OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Criminal Justice Committee

Wednesday 8 January 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 8 January 2025

CONTENTS

	Col.
DECISION ON TAKING BUSINESS IN PRIVATE	1
POLICING VULNERABLE PEOPLE	2

CRIMINAL JUSTICE COMMITTEE
1st Meeting 2025, Session 6

CONVENER

*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Katy Clark (West Scotland) (Lab)
*Sharon Dowey (South Scotland) (Con)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
*Ben Macpherson (Edinburgh Northern and Leith) (SNP)
*Pauline McNeill (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Cabinet Secretary for Justice and Home Affairs)
Dr Alastair Cook (Scottish Government)
Dr David Hamilton (The State Hospital)
Dr Inga Heyman (Edinburgh Napier University)
Chief Superintendent Matt Paden (Police Scotland)
Assistant Chief Constable Catriona Paton (Police Scotland)
Dr Robby Steel (NHS Scotland)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 8 January 2025

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): A very good morning, and welcome to the first meeting in 2025 of the Criminal Justice Committee. Happy new year to everyone. We have no apologies this morning.

Our first item of business is a decision on whether to take in private agenda item 3, under which we will review the evidence that we hear under item 2. Do members agree to take item 3 in private?

Members *indicated agreement.*

Policing Vulnerable People

10:01

The Convener: Our main item of business is an evidence session on the continuing challenges that are faced by Police Scotland officers and staff in responding to people in distress. I welcome our first panel of witnesses. I am pleased that we are joined by Dr Inga Heyman, associate professor, Edinburgh Napier University; Assistant Chief Constable Catriona Paton and Chief Superintendent Matt Paden, Police Scotland; Dr Robby Steel, consultant liaison psychiatrist, NHS Scotland; and Dr David Hamilton, mental health manager at the state hospital. What a fantastic panel. Thank you all for giving up your time—we know that you are busy. We also appreciate the submissions that some of you were able to provide ahead of the meeting.

I refer members to papers 1 and 2, and I thank—in addition to our witnesses—all the organisations that have provided us with written evidence. I intend to allow up to 75 minutes or so for this session. To get us started, I will open with a very general question. We will start with Dr Heyman, and we will then work our way across the panel.

The policing response to people in distress is an issue that the committee has been interested in for much of this parliamentary session. What are your initial thoughts on the progress that has been made in that area of policing generally? In addition, from your respective perspectives, what are the key priorities that need to be considered in further developing a multisectoral or whole-system approach that enables officers and staff to transfer the care of a person to a more appropriate service?

Dr Inga Heyman (Edinburgh Napier University): Thank you so much for giving me the opportunity to present evidence to the committee.

It is important that we start by recognising the huge impact over the past three years of the hard work that has been done by Police Scotland and partners to address some of the challenges, particularly when it comes to the transfer of the care of people in mental health distress to health services. Colleagues will, I hope, be able to talk about that significant work. First and foremost, we should think about what has been happening in the past little while.

It is also important that we think about continuing the momentum of that hard work. We are now discovering many things that probably do not work quite as well as we thought, and people may still fall through the gaps, even with the current service provision—in particular, people

who are intoxicated and who may come to the attention of the police when they are in mental health distress. There are still considerable gaps in our ability to respond effectively to those whose distress might dissipate once they are sober. Sitting in the back of a police car or an accident and emergency department is not necessarily the right place or environment for people who are intoxicated, so we need to consider potential opportunities for dealing with such situations in a different way.

There are also gaps in our ability to respond to people in mental distress who might have comorbidities, such as neurodiversity, autism, a head injury or whatever. We are potentially missing people. As we move forward with the redesign of services, we must consider how to take everybody with us, otherwise it is possible that people will continue to fall through the gaps.

There is really good evidence, particularly in the US and Canada, on alternative safe places, which I know is an idea that is being explored extensively here in Scotland. There is an opportunity to make a shift there.

The Convener: I am sure that we will come on to safe spaces in our follow-up questions. I do not know whether ACC Paton or Chief Superintendent Paden wants to pick up on my general question.

Assistant Chief Constable Catriona Paton (Police Scotland): Thank you, convener. I will start. Good morning, everyone; it is good to see you here.

I am assistant chief constable for policing together, and that is where I want to start on the question about progress. This is about collaborative working and doing it together. Through the meeting, as we unpack specific examples of the progress that has been made, I hope that you will see our commitment to collaboration in practice, which runs right the way through how we are responding to people who are in mental health distress and crisis.

The title of today's evidence session—policing vulnerable people—caused me, as someone who has been in policing for 36 years, to reflect on the demand and burden that doing that puts on the police. There is something counterintuitive in that phrase, because the definition of policing talks about enforcing law and order, maintaining agreements and regulations and keeping people safe. From my experience of dealing with people in mental health distress and crisis, I know that it is not law and order that they need; it is people with time, skill and compassion who can give support.

However, we are here because the reality is that we are policing vulnerable people, as the title of today's session suggests. We are finding ourselves in the position of responding to people who are in mental health distress and crisis, and we are not best placed to do that. In February of last year, in a report to the Scottish Police Authority, the chief constable made it clear that we need to reset the parameters around policing.

On the progress that has been made, which the committee will hear about today, I note that I am heartened and encouraged that we are now working together collectively across boundaries to identify and share best practice, to support training, to be visible and accessible and to understand what is available locally.

The priority—I will finish on this point—is that we need to have the patience and perseverance, and the continued commitment, to see this work through. It is so fundamental to what we need to do as a society, collectively, that we must continue to have the patience and perseverance to say that we are operating in that way, and the foundations and the framework are starting to deliver tangible results. I hope that we can explore some of those with you today.

The Convener: The submissions from Police Scotland and others have helpfully set out some of the work that has been going on, which is welcome to see.

I bring in Dr Robby Steel.

Dr Robby Steel (NHS Scotland): Thank you, convener, and thank you for the invitation to the meeting.

I think that I have been asked to be here because, as a clinician—a psychiatrist—I have been going to accident and emergency departments to see patients for 30 years. Initially, I did so as a junior psychiatrist in Glasgow, where it was the juniors who went in, and then I did so as a middle grader in the old Royal in Edinburgh, where it was the middle graders who went in; we also went into police custody suites. After that, I did so as a consultant for five years at St John's hospital, where my remit included A and E, and I have now done so for 17 years at the Royal infirmary of Edinburgh, where my remit includes A and E. For a few decades, I have been going into A and E to see patients.

On the progress that has been made, I agree with everything that Inga Heyman and Catriona Paton have said. The progress has been upstream and it has been driven by Police Scotland building good alliances. The NHS 24 mental health hub has been a very helpful development, and the police have engaged with it well. That has allowed the police to divert to the NHS 24 mental health hub calls that would more appropriately go there but which previously came to the police. There is probably more progress to be made; I defer to Catriona Paton and Matt Paden on that.

The other development is the distress brief intervention programme, which has been fantastic. It allows the police to guarantee that they will provide support for someone. The police do not have to provide it; they can pass the person on to a service that they are confident will provide what that person needs. Those are two things that the police should rightly be proud of.

What is left are the more high-end, high-risk, very distressed people. The fundamental challenge with them is that there are two competing paradigms for mental disorder. I do not know whether any of you are doctors, but the lay paradigm might be reflected in Scots as "He's no thinkin right" or, if you are being less kind, "He's no right in the heid". We have all had moments in our life when we have felt like that—when we cannot control our emotions and are very distressed; we are out of control and are not thinking straight. We might look back at how we were feeling and behaving in those circumstances and regret it. That is probably a universal experience.

There is also the medical concept of mental disorder, which is that it is mental illness. We know how a given person's brain usually works, and we recognise that their brain is not working in its usual way. We recognise a pattern of symptoms and alterations in the way in which the brain is functioning that are suggestive of a particular mental disorder. That might be depression, mania, schizophrenia or even post-traumatic stress disorder. That is a much narrower definition, and it involves conditions that are longer lasting. A typical depressive episode in a young person will last several weeks to several months. Schizophrenia can be lifelong.

Any of you who have ever tried to use national health service secondary care mental health services will know that they are very boundaried. They say, "We are here to use our expertise in mental illness to provide a service for people who need specialist clinical mental healthcare." The mental health assessment services around Scotland—the people who the police bring people to—are mental health professionals. They are nurses and psychiatrists, and they come at it from that position. They—we—are part of the secondary care mental health service.

From the perspective of the NHS, those professionals have a gatekeeping role. When a person presents, their role is to say whether the person has what the medical concept of mental disorder would say is a mental illness that requires specialist secondary mental healthcare. If the person does, they are for us, and we will take them on. If they do not, they are not for us. Quite frankly, I think that those services are guilty of saying, "It's not my responsibility, because they're not for us."

I have had a lot of engagement with the police. The police clearly work to the lay definition of mental disorder, and they do so appropriately. When they tell me about cases and difficult scenarios that they have seen or been involved with, they are usually talking about someone who cannot control their emotions in that moment. The technical term for that is emotional dysregulation.

That can happen because the person is intrinsically not very good at self-soothing and controlling their emotions. That is often because of adverse childhood experiences, poor attachment and so on. It can also be because they are young and those bits of the brain develop relatively late. It could sometimes be because they are experiencing a mental illness that is affecting their ability to control their emotions or because they are intoxicated—the superego is soluble in alcohol, so we are less able to control our emotions when we are intoxicated. Alternatively, it could simply be the case that an event has happened that is so overwhelming that it has overwhelmed their capacity to control their emotions. Such an event might be a bereavement or some other loss.

10:15

So, most of the time, the so-called mental health emergencies that the police are dealing with actually involve people who are unable to regulate their emotions in that moment. The police bring them to a branch of the secondary care mental health service, where the staff ask a completely different question. They ask, "Is this person suffering from mental illness?" About 20 per cent of the people who are brought in are. The other 80 per cent are not, and that is the gap that I think that people are falling through.

I would love NHS mental health services to change their spots and their whole mindset and embrace a broader lay concept of mental disorder, but I do not think that they ever will. When I make the argument that we need to have an open door, they say, "No—we need to stop non-mentally ill people being brought to us." I call that the King Canute defence; it is just not going to happen.

Instead, we should have front-door services for the police to bring people to that are staffed, equipped and designed to deal with both groups. As Inga Heyman said, if someone who is intoxicated or in an emotionally dysregulated state is given 24 hours, they will usually have calmed down to the point where they can be engaged with in a constructive way. We should have a back door that allows us to say, "Okay, we will not waste this crisis; we will use it to try to support you and gain insight so that we can solve the problems that led to you being here," because that is a much

better solution. At the moment, there is a disconnect.

The Convener: Thank you. I found that really fascinating. It is a perspective that I was not sighted on at all, so it was very helpful in laying out some of the context.

Last but not least, I will bring in David Hamilton. David, is there anything that you would like to add?

Dr David Hamilton (The State Hospital): Thank you, convener. I do not think that I have heard anything from colleagues that I could disagree with. It all sounds eminently sensible to me.

