs are not viewed as medically time critical, or cannot be supported through current legislative frameworks, yet they occupy a space where their safeguarding is sufficiently concerning for police to seek partnership support and intervention. Unscheduled care provision for people who do not require care within an ED setting but do require support or monitoring to ensure their immediate safety, places significant demand on police and ED services. This gap in service can see people oscillate between police and health services, and challenge safe and appropriate transfer of care.

The Safe Spaces Scoping Report: 'Right Care, Right Place, Right Time' explores the feasibility of implementing an additional safe space. It also considers whether the re-imagining of safe spaces can act as a non-clinical community resource to support people in distress and prevent escalation. Multi-disciplinary provision can connect people to local services and encourage people to develop self-management skills to maintain their mental health and wellbeing. Given the growing international evidence for such a redesign, there are calls for an urgent test of change to the current medicalised model of emergency care. The expansion of services through a 'broader or alternative door' rather than a 'wrong door', could further assist in reducing stigma and barriers for people in this 'missing middle' cycle, reduce demand on the E.D. and reduce the police presence in people's homes and primary and secondary care systems.

POLICING AND VULNERABLE PEOPLE.

There is mounting evidence of bettered outcomes for people, communities, organisations, and public sector funds where there has been a re-envisaging of working along, and across policing and public health boundaries. One example of leadership and vision of a public health approach to policing in Scotland lies in the police carriage of Naloxone

*Police Scotland carriage of Naloxone*

Scotland has one of the highest rates of drug-related deaths (DRDs) per capita in Europe, the majority of which involve opioids. Naloxone is a medication used to reverse opioid-related overdoses. In efforts to tackle escalating DRDs, naloxone is increasingly being provided to people who are likely first responders in overdose situations. This includes non-healthcare professionals, such as police officers. A test of change in the carriage and administration of naloxone by police officers was conducted in selected areas of Scotland between March and October 2021. An independent evaluation conducted by Edinburgh Napier University considered the acceptability and experiences of naloxone carriage and administration by police in Scotland. The evaluation concluded most officers shared positive experiences of naloxone administration. Naloxone as a first aid tool suited their role as first responders and their duty and desire to preserve life. Perceived barriers included concerns about police undertaking health-related work, potential legal liabilities and stigmatising attitudes. Yet, the majority of participants (and all community stakeholders) were supportive of the pilot and for it to be expanded across Scotland. Police Scotland leadership responded to the evaluation by rolling out the carriage of naloxone to all officers across Scotland. To date (December 2024) Naloxone has been administered by police officers in over 600 cases with a 99.5% success rate. The carriage of naloxone by police officers in Scotland has received international acclaim for leadership, practice and academic excellence.

RECOMMENDATIONS

- The HMICS Thematic review of policing mental health in Scotland and The Scottish Mental Health Law Review, call for contemporary ways of interprofessional working and communication. Yet a lack of interprofessional preparation to drive innovative practice and courageous cross organisational policy and leadership. Supporting multiagency professional research and education at all levels, would go some way to dismantling organisational structural barriers and ensure adequate resourcing of frontline services. Arguably, interprofessional preparation and socialisation is crucial to developing, testing and embedding well designed, contemporary, collaborative interventions to support vulnerable people and communities.

- There is an urgent need to design, develop and test alternative safe spaces to support the people who come to the attention of police and other emergency services. This could go some way to supporting a more dignified and effective unscheduled care service. Furthermore, it could prevent recurrent presentations of those who may be vulnerable because of cross-

organisational system gaps within the current medicalised model of emergency care.

**Dr Inga Heyman**
**Associate Professor (Policing and Public Health)**
**Edinburgh Napier University**

## Police Scotland

In the recent update provided by the Cabinet Secretary for Justice to the Criminal Justice Committee in August 2024, many strands of work were presented.

The Chief Constable previously said, “We must respond to people in crises but policing is not the best agency to provide people living with poor mental health with all the care and support they need and deserve. Officers should not routinely be performing welfare checks or sitting in hospital waiting rooms for lengthy periods of time.” A Mental Health Taskforce (MHTF) has been established to co-ordinate work to better balance policing’s involvement.

The Mental Health Taskforce are developing and embedding referral pathways such as the NHS 24 Mental Health Pathway (MHP) and Distress Brief Intervention (DBI), as well as operational guidance on how to access community triage, so the public get the right response at the right time.