I want to make it clear that half of my role covers the state hospital service and forensic in-patient care. The other half involves looking after statutory mental health services for South Lanarkshire Council and the mental health officer service. I also continue to practise as a mental health officer, and my work has often brought me into contact with police colleagues in the early hours of the morning in an A and E department. So, for a long time, I have known from personal experience that the current approach is not the right way to address the issue. We need to get people around the table to think about how we can tackle the issue more constructively—not only for the emergency services but for the individual who is in a moment of crisis. It is a really challenging approach.

I am aware of really good work that has been done with Police Scotland and NHS Lanarkshire around our unscheduled care services. I have had dialogue with my colleagues from health in respect of the great successes that they have seen. We see pockets of really good practice across Scotland. We need to look at different health boards and local authorities and ask how we can take those success stories, provide data and evidence that those approaches work and replicate them in other areas that have different resourcing challenges, different demographic make-ups in terms of rurality, population centres and deprivation levels, and different targets. We need to think about how we can use data-driven evidence to support an approach that can tackle what is a key issue across Scotland.

The Convener: I am not going to ask any follow-up questions, because I am conscious of the time. That was a very helpful opening session. I will now hand over to Liam Kerr.

Liam Kerr (North East Scotland) (Con): Good morning, everyone. My first question is for Assistant Chief Constable Paton. Police Scotland has a data dashboard that helps to provide an understanding of mental health demand on police time. The cabinet secretary told the committee last year that it would be rolled out to other partners. How is the dashboard performing, what are you doing with the data and has it been rolled out?

Assistant Chief Constable Paton: I will say at the outset that you have just heard from Robby Steel about some of the challenges in knowing what we mean when we speak about mental health and about the information that is in that dashboard. A lot of the work that we have done up to this point has been to ensure that we understand what we mean by a mental health incident and has been about pulling that together to provide meaningful data.

We have gone through a number of quality assurance measures and the dashboard is now live internally. Matt Paden can say more about some of the detail behind that. Our updates have mentioned a partnership delivery group. We are working through that group to understand how we can combine data from the dashboard with other partnership data and how we can use that to inform practice, particularly the practice that we are looking to build up to reduce demand, transfer care and strengthen community-based provision. We will do that by using the information that we have about mental health demand and the pressures that that causes.

Do you want to say more, Matt?

Chief Superintendent Matt Paden (Police Scotland): I can confirm that that dashboard is now live and that we will be sharing that data with key partners through the governance structures. As the ACC said, we wanted to ensure that the dashboard was 100 per cent accurate. A review has been undertaken and we are now in a position to share the information internally. As we move through the governance cycle during the course of this year, the dashboard data will be shared with partners.

Liam Kerr: That is obviously important work. You have also set up a mental health task force and a mental health strategic oversight board. His Majesty's Inspectorate of Constabulary in Scotland has recommended that you produce a mental health strategy and a delivery plan.

However, some evidence that the committee received in advance of today's meeting suggests that the impressive array of work that is being done at strategic level is not translating into operational delivery for front-line officers. ACC Paton, what is Police Scotland's view of that assessment? Do you agree with it? What are the potential barriers to the translation to operational delivery?

Assistant Chief Constable Paton: That is a good point. We need to know about the felt experience of our officers and of those who need

our support and services when they find themselves in distress or crisis.

There has been a tangible difference at the front end and I can go into some examples that Robby Steel touched on. Since the inception of the mental health pathway, there have been 11,000 calls that have not resulted in police officers attending but which would have had that result before. I have been in policing for 36 years and there has never been a time when I have not been busy, but what matters is what we are busy with. That felt experience may not always be readily noticeable for some of our officers and staff at the front end, which is why all the work that we are doing is supported by a communication strategy. We are trying to raise awareness that we are building the foundation that will allow a whole-system change. In the meantime, there are tangible activities that are having an impact on how we police and respond to mental health, even if that is sometimes not noticed.

I spoke at the outset about patience and perseverance. If we are going to do this, we must do it right. We cannot solve risk in one area but create it in another. We have a duty to work in collaboration. All my experience tells me that the work that we have done through the framework for collaboration and the commitments that are laid out in that framework are truly collaborative. I believe that they provide a solid foundation for the whole-system, sustainable change that we need. I am also cognisant that, as an organisation, we must redress the balance. The work that we have been doing through the mental health pathway, the mental health index and the training and support of our own staff is all leading us towards being able to have less of a role in responding to people who are in distress or crisis.

Liam Kerr: I have one final question, which is also for ACC Paton. You have talked about the initiatives that are going on and the positive impact that they are having. However, both ASPS and the SPF, in their evidence to the committee, mentioned the right care, right person approach, which is used throughout most of England and Wales, I think—those are my words, not theirs. What is your view on that model, and should it be adopted by Police Scotland?

Assistant Chief Constable Paton: The principle of right care, right person is absolutely right—we want to provide the right care to the right person at the right time. However, that programme has been rolled out in England in the absence of the legislation that we have in Scotland—the Police and Fire Reform (Scotland) Act 2012—which requires us to work in collaboration. There is more willingness down south, in England and Wales, to say, "Our role ends here and we are stepping away." We want to be able to use the approach in a collaborative way that means that we can step away because there is an alternative—because we have been working with our partners to be able to say that there is a safe alternative and a safe space that is not an accident and emergency department or police building but somewhere else in which there are people with the right skills.

I recognise that we sometimes draw comparisons but, from my personal experience—I have read a lot about the right care, right person model, and Matt Paden has gone down south to look at how it works—I think that the approach that we have in Scotland will be far more sustainable, and far more supportive to the needs of individuals who are experiencing mental health distress crisis. We are not stepping away, but we are ensuring that such individuals are absolutely with the right person.

Ben Macpherson (Edinburgh Northern and Leith) (SNP): I thank the witnesses for being with us, and for their feedback and comments so far. I engaged with this issue initially as a constituency MSP in Edinburgh. However, I found that the evidence that we received from the SPF, for example, ahead of today's session resonates with the challenges that have been experienced in the capital, in that—to quote from the SPF submission—

"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."

That is a challenge with which we are all wrestling, although I recognise the increase in collaboration and perseverance, and the progress and the reduction in demand.

In that context, I have two questions. First, I am, and the committee is, aware of initiatives that are being implemented by the police such as mental health triage cars in Edinburgh and a community triage service in Lanarkshire. Are you aware of other initiatives that are examples of good practice in addressing the issues around the policing of vulnerable people? How could those be rolled out, if appropriate, on a national basis?

I turn to my second question. Dr Steel, you talked about how we create a door that accepts both, if that is an accurate way to quote your key message back to you. How far away are we from that?

Assistant Chief Constable Paton: Thank you for your questions—I will start on the first question and then hand over to Matt Paden, who can go into a bit more detail on the second question.

We now have the framework for collaboration, which has been developed through the partnership delivery group. The purpose of all those

collaborative commitments is to enable us to identify best practice across what is happening locally. We know from looking at a range of areas, not just policing, that services need to be delivered in a way that meets the needs of local people in local communities. The partnership delivery group is, therefore, identifying best practice and, where relevant, mainstreaming it.

One of the priorities in the collaborative commitments is strengthening local-based provision and using that opportunity to share best practice, and there are a number of good examples of that. Matt Paden has been looking at that with the team in the partnership delivery group and a range of other people to ensure that there is an opportunity to feed that best practice back through our local authority representatives and to continue to support progress in that regard.

Do you want to highlight anything, Matt?

Chief Superintendent Paden: Yes. I thank Ben Macpherson for the question, because that aspect is very much a focus for the partnership delivery group, and the work that we are doing through the task forces is looking nationally at areas of best practice while recognising that—as David Hamilton touched on—there is not necessarily a one-size-fits-all approach, given the nature of the geography and the demographic variations across Scotland.

However, within that, there is clearly a remit to identify best practice. We have touched on some of the initiatives in Lanarkshire, and we are aware of a number of others. We have held three national workshops throughout the country—some of the panel members today were involved in those. We brought together 90 representatives from a range of services to do that very exercise of mapping some of the excellent practice that exists across Scotland, to harness that and to capture practice that can be rolled out nationally, if appropriate.

10:30

For example, as the ACC touched on, the framework for collaboration and the collaborative commitments very much capture the ethos of scoping out safe spaces. Some of those exist and are utilised very well across Scotland. On Robby Steel's point about the area of vulnerability, accident and emergency departments are not always the priority area for somebody who is vulnerable and who has comorbidity issues. We are most definitely evaluating and looking at those aspects.

Through the internal Police Scotland task force, we are already rolling out some good practice. In our written submission, we touched on the mental health index. That project has been delivered through the partnership delivery group, supported by the Scottish Government, and the information is now in the hands of every operational police officer across Scotland. That means that, when officers are deployed to a scene where somebody is in crisis, they are equipped with information on the point of contact in their NHS board—the mental health clinician who can provide one-to-one support and direction.

Police officers will never be trained to the level of a mental health clinician, which is why the partnership component is vital and is a cornerstone of the approach that we are taking through the partnership delivery group. Essentially, when officers are at the scene where somebody is in crisis, they can now readily gain access to the mental health clinician in their area, who quite often speaks to the person who is in crisis and is thereafter able to provide direction and support.

We launched a full training package in relation to that at the tail end of this year. The index is now on every officer's personal digital assistant—PDA—and that has been supported through training that has been rolled out internally. We are going through a very early-stage evaluation of the benefits that that is delivering.

That work is on top of the mental health pathway work that you have heard about, which takes the individual who is in crisis to a more appropriate agency through the NHS hub. As has been touched on, there have been 11,000 such referrals over the past number of years. That figure is growing every month, because we have only recently completed the training of all our contact, command and control—C3—staff. We are continuing to revisit that, build on it and ensure that quality assurance is built in.

Those are some examples of national and local practice that has been scaled up in recent years.

Dr Steel: That is a very good question, and it is a key one. The Scottish Government has established a health programme called the redesign of urgent care, which is based around the right place, the right time and the right person. That came about during Covid and was designed to prevent people from just coming to A and E. Instead, people phone NHS 24 and are triaged to the appropriate place. If they need to go to A and E, they are told, "We've passed the information to A and E and if you go at 11.30 am, they'll be expecting you, so you won't have to wait in a waiting room and cough over people and so on."

That approach has been expanded to mental health, and both Matt Paden and I are on the group that co-ordinates that. The first piece of work that the group did was to try to ensure that, if somebody from NHS 24 or Police Scotland is

seeking mental health advice from a geographic health board, there is a single point of access to get directly to a suitably qualified senior clinical decision maker, who is usually an experienced psychiatric nurse. The nurse can then speak to the police officer or NHS 24 staff member, triage the case and say, "Send them up and I'll see them," or, "I'll speak to them via videolink or over the phone." Alternatively, the nurse can say that the case should go to the NHS 24 hub or back to the general practitioner. That first piece of work, which involved ensuring that each geographic health board provides a single point of access that guarantees that there is a nominated senior clinical decision maker for mental health, has been done, and it has helped.

At the other end, there are the health and social care partnerships, which are developing what you might call crisis services of some sort—for example, for people in distress or people struggling with addiction, housing or mental distress. Almost everywhere in Scotland, services are now open, usually Monday to Friday, where people can drop in or make an appointment and get help. They are called different things in different places; for example there is the care when it counts—CWIC—service in East Lothian, and there are Thrive welcome centres in Edinburgh. They are all over the place, so the gap that I spoke about is closing.

What is left, as I said earlier, is the very acute end. Our NHS psychiatric nurse-delivered teams are not working in partnership with third sector link workers, peer workers or addiction workers. They are working more in isolation or coming into A and E and seeing people there. We do not yet have physical spaces and a multidisciplinary mix of staff, which would need buy-in from both sectors. I know, having tried to get that off the ground in Lothian, that the health sector will not fund those things. It will say that it is doing the mental health stuff and that it is for the third sector and HSCPs, if they want to have peer workers, link workers and people in there to contain distress, to join and partner with it. However, the gap is narrowing, and the mindset of the Scottish Government group is that this is the direction of travel. I am pleased to say that, from the outset, I argued that the best metric of our success as a group would be the reduction in police time spent on mental health calls. That was not contested in the group—it was agreed that that was a reasonable metric of output for it.

With regard to spaces on the ground, you will be aware that Scotland is so geographically diverse that, although you can have dedicated staff and a 24/7 unit in a major city because the critical mass exists to support it, unfortunately, you cannot have that in the Western Isles. Different geographic health boards will necessarily have to come up with different models. The idea of having an open door and staff who are appropriately trained in both groups—those with mental disorder and those with distress—has been embraced but has not yet been delivered. However, the gap is closing.

Ben Macpherson: You are saying that we are getting closer but we do not know yet—

Dr Steel: It will need collaboration between geographic health boards and HSCPs commissioning third sector organisations, which, at a time of budgetary constraint, will need a lot of persuasion. There is a willingness to pursue that model, but there are barriers—historical divides, with the NHS protecting itself as the NHS, and even just space. Studies suggest that the optimal place is adjacent to an emergency department, but acute hospitals are saying, "We're squeezed for space, we don't have 120m^2 to provide that, so you'll have to go elsewhere." There are significant barriers, but that is the direction of travel.

The Convener: I know that you want to ask a follow-up question, Ben, but I will bring in other members and we will come back to you. I ask for fairly succinct questions and responses to allow all our witnesses to come back in.

Fulton MacGregor (Coatbridge and Chryston) (SNP): My first line of questioning follows up on what my colleague Ben Macpherson asked about and what was said earlier about some of the local initiatives. David Hamilton, in your opening remarks, you mentioned the initiative in Lanarkshire, which I know that you have had some involvement in. Will you expand on that to allow the committee to understand what is happening there? I am aware that it is a good piece of work.

Dr Hamilton: I will probably steal some of my police colleagues' thunder, because the work on triage and unscheduled care is very much driven by them, in collaboration with NHS Lanarkshire. They did data analysis of the period since the initiative launched in 2023, which found that police attendance at A and E was down by 80 per cent. That saved something in the region of 18,000 police man-hours, so the success is quite astonishing.

We are also making sure that people are triaged by a mental health professional and appropriately diverted, at source, in the community. In regard to statutory mental health officer services, we must think about how we respond to people who present at A and E and require statutory intervention, and be able to respond quickly, so that our police colleagues are not spending inordinate amounts of time at A and E.

Locally, we have done a lot of work around staffing. Our MHO wrote a 24/7 guide, and a lot of that is about recruitment and developing our own MHOs, delivering the training and going through a painful process of amending contracts so that newly qualified MHOs will commit to doing out-of-hours work and can provide that rapid response. That has been successful, and we have been able to respond very quickly when people are in mental health crises.

I take Robby Steel's point about those people who are mentally unwell and perhaps require interventions under the Mental Health (Care and Treatment) (Scotland) Act 2003 and, to the side of that, those who are in acute distress but would not necessarily be detainable, because they do not necessarily have a mental health condition but are simply experiencing high levels of distress.

I have been interested in the work around safe spaces, which has been highlighted by a number of our colleagues. Is there a different way to look at that? We know that A and E can be stigmatising for people, particularly when they are in distress. If, for example, a person is with two officers in a very busy public space, that can be highly distressing for them. A lot of good work has gone on in that area.

Everything takes resources. It would be great to say, "We will look at having a safe space," but we cannot magic up an area within or adjacent to an A and E department. Creating a safe space requires commitment from multiple agencies, and we also need to get our third sector colleagues on board and determine whether they are sufficiently resourced to provide that because, often, pressures and crises occur during acute, out-of-hours times.

Locally, there has been good contact with our police colleagues with regard to on-going adult support and protection work, and we have regular debriefs and meetings to discuss the individuals we know we are going to be seeing every couple of nights, and how we are going to help to break that cycle. There have been good discussions involving police, health, social work and the third sector about how we support people who have borderline personality disorder traits and we know will be seeing a lot. They do not need to go to A and E or take up a lot of police time. How confident do the police feel in appropriately diverting those people? When someone is on the edge of a bridge in Glasgow, saying that they are going to jump into the water, it is highly distressing for the officers who are responding to that as well as that person, and the officers need to feel confident that there is a robust pathway in place. I have seen that work well in adult protection work. Can that be replicated in the mental health care planning arrangements?

Fulton MacGregor: Thank you. I will not repeat the earlier discussion about how we get some of those good local initiatives to work on a more national basis, because that has been covered, but it I thought that it was important for the committee to hear what is going on in Lanarkshire. It sounds really good. As I said, I am an MSP for that area, so I was aware of some of that work.

My second question is around resources. Dr Hamilton, you touched on that, but I want to hear—both from a police perspective and an NHS and social work perspective—about the extent to which issues with staffing resources are impacting on the ability to move the collaboration work forward. What I mean by that is, do we have the necessary number of police officers, social workers and health professionals? Are there any challenges that the committee should be more aware of? Given that we have a session with the cabinet secretary coming up after this evidence session, are there issues around resources in the current climate?

Assistant Chief Constable Paton: The burden and demand on policing is the reason that we are having this conversation. As I touched on at the start, we are talking about policing in an area that is in some ways counterintuitive to our role in improving safety and wellbeing, because we are not the best placed service in that regard. We need to reset the parameters and redress the balance, and we need to be really clear about the role of policing. That of course has an implication for our day-to-day resources, and we are trying to understand things in more detail through our mental health dashboard.

10:45

You have seen the chief constable's commitment, in what is within her gift, to implement our mental health task force, with me and Matt Paden leading on the work, driving a collaborative momentum and building alternatives to policing being front and centre.

You will have read in some reports about the funding that the Scottish Government has provided to policing in Scotland and to mental health. You have heard from other witnesses that the lack of funding locally for the next steps will be one of the biggest challenges. For me, it is not necessarily just about policing resources; it is about resourcing the whole system in a collaborative way, and the whole system requires us to have alternatives that are safe places for people in situations that Robby Steel described so well, when emotionality can be reduced, so that we can start to help people to make better choices. There is definitely a continued need to support resourcing across the whole system and to avoid any part of it being looked at in isolation.

Fulton MacGregor: Thanks. Robby Steel and David Hamilton, what would you say from a health and social work perspective?

Dr Steel: In mental health, Scotland struggles to fill all the consultant psychiatry posts that it currently has. That is a long-standing problem, and there are workstreams for trying to address and resolve that. Scotland also struggles to fill all its mental health nursing posts. Again, that is a chronic problem. You could throw money at the problem, but you simply would not be able to find the staff to employ.

It is not additional mental health staff that are needed; it is additional peer workers, link workers and so on, to deal with the non-mentally ill people. Those workers are trainable and appointable. If you advertise those posts, you fill them with good people. Additional resource would help to close the gap, even though mental health professionals are thin on the ground.

Dr Hamilton: It has been a challenge. We have welcomed funding from the Scottish Government in recent years to bolster the mental health officer workforce. There are challenges with filling the posts, as we have seen. I think that 600 MHO posts are filled out of 700 available posts across Scotland, so we can see that there is a challenge in filling those posts. Locally, there are real challenges with filling consultant psychiatry posts.

From conversations with health colleagues we know about the success of the unscheduled care project, but it is also being asked to make savings, and savings come from staffing, because there is not really any capital expenditure associated with that work. That is a real risk for this area. We need those mental health professionals and the third sector investment in order to make a go of things and make them work.

On mental health officers, we have used some funding to bolster the regular social work staffing to free up statutory time for mental health officers so that they can focus on the crisis and statutory interventions under the legislation. The demands have escalated, however.

I was doing my response to the Mental Welfare Commission for Scotland at the end of last year. Looking over the 10-year period, we can see that the demands on services have been increasing year on year in terms of the statutory interventions. The additional funding is welcome, but I would say that it is allowing us to stay where we are, while perhaps not addressing the increasing demand that we are facing year on year.

Fulton MacGregor: Thanks for that.

Apologies, convener: I had meant to declare an interest before asking my questions. I am a registered social worker with the Scottish Social Services Council, as per my entry in the register of members' interests.

The Convener: Thanks for that, Fulton.

Pauline McNeill (Glasgow) (Lab): Good morning. I have found all the evidence enlightening and helpful, so thank you for all your evidence so far.

Dr Heyman, you started off by talking about the significant gaps in provision, particularly for those who were intoxicated. I was trying to tie that up with what Dr Steel was saying about the gap. Ben Macpherson referred to having a front-door service to deal with both things. What does that mean for the model that we are trying to create? I am familiar with many such cases, and I agree that, rightly or wrongly, the NHS will not take someone who is drunk, so the police are quite often left with them; otherwise, the person is in danger. Does the service that you are talking about creating deal with those types of cases?

Dr Heyman: Absolutely. It is about dealing with people in that missing middle group, who should definitely not be in-patients in hospital, because, often, as Robby Steel has explained, when the initial distress has gone and the person is sober, there is no issue. Inpatient psychiatric care is therefore not the right place for them.

The opportunities that are happening, particularly in the United States, allow people to have a safe space, usually attached to an A and E department, but not always; as we have said, that is a bit difficult. The reason for that is, if there has been a head injury, or something else has happened that has not been noticed immediately—the person might appear to be intoxicated but something else might be going on—it is important that they are close to emergency services.

It is an environment in which people can become sober, then be assessed as to whether there is an opportunity to go home, whether they have someone to support them, and whether they can be tied into any services that they need. People should not just be discharged. We should be able to tie them into care and the right services. It is a bit like what the stress brief interventions do. That care should be brought in right away, so that there is no repetitive return to a safe space.

Pauline McNeill: Dr Steel, it seems that a significant resource would be required to create such a model, notwithstanding what you said about health boards in different parts of Scotland. Do you also agree that one of the reasons that the police pick up those cases is because they are the service of last resort and they work 24 hours, seven days a week, which a lot of services do not.

Do you agree that we have to sort that situation in order to create the model?

Dr Steel: I agree with everything that you have said. The other service that is up over 24 hours is A and E, and the psychiatric nurses who provide input to that. That is true. That is what we are left with, almost.