### Governance

A governance structure has been established providing both internal and external/partnership oversight of the work. Internal groups include the creation of a Mental Health Strategic Oversight Board, providing strategic leadership and governance for matters relating to the policing response to incidents involving mental health distress and suicide prevention. In addition, the Mental Health and Policing Partnership Delivery Group (PDG) is coordinating the policing system’s response to mental health distress by considering a whole system approach. Furthermore, a Mental Health Reference Group (MHRG) has been established to provide Police Scotland (PS) with the voices of professional, expert and lived experience to support the development of new, and improved, person-centred approaches.

### Framework for Collaboration

The Framework for Collaboration (FfC), developed by the PDG, outlines the responsibilities, processes and principles for a whole system collaborative approach to distress.

This runs in line with the Police Scotland three-year plan where, working with partners, we will deliver better outcomes for people in mental health crisis, while achieving whole-system efficiencies, including reducing the time officers spend in NHS emergency departments.

This Scottish Government (SG) authored document has been developed through consultation with Emergency Services, NHS, Social Care, Social Work and third sector and community organisations. This has been the subject of wide-ranging consultation and feedback.

The Framework for Collaboration makes a series of collaborative commitments across a range of priority thematic areas:

- Communication
- Improved transfer of care between partners
- Building capacity and capability, including improved data and evidence available to partners

- Strengthening community-based provision

This has an anticipated launch date of January 2025. This approach will seek to align with Recommendation 1 within the HMICS thematic review of policing mental health in Scotland – "*Scottish Government should commission a strategic review of the whole system relating to mental health, involving a range of scrutiny bodies."*

**HMICS Update**
The Mental Health Taskforce continues to progress work on all 14 recommendations from the HMICS thematic review of policing mental health in Scotland in accordance with the associated Improvement Plan. Some of the key activity can be summarised as follows-

Recommendation 7 - Training Needs Analysis
The Mental Health Taskforce have conducted a full Training Needs Analysis which provides a clear understanding of the organisational requirements to empower our officers and staff when policing mental health related incidents. The Mental Health Taskforce are developing training materials and processes ensuring alignment of current learning resources.

Recommendation 9 - Place of Safety (PoS)
Standard Operating Procedures have been amended to reflect the interim and subsequent consultations with the Mental Welfare Commission ensuring their recommendations regarding Section 297 powers are appropriately captured.

Recommendation 10 – Demand - Policing Mental Health
Police Scotland has adopted the NPCC definition:

"Any police incident thought to relate to someone's mental health where their vulnerability is at the centre of the incident or where the police have had to do something additionally or differently because of it."

This definition will allow more precise data relative to policing mental health crisis/distress.

Recommendation 11 - Psychiatric Emergency Plans (PEPs)
The Mental Health Taskforce continues to engage with all partners on a fortnightly basis to review and progress the national approach to PEPs. The group are scrutinising PEPs on a thematic basis, the Taskforce are engaging with all Local Policing divisions to provide practical operational overview.

Recommendation 13 – British Transport Police (BTP) access to iVPD
An Information Sharing Agreement has been approved and a technical solution identified. Mental Health Taskforce are leading on this work and chairing further meetings to test and build.

**Mental Health Pathway**
The Mental Health Pathway(MHP) is a Scottish Government funded collaboration between Police Scotland, NHS 24 and the Scottish Ambulance Service (SAS) which enables Contact Command and Control (C3) officers and staff to effectively assess

and refer people in Mental Health crisis/distress, who initially contact Police Scotland, directly into the NHS24 Mental Health Hub (MHH), following robust risk assessment.

Between August 2020 and November 2024, over 10,900 referrals have been made by Police Scotland. Only around 6% of these referrals result in an emergency outcome involving Police or SAS. Work is ongoing to maximise use of the pathway, while monitoring quality and appropriateness of the referrals.

The MHP allows individuals to be directed to the most appropriate support for their needs, not only providing the best outcome for the caller, but also reducing demand on Local Policing. The MHP has been delivered in a phased approach, with evaluation embedded throughout. This evaluation included that of the user voice, allowing the experiences of the callers to Police Scotland who were directed to the MHP to be heard. These insights were invaluable in recognising the positive work of Police Scotland and NHS 24, with one stating during their interview that “the police couldn’t have offered a better support for me that day”.