We need to have a single door that encompasses both services. Take a situation in which the police are called to a man who is intoxicated and threatening to jump into the Clyde, and they bring him to the emergency department, where he proves to be too intoxicated for a meaningful assessment, but needs to be kept safe. You could put him in a busy, noisy A and E department—I am sure that you have all been to one—but that is not the most calming environment for someone who is in acute distress and feels suicidal. However, if you could put him in a calm place, with a bit of shortbread and tea and people to speak to, who do not need to be mental health trained, until he has calmed down, you might find that he says, "Sorry, I am absolutely fine, I just got drunk. I've got a drink problem," and you could get alcohol services for him. Alternatively, you might find that he sobers up and says, "Yeah, I want to jump into the Clyde. I want to die. I had a drink to give me the courage to do it." In that case, mental health services become the appropriate service for him.

When people first present, you cannot tell who needs mental health services and who needs some other service. That is why I feel that an open door is needed, to give time to de-escalate the situation, then an appropriate back door—for example into alcohol services.

At the royal infirmary, we do a bit of that. We have alcohol liaison nurses and drug liaison nurses. The Cyrenians homelessness charity now does hospital inreach. When we are asked to see someone in the emergency department, we have those options to offer. That makes it a much better service. Interestingly, if the same person presents to the Royal Edinburgh hospital, which is a psychiatric hospital, they do not have access to those services, so the poor psychiatric nurses are left with no option other than, maybe, to go back to the police.

I hope that I have answered your question.

Pauline McNeill: You have answered it: the service would need to be 24/7 in order to capture those people. Otherwise, we will be back where we started—with the police.

My next question is for ACC Paton and Chief Superintendent Paden. The Scottish Police Federation's evidence to the committee states:

> "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",

which is what I think that you were saying to the committee earlier. However, it also says:

> "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."

I suppose that that goes back to Ben Macpherson's question. Police Scotland has to deal with the here and now, and the model that we are talking about seems quite a long way off. Do you want to comment on that, ACC Paton?

Assistant Chief Constable Paton: The important thing that I would highlight is that, although we have spoken about the work and the progress that has been made, that gap remains, and it cannot fall to the police to be the organisation that is left dealing with people who are in mental health distress and crisis. However, we want the transfer of care to be done in an appropriate way.

You are right about the requirement for 24/7 provision. There has to be an alternative. Knowing that there is a gap is one thing, but how do we implement a change in practice? That is the focus of the next phase of the framework for collaboration. The collaborative commitment is to implement the improved transfer of care and the strengthening of locally based provision that is available 24/7. No matter what, even if there is anecdotal information from the federation about there being some pushback and a lack of capacity, what is the alternative?

This model is not a magic wand that will fix every situation, but what it is doing is taking a whole system approach. We are already seeing the tangible benefits of that, with officers not having to go to 11,000 call-outs, and not having to go with as many people to A and E because they are able to connect the person to a clinician when they are at their house.

Pauline McNeill: Is that because you can tell that the number of calls has reduced?

Assistant Chief Constable Paton: The mental health pathway is a really good example, because it has led to just under 11,000 calls being diverted to NHS 24. Those are calls that police officers would have attended before the pathway was implemented. That, in and of itself, is really important.

I am glad that you asked that question, because I want to highlight that we need to maintain that momentum. Robby Steel made a great point about the issue not being whether the appropriate service will be NHS 24 or policing. The reason why we have the reference group is to see what

the third sector can do and what other opportunities there are to fill that gap, 24/7, and provide a safe place in which we can get a better understanding from a health perspective of what a person needs.

Police officers need to step away and go back to doing what the public expect us to do—the core purpose of policing that I mentioned at the outset.

Pauline McNeill: Chief Superintendent Paden, do you want to add anything?

Chief Superintendent Paden: I would just build on that by drawing out two key aspects. First, I welcome the Scottish Government's document, "Safe Spaces Scoping Report: 'Right Care, Right Place, Right Time'", which lays out the full narrative for the national picture and steps that can be taken to build on some of the excellent practice that already exists to ensure that we have a person-centred, trauma-informed approach to individuals who are in crisis and sets out what that might look like.

Secondly, one of the key themes of the collaborative commitments is building on locally based practice and strengthening that type of provision within communities to ensure that people are getting the right support at the right time. We absolutely recognise that not every person in crisis benefits from going to accident and emergency. The position that police find themselves in on occasion with that issue is replicated to some extent in the Scottish Ambulance Service, which also forms part of the partnership delivery group. That is why looking at the transfer of care is another key aspect of the work.

On the issue of safe spaces and knowing what they look like, I have visited some excellent examples of them across the country. Hope Point and the Neuk are excellent examples and there are others, but they do not necessarily fit in all areas. Again, it is about understanding which particular partnerships and communities would benefit and where some of the gaps are. That is a key focus of the partnership delivery group, which is why it has been teased out as a key theme of the framework for collaboration. Real energy has been put into realising some of the ambitions of that.

The Convener: I advise members that we have a bit of extra time available, so I propose that we extend the meeting by about 10 minutes. If members want to come back in with questions, we should have some scope to allow that to happen.

11:00

Rona Mackay (Strathkelvin and Bearsden) (SNP): Chief Superintendent Matt Paden, for context, how many safe spaces are operating throughout Scotland at the moment?

Chief Superintendent Paden: The framework for collaboration captures some of them—for instance, in Edinburgh, at the Neuk in Perth and at Hope Point in Dundee. There are multiple examples, but there are gaps as well, because not all areas have the ability to take somebody who is in distress to a service such as one of those that Robby Steel touched upon—hence the need to commit to looking for solutions and, to go back to an earlier point, scaling up as appropriate.

As part of the workshop activities that I spoke about, which took place throughout 2023 and 2024, a lot of that was brought to the surface for the very first time. We have also shared the ethos and practice that have allowed some of the partnerships to flourish, such as the community triage model in Lanarkshire. I chair a mental health working group and we have had detailed input from Lanarkshire in relation to what made that model work, how those connections were made and the benefits that were derived, some of which have been touched upon. The governance structures that have been established are the foundation for taking some of this forward.

Rona Mackay: Okay. Thank you. I want to ask about the mental health of police officers during all of this. We have focused on vulnerable people and the help that they get. Obviously, police officers have always been the first responders for crisis situations and so on. The SPF advises us that, in its exit surveys, workload and mental stress are among the top reasons for people leaving the service.

I have two questions. How are you addressing that issue in relation to the police officers? Also—this is more of a generic question—could you talk about the changing nature of your workload in relation to mental health responses and how that has increased over the years, if it has?

Assistant Chief Constable Paton: I am glad that you mentioned that, because it is a priority. I want to emphasise that the chief constable's vision for 2030 has a thriving workforce as one of the four priorities, which are safer communities, less crime, supporting victims and a thriving workforce. To be a thriving workforce, they have to be mentally well. I do not need to tell the committee about the challenges that are experienced not just by police officers but across emergency services that are in demand.

Our written response—again, I can touch on any element of it—talks about the level of support that, as an organisation, we continue to provide to our officers and staff. The work is important because achieving that and having officers able to do their core duties will enable them to say, "I'm doing

what my skills and ability are designed to do." That is why the chief constable has committed us, as an organisation and through our own internal resources, to supporting this whole-system approach.

I can certainly talk about the difference in demand over 36 years in policing. I was a hostage and crisis negotiator for over 18 years, so stories like the one that Robby Steel mentioned, about dealing with people on a bridge who are in crisis and what you do after that, are very real to me as an individual. We have a core responsibility, but we also have a responsibility to keep people safe. We will never step away from threat, harm and risk. However, when the immediacy of such threat, risk and harm is over, our responsibility must be to provide the right support and care.

In the meantime, we are making sure that our officers are equipped to have that conversation, because, inevitably, they will still have to turn up to somebody who is on a bridge and engage in that conversation. What skills, knowledge and experience are we giving them? We are doing that through programmes of work such as "Act don't react" and other training that equips our officers and ensures that, even in that particular moment, they have the opportunity to make a positive intervention as we continue to understand who is best placed to deal with the situation.

In the same way as mental health affects people differently at different stages, there is no single answer that will support all our officers and staff. It is all of these things together, as well as our determination and commitment as an organisation to do all that we can to support officers, to ensure that they are equipped to do what we ask them to do and to alleviate the pressures and stressors that it is in our gift to alleviate, either individually as an organisation or, as in this work, collaboratively. What I can say with absolute certainty is that it is a priority for us, as an organisation, that all of our staff feel well when they come to their work.

Rona Mackay: If staff require counselling after a specific incident, do they know that that is there for them?

Assistant Chief Constable Paton: Absolutely. We have a range of support. For example, we have trauma risk management, which is a trauma-informed programme; information can be provided through occupational health; and people have been helped through Lifelines Scotland training, which is a package supported by the NHS. Of course, this is not just about referring people; it is about colleagues identifying these things in themselves and in each other, so that they are much more confident about having the conversations that are needed to identify the signs and symptoms in someone who might be moving in the direction of being distressed and engaging early in conversations to ensure that people are signposted to the right help and support.

We have a kind of sliding scale, as you would expect. Some people will want to approach things and engage in a particular way, and others will want to do that differently. Our job is to ensure that they know how to do it. I would take as an example our intranet and the PDAs. Another change that has happened in the past 36 years is that everything is now electronic and our officers can find support, help and signposting at the touch of a button.

Rona Mackay: Thank you. That is reassuring. I wonder whether Robby Steel or David Hamilton would like to comment.

Dr Steel: It is important for the committee to know that Scotland should be proud of its world-leading position with regard to the mental health support that it offers its emergency services. There is a magnificent therapist called Gill Moreton, who has a social work background but is a very experienced trauma therapist. Her work is shared throughout the world as an example of best practice, and she supports the police, ambulance and fire services.

Dr Hamilton: There is increasing recognition that we have to look after our staff as much as the people in the communities with whom we work, because the work can take its toll. All organisations have invested heavily in trying to ensure that support is in place for staff from a trauma-informed perspective, with reflective practice being used as part of their professional development, too, and people being given a safe space in which to voice things. Over the years, cultures can develop that are resistant to such open conversations about people's emotional health. Moreover, we might be very good at talking about other people, but how do we deal with impacts of trauma ourselves?

I have seen some positive changes in recent years. Certainly with my other hat on, as manager of the state hospital, I know that there has been a big shift in the direction of travel and in the culture, with the embedding of reflective practice and relational approaches to care, so that we are thinking not only about the patient's needs but about the impact on staff and ensuring that they are supported.

Rona Mackay: Thank you.

Sharon Dowey (South Scotland) (Con): The evidence has been excellent this morning, and I have found everything really interesting. I just wish that I had the magic wand that would help us to find the solution.

Obviously, as a justice committee, we are looking at the issue of justice, but, given a lot of

the things that we have been listening to, this seems like a healthcare problem, too. I agree with the police wanting to go in and do a reset in order to see what functions they should actually be taking control of, but another issue to think about is antisocial behaviour. We, along with many other members, are bringing that issue up a lot in the chamber, and it is a huge issue for constituents and businesses. However, the police are unable to respond to it, because they are tied up.

In its evidence, the SPF has said that anyone in crisis but

"under the influence of alcohol will not be"

assessed

"by a medical professional",

which means that police officers are required to wait with them. We have heard a lot about collaborative approaches and partnership working, and it all sounds great, but I am interested in what is being done on the healthcare side of things to take the pressure off the police.

Dr Steel mentioned services but talked about them being provided from Monday to Friday. He then mentioned the care when it counts service, but I thought, "Well, it's not when it counts if it's only Monday to Friday." Because we have a huge alcohol problem, a lot of that will happen out of hours—it will not be from Monday to Friday, when people are at work; it is when they get home at night or at the weekend.

I am interested in all the conversations that you are having about collaborative working. What are your partners saying about improving services and providing a 24/7 service, as the police force already does?

Dr Steel: You are absolutely spot on. The police should be dealing with antisocial behaviour, not mental health crises. I think that everyone in this room agrees with that. Services such as care when it counts are local crisis services and they are usually run by HSCPs, but, unfortunately, there just is not the critical mass of demand to have those services provided 24/7.

I do not think that health steps in. If you speak to an emergency department consultant, they will say that being intoxicated is not a medical condition. They will ask whether the person is able to protect their airway; if they can, they are not for the ED. That is the sort of standoffish approach of health.

What has stepped in, helpfully, is the third sector. In Edinburgh, we have Street Assist, which is a voluntary organisation that patrols on Friday and Saturday nights and picks up people who are intoxicated or at risk and supports them. Interestingly, its model is that it predominantly uses volunteers, but the volunteers tend to be paramedic students who are obliged to do some volunteering as part of their training, and it is the perfect volunteering opportunity for them. It is a really good service, and we have managed to secure enough funding to guarantee that it is secure. Most places have something akin to that.

I do not think that it is about the police or health. Third sector organisations are very important in filling the gap, and they are probably the people best placed to do that.

Sharon Dowey: Do you see enough movement on 24/7 services being made available?

Dr Steel: No, I do not. I am old enough to remember that people who were intoxicated and not able to keep themselves safe used to get to sleep it off in a police cell.

Sharon Dowey: That was another question.

Dr Steel: They do not get that any more. I remember wondering why that is, and the reason is that they could go to mental health, the emergency department or the police. Mental health had a get-out-of-jail-free card in the specific exclusions in the Mental Health (Care And Treatment) (Scotland) Act 2003, which say that a person is not mentally disordered solely due to intoxication or withdrawal from drugs or alcohol, or because they are behaving as no prudent person would. Mental health professionals would therefore say that an intoxicated person is not for them.

An emergency department would take the line that intoxication is not a health problem. If the intoxicated person can protect their airway, they are not for the ED. The poor police were left without a strong excuse, so they ended up holding those people. However, about 15 years ago, a policy change said that being intoxicated is not, of itself, a breach of the peace. It is not a reason to arrest someone and put them in a police cell. They are right about that, but that rather inappropriate workaround has now gone and nothing has properly filled the gap.

Sharon Dowey: It was possibly a safe space for 24 hours.

Dr Steel: It kind of was.

Sharon Dowey: You said that in your earlier evidence—that, after 24 hours, they were a different person.

Dr Steel: I used to go in to see those people.

Sharon Dowey: They could sleep it off overnight, and they were probably not all charged in the morning.

Dr Steel: Yes.

Assistant Chief Constable Paton: On that point, and for the avoidance of doubt, a police cell is not the place to put someone on the basis of intoxication or, indeed, on the basis of their being suicidal and threatening harm, for the reasons that Dr Steel has explained. Policing, like every service, is different now from how it was 30 years ago.

You are, however, right that there is a question to be asked about the alternatives that are available 24/7. That is why the implementation of the collaborative commitments needs to get some traction in the next year. There needs to be an alternative to a police cell, because it will never be the place for somebody who is intoxicated or threatening self-harm.

That set of circumstances is a good example of our role in assessing threat, risk and harm. If someone is on a bridge and about to jump, our job is absolutely to keep them safe. However, once that immediate risk has gone, whose job is it then? Putting somebody in a cell is not justice. It is about influencing behaviour and helping people to make good choices with the support of the agency that is best placed to help them to do that. That is why the chief constable is clear that we need to reset the balance and keep that momentum going.

11:15

Sharon Dowey: Are you seeing enough movement from other agencies on 24/7 provision? Once you have managed to get someone off the bridge, or if you have someone who is drunk and incapable, is there provision from the third sector or anywhere else?

Assistant Chief Constable Paton: The answer to that is no, not consistently for us as a national organisation, although there is good practice, as has been mentioned. We now have the framework for collaboration and the collaborative commitments, one of which is about strengthening locally based provision. We have the reference group, which is about bringing together third sector organisations so that we can get an understanding of what is available across the country. In the coming year, we need to see the tangible mainstreaming, across the length and breadth of Scotland, of service provision that is an alternative to emergency departments and to police having to wait with people. The Scottish Government's report on safe spaces looks at how we can make that provision tangible and available across Scotland.

However, the answer is no, we are not there yet. The main point is that, over the next year, we need to build momentum on that. That provision needs to be available as an alternative to accident and emergency departments and the police.

Sharon Dowey: Dr Heyman, do you want to make any comments?

Dr Heyman: I totally agree with what my colleagues have said. I have worked as a custody nurse and as a nurse in A and E. For somebody who is intoxicated, neither of those places—custody nor A and E—is the right place. That approach is undignified for the individual, it is unsafe and it puts huge demand on services. Watching somebody in custody places a huge demand on resources, and the resource is not in the right place. We need to think about providing somewhere that is much more dignified and that is safe for the individual.

To go back to the very beginning of our conversation at the start of this session, the partnership working that has happened in the past three, four or five years is significant. Such conversations did not take place previously. I have worked for Police Scotland and in this area for a number of years. There is real momentum behind exploring the new opportunities and shifting what happens.

I have concerns about what is happening in our English forces through the right care, right person approach, which just pushes demand into another area that is not equipped. As Dr Steel said, the health service is not equipped to have a huge amount of people come into emergency departments and just be moved into another area. The capacity is just not there.

The evidence that is already starting to come through from England on that programme is that people are falling through the gaps and that partnerships are breaking down. All of this really amazing work is happening in Scotland, but those partnerships between health and police services are starting to break down because people are coming from different perspectives and just trying to move a problem to a different area or shift it back and forth. We end up with more high-intensity users—I hate that term—and more people cycling through either the criminal justice system or the health system. That is not right. It is not right for the individual and it is really poor for our services at a time when resources are significantly low.

We have spoken about mental health nursing. I work on the recruitment of mental health nurses into universities, and I know that we are really struggling to recruit and retain staff. Therefore, it is important that we keep pushing and that we find good solutions through the partnership work.

Sharon Dowey: From the evidence, it seems that one of the conversations that still needs to happen through the partnerships and collaborations is about who actually pays for this. We spoke earlier about physical spaces and

multidisciplinary staff, but we also heard that the health service will not pay for those. It sounds as though this is a health problem that the police are having to pay for. As the Criminal Justice Committee, we want to get those conversations concluded so that the police can go back to policing.

Dr Heyman: Maybe there is a conversation to be had around shared resourcing.

Sharon Dowey: Yes. Thank you.

The Convener: I will bring in Liam Kerr and Ben Macpherson to ask two very quick supplementary questions and I will then have to end this evidence session, as we have only five minutes left.

Liam Kerr: I will speak quickly, convener. I will put my question to ACC Paton, if I may. Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 gives the police powers to remove

"a person ... in a public place ... to a place of safety"

if they reasonably believe that there is

"a mental disorder"

and some other conditions apply. The police cannot remove the person from their home, and such removal requires there to be a mental disorder, which police officers are not necessarily trained to assess. I go back to Dr Steel's point that police officers often respond to mental distress rather than mental disorders. Should the committee consider whether the 2003 act needs to be amended or improved to help you to do your job?

Assistant Chief Constable Paton: As you rightly say, those powers are very unique and, in the cases of the vast majority of people that we encounter in those circumstances, we are not able to understand the diagnosis, so we end up at the emergency department. Anything that adds value and adds to our knowledge of our role in that assessment is welcome, as is anything that can bolster our support.

We have spoken around but not actually highlighted risk aversion. There is a concern that, if we step away from somebody who needs such care and perhaps detention, officers could find themselves in a position where the person goes on to harm either themselves or somebody else. That issue could be considered in and of itself but, from my experience and what I have seen in the information and evidence, I do not think that it will change the direction of travel that we need to take as an organisation. It will not substantially reduce the demand that we have or substantially change our approach, because our first assessment is always about threat, harm and risk, which is sometimes not easy to understand. From that assessment, we determine what powers we have to address the threat, harm and risk and whether we need to seek support or whether we can make the assessment.

We are part of the partnership delivery group, which is all about looking at governance and support. You will shortly be speaking with the Scottish Government about opportunities for bolstering legislation and other aspects of work. From a policing point of view, anything that provides greater clarity and support for our officers in their roles would be welcomed.

Liam Kerr: On that point—

The Convener: Please be very quick.

Liam Kerr: I will be very quick, convener. On that point, ACC Paton, you have talked a lot about the improvements and the good work that is going on, but ASPS and the SPF were very clear that that is not necessarily translating to the front line. If I ask them in a year's time whether that has improved, will they tell me that there has been a tangible improvement at the operational level?

Assistant Chief Constable Paton: That is an interesting question. If you ask them that question, you will perhaps get a statement like the one that you have now. However, I would ask the committee whether there is evidence to support what I am saying about some of the tangible progress and/or evidence to support an alternative, and where the middle ground is.

My answer to you is yes. They absolutely will, because there is already tangible progress. I absolutely acknowledge that it does not always translate into a tangible, felt experience for officers, because they do not see the 11,000 calls that they are not going to. They are still going to calls and, because gaps still exist in the whole-system approach, which we have articulated today, they are going to A and E and spending time there. I recognise that. The simple answer to your question, however, is that ASPS and the SPF will absolutely be able to say that there has been tangible progress in this space. It is a commitment of our chief constable and, as Inga Heyman mentioned, we are working in a far more collaborative and progressive way as a result. That is certainly the case in my experience in policing.

Liam Kerr: I am very grateful—thank you.

The Convener: I am really sorry but I must draw this session to a close.

Ben Macpherson: Can I ask one more small question, convener?

The Convener: Yes, if you are very quick.

Ben Macpherson: David Hamilton mentioned that the Lanarkshire project saved 18,000 police

man-hours. As a follow-up, ACC Paton, are you able to give the committee an indication of the number of man-hours that we might save if we make progress with the implementation of the collaborative commitments, and of what the financial gain might be? That would enable us to help with calls on the budget—potentially the big health budget—to support that work.

That question was as quick as I was able to make it, convener.