**High Intensity Use Work**

Individuals who regularly contact emergency services in relation to their MH are often referred to as High Intensity Users. These individuals are generally being supported by Social Work or local Mental Health Services and have a care plan in place, however for whatever reason, reach the point of crisis where they feel the best option is to contact emergency services.

It has recently been agreed a collaborative review, led by Scottish Government, with Public Health Scotland will progress this area of work. The Mental Health Taskforce will seek to consider this from first contact (telephony or digital) in C3 through to attendance by Local Policing, examining the user journey and all associated processes.

We will seek to create processes that provide a consistent approach to the management of individuals who regularly contact services who are not the most appropriate to their care, thereby ensuring action is both effective and appropriate to an individual’s care plan.

**Distress Brief Intervention**

The DBI programme creates a time limited response to persons in distress. It is a two-level approach: DBI level 1 being trained persons (including police officers) who can provide a referral option to those in distress, and DBI level 2 consisting of trained 3rd sector staff who receive the referral and contact the person in distress within 24 hours, offering support for up to 14 days.

Over 1,600 officers are now trained to DBI level 1 and over 4,200 referrals have been made since 2017. The Mental Health Taskforce take responsibility to co-ordinate and oversee this rollout whilst providing DBI training to officers and members of police staff.

**Mental Health Index**
The Mental Health Index (MHI) was created by the Mental Health Taskforce, in collaboration with Scottish Government, to structure a consistent approach to community triage support. Furthermore, it aims to support frontline personnel, and those in specialist divisions, who are engaging with a person experiencing mental health crisis/distress.

Early indications have shown the benefits, with positive feedback being received. Time spent at incidents is greatly reduced where the MHI process is followed. Quality assurance of the Index is ongoing with engagement with Local Policing officers in early 2025 to identify areas of improvements.

**Psychiatric Emergency Plans (PEPs)**
The Mental Health Taskforce has formed an integral part of the SG-led group reviewing and developing the guidance to ensure a nationally consistent approach. This has allowed Police Scotland to ensure that the guidance reflects the thresholds for Police involvement, ensuring the most appropriate options are considered based on individual needs. Additionally, where Police are involved at point of crisis, this guidance will seek to minimise Police involvement once the point of crisis has passed. Once this guidance and template are published (Spring 2025), the Taskforce will seek to encourage and support Local Policing divisions to review their own PEP's to ensure shared awareness and compliance.

**Risk Assessment**
Within the PEP's, there is reference to risk assessment of individuals in crisis. This is a piece of work currently under development by the Taskforce, with benchmarking carried out across the UK. This work will seek to provide a risk assessment structure for Local Policing (similar to Mental Health Pathway Guidance Framework) in order that the Police response is proportionate in line with the risk presented.

**Transfer of Care**
The development of the above risk assessment will align with an appropriate and efficient transfer of care to health, once the point of crisis has passed. This will ensure that Police officers are able to return as swiftly as possible to their core policing duties. There is complexity due to the differing Mental Health Unscheduled Care arrangements across the 14 health boards, however it is anticipated that the Framework for Collaboration and work of the PDG will allow a collaborative approach. Ensuring that the needs of the individual are met by the most appropriate service. We have also recently commissioned academic review to consider best practice models.

**Officer Health and Wellbeing**
Police Scotland recognise and are committed to the mental health of our officers and staff and has ensured that mental health and suicide prevention is a key focus within the Health and Wellbeing programme action plan.

Police Scotland aims to develop a systematic approach to managing wellbeing to ensure that following injury, assault or exposure to trauma in the workplace, people are given appropriate and timely professional support. Approaches currently being considered include the development of a trauma tracker, such as PTEC (Police

Traumatic Events Checklist from Police Care UK), enabling line managers to monitor and act, other measures include-

- The Employee Assistance Programme offers a direct 24/7 contact line for support.

- The Trauma Risk Management (TRiM) process is in place to support officers and staff affected by potentially traumatic incidents at work.

- Occupational Health provide advice and guidance on support to facilitate a return to duties or if at work amendment to duties or hours to address issues being experienced.

- The Health and Wellbeing intranet site has been redeveloped and now provides urgent care and support information and details of specific services covering psychological, physical, financial and social wellbeing.

- The Lifelines Scotland programme continues to be rolled out with around 2000 trained to date and around 100 trained facilitators now within the organisation. The training consists of 3 modules - Staying well, understanding resilience and self-care, supporting colleagues and Post Trauma Support providing Psychological First Aid.