Assistant Chief Constable Paton: Very quickly, in answer to that—

The Convener: If you want to provide a follow-up answer in writing, that would be helpful.

Assistant Chief Constable Paton: Absolutely. The whole point of our having the mental health dashboard is to enable us to understand the demand. You will see that in the round across the wider performance in policing. To be honest, the most important thing is that the person in crisis gets the right care that they need from the right agency at the right time.

I am happy to follow up on anything in writing if there are further questions, convener.

The Convener: Thank you—we managed to get that question in.

I am looking through the door and I do not think that the cabinet secretary is outside yet, so I will shamelessly insert a final question. [*Laughter.*] It is on a point that is made in the Social Work Scotland submission on the basic issue of the police being able to make contact with services. I direct this question to David Hamilton—you may need to take it away, David. Do police officers have available to them the core access that local arrangements should be supporting?

Dr Hamilton: I was going to come in on Ben Macpherson's question, but it was cut short. However, this point follows on from that question. With regard to section 297 of the 2003 act and the provisions for removal

"to a place of safety",

we have seen really positive use of that by police. We know that people are not going to cells and are getting taken elsewhere, but we need to get them to the right place.

At the other end, where people are in private places, mental health officers will have contact with their colleagues in the police and in health. The approach to planning and co-ordination needs to be driven by collaboration, and the relationships between the local mental health staff and the local divisional sergeants are key. That has been really helpful, and my colleagues have raised no issues regarding input or willingness to support the execution of warrants at a local level.

The Convener: Okay—great. That is the final word. I thank you all for what has been an excellent session. We could probably have run on for another hour.

We will have a short suspension to allow a changeover of witnesses.

11:27

Meeting suspended.

11:33

On resuming—

The Convener: We are now joined by the Cabinet Secretary for Justice and Home Affairs and her officials. I wish you all a happy new year. Accompanying the cabinet secretary from the Scottish Government, I welcome Lynsey McKean, policy team leader in the police division, and Alasdair Cook, principal medical adviser with the mental health division. I refer members to papers 1 and 2. I intend to allow about 75 minutes for this evidence session.

I invite the cabinet secretary to make some opening remarks.

The Cabinet Secretary for Justice and Home Affairs (Angela Constance): Thank you, convener, and happy new year to you and everybody on the committee.

I am grateful for the opportunity to speak about some of the work that I have outlined in my correspondence to the committee, and for the opportunity to principally focus on policing and mental health. In relation to mental health concerns, the Scottish Government believes that there should be no wrong door to accessing unplanned or urgent mental health support, and that anyone in need of that support must receive the right care in the right place at the right time.

At the outset, however, it is only right that I acknowledge that not everyone who may have a mental health-related concern is vulnerable or in distress. There are many circumstances not related to mental health in which a person may be classed as vulnerable, unable to protect themselves or at risk of harm and exploitation.

It is also important to acknowledge that distress can be a normal response to life-challenging situations, and that does not mean that everyone experiencing distress will need formal mental health intervention. In any and all of those circumstances, individuals should be able to access the service that is best placed to meet their needs.

However, there are undoubtedly continued concerns about the demand that mental health-

related calls in particular place on policing. We are working with partners, including Police Scotland, to improve individuals' experience of accessing support and to ensure that resources are deployed appropriately to reduce unnecessary demands on police officers.

Since 2021, we have been working with partners, including health boards and Police Scotland, through the mental health unscheduled care network to improve the mental health unscheduled care response and to ensure that those in need of urgent or unplanned mental health care are directed to the most appropriate service and receive support quickly. That is being facilitated by the 24/7 availability of a mental health clinician in every health board for those who require urgent mental health assessment or an urgent referral to local mental health services. Those clinicians are available to front-line services, including Police Scotland, through local community triage pathways.

Through the development of the enhanced mental health pathway, we have enabled Police Scotland's command and control centres to direct calls from individuals who have been identified as needing mental health advice and support to NHS 24's mental health hub. In her update to the Scottish Police Authority in November, the chief constable acknowledged the impact of the pathway in helping to reduce demands on officers: 10,611 referrals to NHS 24 have allowed 54,328 officer hours to be redirected to other duties.

More broadly, we are working with a number of partners to deliver the actions in the mental health and wellbeing strategy's first joint delivery plan and workforce action plan, which were published jointly with the Convention of Scottish Local Authorities. They seek to create real and lasting change in the country's mental health, with a whole-systems approach that has a renewed focus on prevention and early intervention.

In its thematic review of mental health demand on policing, HMICS recognised that mental health is a multifaceted issue that needs an effective whole-systems partnership response. HMICS set out a number of recommendations for Police Scotland, the Scottish Police Authority and the Scottish Government. As part of our commitment to implement the review's recommendations, the Scottish Government, the Scottish Police Authority and Police Scotland have established a partnership delivery group, or PDG, which is working across organisational boundaries to identify and deliver support to individuals that can be delivered in a person-centred and trauma-informed way.

I am pleased to inform the committee that those on the group have worked together to support the Scottish Government to develop a framework for collaboration. The framework, which will very shortly be published, aims to promote—crucially—a multi-agency collaborative approach to improving local distress pathways. Alongside the framework, a mental health and policing action plan will be published, outlining numerous collaborative commitments across sectors, which will further bolster the PDG's aim of improving the multi-agency approach to mental distress.

I extend my heartfelt thanks and gratitude to our partners for their support in developing the framework and collaborative commitments, and I acknowledge the tireless efforts of all those who continue to contribute to the delivery of mental health services, including our ambulance, policing and third sector partners, whose roles are crucial.

In all of this, partnership working is undoubtedly the key that will unlock many shared challenges. It is only by working together that we can deliver real, lasting and meaningful change. The Scottish Government remains fully committed to continuing the partnership approach that has been so crucial to the development of the framework and collaborative commitments, particularly as we move forward to implementation.

The Convener: Thank you very much, cabinet secretary. That has been very helpful. I think that all members would endorse the comments that you made in recognising the commitment of everybody who works across health and social care, particularly in the mental health and wellbeing space. We associate ourselves with your comments.

Based on the submissions and the helpful letter that you sent in August, personally, I think that it is fair to say that the dial is shifting on the work that is being done to support policing in relation to those with mental distress. That was borne out in the evidence of the previous panel, when we heard about a range of initiatives and approaches and the more strategic work that has been going on. That was helpful in setting some context. It also helped us to understand the complexity of the demographic of people that we are collectively dealing with. It is not always people who are in a state of distress—obviously, it can be much more complex than that.

One thing that I am particularly interested in and encouraged by is the Government's scoping report on safe spaces. To be honest, I was unaware of the extent to which safe spaces have been, or are being, developed in Scotland, so I found that welcome. In regard to safe spaces, can you outline more on the direction of travel? Based on the work that the Government has already been doing, where do you see that going?

Angela Constance: It was remiss of me not to commend the committee for its on-going interest in

and work on the issue. You have certainly helped to keep the wind behind the sails of the Scottish Government and all our partners.

You are absolutely correct that the demographic around vulnerability is indeed complex for policing partners and other services to deal with. Although we know from adult protection referrals that those struggling with mental health are the biggest single client group, there are a number of indicators of vulnerability, including learning disability, age and a whole host of other challenges. It is right that we recognise vulnerability in the broadest sense, but a sharp and forensic focus on mental health is particularly important.

I appreciate the recognition that, although we still have some way to go, we are shifting the dial, which is imperative for people who need to quickly access a service. We also need to ensure that policing resources are appropriately deployed because, at the end of the day, that will ensure that we reduce unnecessary demands on police officers.

The work on safe spaces is very interesting and complex. There are good examples of peer support in community settings. We know from the scoping work that, when the approach is prioritised and designed locally, it can become more of a reality of service delivery. There is a sense of reimagining and rescoping safe places, and ensuring that there is a wider spectrum of support. That should include non-clinical support, but we need to ensure that such support has the necessary links to clinical care. Safe places can be crucial in preventing an escalation of matters.

11:45

It becomes more complex where we get into issues around the proximity of a safe place to A and E departments. The need varies geographically, so the type of formalised service that works, for example, in Glasgow—the city has a mental health assessment unit to which police can refer people on—might be different from what is needed in other areas of Scotland.

We always come back to issues of safe staffing and the ability to accommodate various population groups and people of different ages. It may be that tiered provision is required that can cater appropriately for different population groups. There is also the issue of how we ensure access in particular for those who are affected by substances.

The nuts and bolts of mental health provision relate to standards, care planning and risk assessment, safe staffing and what the procedures are when matters escalate. That work is in-depth and complex but potentially very important.

Colleagues in Government, in particular those working in mental health, are considering the next steps. Part of meeting the collaboration commitments will be to consider what is next, following the scoping work. We can perhaps look at a toolkit that supports local development. It is fair to say that there is still a fair amount of work to be done in the area.

The Convener: That is helpful to know.

I will stop there and bring in members, starting with Liam Kerr.

Liam Kerr: Good morning to the cabinet secretary and her officials. Cabinet secretary, you will have heard in the previous session—you will no doubt have considered what was said—that ASPS and the SPF have, in their submissions to the committee, highlighted several concerns. One of those is that the police, rather than other organisations, are having to lead on this area.

I give you the opportunity to give your views on that and to say whether you think that there is sufficient input and leadership from other organisations and portfolio areas to address mental health and policing.

Angela Constance: The short answer is that I do. I will expand on that in a moment, but I first want to acknowledge the scale of the issue and the demands that are placed not only on individual police officers but on Police Scotland at an organisational level.

The committee may have heard about the 100,000 calls received by Police Scotland in relation to mental health, and the fact that the vast majority of those calls involve no offence. I understand some of the frustrations that policing partners have, but I am encouraged in particular by the comments from the deputy chief constable. As we would expect, senior police officers always speak truth to power, so it is good to hear that the police are encouraged by the partnership working, in particular around the enhanced mental health pathway and the mental health index. Deputy Chief Constable Jane Connors talks about the central role of good collaborative partnership working and the value that has been placed on that.

On ASPS's comments about policing having to lead, I agree entirely with HMICS that the issue requires a whole-systems approach. I very much support and understand the desire of ASPS and the Scottish Police Federation to see that organisational change on the ground, but we will get that only with partnership work and a whole-systems approach. It will not happen if services are working in isolation.

The partnership delivery group that is chaired by the Scottish Police Authority has significant

policing input at the chief superintendent level, both from the policing together work and from the chief superintendent who is involved with local policing, as well as the individual who is head of service delivery. There is also substantial input from the Scottish Government, the Scottish Ambulance Service, NHS 24 and, in particular, the mental health unscheduled care network. I believe that we have the right buy-in across the services and, significantly, from a senior enough level.

I will give an example of where it is clear that actions and decisions have to be led by clinicians. When people are utilising the mental health index or accessing the out-of-hours mental health clinician, it is very clear that decisions on clinical issues, as you would expect, are made by clinicians, but they also have to arrange the care. There is greater clarity on who does what when, and that has to be welcomed.

Liam Kerr: You heard me ask about the data dashboard, and I am pleased to say that ACC Paton gave a pretty positive report. We know from one of your earlier letters that it was intended to be rolled out by the end of last year, but I think that I heard earlier that it is not quite there yet. Will the data arising from the data dashboard be shared with the Scottish Government, or is it operational and only for Police Scotland? What is your view on the roll-out if the timescale has not been met?

Angela Constance: The data dashboard that you heard evidence on earlier is owned by Police Scotland. That is an important piece of work, and we support Police Scotland's work on it. My understanding is that it brought that part of its work to fruition, as it committed to do, by the end of last year.

Our focus in 2025 is on implementation, and I have to acknowledge the role of data in that, particularly in understanding the nature of demand and the geographical variation. It is about considering data, but not just police data in isolation. I have heard, and the committee may have heard, the chair of the Scottish Police Authority, Martyn Evans, speak often about how important it is that data systems across agencies speak to one another and are linked. That is important because, although data from Police Scotland will tell us, encouragingly, how many referrals have been made to the NHS 24 mental health hub, and although we can track how many adult protection referrals and distress brief intervention referrals police make, we want to know the whole picture and the journey for the patient or the person in distress.

We will continue to discuss with Police Scotland the data that it has collected. My officials are engaged in those discussions. In particular, we want to understand more about the methodology. Although it is very important that we understand the quantum and that X number of police hours are being redirected to other activity, that will not be the only measure of success. Part of the whole-systems approach is about getting folk the treatment and support that they need, which will in turn reduce demand on policing.

In short, I am saying that there is further work to be done across the agencies on data that can provide a bigger, whole-systems picture.

Liam Kerr: In 2021, the Lord Advocate made a statement on diversion from prosecution. She stated that recorded police warnings could be given for possession of any class of drugs. I appreciate that you might need to come back to me on this, but do you have statistics to hand on how many such warnings for possession were given pre and post that announcement and positioning? Is that broken down for different substances? Crucially for our purposes today, are you aware of any direct impact of that positioning on policing time spent on people experiencing harmful substance abuse?

Angela Constance: I will check whether the Crown Office wishes to do this, but I will ensure that the committee gets that factual information from the most relevant source, whether that is me or the Crown Office, on the pre and post positions with respect to the change in recorded police warnings that took place in 2021.

Liam Kerr: I am very grateful for that—thank you.

Katy Clark (West Scotland) (Lab): Cabinet secretary, you have spoken this morning about a number of workstreams and action plans. As somebody who is not involved in that, I sometimes find it quite difficult to understand the terrain. You have made clear the commitment to whole-system approaches and to partnership work.

As I understand it, the Scottish Government established a mental health and capacity reform programme to address the recommendations from the Scottish mental health law review. That programme does not sit under the justice portfolio. Indeed, much of the work will sit outside justice, although it obviously has a massive impact in relation to your responsibilities. Will you say a bit more about the work under the reform programme to deliver the recommendations of the Scottish mental health law review, about your oversight role and about the extent to which it relates to other parts of Government?

Angela Constance: I have always been clear that, internally in the Scottish Government, we need to practise what we preach if we expect our partners to take a whole-system approach, working outwith operational boundaries and silos. In Government, we need to be doing likewise. Cabinet Secretary for Justice and Home Affairs is

the eighth ministerial role that I have held over a number of years, and this is an area in which I have seen a vast improvement internally.

I will give one example. Obviously, the Cabinet meets, but, as far as work on adult social care and adult protection is concerned, you are right to point out that there is a myriad of workstreams, plans and interventions. I chair a ministerial group that involves three health ministers, the children's minister and the equalities minister. The group oversees six divisions of Government. That is just one example of working across portfolios, and there are many others that I could give you.

12:00

The mental health review that was undertaken by Lord Scott was a substantial piece of work—it was quite incredible, actually. Indeed, I remember its 900 pages dropping into my inbox when I was the Minister for Drugs Policy. It is a substantive bit of work to implement. What health colleagues have done thus far is, as you would expect, take a bit of time to consider Lord Scott's recommendations and his very thorough and detailed report, because it looks not only at law reform, capacity and the importance of support but at increasing accountability, and our commitment to human rights is woven through all of that, too. Health colleagues undertook to devise an initial delivery plan, and last June they published the mental health and capacity reform programme.

Although the overall work will take several years to implement—and colleagues have been very up front about that—action has been planned and pursued from October 2023 to April 2025, and colleagues have prioritised what can be achieved quickly and, indeed, within existing resources. They will start to scope out new work on the next steps. That work contributes to the outcomes in the mental health and wellbeing strategy, which is led by health but is, of course, a cross-Government endeavour.

Katy Clark: You wrote to the committee in August in relation to the mental health and wellbeing strategy and the delivery plan. It would be extremely helpful if the committee could be kept advised not only of the work on the delivery plan that you have referred to with regard to the reform programme, but of whether this actually sits under justice. After all, we have to ensure that there is ministerial drive on this. I have to say, though, that it sounds as if you are not concerned about things falling through the cracks because some of the responsibilities do not lie within your remit. Do you still feel able to have oversight and to ensure that, on the subject of policing vulnerable people that we are looking at today, action is being taken as quickly as possible to implement policy?

Angela Constance: I am content that we have the right connections with regard to information internally in Government. Our job in Government is not only to collaborate and co-operate, but to challenge one another and ensure that colleagues are aware of any unintended consequences of work that they are pursuing in their area and the impact that it could have on others. I hope that that goes without saying.

All of my work is located in the justice vision, which places an obligation on me to contribute towards improving the physical and mental health and wellbeing of people who come into contact with the justice system. We know that, among those who come into contact with the system, there is an overrepresentation of vulnerable people and people with poor physical and mental health, so I have a direct interest in the work being led by health colleagues, just as they have a direct interest in my work, too. It is an obvious point, but we will of course keep the committee informed.

Sharon Dowey: I have questions that are probably on the same lines as Katy Clark's. We heard in the previous and really interesting evidence session about the significant work that was going on, and the assistant chief constable told us that she was heartened and encouraged by the partnership working that was taking place. However, we also heard about services that ran only Monday to Friday, and we were told about physical spaces that needed multidisciplinary staff but which health would not fund.

Obviously we are getting to a crucial point now, and I am sure that you are having regular discussions about your budget, but I feel that a lot of this particular budget should be covered by health, to ensure that your police budget is spared. What conversations have you had in that respect with the health secretary and his team in order to alleviate the pressure on the police? Can you share with us any of the conversations about the work that he and his team are doing? Are you happy that they are implementing measures that will provide the sort of 24/7 service that the police force gives?

Angela Constance: When it comes to the budget, any cabinet secretary will want to negotiate the best possible deal for their portfolio in their direct engagement with the finance secretary, and I am very pleased that the resource budget for policing will be increasing by £57 million and that the overall investment is £1.62 billion.

That said, any cabinet secretary also looks beyond what they negotiate for their own portfolio. You look at what investment colleagues have in their areas—in this case, health—and how it can be aligned with your own work. I always take a pragmatic approach to this; I am less bothered about trying to carve out or capture part of another

portfolio's budget than I am about how that budget is being directed and aligned.

Sharon Dowey: I am sorry, but I am not talking about carving out or taking somebody else's budget. My question is whether they are making the best use of their budget. For example, the Scottish Police Federation has said in its evidence that anyone who is in crisis but

"under the influence of alcohol will not be"

assessed

"by a medical professional",

so police officers will be required to wait with them. While the police are sitting with people who are under the influence of alcohol, we have other constituents who are sitting complaining about antisocial behaviour. That sort of thing is taking the police away from their role, which is policing. From the conversations that you have had with other cabinet secretaries and among the group that you chair, do you think that they are doing enough? Are you seeing actions that are helping to alleviate that particular pressure on the police?

Angela Constance: Policing is absolutely is a 24/7 service, but so is health—

Sharon Dowey: In some areas.

Angela Constance: It is a 24/7 service, although I acknowledge that some services are not available 24/7.

The work of the mental health unscheduled care network and partnership is particularly important in this area, and there is specific investment in and a strand of programmed work on unscheduled care with regard to mental health. Obviously, this forms part of the enhanced mental health pathway, and the use of the mental health index has been rolled out across Police Scotland, too.

However, I would point out that the police can access clinicians 24/7; in particular, they have access to the mental health hub via NHS 24, and, as I outlined in my opening remarks, that access can happen directly through the command and control centres. I would highlight, too, the work of the distress brief intervention programme, to which referrals can be made not just from the command and control centres but from an operational on-the-ground centre. Obviously, that might also involve third sector partners.

As for assessments of those who are impacted by substance misuse, I will ask Alastair Cook to address that matter, but my understanding is that things have moved on in the past decade or so—and certainly since Mr MacGregor and I were in the field—and that, unless someone's functions and communication have been severely impacted by intoxication, assessments can still take place if the person has consumed substances. However, I will ask Dr Cook to say a wee bit more about that, because I think that you might find it interesting.

Dr Alastair Cook (Scottish Government): It is a contentious issue and different stories are sometimes told about it. When the unscheduled care network asks about practice around the country, we hear from all the services that they take a pragmatic approach and that clinical judgment is applied to whether someone can be assessed because of their level of intoxication. The blanket ban on seeing someone who smells of alcohol is certainly something of the past.

There are still issues to be addressed around safe handover. If somebody is too intoxicated to be assessed and there is a requirement for them to wait so that they can be assessed, could we get to a position where the police can hand that person over to be clinically supervised until they can be assessed? That is an area that we still need to work on and it will be part of the collaborative work that needs to be done. Some of the safe spaces work that was referred to earlier could offer a solution to that, but it is not a universal solution that could be applied everywhere. It is something that we need to work on, and it needs to be worked on at local level because one size does not fit all.

Sharon Dowey: That is one of the pinch points and there is still more work to be done on that.

Dr Cook: Definitely.

The Convener: I will note a point that ties in a little bit with what the cabinet secretary and Dr Cook have just said. In our earlier evidence session, Dr Robby Steel set out some of the challenges and perhaps gaps when the police take someone to an A and E or an emergency department, for example, and, for whatever reason, that person is assessed as not suffering from a mental disorder but is considered not to be in a state in which they can be allowed to just walk out or leave of their own volition.

At the same time, for obvious reasons, an A and E department is not really in a position to allow such people to just remain, sleep it off, settle down and de-escalate the situation. Dr Steel was trying to reflect the fact that there is a gap, which links in a little bit to what Dr Cook has just outlined. Is that something that you would seek to address, or is there scope to address it within the wide range of work that is being undertaken?

Angela Constance: I suppose that there are two aspects to that, convener; Dr Cook can pitch in after me. On the one hand, we need to move away from practice that is unduly risk averse and make sure that positive decisions are made around risk assessment. I fully support the chief constable in her drive for safe and timely

handovers, for a host of reasons that you will be well versed in.

On gaps in provision, the work around safe spaces is also potentially important in that sphere. However, the purpose of the partnership development group and its action plan and collaborative commitments is to give local areas the tools and wherewithal to ensure that they have good local relationships and that there is direct communication from services and people on the ground that is specific to individuals, and that local protocols and distress pathways are more clearly visible and identified.