- A People Manager Development Programme is being delivered with the emphasis on supporting our people and 'Promoting a Positive Workplace'. The programme focuses on Wellbeing with a particular emphasis on mental health.

- The Stress Risk Assessment is available for individuals who feel their health is being affected because of either work-related or personal issues. Managers and supervisors can support officers and staff by jointly carrying out a risk assessment using the Individual Stress Risk Assessment Questionnaire & Action Plan.

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**HM Inspectorate of Constabulary in Scotland**

Dear Convenor

**Written Evidence Update on Mental Health and Policing**

Our Policing Mental Health report was published in October 2023. This report made 14 recommendations. Since the publication of this report, we have been (and continue to be) engaged with colleagues from Police Scotland and from Scottish Government in the development of a multi-agency agreement to ensure people experiencing poor mental health receive the right support from the right agency. A Partnership Delivery Group was formed, involving a group of stakeholders – Police Scotland, Scottish Police Authority, COSLA, Health, Scottish Ambulance Service, British Transport Police, mental health unscheduled care, third sector and voices of lived experience who helped inform a 'Framework for Collaboration'. The whole Partnership Delivery Group (PDG) own an action plan, titled PDG Collaborative Commitments, which accompanies the Framework for Collaboration.

Whilst none of the recommendations made in our report have been discharged, in addition to the development of the Framework for Collaboration and the PDG Collaborative Commitments, there has been a considerable amount of progress made, as follows –

<u>Psychiatric Emergency Plans (PEPs)</u>

- Police Scotland engagement with the Scottish Government led Mental Health Unscheduled Care PEP review group has now concluded, all parts of the proposed PEP Guidance has been reviewed. Police Scotland have formed an active part of this review to ensure policing is duly considered at every stage.
- Once the guidance and template are published in early 2025, liaison will commence with local policing divisions to raise awareness and encourage review with health partners.

<u>The development of a Community Triage Guide for Police Scotland and the Scottish Ambulance Service</u>

- The Mental Health Index (previously referred to as the Community Triage Service Reference Guide) was published in September 2024 and is now operational in all Police Scotland local policing divisions. This was accompanied by a communications release to raise awareness.
- Quality assurance is ongoing to ensure pathways are operating appropriately and Police Scotland is receiving the support required from the territorial health boards.
- Plans are in place for focus groups (to be carried out by the Police Scotland insights and engagement team) with local policing officers to gain feedback and explore any potential opportunities to improve the Mental Health Index. This will be completed in early 2025.

The development of the Enhanced Mental Health Pathway

Work to improve the use of the Mental Health Pathway continues, including:

- Cross-organisational visits between Police Scotland C3 Division and NHS 24 Mental Health Hub
- Ongoing quality assurance to identify and understand learning opportunities
- Further communications to utilise skills of high-level users to encourage peers.

The next phase of work will focus on High Intensity Users. This will be a Scottish Government led piece of work seeking a collaborative approach to those who regularly contact emergency services when experiencing mental health crisis/distress, to ensure they are fully supported by the most appropriate service for their needs.

- The first stage of this work will be a service design session to outline the remit of the group, explore what is currently in place and where improvements can be made.
- This work includes Public Health Scotland, Police Scotland, NHS 24, Scottish Ambulance Service, Scottish Fire and Rescue Service and British Transport Police.

Of note, the Police Scotland Mental Health standard operating procedures (internal guidance for officers and staff) will be updated to reflect revisions and progress in all of the above areas.

In terms of police officer and staff wellbeing this is an ongoing piece of work with Police Scotland developing an action plan to deliver improvements in the levels of wellbeing support and consistency of delivery across the organisation.

**Craig Naylor**

**CJ/S6/25/1/1**

## Scottish Police Federation

May I, on behalf of the Scottish Police Federation thank you for the opportunity to provide written evidence to the Criminal Justice Committee.

The areas under discussion remain some of the most significant we need to address in Policing in Scotland, and the opportunity to provide our views on the work being undertaken in relation to the policing of vulnerable people in the community is most welcome. We acknowledge the commitment of the Cabinet Secretary for Justice to act on the findings of the HMICS review of the servicing of mental health demand on policing from 18th October 2023, and the subsequent Mental Health Index for Police Scotland from August 2024.

Earlier this year, the SPF provided feedback regarding the multi-agency partnership approach to Mental Health which included the Framework for Collaboration (FFC). I acknowledge the FFC will provide the foundation for the national review of the Psychiatric Emergency Plans. Whilst we accept the Police may have a role in the transfer of those suffering from psychiatric emergency, we find too often that we have the primary role in the that transfer and initial care until the individual can be seen by trained health practitioners. This situation is unsustainable and deeply impactive on our ability to deliver Policing across Scotland, as well as being potentially detrimental to the individual concerned.

The Framework for Collaboration events were hosted by Health Boards in Highland, Lanarkshire and Forth Valley, with the aim of learning from local practise, and to inform the development of transfer of care pathways. The SPF welcome the inclusion of the rural lens to this piece of work, however, think there would be real merit in extending this work across Scotland to give as broad an evidence base as possible to establish its potential impact. We believe the success of this work will be predicated on the continuing resourcing of the principles of the FFC and ‘buy in’ from partners across the public sector. Our view is that Police Scotland should not be the lead agency in trying to resolve these issues, but that it has become exactly that. A cynical view could be that this is due to a potential lack of willingness, or resource from partners for a potential change in business practice across this area of work.

The aim of the Partnership Delivery Group action is to improve consistency, remove barriers to multi agency working and to clearly articulate roles and responsibilities. It is our view that, whilst clarity about roles and responsibilities is helpful, our feedback from operational officers across Scotland remains the issue of partner capacity continues to be damaging in terms of delivering the core functions of the Police. It is not the case that partners are unaware of their roles and responsibilities, just they are unable to service their demand in the current situation, far less should practices change to create capacity in Policing which would clearly increase their workloads further.

The ongoing development of the enhanced Mental Health Pathway is acknowledged. The SPF are members of Police Scotland’s Mental Health Strategic Oversight Board and the commitment from all members is welcomed.

Analysis shows that around 400 calls per month are being diverted from Police Scotland control rooms in C3 division to the appropriate health resource. This is evidence of clear progress in addressing the demand on Police Officers, but there are concerns, at the time of writing, regarding the potential for strike action being considered by highly trained support staff colleagues during this ongoing pay dispute. The impact on the Police Scotland should this take place, should not be underestimated in terms of both capacity and quality of service.

We also have concerns that any narrative regarding how this is 'taking demand' away from Police officers in Scotland and consider any reference to such should be treated with caution. There is some evidence from our research that there are the embryonic changes to the type of demand being faced by front line officers, but that, for example, if a member of the public does not want to engage with NHS 24 colleagues, the default will be back to Police Scotland as per the current processes.

There has been a great deal of preparatory engagement and planning at a strategic level within Police Scotland to try and create a more efficient and better serving processes when dealing with those suffering from mental health distress. Our view is that whilst elements of this have transferred to the operational policing environment, e.g. the provision of contact details for health colleagues on officer handheld devices, there has been no real and organisational change to the way Police officers are dealing with those in crisis.

Our evidence is that anyone under the influence of alcohol will not be seen by a medical professional, and officers are still spending extended periods of time with individuals whilst they wait for assessment. Policing practice in this area is still far too risk averse and a significant amount of work has to be undertaken to give, particularly front-line Sergeants and Inspectors, the confidence in Police Scotland's process and procedure for this to change.

There have been a number of pilots across Police Scotland to try and change the way this area of business is dealt with; the SPF acknowledges with some success in local service delivery. Examples from these pilot areas and the wider divisions of Police Scotland provide evidence of extended waits with people under the influence of alcohol, or in any way injured due to an absolute refusal from health partners to assess these individuals. The default is that Police Scotland officers will be required to remain with these people as the risk averse position from Police Scotland to prevent individuals from leaving medical facilities and becoming 'high risk' missing persons still exists.

I would like to be absolutely clear that, from the information provided to the SPF, this work has not created broader 'capacity' for Police officers who are still dealing with relentless demand on their time. In our view, the continued demand on Police officer time dealing with those suffering from a 'health crisis' continues to have the most significant impact on Police Scotland's ability to deliver core policing services.

Our view is that there is still no national approach to dealing with those suffering from any form of 'health crisis'. Police Scotland has not yet developed policy and procedure to allow those in front line operational roles to make decisions which stand scrutiny but are more risk positive. That lack of confidence comes from a fear of the

consequences that should something go wrong ‘post contact’ with the Police, potential involvement from the PIRC, Professional Standards or even being the subject of criminal proceedings are most cited as barriers to risk positive decision making. To be absolutely clear, officers are not trying to avoid dealing with members of the public who need an immediate intervention but tell us that the ‘handover’ from the Police to the most appropriate service is, at best delayed, at worst non-existent. We have evidence that community triage teams are now pushing back on calls from Police Scotland due to a lack of capacity within their area of business.

In summary, our view is that the strategic work of Police Scotland’s Mental Health Strategic Oversight Board has yet to translate from strategic planning to operational delivery for frontline officers. We are confident that Police Scotland see this work as an absolute priority, but less so that partners have the same enthusiasm for change due to pressures in their area of business, culminating in a clear and well evidenced loss of capacity in policing. Our view is that a more ‘right care, right person’ approach, as adopted in other areas of the UK may eventually be required if we are to see meaningful change and capacity creation for Policing in Scotland.

It is our view that this area of business is the single biggest inhibitor in operational officers across Scotland being able to carry out their core function to deliver basic policing services across our communities.

Regarding police officer wellbeing, we cannot provide any statistical evidence of the specific impact that comes from dealing with Mental health calls, but from our own SPF exit surveys, we are now seeing resourcing and workload as two of the top three reasons why officers are leaving the service. We are also seeing record levels of officer absence and police assaults being recorded and consider the ongoing ‘model’ is reflected in Police Scotland’s recent workforce survey showing that only 27% of those surveyed considered there was sufficient resource in the organisation, and only 40% would recommend Police Scotland as an employer.

There is also a significant anecdotal evidence base through internal SPF surveys, media reporting and engagement with officers that they did not join the Police to ‘sit in A&E wards’ and that is having a direct impact our ability to recruit, and more importantly retain Police officers in service.

In closing, there has been significant work undertaken at strategic level to try and address these issues across Scotland. Pilots undertaken appear to have delivered some positives in terms of developing a model for Police Scotland to evolve its processes and create capacity to allow policing to be delivered in a different way for the benefit of communities in Scotland. That said, there is little change that I can report from operational officers across Scotland, and much work has to be done if we are to effectively create the capacity that we believe exists in Policing across our communities.

Yours sincerely

**David Threadgold**
**Chair**

**CJ/S6/25/1/1**

**The Association of Scottish Police Superintendents**

Dear Convener,

Thank you for the opportunity to comment on behalf of the Association of Scottish Police Superintendents (ASPS) on the current position in respect of policing and vulnerable persons within the community and what needs to change. I know the Committee have heard from the Association before on these matters, and this response should be regarded as a positional update to our previous evidence.

I note the update provided on the 8th of August by the Cabinet Secretary for Justice and Home Affairs, as such I will focus much of this response on the matters referred to therein.

The central issue for policing at a strategic level is that there have been increasing societal issues around the prevalence of mental health and related vulnerabilities. This has led to a "mission-creep" from the core police mission, the demand from which today weighs upon police resources to such an extent that police performance in other areas is suffering badly. For example, the recent HMICS Inspection of Road Policing noted that, since the inception of Police Scotland in 2013, the number of road traffic offences being detected in Scotland has dropped by 63%, while the number of people killed on the roads has increased each year since 2020.

For absolute clarity, people suffering mental health issues should face no stigma and should receive the appropriate treatment and support. Police involvement with people suffering mental health issues should be the same as their involvement with any other member of the public: in emergency situations where there is an immediate threat to the safety of the public or individuals, or if they are the victim or perpetrator of crime.

The response from the Cabinet Secretary states:

> "…people seeking urgent or unplanned mental health support receive the right care, in the right place, at the right time, regardless of where or what time of day they present – there should be no wrong door."

Unfortunately, there is a "wrong door" and that is a cell door – behind which too many people suffering mental health crisis still end up. While arguably a laudable, aspirational goal, the operational reality of this approach is a patchwork quilt of differing arrangements across the country, with police officers, available 24/7, often called to fill gaps when NHS and health and social care services are either not available, or Ambulance services cannot respond.

Research suggests it can be distressing and harmful for patients to be met by police offices, nor is it the job officers signed on to do. They have no clinical or therapeutic training beyond emergency first aid, nor should they need to. As a society, we must stop routinely sending resources with batons and handcuffs to calls of people suffering from mental ill health. When the results are less than optimal, we should be unsurprised and the last people to blame are the attending officers, who do not get to choose which calls they answer.

Incident demand (calls for assistance from agencies and members of the public) has been on an upward trajectory for years. Calls to the police relating to Mental Health have gone from just under 400 per day in 2018 to an average of 666 per day in Quarter 1 of 2024.

The response from the Cabinet Secretary references the Framework for Collaboration. ASPS have given feedback on a draft of the document, which provides that, for policing, it is a largely reflective of the current and long-standing context of partnership working in this area. It certainly falls far short of what is necessary to effect change in operational practice. The extent of mental health incidents during year 2023/24 and the 1st Quarter of the current year required officer time equivalent to 612 FTE police Constables. This figure is larger than the entire officer complement of 5 out of 13 Local Policing divisions. A further 90 full-time police officers' worth of time was spent carrying out hospital or custody watches over arrested persons with mental health issues. These figures should help the committee understand the cost in resources and time that mental health demand incurs in policing.

We note the workshops which were the precursor to the Police Scotland's establishment of a Mental Health Strategic Oversight Board (which we sit on as observers) and the appointment of a Chief Superintendent to oversee the many initiatives the Service is undertaking in this area. While these initiatives are universally well-intentioned and anecdotally benign in character, none of them has yet to have a systemic impact on the colossal demand felt by policing in Scotland. There is, of course, no equivalent senior Area Board member, clinician or manager in the NHS with a portfolio for Crime. If there were, there might be someone who could be asked why 13 of the top 20 repeat locations where police are called to deal with mental health incidents are all NHS hospitals. These calls comprise circa 70% of all mental health incidents.

The effect of this growing level of demand is to distort the character of policing in Scotland. Whilst that may sound dramatic, when officers are prevented from discharging their core functions of community policing, preventing crime, pursuing offenders and keeping the peace, due to Mental Health incidents, it is little wonder that we have seen violent crime go up, as it has this year.

A further, faster approach is needed, akin to the "Right Care, Right Person" model that almost all of forces in England and Wales have now adopted. Unfortunately, there is nothing in the Cabinet Secretary's letter to suggest that the Scottish Government truly understands the impact of Mental Health incidents on Police Scotland. It does not acknowledge either the negative impact on core policing functions or describe a need to alleviate the pressure on policing. The letter may describe aspects that may stem or at least slow the surging tide of people with mental health issues, but I cannot say for certain if these will be effective, as this is outside my professional expertise as a senior police officer. What I do know is that, without a concerted effort to extricate policing from what remains a central role in mental health response, any progress will be at the expense of a police service already creaking at the seams of unsustainable demand and the service to the public will suffer.

A final thought: it would be remiss of me not to take the opportunity to point out that while police officers of all ranks wrestle with the challenges of Mental Health incidents, all the while wondering if this was the job they signed on for and what training might help them, they find themselves in the midst of a pay dispute. The irony is that officers have simply asked for the same pay increase already awarded to public sector colleagues in the NHS. Whenever that dispute finally resolves, a much clearer delineation of police responsibilities and a more transparent recognition of the impact Scotland's mental health crisis on policing is needed.

I trust the foregoing is useful, thank you once again for the opportunity to participate and please don't hesitate to contact me if I can assist further.

Your sincerely,

**Rob Hay**
**Chief Superintendent**
**President**

## Social Work Scotland

Social Work Scotland (SWS) is the professional body for social work leaders, working closely with our partners to shape policy and practice, and improve the quality and experience of social services. We welcome the opportunity to contribute to the development of the policing of vulnerable people.

We recognise that our colleagues in the police are at the forefront of responding to people with mental health difficulties and that this can be unpredictable. We understand that this requires diplomacy, knowledge, skill and compassion, whilst at the same time there will be an impact on the professional who cannot ignore their own lived experiences and emotions.

We also recognise that the geography and structure of services presents challenges across the country, however, we feel that the key to addressing some of the challenges lies in clearer lines of collaboration and communication. At present there are barriers to information sharing because of centralised reporting processes, all too often with social work staff having to go through the 101 number to contact police staff when seeking assistance. We are aware that this can be a problem for staff in the police force too when they need to seek information from social work, and it can be challenging to know where and how to seek the required professional input.

Historically, social workers could contact their local police station and deal with the Sergeant there, and this helped to establish working lines of communication between the two professions. Many social work departments across Scotland still try to maintain these connections and do offer direct numbers for local area social work teams, but we recognise this is becoming more difficult as contact numbers are centralised. We feel that if these communication lines which encourage direct contact were to be enhanced, this will have a positive impact on building relationships which, in turn, can be utilised to provide briefings, support, and assist in managing officer wellbeing.

Our MHO subgroup members at Social Work Scotland report better outcomes when they can plan and coordinate police contact (for example, when executing a warrant) and state that the police work very well in partnership with the RMO/MHO in attendance. Where things do not work so well is when there have been challenges in coordinating those interactions.

Strengthening these community links will also provide greater opportunity for de-briefing. Some of our local authority social work teams offer staff the chance to come together at the end of a case to examine good practice, and areas for development, using this as a learning opportunity to strengthen personal and professional knowledge. We feel this could be utilised with our colleagues in the police force to further learning and strengthen wellbeing and collaboration.

In summary, Social Work Scotland welcome the focus on wellbeing for professionals involved in challenging front line practice, in this case, the police force, and would

embrace opportunities to improve communication and collaboration as a means of achieving better outcomes for staff, and for those who require our services.

**Neil Gibson**
**Adult Social Work Policy and Practice Lead**
**Social Work Scotland**

**CJ/S6/25/1/1**

**Scottish Government, Mental Health Primary and Unscheduled Care Team**

I would like to thank the Criminal Justice Committee for its invite and the opportunity to give evidence on the recently published Safe Spaces Scoping Report: Right Care, Right Place, Right Time, produced by the Scottish Government's Mental Health Unscheduled Care Policy Team. Unfortunately, due to a combination of maternity leave and annual leave, the policy leads are unable to attend the session on Policing and Vulnerability on 8 January 2024.

As the Committee may be aware the purpose of the report was to explore the implementation of additional safe spaces for people experiencing crisis and acuate emotional distress. While it is recognised that Emergency Departments (ED) have and will continue to be an important space and service for people experiencing crisis and acute emotional distress, evidence shows that they are not always the most appropriate environment for people in these situations. The report therefore looks at the use of safe spaces, in addition to ED, to support people in crisis within the community, and as an alternative to ED as a place of safety.

The report is clear that they are not intended to replace clinical mental health interventions. They are also not a single space with a single purpose. The report's examples of existing safe spaces support the concept that their purpose should be considered alongside the needs of individuals and communities, suggesting diverse types of spaces are required to meet particular needs.

The report summarises the breath of support for safe spaces but also notes that calls for additional and or alternative spaces/ services have sometimes been made without the accompanying detail of who they can best support and under what circumstances.

The report concludes that safe spaces should ideally be designed to be accessible to all, including children, young people, older adults with a range of mental health and wellbeing needs. They should also be accessible for those who may also be substance affected, encapsulating both drugs and alcohol. However, in practice the implementation of a service/use of a safe space which caters for all, poses potential safeguarding and possible cultural difficulties.

The report notes safe spaces could be defined in many ways depending on the support needed and the specific characteristics of the individual(s) accessing the support. It could, for example, be described as a space that provides:

- a feeling of safety for people who may have experienced barriers or discrimination in accessing and/or using services;
- a calm therapeutic environment for individuals to receive specialist support, assessment, and treatment;

- non-specialist safety monitoring over a limited time period to support the individual over the acute crisis phase of their episode of distress;
- a comfortable space to be monitored and/or remain safe while intoxicated;
- an alternative legal place of safety providing a more comfortable non-clinical environment while a person is assessed/waiting to be assessed; or
- a community safe space which may or may not be staffed by the wider mental wellbeing workforce.

These examples are not exhaustive and not necessarily exclusive of each other; there may be benefits of taking a mixed approach. The report also highlights the substantial number of protocols and service features that must be considered to successfully provide a safe space and deliver services, ranging from scrutiny and standards, care planning, risk and impact assessments, access to medication, escalation procedures and safe staffing.

It was compiled predominantly as a desk-based exercise, utilising existing evidence, lived experience, resources and best practice to better understand the issues associated with making safe space consistently available across Scotland. Some additional consultation was also undertaken with key stakeholders such as the Mental Health Unscheduled Care Network, the Mental Health Equality and Human Rights Forum and some safe space providers in Scotland, such as Hope Point in Dundee, the Neuk and the Lighthouse in Peth and Woodland View in Ayrshire and Arran. The Mental Health Diverse Experiences Advisory Panel also provided their views to help shape the report.

If the Committee has specific questions on the report, we would be happy to provide written responses to help inform the Committee's discussion.

**Scottish Government**
**Mental Health Primary and Unscheduled Care Team**