The central goal is, I suppose, for every area to have well-developed distress pathways. We cannot fit everybody into a box. We have to recognise that, whether we are talking about health services or Police Scotland, first and foremost, they are dealing with people, and they are also dealing with dynamic situations.

12:15

The strength of the work is that it looks to support and develop from the ground up, as opposed to imposing a solution from on high, and I know that HMICS would endorse that point. However, not all the focus should be on the front line. Part of the partnership development group approach is that the people who are involved at strategic level all have responsibilities to implement decisions at that level. When the framework and the collaborative commitments are published, you will see that very clear commitments are made by named individuals in organisations.

I will check with Dr Cook whether there is anything more to say from a practice point of view that would help.

Dr Cook: You have covered a lot of it. The convener mentioned the idea of someone being able to sleep it off in an emergency department. In the not-too-distant past, that was feasible, but it is not feasible now, given the levels of activity in emergency departments and the pressure within them. That gap, which probably was not there previously, is appearing now, and there is a requirement to have an alternative.

In terms of risk management and risk tolerance in the system, the cabinet secretary mentioned the development of local relationships, which is absolutely key. The areas where we see progress are where collaborative working arrangements are already in place. In those places, local clinicians regularly have discussions with police colleagues about what is working, what is not working, where opportunities have been missed and how things can be improved. That develops a higher level of trust, which means that, when a clinician says that it is safe for a person to be allowed to go and the police officers are still a bit concerned about the risk, the decision that it is safe to allow the person to go has been taken by someone whom the police officers trust. We want to reach that position in more places.

The Convener: One of the things that was highlighted in the paper on safe spaces was the need for peer support, which the cabinet secretary referred to, as well as the need to work alongside clinical staff. The clinical aspect of overall care is important.

Rona Mackay: Good afternoon. I have a brief question about the mental health of police officers who deal with vulnerable people. The previous witnesses were very positive about that and said that enough has been done to give police officers support in that respect. We know that the issue affects a lot of police officers, and the SPF says that many people leave the profession because of the mental stress that they are under. Are you happy that enough has been done in that respect? Are you happy with the measures that have been taken to support officers?

Angela Constance: That is a very live issue that features in many of my discussions with the SPF and ASPS. It has always been very clear to me that, in the day-to-day work, cases that have a strong mental health feature and less of an offending behaviour feature place an additional obligation and demand on individual police officers, and that will have an impact on their wellbeing. There will also be a huge impact when there are emotionally charged, disruptive or difficult circumstances when things perhaps do not go well. There are instances that are particularly traumatic in their own right.

Police Scotland has an obligation as an employer, and the oversight of that principally comes through the Scottish Police Authority, although we all have an interest in the wellbeing of our police officers. You might have heard that Police Scotland has an employee assistance programme, in which £17 million has been invested. The programme has a focus on mental health and enhanced occupational health services. With that programme, Police Scotland is trying to take a preventative approach, by looking at assessments of resilience and stress risk, and recognising the day-to-day attrition and demands on police officers. There is also specific work through the trauma risk management programme for officers who have been exposed to particularly traumatic events.

Police Scotland is one of the first services in the United Kingdom to implement mandatory mental health and suicide intervention training for all officers. That is particularly important. It also offers a range of services to care for psychological,

physical, social and financial wellbeing through the your wellbeing matters programme.

Rona Mackay: Historically, Police Scotland—or the legacy forces—did not have a good track record in that area, but I am really encouraged to hear both what the previous panel of witnesses said was going on and what you have reaffirmed today.

Pauline McNeill: Good afternoon, cabinet secretary, and Lynsey McKean and Alastair Cook.

I want to go back to the central reasons why the committee has set time aside to conduct this important inquiry. We have had strong and encouraging evidence. I will quote from the letter from Association of Scottish Police Superintendents and I would like to hear your response to that. The letter refers to the cabinet secretary's update letter of 8 August. The first thing that I picked out is probably accepted. The letter says:

"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."

The recurring theme is the impact of those issues on policing our communities. That is why we are driving this work forward.

The letter from the ASPS also goes on to say:

"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."

I thought that that was pretty direct. Do you want to respond to that?

Angela Constance: I believe that I do understand the direct impact that mental health-related calls and issues in our community have on policing. There is a reason why our work around mental health and policing features in the programme for government, and I hope that that gives out the strongest possible signal and demonstration that we take that range of matters very seriously indeed.

I am conscious of the evidence that has been given by the policing associations—the Scottish Police Federation and the Association of Scottish Police Superintendents—and the chief constable. I think that I mentioned earlier that the vast majority—87 per cent—of the 100,000 mental health-related calls that are received by the police involve no offence.

At the tail end of last year, when the chief constable gave evidence to the Scottish Police Authority in November, she mentioned the fact that, on a busy day, the police can get three to four calls a minute in relation to mental health, which equates to 600 police officers per year. That is a very stark statistic. From the adult support and protection work that I am involved in, I also know that in excess of 40,000 adult support and protection referrals are made, nearly 30 per cent of which come from the police.

I accept that too many people still go through the wrong door, if I can put it like that. However, we can demonstrate—the committee has heard evidence on this from a range of stakeholders—the breadth and depth of the work that is being done in this area. There needs to be clarity on people's respective roles and functions, and I do not think such clarity always exists. I hear different views expressed by different stakeholders about what they think their partners should or should not be doing, but I am very conscious that, under section 32(a) of the Police and Fire Reform (Scotland) Act 2012,

"the main purpose of policing is to improve the safety and well-being of persons, localities and communities in Scotland".

By its very nature, that is not a narrow responsibility.

I make it crystal clear that the whole purpose of my interest and commitment in this area of work is absolutely to improve services to individuals, but it is also to ensure that policing resources are deployed appropriately and that the demand on policing is reduced.

Pauline McNeill: Thank you—it was helpful to get that on the record.

In our session with the first panel of witnesses, I quoted the Scottish Police Federation, which said:

"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."

I presume that you are aware of that. Is that part of the issue?

Angela Constance: I would want to see the evidence for that. I am not trying to be facetious or pernickety, but if people communicate concerns of that nature to the committee, to other stakeholders or, indeed, to me, I would want to see the evidence. That speaks to the broader need for better data that tells us what we need to know about demand and impact.

Pauline McNeill: I agree. I, too, would like to see the evidence. However, that is a comment that has been made. I suppose that it is a case of matching up the aspiration with the reality that we

are faced with. That is what we are all interested in.

In our session with the first panel, we heard about a model that involves providing another space where the police do not need to get involved, which sounds like the right model. That means that the police get their hours back and the vulnerable people concerned get the right service. However—Sharon Dowey and I have been pursuing this issue—although the NHS and the police work 24/7, not all services do that. Without that being the case, it will be difficult to achieve that model, because a lot of the calls that we are talking about will be made out of hours. I do not know what the numbers show.

I will quote from the letter from ASPS, if you do not mind, to illustrate how far away it thinks we are from that. It says:

"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."

That is just the association's version of where we are now. Do you want to respond to that?

12:30

Angela Constance: I will quote the outcomes from the work in North Lanarkshire with Q division of the police. I have visited the service. It has a triage opportunity whereby there is 24/7 access to a psychiatric liaison nurse. The result of that is that potential police attendance at A and E has reduced by 80 per cent. The North Lanarkshire community triage service has been used on 2,000 occasions. The latest figures for that are from 2023. It is a good demonstration of what can be achieved. It is a win-win for individuals, the police and the NHS, because there is a 24/7 service and people are referred to the appropriate service at the appropriate time.

I recognise the frustrations of the Association of Scottish Police Superintendents. I am not blind to those and I am not unsympathetic or insensitive in any way to them. However, 2025 is the crucial year for implementation. There is demonstrable progress, but it is clear that, without a whole-systems approach, organisational change will not happen on the ground.

The partnership development group, the action plan and the collaboration commitments are all about driving forward action and that whole-systems approach. Justice services do not operate in isolation, because you cannot pigeonhole people. To a great extent, how justice agencies interact and the service that they deliver depends on other services—social services and health services in particular. I hope that, by this time next year, the Association of Scottish Police Superintendents will feel more positive about the work and that it is making a demonstrable difference on the ground because 2025 will be a crucial year for embedding it and moving forward in outstanding areas.

The Convener: I will bring the evidence session to a close with a final question, cabinet secretary. It relates to the review of psychiatric emergency plans. I do not think that we touched on it in our previous evidence session, but we are aware from the update that you provided that a review has been going on and that the work was expected to be completed at the end of last year. We hope to see a template and guidance towards the spring of this year.

I highlight a comment that HMICS made in its review into mental health. It outlined that there was "a lack of consistency" in the expectations on the police within different PEPs. It also

"found varying levels of awareness of the PEP among senior officers in local policing divisions."

Do you have any further comments on the PEP review? Where do you see PEPs fitting into the other work going on at the more strategic level that we discussed?

Angela Constance: Following the HMICS review, the mental health unscheduled care network took forward a lot of the work. It was led and supported by the Scottish Government, although I think that the original recommendation suggested that Police Scotland lead it—however, Police Scotland is a member of the mental health unscheduled care network.

The national review was completed in December last year. In a minute, I will ask Dr Cook to talk about the work on developing the national guidance and the template. The core purpose of that work was to ensure consistency across 14 health boards and to remove barriers to multi-agency working. Some of that is about training. The Police Scotland mental health task force has undertaken a full training needs analysis of the police workforce. One of the recommendations was to have more joint training for leaders across different sectors and about good communication and relationships on the ground.

The other purpose of the work on psychiatric emergency plans was to be crystal clear about roles and responsibilities when responding to issues. I ask Dr Cook to add a bit more flesh to that.

Dr Cook: I had the honour of chairing the PEP review, which was a helpful exercise. Just prior to the pandemic, the Mental Welfare Commission did a review of PEPs, which was never taken forward. HMICS recognised that there was a need for us to

build on that in ensuring the consistency of PEPs across the country.

One of the core purposes of the PEP is to ensure that, when there is an emergency in the community or in a hospital, there is absolute clarity about what the process is to help the person to get to the place in the system where they can get the help that they require. That involves working with all the different agencies that might be engaged in that, such as primary care, the ambulance service and the police. The collaboration with the police on that has been a side effect of us taking forward the work on PEPs but it will contribute to the collaborative working that we talked about throughout the rest of the evidence today.

The Convener: I assume that, within that work, issues to do with the arrangements for remote and rural areas are addressed. Is that correct?

Dr Cook: Very much so, yes. I expect that we will have a chapter on remote and rural areas within the guidance.

The Convener: That is good to hear.

As there are no more questions, I bring the evidence session to a close. I thank the cabinet secretary and her officials for joining us. It has been helpful.

Next Wednesday, we will hear from the Police Investigations and Review Commissioner on her work over the past year.

12:39

Meeting continued in private until 12:49.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447
Fax: 0131 348 5423

The deadline for corrections to this edition is:

Friday 7 February 2025

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba