CJ/S6/22/16/1

Criminal Justice Committee

16th Meeting, 2022 (Session 6), Wednesday 18 May 2022

Policing and mental health

Note by the clerk

Introduction

1. The Committee is to hold a roundtable evidence session on policing and mental health on 18 May 2022.

2. The evidence session will focus on the demands placed on the police service when dealing with people with poor mental health, how Police Scotland deal with people with poor mental health who are taken into custody, and the impact on the mental health of police officers and staff due to the demands being placed upon them in the course of their duties.

Participants

3. The Committee will hear from:

    - Dr Inga Heyman, Associate Professor, Edinburgh Napier University;
    - Alan Staff, Chief Executive, Apex Scotland;
    - Martyn Evans, Chair of the Scottish Police Authority;
    - David Hamilton, Chair of the Scottish Police Federation;
    - Assistant Chief Constable John Hawkins, ACC Local Policing North; and
    - Superintendent Mairi Macinnes, Criminal Justice Services Division, Police Scotland.

Format

4. Members of the Committee and witnesses will be attending the meeting in person for this roundtable evidence session.

5. The Committee received written evidence in advance of the session, which can be accessed at Annex A.

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Clerks to the Committee
May 2022

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Annex A – written submissions

Dr Inga Heyman

Introduction

The Scottish Parliament's Criminal Justice Committee, prior to a roundtable evidence session on Policing and Mental Health on the 18th of May 2022, have asked for a written submission on a number of issues.

In my role as Associate Professor (Criminal Justice and Public Health), Edinburgh Napier University, I can provide a response on the following:

- Any legislative barriers to the options available to police officers.
- How a person's mental health needs are assessed and how a consistent approach is applied.
- Details of any challenges faced in accessing the necessary support, and how these are, or could be, overcome.

The evidence within is informed by national and international policing and mental health research, including my own research exploring the experiences of people in mental distress, police and out of hours health services and the intersect of safeguarding. Evidence is also drawn from recommendations of the multiagency Policing, Mental Health, and the Emergency Department National Summit (Edinburgh, 2019).

Within the context of this evidence, it is important to acknowledge ongoing Scottish Government developments to improve mental health support for people coming to the attention of police. For example, the Mental Health Strategy 2017-2027, Redesign of Urgent Care, Policing 2026, Police Scotland and Public Health Scotland collaboration on public health and well being,and ongoing review of mental health law in Scotland.

Legislative Barriers

Three key pieces of legislation underpin how services work together to support people in mental distress. The Mental Health (Care and Treatment) (Scotland) Act (2003), the Adult Support and Protection (Scotland) Act (2007) and the Adults with Incapacity (Scotland) Act (2000). In addition, the Police and Fire Reform (Scotland) Act (2012)and the Public Bodies (Joint Working) (Scotland) Act 2014set out how public services work together to ensure they are inclusive and protect people and communities. Police Reform in Scotland (2012), articulated a new narrative about policing putting a focus on community well-being, suggesting an important shift from a narrow enforcement-led approach to policing. This acknowledgement recognises the population, which police officers are in contact with, is frequently a vulnerable one in health and well-being

terms and underscores the breadth of the police officer role beyond law enforcement. Yet, despite Scotland being championed for its progressive mental health legislation and an ambitious target to reduce the death of people by suicide, there remains failings in Scottish legislative frameworks and services which can find some people excluded from support.

There remains a high number of police referrals to the Emergency Department (E.D), a high number of people returned home following police transportation to a Place of Safety, and a high number of police concern reports shared with health and social care services. This suggests there is a group of people who occupy a space where their distress is sufficiently concerning for police to seek partnership support and intervention, yet their needs cannot always be supported within the current model of emergency health care or legislative frameworks.

In part, this can be due to a focus on the diagnosis, medicalisation of mental health and lack of clarity of the term 'self-harm' embedded within the legislation. Thresholds for multi-agency intervention can be reliant upon diagnosis of mental disorder. Yet, the absence of 'disorder' can exclude people from support and protection when their mental distress is associated with socio-economic problems such as unemployment, or homelessness. Furthermore, diagnosis can vary according to time and space, and by practitioners. Multiple factors such as intoxication or trauma can also confuse the diagnostic picture. This brings into question the continued authority and validity of psychiatric diagnosis on safeguarding legislation.

The medicalisation of mental unrest and emotional pain has a powerful effect on the management of people within police and health systems. Police officers, to some extent also, medicalise mental distress by seeking to transfer everyone they apprehend who indicates self-harm into the hospital system. Operationalisation of inter-agency collaboration through reliance on psychiatry may restrict opportunities to intervene, support and protect people whose self-harm is associated with social factors such as loneliness or abuse, rather than a psychiatric diagnosis. This gap can find police officers, unable or confident to discharge safeguarding responsibilities when they, or the individual perceive their needs are unmet, and they remain at risk of harm.

It is possible the mismatch of police policies against health service provision for some people, could account for the high number of people being referred to care by police, yet returned home with their distress needs unmet. Unless several meanings of self-harm and distress are acknowledged, then the likelihood is that conventional and ill-fitting responses will remain.

A significant shortcoming in Section 297, The Mental Health (Care and Treatment) (Scotland) Act (2003), is in the police management of people in mental distress in their own home (private dwelling). Difficulties lie in cases when people are unwilling to leave their home to be transported by police to health services for assessment. If no offense has been committed and there is not at immediate risk of life, police may not legally remove them from their home for assessment or safeguarding-from a Place of Safety (private dwelling) to another Place of Safety

(hospital setting).This finds police reliant on out-of-hours G.Ps to attend and conduct assessment. This may take some time and does not account for the demands, agility, and limitations of G.P. services to respond quickly, placing significant resource demands on police officers. Additionally, there are situations where a G.P led assessment cannot be made when the individual is intoxicated, meaning police officers can be faced with a serious dilemma–the individual cannot be removed from their home, nor can they be left by police officers if they are at risk of harm.

The current legislation does not allow for flexibility in circumstances such as those described above. This can find people being arrested and transported to police custody to keep them safe. Despite significant improvements in mental health care for people in custody, custody can be experienced by people in mental distress as an unsafe place which is confusing, humiliating, frightening and undignified. Despite police custody being highlighted as a 'place of last resort' to keep people safe, there remains circumstances because of gaps in service provision and legislation, where people are criminalised to manage their mental distress.

Mental Health and Risk Assessment

Evidence suggests there is an increased risk of serious self-harm associated with intoxication. It is unsurprising therefore that co-occurring intoxication and aggression are commonplace in police and emergency health responses to people in mental distress. These interrelated complexities can impact on mental health assessment, care delivery, and police and E.D. resources.

Co-occurring intoxication, mental distress and aggressive behaviours can delay decision making and challenge the supervision of people in clinical and police custody environments. In part, this is due to lengthy wait times awaiting sobriety, availability of health specialists to 2 conduct a mental health assessment and variation in clinical approaches to acceptable levels of sobriety to make an accurate mental health assessment. Such inconsistencies can contribute to tensions and transfers between police and emergency services, and at worst, safeguarding of people in police custody awaiting sobriety and mental health assessment.

Safeguarding and assessment is more complex, undignified, and traumatic for people with mental health needs who are intoxicated. This suggests a need to develop clear national clinical assessment guidance, nationally agreed police and NHS policies, and alternative safeguarding environments to reduce demand on police and emergency health services to support the safety and dignity of people in mental distress who are intoxicated.

Challenges Faced in Accessing the Necessary Support

The Scottish Government Redesign of Urgent Care builds on opportunities to support access to the Right Care in the Right Place at the Right Time. This actively seeks to address the mismatch of services and the needs of people seeking mental health support.

Yet, missing from the reimagining of services and mental health pathways is interprofessional education to support interagency practice. Evidence suggests

police, health and social care practitioners can view vulnerability and risk through different professional lens'. Interwoven within this can be difference in occupational cultures resulting in a clash of risk positive/risk-averse professional understandings and approaches. This can result in police, health and social care professionals responding to people in mental distress in conflicting ways. Caught up in the middle, the individual can be 'bounced' between services. There is an essential gap in professional understandings and shared assessment, which could collectively consider both individual and community perspectives from both disciplines to better understand individuals needs and risk of harm.

Information sharing is an integral element of the multi-agency collaborative process at the nexus of safeguarding legislation, policing, and health practice. Despite the development of technologies to deliver remote mental health assessment and interventions in response to the COVID-19 pandemic, there remains a gap in interagency solutions to remotely connect community-based police officers, people in mental distress and emergency health services. Access to remote technologically assisted assessment may facilitate more dignified and person-centred mental health support and reduce impact on police and emergency health services resources.

Equally, technology could be explored to 'in reach' to police custody to extend successful mental health approaches such as Distress Brief Interventions. Through remote contact, assessment and referral, there are opportunities to connect and coordinate compassionate community-based problem-solving support, wellness and distress management planning and signposting to support people on release from custody.

Recommendations

- Review and reform Section 297, The Mental Health (Care and Treatment) (Scotland) Act (2003), in the police management of people in mental distress in their own home (private dwelling).

- Further work is required to establish the impact of intoxication on care pathways of people in mental distress coming to the attention of the police. In so doing, there are opportunities to develop new knowledge associated with clinical decision-making in situations where there is a need to keep people safe; balanced against the capacity to engage in assessment and clinicians and police officers legislative and ethical judgements. The development of evidence based national clinical guidelines in the mental health assessment of people who are intoxicated would go far to support this.

- There is a pressing need to develop inter-disciplinary education to support multiagency working at the intersect of police and health services. Crucially such education should be informed by the experiences of people seeking support, understandings of professional motivation in practice, diversity in professional knowledge, legislative constraints, and occupational cultures. As such, there are opportunities through inter-disciplinary education to improve safeguarding practice, and professional relationships at the police / health intersect.

- There is a need to move beyond the current binary system of policing and medicalised models of healthcare. Inclusion of emergency social support for those attended to by police in mental distress, could better address the needs of those who frequently come to police attention where their distress is associated with loneliness and socio-economic problems, rather than mental disorder. Moving beyond a medical model of care could disrupt distress cycles and displacement of people between criminal justice and emergency health services.

- There is a need for alternative multi-agency environments which are safe, accessible, and dignified to support people who do not require inpatient care but are unsafe to return home because of self-harm or intoxication. Potentially, this would reduce stigma and embarrassment, and reduce demand on the E.D. and reduce the police presence in people's homes and primary and secondary care systems.

- A collective response to the complex needs of people discussed in this evidence report shines a light on the need for a multi-agency, evidence informed, strategic hub, connecting at a national level on shared strategic objectives to deliver the national performance framework. There are opportunities to extend Police Scotland and Public Health Scotland formalised collaboration to other partners at a strategic level to deliver joint outcomes and continued innovation.

Dr Inga Heyman, Associate Professor (Criminal justice and Public Health)

Edinburgh Napier University

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Apex Scotland

Written submission for Justice Committee from Alan Staff. Alan is currently CEO of Apex Scotland and Deputy Chair of the Criminal Justice Voluntary Sector Forum. He has a background in mental health nursing, nurse tutoring and NHS/Social Care management specialising in addictions, CAMHS and Forensic services. His current role is primarily focussed on employability and life skills for people with conviction history and diversion from offending for those at risk.

When considering the interaction between the justice system and people's mental health it is key that we avoid labelling or attempting to categorise certain types of people or behavioural sets. In reality the lines between individual circumstances and needs are always complex and often indistinct, defying even the most knowledgeable practitioner's desire to identify the main or presenting problem. As we have learned from recent research into trauma and its impacts at all stages of life what presents outwardly as a problem is rarely something which can be isolated and treated or managed as though it were an illness. It is widely understood that a significant proportion of those coming into contact with the justice system have some form of recognisable mental health disorder, but it is not always very easy to identify exactly what or differentiate from substance dependency. Nor is it easy to gain any consensus from mental health professionals where the debates still rage around what exactly personality disorder is and whether they can only really be concerned with diagnosable and treatable illnesses rather than behavioural issues or general lack of wellbeing.

With this in mind anyone, including police, who work with people under stress need to have a good understanding not only of mental illness but also of the impact of trauma and childhood behavioural issues. This is because the overall picture is so opaque. There is a strong temptation to rely on protocols and matrixes which can either pathologise what is reactive or adaptive behaviour, leading to labelling and treatment-oriented approaches which can be damaging, or trivialise them leading to ignoring of danger signs and misuse of justice approaches to control rather than reduce psychological pressure. Our evidence is drawn from the experiences of some of our clients and also from staff engaged in working in custody areas such as arrest referral. From these we would like to highlight three key concerns we have with the current model of mental health management and provide examples of good practice and experience of clients.

1 Assessment of mental health and wellbeing in custody

Our clients expressed concerns about the differences in experience from one area to another in the way in which they were assessed. For some there was no apparent assessment other than the observations of the custody staff, even when informed by the individual of their mental health issues or needs. Anecdotally the only way to ensure that you get attention in this situation is to claim suicidal ideation even when that is not the case, and this is a well-known approach among our clients. Where there is a formal process for assessing mental health again there are huge disparities in the tool used, the approach of those undertaking the assessment and the timescales involved. Some areas have access to external agency support or mental health professionals, but others seem to have difficulty accessing these.

2 Access to specialist services

We are concerned by the way in which our clients may use a mental health diagnosis, real or fabricated, to manipulate their situation and the difficulty those assessing may have in either confirming or responding to this. There are anecdotal examples of individuals on regular treatment programs which may be time sensitive, being unable to continue their treatment due to difficulties in liaising between mental health services, local health staff and the custody staff. This places stress on everyone concerned and may in reality be a breach of rights. This is a fundamental problem across all agencies related to continuity of health care, sharing of information and collaborative working which we believe needs to improve significantly.

3 Managing role conflict

We are concerned that significant stress is placed on police staff by the conflicting expectations they have to manage especially those concerning ensuring the individual's welfare whilst at the same time protecting the public, upholding the law and being aware of public opinion and its potential impact. Good supervision is considered vital for anyone who is working with those with mental health challenges, but this may be a problem if there are pre-existing attitudes such as those which prevail in 'canteen culture' institutions. While we know much is being done to counter these negative pressures, we are still aware that some police staff struggle with this role identity issue and their relationships with their colleagues.

Anecdotal evidence

" When I was assessed all they wanted to know was if I was suicidal, they did not want to talk about my fears or worries especially about the bairns and they weren't really interested in anything"

"I kept telling them I was on medication, but they didn't believe me. Eventually I just started kicking off and then I got some Valium, but no one would talk to me"

"The custody staff were brilliant even though I was shouting and calling them stuff. They were able to get me the help I needed from the local team and stayed calm even though I was really frightened. Thought I was losing my head you know? Out of control like. Can't fault them really, they sorted me out"

Examples of Good Practice

Where custody services are enhanced by external independent resources such as arrest referral, Navigator or assessment response teams these are generally appreciated by the client and we have numerous examples of our staff in Apex working into custody suites and picking up serious mental health issues undetected by the custody staff or being able to de=escalated situations in partnership with professional colleagues. There is a high uptake of community service provision on release by individuals who have been linked to local schemes such as those provided by Apex, and this is valuable in preventing further problems, ensuring appropriate treatment and

support including for families, and in beginning to plan a recovery pathway for those requiring it.

However, such schemes are rare and usually time limited due to their funding model so confidence in them tends to be low among professional bodies, and there is a very obvious difference in availability across the country. Collaborative working is great when it works but our experience is that bureaucratic processes inevitably make joint working schemes hard to establish and very slow to get going due particularly to problems of information sharing. Most examples of independent agencies operating into custody areas are now either grant or sometimes local authority funded on a year-to-year basis which offers little in effectiveness and are frankly uneconomic for providers to maintain. If we are to realise the potential of the well trained and motivated third sector workforce in this field there needs to be committed intentional funding across justice, health and social care to ensure future provision.

While on the subject of good practice we believe that the Medication Assisted Treatment (MAT) Standards being adopted by Police Scotland are excellent where medication is appropriate, and represent an informed and evidence-based approach which we strongly support.

Alan Staff
Apex Scotland
11 May 2022

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Scottish Police Authority

Introduction

The Scottish Police Authority welcomes this opportunity to contribute to the Committee's roundtable on mental health in policing. This submission seeks to offer the Committee additional insight in respect of the Authority's ongoing considerations and interest in examining the response to mental health issues both in our communities and in our workforce, and specifically the implications for policing.

There is growing acceptance across civil and civic society that in general terms, the needs of people with mental health issues are not being appropriately met, and that demand for effective and timely support services is exceeding the current capacity to meet it.

The implications on policing are significant and growing as the police strive to fill this current capacity gap to maintain citizen wellbeing. The policing response to incidents linked to mental health and vulnerability are having a substantial impact, through the opportunity costs for policing, resulting in a reduced ability to resource other priorities within a fixed policing budget.

Background

The issue of mental health in policing has been subject to significant reference and discussion in recent years. The Authority would draw the Committee's attention to:

Dame Elish Angiolini Independent Review - Dame Elish reported in her 2020 Independent Review of Police complaints handling, investigations and misconduct issues, that dealing with members of the public who are vulnerable or have mental ill-health issues represents a significant challenge faced by police officers. Dame Elish acknowledged that the issue was placing a growing demand on policing and that the police service is not always the most appropriately skilled service to provide people with the specific help that they need.

She reported that early intervention, advice and referral should ease the burden on the police service but it is inevitable that health services will still have to deal with some individuals who are in crisis. "I therefore believe that A&E facilities should be designed to be able to deal safely with mental health care and acute crises".

Dame Elish recommended as part of her review that HMICS, along with the appropriate health inspection or audit body, should conduct a Review of the efficiency and effectiveness of the whole-system approach to mental health. The Authority is supportive of this as a next step in understanding the challenge.

Her Majesties Inspectorate of Police in England and Wales - The HMICFRS report, 'Policing and Mental Health: Picking Up the Pieces- 2018' questioned whether the police in England and Wales should be involved in responding to mental health problems at the current level. The report called for fundamental change in the way those with mental health problems are supported by the state. The view expressed in

the report is that police in England and Wales should be the last resort in responding to mental health incidents and not the first port of call.
HM Inspector of Constabulary Zoë Billingham said: "We cannot expect the police to pick up the pieces of a broken mental health system. Overstretched and all-too-often overwhelmed police officers can't always respond appropriately, and people in mental health crisis don't always get the help they need. All too often, the system is failing people when they most need help. This is not a problem that the police alone can solve. Other services need to stop relying on the 24/7 availability of the police." Ms Billingham's report emphasised that there needs to be a "radical rethink and a longer-term solution to what has become a national crisis."

The HMICFRS report also contained some data on the **public's views** about the role of the police service in helping people with mental health issues. It found:

- 2% of people surveyed felt it was the police's responsibility to respond to mental health calls.
- 70% of people felt it was the main responsibility of the health services to deal with people with mental health problems; and
- A further 10 percent felt that the local authority or council were responsible.

Strategic Review of Policing in England and Wales - Sir Michael Barber's Strategic Review of policing in England and Wales published in March 2022 reported the following evidence relating to policing and mental health:

- High thresholds for mental health assessments means that police still have to deal with a huge amount of mental health demand, either because an individual's needs are not deemed to be acute enough for mental health specialists or the fact they are under of the influence of drink or drugs means they cannot be assessed (Singh, 2021).

- Mental health services are not available 24/7. A 2018 inspection by HMICFRS found that, at the end of each working day, partner organisations shifted responsibilities for mental health onto policing, resulting in worse care out-of-hours (HMICFRS, 2018).

- Where someone has been arrested for a criminal offence but then assessed as having mental health needs, shortages of beds in mental health units mean they can wait days in a police cell before there is a space for them to be admitted.

- The police are routinely called out when someone has 'absconded' from a mental health setting, when there have not been enough medical staff to either prevent someone from leaving or to locate them. (Brown, 2020).

The Strategic Review concluded that the way the police perform their emergency response function will need to adapt to changing demands. In particular, the growth in the number of incidents involving people with complex needs requires a local public service system that is much more collaborative and integrated. The review noted two implications for a police response function:

- **Multi-agency response teams:** Multi-agency response teams might be brought together to deal with certain categories of incident or be focused around certain locations. These would involve police officers but also other professionals whose skills may be required to address complex needs. Potentially, response teams could come together at certain times or in certain locations, involving professionals with expertise in addiction issues, street homelessness or environmental health issues.

- **Creation of hybrid response roles:** The development of hybrid response roles was also suggested, which combine police powers with competencies in other relevant areas, such as social work, housing, youth work, drug and alcohol addiction issues and so on. The review argued that it should be the responsibility of local public service partnerships to develop workforce strategies that think across professional boundaries to design roles that best meet future demands.

Authority's Oversight

In relation to the Authority's oversight of mental health and policing, we have explored a number of issues with Police Scotland to better understand the challenges and support the development of action to address it. This has taken place both in a formal governance setting and in a number of working groups and workshops. Discussion with Authority members has included:

- An update on Mental Health Demand (November 2020) setting out plans to develop and understand demand data in relation to mental health.

- An update on the preliminary evaluation of Mental Health Pathway (May 2021). This is a collaboration between Police Scotland, NHS24 and the Ambulance Service established as a mechanism for providing a suitable mental health response at first point of contact.

The Authority also supported and closely monitored the roll-out of Police Scotland's Contact Assessment Model, a new call handling approach to better triage calls, training Contact, Command and Control (C3) staff to assess callers' needs on the basis of risk and vulnerability. The call handlers can refer both 101 and 999 calls to the NHS24 mental health hub, if they consider the member of the public to be in mental health crisis.

As part of the further development of the mental health pathway work, the Authority has also considered Police Scotland's new co-location model, where five mental health nurse practitioners work alongside mental health trained police officers in the resolution teams in the Govan C3 facility. Further evaluation on this model is expected to be reported to the Authority later in the summer.

The impact of mental health on service delivery is an important area of interest for the Authority's Policing Performance Committee (PPC). Updates scheduled for future meetings will focus on seeking to better understand the variation in demand across divisions and identify/quantify the impact of mental health vulnerability on the policing system.

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The wellbeing of our workforce

The wellbeing and impact of mental health on our workforce is an important area of focus for both the Authority and Police Scotland. The policing workforce is made up of circa 23,000 officers and staff working across Police Scotland, Forensic Services and SPA Corporate. Across the workforce and in the year to March 2022, absence due to psychological disorders remained the second most common category for absence behind COVID related absence.

The results of a staff survey conducted in March 2021 of more than 7000 officers and staff (31.2% response rate) reported the energy levels of officers and staff as 'moderately average' with more than 40% of those surveyed indicating they had experienced high levels of fatigue in the two weeks before completing the survey.

The Authority's oversight of the wellbeing of our workforce is led by our People Committee through quarterly reporting throughout the year. The committee has considered in detail the staff survey results and the associated implementation plans to address issues raised. The Committee will continue to track and monitor progress against these.

Next steps:

The Authority warmly welcomes the opportunity for a roundtable discussion with the Committee and stakeholders about the current impact of, and focused whole system response, to this issue. There is no doubt that it is right and proper that the police respond to calls for assistance from anyone in distress. The challenge is to direct individuals to the most appropriate professional services.

We would encourage further pragmatic and collaborative debate and would be happy to facilitate further discussion about this issue for policing and the wider system. The Authority is particularly keen to explore the extent to which, and the root cause of why, we currently over-rely on policing as a mental health crisis care provider; the role of police officers in attending an incident where there is a clear mental health issue or vulnerability; and the strong correlation between confidence in policing and its response to those in most need.

Scottish Police Authority
11 May 2022

CJ/S6/22/16/1

Scottish Police Federation

Policing and Mental Health

I refer to the above and thank you for the opportunity afforded to the Scottish Police Federation (SPF) to contribute to this important topic. When we invited input to this consultation from our wider representatives it triggered one of the largest responses to a consultation ever.

It is clear from the content and volume of responses that this is a very emotive subject for our members, and many of their testimonies make difficult reading. To this end we have taken the unusual step of enclosing a selection of those replies as an appendix to this response. Our members feel strongly that the realities of their daily working stresses and demands need to be made know to our parliament, and through publication of their testimonies, to the public too. Redactions have only been applied to prevent identification of the officers, the incident, or the suspect / patient. Where the redaction relates to a hospital premises that is clarified by the addition of {hospital} after the redaction. Where initialisations are not immediately obvious in their meaning, these have also been provided in full.

Whilst the Police Service of Scotland (PSoS) is better placed to deal with the metrics of policing mental health given the datasets it holds, it would be remiss of us not to make some kind of comment given the significant impact it has on police officers working lives, and all too often, their private lives too.

We expect you will hear from the PSoS about the staggering scale of the challenge that faces us, and how mental health is laced into so many of our calls. Police officers fully appreciate the need for the Service to respond to mental health emergencies but believe the police activity should be limited to an immediate response.

Police officers should not be the providers of nursing, or supervisory community, or hospital observatory care. We are not medical professionals; we do not receive anywhere near a sufficiency of training, and frankly all too often feel abandoned by a working environment and legislative framework which leaves nothing but exceptional risk for police officers.

Police officers are also frustrated by the length of time that it takes to pass those requiring assistance on to the care and custody of medical professionals. Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 empowers officers to take people to a safe place but their duty of care ends only after the person has been assessed by a medical professional and other powers of detention applied.

This process usually takes hours and results in 2 officers sitting with a patient that entire time. Often there are queues of officers waiting with their patients and it can see police officers having to restrain mentally ill people for excessive periods of time.

Whilst the SPF welcomes attempts to tackle this through initiatives such as triage cars, and local partnerships, these pilots are rarely sustained and are seldom scalable. Too often pilots get lots of media attention at inception but then quietly dissipate away.

In evidence given to the Scottish Police Authority (SPA) 3 ½ years ago[1], the then Divisional Commander of Tayside Division stated that he had 'hit the buffers' in what he could do locally and needed help from the authority. Unfortunately, we have seen and heard nothing of that since.

The Committee's interest in Police Officer mental health is welcomed. Survey after survey after survey has been flagging the terrible state of officers' mental health. As well as the Forces "Your Voice Matters" (2020), Staff Survey (2015) and Pulse Survey (2016), the SPF supported independent academic research in 2017, 2018, and again in 2020. We see the same issues presenting in all of them.

In 2017 our supported research showed that 1 in five officers were at risk of burnout. 50% were exhausted after every shift and 1 in 5 had high levels of depressed mood. The causes then, as they are today, are insufficient staff, a can't say no culture, public expectations, and volume of work.

Whilst this was bad enough, we saw things get worse with policing of the pandemic. In 2020[2], the research team recorded yet more hours being worked (a 44-hour average), continued disruption to rest by insatiable demand, and a sense of abandonment by Governments - who stubbornly refused to give early vaccine prioritisation to those who it had legislated to deal with COVID-19 in the community. The SPF had many calls of despair from frontline officers who felt very vulnerable and exposed through the lack of protection.

All of this data was shared fully with the PSoS and SPA but there was and remains a stubborn unwillingness to acknowledge it, yet alone act on it. The Force's response to its 'Your Voice Matters' has not delivered any substantive changes. Unlike the SPF supported research, it failed to get into the causes that would assist with prevention and instead the PSoS has focused on responses to problems such as reactive counselling with questionable success.

Even problems that have been recognised haven't been resolved. It may seem a ridiculous example but the fact an officer who can deprive somebody of their liberty is still not trusted to replace a ripped pair of trousers from stores without it being authorised first by their line manager, is indicative of just how much of a lack of trust the Service has in those who deliver the service.

The most obvious manifestation of this frustration has been the recent exodus of officers from the service. A change in Pension arrangements has given people the vehicle to now leave the service, and they are doing so as there is no impetus to remain. Our most frequent comment is "I've just had enough".

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1 https://livestream.com/spa/dunkeld/videos/182415671?origin=stream_live&mixpanel_id=13f9ac22092c4e-0f60c6a3f10951-1d7f7848-c0000-13f9ac220a21a77&acc_id=9780438&medium=email 2:08:50

2 https://spf.org.uk/spf-wellbeing-survey/

This should not be a surprise to the PSoS as the SPF and other staff associations (as well as the data) have been warning of this for years. Unfortunately, the Service has shown itself to be tone deaf to these issues, concentrating almost exclusively on wringing more and more from officers who have nothing left to give.

A further issue for the Service is the phenomenon of 'presenteeism'. In the 2019 SPF supported research, a third of officers reported going to work mentally unwell. The Canadian research team who have conducted similar research in a number of countries and Forces were aghast at this figure. Qualitative data suggests that this is because colleagues don't feel they can leave additional work for their colleagues. The SPF has recently conducted a deep dive in a separate part of the police service, and whilst the results of that are still being analysed, the early findings reinforce this same message.

In summary, whilst the issues of both policing mental health and Police Officer Mental health has been known for many years, nothing has changed. Both issues have been recognised but responses require both the PSoS and SPA to be honest about the scale of the problem and tackle it strategically with other partners. That is long overdue, and we hope that their evidence to the Committee will kick start that.

The SPF suggests that the Committee should invite the SPF supported research team to provide oral evidence to them. The importance of independent, and research informed, voices on a matter of this magnitude should not be understated. The SPF is happy to try to facilitate this.

Yours sincerely

CALUM STEELE
General Secretary

CJ/S6/22/16/1

Appendix

Criminal Justice Committee – Policing & Mental Health
Scottish Police Federation

Officer 1

"Sitting in the office collating the evidence for the Criminal Justice Committee and listening to the police radio. First 3 calls of the backshift in [REDACTED]

1) Male overdose
2) Male schizophrenic having an "episode" having taken all his sons medication
3) Female concern for (mental health)

All health-related calls - All passed to Police for response. This is fairly indicative of every shift at [REDACTED]

Officer 2

"I have hundreds of examples of time wasted at hospitals and dealing with people with mental health issues. However here is my most recent one three weeks ago. Sorry its long!

Officers attend a call of a suspicious [REDACTED] in [REDACTED] and discover it has been left by a woman reported missing from [REDACTED]. She clearly has mental health issues and is taken to the [REDACTED] {hospital} by a Constable and a Sergeant. After over an hour of them waiting for her to be seen I go up to take over from the Sergeant so he can get away – **past his shift finishing time.**

Meanwhile two other officers arrive with a medical case they have brought from the [REDACTED] {hospital} to be assessed by the mental health team at the [REDACTED] {hospital} and they are now waiting in the next room.

The female is agitated and rambling/ranting at us getting wound up that we are fake police officers. She is begging to be let out for a cigarette and has previously done this and come back inside no bother before I took over, so my colleague let her out for one. She has been waiting with us for over 2 hours now.

She refuses to come back in. She screams and goes to fight with us every time we go near her or her bags. We ask for medical staff to assist. The nurse comes out and says, 'nothing I can do you're just gonna have to get her back in'. This nurse tells her she will be seen by a doctor as soon as she goes back inside. I ask the nurse to get one of the other police officers out to assist us.

After about 40 minutes of talking and explaining she is still refusing, so we put hands on her arms and she kicks off and goes fighting with us. Two of us end up assaulted and bleeding, over three weeks later I still have the scars of three deep cuts to my hand that

she caused by purposely digging her nails in. After a long struggle where she displays immense strength and screams throughout, three of us manage to cuff her and get her back inside, all of us sweating and breathless with masks on. The nurse walks past, and I ask if she saw what happened. She says she heard. Absolutely no one came to assist which I find ridiculous given we were struggling for minutes at the main entrance. I ask how much longer we have to wait given two officers have now been assaulted and the female is sitting extremely agitated and uncomfortable cuffed to the rear. She says she doesn't know. The female doesn't let me adjust her cuffs for about 40minutes because she is so wound up. We then continue to take a ream of abuse from her.

We waited until [REDACTED] hours, nearly 4 hours total, until other officers take over from us so we can get away, and then she was seen. The two other officers who came in with someone (calm) were seen before us.

I was so angry and frustrated at the situation I ended up crying on my return to the station, spoke to a Sergeant who saw me upset, and went home and drank half a bottle of rum so I could get to sleep. I'm genuinely angry again writing this now. I think 10 years ago I wouldn't have been so angry but knowing nothing has changed since I started this job and I'm still wasting hours sitting around waiting on unhelpful medical staff gets more and more frustrating every time it happens.

The four of us officers stood in the corridor in the [REDACTED] {hospital} discussing how frustrating it was to sit there babysitting someone again whilst listening to our colleagues on the radio asking for assistance or calls coming in that we can't answer. I don't understand why medical staff cannot sit with people who are not under arrest. How did that ever become a police responsibility?

This whole thing could have been avoided had the [REDACTED] {hospital} done their job quicker. The female was kept in for mental health reasons and we didn't charge her because the whole incident was totally avoidable and there's no point. That causes more frustration that I have five cuts to my hands for weeks and I just have to put up with it.

Right rant over. Can you tell I'm still angry!"

Officer 3

An example I have is for a local male who lives in a flat on [REDACTED], I assisted [REDACTED] with collating how many call outs to the address happened in the month of April – 27 all related to his anti-social and erratic behaviour – shouting, screaming, throwing stuff around his flat etc. He is a schizophrenic and has meds from the hospital but does not take them or they don't work. There has been a lot of intervention both by police and council. Police have attended to almost all of these calls this month alone and the impact it is having on neighbours is huge. On each occasion the male says he'll stop the noise and a VPD {vulnerable person database} is submitted.

I think every organisation as well as the individual concerned, and the community would benefit if there were several mobile mental health teams who could attend (perhaps along with police) and see first-hand how these people who are so desperate for help are conducting themselves in the community.

Officer 4

I've been in a rape team for the last 2 years and a SOLO {sexual offences liaison officer} for the last year. Due to burn out and natural wastage with people moving on there is a severe lack of SOLOs in the rape teams, at current count 4 for 5 live teams. This is having a detrimental impact on those remaining, being constantly exposed to those who have suffered horrendous things happening to them and having to provide support to them. The risk of vicarious trauma is well documented and while I can't fault my immediate line management chain, there appears to be an institutional disregard for those doing the job.

I won't bore you with complaints about the lack of resources as I know everywhere is the same, but SOLO deployments should be monitored and managed. As it stands this just isn't possible and burn out is a real risk. I find myself taking longer and longer to recover from incidents and my mood is often up and down. How are we supposed to deal with a high-risk environment and provide a service to sexual violence victims when we are not operating at full capacity ourselves?

To the best of my knowledge there has not been a SOLO course for over a year and there are plenty of people wanting to be trained to help lighten the load. Whilst I understand the impact of COVID on face-to-face training, there does not appear to be any urgency in rectifying this or recognition of the impact on the remaining SOLOS.

Thanks for the opportunity to have a moan!

Officer 5

I'm not sure how useful my response will be as I don't have any specific examples of incidents however, I'm sure my feelings will mirror the general consensus of other officers who have replied.

I have found that when there are a number of jobs in that may potentially have an element of mental health concern to them, they will tend to take priority over other incidents that are more policing orientated. I have found on a number of occasions that myself and my colleagues will end up at the hospital or waiting for an individual to be seen by Ambulance or MHAS, even when there is no criminality evident. While dealing with these individuals it is often the case that we are therefore unable to attend incidents where crimes are being or have been committed or further enquiry is required to establish whether or not there is any criminality.

As above, if a suspect is taken into custody with poor mental health (which the majority do suffer from) we often end up at the hospital. The hospital's refuse to MHAS anyone who is under arrest however if an arrested person is taken to custody, then custody staff usually expect the mental health assessment to be dealt with prior to the suspect being taken to any police station.

From a personal point of view, I often find myself frustrated that, as a Police Officer, I spend a significantly larger amount of time dealing with mental health issues than crime. Helping people is part of the job however criminality and everything else seems to take a back seat when there is a mental health job to be addressed.

In terms of support that we receive from work, I cannot fault it. If we deal with any traumatic jobs, the aftercare and support that we are offered is great and I would feel very comfortable using these services if I required. However, I do not feel that traumatic jobs are the cause for any decline in an officer's mental health. For me, and a lot of my colleagues I have spoken to about the issue, feel that we are constantly fighting a losing battle to be able to take holidays, take re-rostered rest days, claim for entitled overtime etc.

One example of this is one of my colleagues having applied to get 2 midweek nightshifts well in advance of the 5-week cut off. She was told that she needed to use someone else's A/L allowance to be able to take this time off due to it not being within her A/L block. I cancelled booked A/L to allow her to use my A/L code however when she then replied to advise she was now using my leave code she was told she could no longer use it because it was under the 5-week deadline.

A number of my colleagues also worked an overtime shift advertised in an email at Rate 2, this shift has been worked and the overtime has been paid out. This week they received an email stating that this overtime should not have been rate 2 and instead should only have been at our normal rate. They have now been told that the "overpaid" overtime will be deducted from their wage this month.

Sorry if none of this is of any use or if it comes across as perhaps more of a rant than any constructive feedback. The above feelings are shared widely across the division amongst my colleagues and many of us feel like we are fighting a losing battle in terms of any real changes or improvements being made in the near or distant future.

Officer 6

You have opened a can of worms with this email!

I'm going to be selfish and talk about me/police mental health first, tough were to start…

1. As a supervisor having low numbers of officers on the teams, bigger area, larger call volumes (very view of which are actual crimes to deal with but more mental health / ambulance calls/concern for's etc.). Not having a background in these

types of organisations we have to deal with them under the police rules / expectations / threat of PIRCS etc, which adds a lot of pressure to jobs.

2. I have seen my hands shaking on my way into some nightshift knowing I may only have 1 or 2 cars available, just that added stress of increased call volume and low staffing levels is shocking.

3. COVID – we worked as normal as the rest of the world stopped, yes, we were given mask and suits, but we still had deal with the violent and deranged members of the public that no other organisation had too, or if they didn't want to go they would ask the police to go in their stead. No home working for the front line, and no let up as the pandemic eased, if anything a greater number of calls and more risks. But it's okay £150 will make us feel better (hopefully keep us quite), while teachers got £250 for working from home and nurses NHS get a big pay rise….
4. A continually changing organisation that feels sending out memos and telling you to do Moodle Courses will equip you for all the changes. When does the front line have time to do Moodle's (they can say mandatory all they want, doesn't mean we get time to do them if not allocated on scope), I have taken several hours to try and write this email, not looked at Moodles in months…?

5. A general feeling of we are just numbers not people, and those numbers are getting smaller by the day (especially with all 25+ years officer retiring), I thought it was bad when we went to PSoS but somehow it is getting worse. Those left on the front line have very limited service (5years is the experience cop on the team), **the probationers are poorly trained and do not get an opportunity to learn properly on the job**.

6. Red days let's just make every day red and be done with it…. enough said really on that.

7. All of the above is leading to burn out, stress and frustration throughout the front line (by that I mean response 24/7 shifts), but as always it is hard to but your hand up to say you are struggling as you know everyone else is to and it's not going to change anytime soon….

Mental health calls

1. The other night, same male called in on 4 separate occasions. We dealt with the second "suicidal" call, male traced, contacted MHAS and [REDACTED] mental health. Both refused point blank to see him or speak to him on the phone (as he had been seen earlier that day buy psychic prior to release from [REDACTED] Custody). We had no reasonable person to leave him with so had to return him home, he has then went missing about 1hr later and was traced on a bridge by [REDACTED] officers… it means all the risk lies with the police, what would happen

if he didn't phone police or they had no one to trace him – a big PIRC enquiry I'm guessing.

2. [REDACTED] {hospital} not properly risk assessing individual prior to given them passes and waiting hours to report them missing. Same with [REDACTED] {hospital} taking a couple hours to report someone missing.

3. Doctors from [REDACTED] {hospital} almost demanding police attendance so they can execute a mental health warrant and being upset when we are not there in the doctor's time scales.

4. Just the sheer volume of mental health and concern for calls we deal with these days, it feels like dealing with crime is the exception. It is telling when officers can complete VPD's in their sleep, but now struggle doing simple SPR's {standard police reports}. I couldn't put a number on it, but we do spend more time dealing with M/H issues than crimes.

I hope some of this helps and not too ranty.

Officer 7

Apologies it's a bit of a long email!

This does come under the heading of things effecting mental health on the shift but something I wanted to bring to the attention of the Fed anyway, leave not getting approved.

Our whole team at [REDACTED] have been having issues with this recently. The main problems are surrounding requests for leave out with your block and RRRD's {re-rostered rest days}.

Requests for RRRD's are simply not getting approved, despite significant prior notice. I have 5 days in my bank that I am unable to use.

The main issue we are having with annual leave out with blocks is being made worse by the way the RDU {resource deployment unit} seem to be going about it.

The example I have personally of this is a request I put in for both today and tomorrow as annual leave, this was approved through my line manager on [REDACTED] At that time as far as [REDACTED] was concerned we had a full team and there would have been no issues with this being granted.

RDU are not approving or declining the requests, meaning it is sitting as "leave requested," on SCOPE right up until officers contact them a couple of weeks before to chase it up. By this time OBLs {operational base levels} are too low, as they are on every single day, and the request gets declined. This has happened to several of my colleagues so far this year and one officer has had this occur for more than one request.

I haven't contacted them, as I knew the answer I'd receive and mine is still sat as leave requested. My inspector advised me that in this case as it hasn't been approved by RDU I'd have to come in, so here I am.

A few years ago, with a similar request, if numbers were going to be low, RDU would contact officers directly and say they wouldn't be able to approve the request however if they found someone with that leave block who wasn't using those days then they would approve it. They seem have gone back to this as their default stance on requests but have not communicated this at any point.

It's having a significant impact on the morale of the team every single day. Our Inspector and Sgt have been quite good in saying that if we are needing leave for important occasions such as close family weddings, they can push things through but short of that there's nothing they can do.

Basically, if you're wanting time off to rest or simply spend time with your family, it's not important enough. If something doesn't change soon the division is going to be running the risk of absences going back up as response officers burn out.

It's having a significant impact in officers family lives and has caused tension between some officers and their partners as they are also impacted, having to cancel plans and not book holidays.

Again, sorry for the long email, I appreciate you're probably getting loads of different issues raised, this is probably the most significant one when it comes to Team 1 at [REDACTED].

Officer 8

Positives:

- We have improved our practice since the days of "suicidal breaches", which I think reflects a willingness to trust mental health partners' assessments (or at least being prepared to transfer the risk to them)

- The phone triage service offered by some trusts is very beneficial. It saves police a lot of time by often removing the need to take a patient to hospital for full assessment.

Frustrations:

- Waiting times – I appreciate this is due to NHS staffing. There is often a long delay between a decision being taken to detain a patient and hospital staff then taking physical responsibility for them. As an example, I once had to physically restrain

a person for three hours while hospital staff processed their treatment order, then transported that person in a police vehicle and physically got them onto the secure ward. By “physically restrain”, I mean I had hands on them continually, frequently having to hold them prone while they tried to beat their own head on the floor. I feel this time period was an unacceptable risk to the patient and to us.

- Being asked to restrain a returned patient while hospital staff administer medication. This request is made occasionally, although quite rightly police officers usually refuse to do it. This is completely different from the situation in which a patient is already restrained by police (for example because they are attempting to self-harm) and is then sedated by hospital staff so that they can be treated, but not all hospital staff seem to appreciate the distinction.

- Being told that a patient needs to be returned to hospital but does not have a CTO or being asked to go and collect a patient who does have a CTO but is at home and does not have a Removal Order in place. In this situation you can be caught between failing to respond to a concern that has been raised or acting out with your legal powers.

- Lack of power to remove people from their own homes. I have seen a male who was clearly in need of treatment – shouting incoherently, crawling around his living room, convinced that the person on his TV screen was about to attack him – and lacked the legal power to take him for assessment (short of arresting him, which would have been wrong). We had to wait for a GP to attend before the man could get any help.

- MH assessment teams seem reluctant to engage with patients with Personality Disorders, particularly people with suicidal ideation. Their attitude seems to be “well, this person will kill themselves sooner or later, there’s nothing we can do to stop it”. Realistic perhaps, but it is that patient’s relatives, and often the police, who have to deal with the consequences of that attitude.

- I can think of one person who tried to jump from a tenement window, was assessed and deemed not to need treatment, then succeeded in the same attempt a few days later. Her death was among the most gruesome scenes I have witnessed in fourteen years’ service. That made me feel that the police’s responsibility to preserve life was not shared to the same extent by the local mental health team.

-

<u>Own experience:</u>

I have occasionally experienced traumatic incidents and feel that the organisation is quite good at identifying those incidents, offering initial support (TRIM) {trauma risk incident management} and signposting to other bodies.

Long term, I don’t think we do very well. Response Policing is the only branch that does not have the option of turning work down and is disproportionately affected by alterations to rest days and difficulty having time off approved. Added to this is the constant build-up of work, leading to stress. For those who have left Response, returning is often seen as a punishment. We could avoid this by rotating officers out of Response routinely – I think this would be good for individuals and help to upskill the organisation.

I have experienced a period where I was very stressed at work. While I could recognise the signs within myself and the factors causing it, I felt there was nothing I could do to change the situation and didn't know what, if any, support the police could/would offer. Eventually I was transferred to a different post, which helped, but the move was for organisational reasons, not because of any welfare concern for me. The new post also came with different stressors, and again I felt unable to speak about them.

I think although senior management will talk about prioritising mental health, the organisation's tendency is always to reach for the relevant SOP or Regulation when confronted by a staffing "issue", which will be applied inflexibly by middle management. At a peer level, there is a reluctance to admit that you are struggling, for a few reasons:

- You're unlikely to get much sympathy – everyone is in the same boat in terms of work pressures.
- The police are terrible gossips, I would be very wary of telling colleagues much because it probably wouldn't stay secret for long.
- A cultural belief that you need to be mentally tough for the job (to a degree this is true, however it becomes toxic when this develops into a refusal to recognise where a problem has developed, or when people deem the problem to be due to weakness)
- We operate in a blame culture, which does not encourage people to be open about difficulties. I would be worried about the professional consequences of admitting I wasn't coping well. If unaddressed mental health problems contributed to an error of professional judgement, I do not have any confidence that that would be taken into account. The organisation's view genuinely seems to be that you are only as good as your last mistake.

Officer 9

There is no single anecdote I can offer. It is constant.

We are dealing with more MH jobs than crimes more often than not. The repeated failings of the government to properly fund the NHS and mental health services have led us here, and it feels that we have more of a duty of care than healthcare providers in the UK.

The healthcare services are so stretched that they will only entertain dealing with someone who portrays an immediate and real threat to the safety of themselves or someone else. And even then, they do not always have the resources for that. SAS routinely contact police to request our attendance at a MH call because they "have no crew allocated to it". The SAS' lack of resources should not mean it falls to police, but it does every time, which means that where police pick up the slack time and time again, there is no imperative for the catastrophic situation in the SAS and NHS to be addressed with any urgency.

We deal with a wide range of issues such as people who have mental health issues which do not cause them to be considered a real threat, and as such NHS are not interested. We have many "frequent fliers" who call the police multiple times a day for help. When police arrive, they do not want to see police. Due to the years long pattern of this, there is one person in our area in particular for whom there is now a care plan in place which was drawn up between police and partners.

We still get sent to see her as ACR {area control room} supervisors go over divisional officers' heads and go against the care plan and ask for officers to attend. She could get arrested for wasting police time or comms offences, and on occasion she is at the behest of a boss. This then results in constant obs either at hospital or custody, taking more police off the streets. Huge amounts of admin is involved with regards to getting call recordings from NHS24 to evidence the offences (because there are no uniform pathways for getting info from NHS24 as a police partner), only for the PF to bin the case which happens time and time again. My most recent case for her had around 7 or 8 subsequent breaches of bail linked to my original case when the case was dropped.

This happens every time because what will the PF do with her? She is arguably too mentally ill to be given a custodial sentence. Her crimes are, on paper, small scale (due to the sheer amount which are marked no further proceedings). She is effectively above the law, which is absurd and demoralising. The NHS take nothing to do with her due to their care plan (which they follow) and yet we cannot take this approach.

Frontline officers are at the end of their tether, and it's causing people to leave response in droves. Response is now largely manned by cops with under 4- or 5-years' service which effects the service given to the public for the crime we do get the opportunity to deal with. We are not trained in mental health sufficiently, nor should we be, because it is not something police should routinely be dealing with. We should be dealing with serious MH emergencies, and these are few and far between.
The issue in my view is not the police but a complete lack and failure of the MH agencies including SAS and the NHS which should be adequately supplied with the resources needed to meet the demand.

Furthermore, the current rhetoric is to blame 'Covid for the rise in demands on MH services, presumably to provide the argument that as 'Covid disappears the demand will diminish also. In my experience the issue was there long before 'Covid, and SAS and NHS were improperly equipped to deal with the existing demand prior to 'Covid.

All of the above, plus constantly fighting with depts like RDU for leave, or overtime, or cancelled rest days, or RCMT {recorded crime management team} over absolutely everything, dealing with urgent PF requests, being absconded for details/hospital watches/constant obs, your own workload, citations in their bucket load, or actually going to jobs in between all this in a division with catastrophically low numbers, it is no wonder police mental health is also shocking. The fact that we have station sergeants spending their well-paid time furnishing stations with pictures of beaches and fake leather sofas is even more of an insult, in all honesty. The fact that this is our welfare "support" is more demoralising than having nothing at all.

Officer 10

I think I might have an example in regard to issues surrounding 'the support to police officers and staff':

On afternoon in May 2019, I was the first officer that attended a murder at [REDACTED]

I found a [REDACTED] year old male, [REDACTED] with catastrophic stab wounds to his [REDACTED]. Immediately instructed my colleague to apply pressure to the [REDACTED] wound I began CPR. Going into work mode I took control of the situation by utilising my radio to give updates, request more colleagues, request an SAS, request traffic in anticipation of a fast escort, gather information from horrified witnesses as to where the suspect went – who was ultimately traced and arrested within moments. All

whilst giving CPR to a poor guy whose life was leaving him faster than the blood pouring out from him.

I will never forget the moment when my ACR shouted up to me to tell me that his mobile phone line was live and his mother could hear me and my colleagues trying to save the life of her dying son.

But the 'work mode' wore off. And the realisation of what happened hit me a couple of hours later, whilst in the shower washing the blood from a stranger off of my hair, arms and legs and watching it swirl down the drain.

I was offered a TRiM which I did a couple days after the incident. However, there is nothing implemented, as far as I'm aware, thereafter the TRiM. And I wasn't asked again how I was getting on.

The following also occurred at differing points in time after the incident:

- four days after the incident, whilst in the station, a sergeant (not on my team and was NOT on duty at the time of the incident) phoned the employee assist helpline without my consent or knowledge and telling them I was struggling (I was never asked by that sergeant if I was struggling and was never actually asked how I was feeling). The same telling me that because I was a 'cute, small' female, people would understand if I was upset. And thereafter not allowing me to go to home when I asked because I 'lived alone' and implied I was a risk to myself – which was just ludicrous

- three months after, being accused by a member of the SMT of using the incident as an opportunity to buy more expensive work boots than those that were seized, and then not paying me the expenses. (The expenses were eventually approved by a different member of the SMT. But I received no apology/acknowledgement of the further upset this caused me)

- 18 months after the incident I contacted the Employee Assist Program myself and was told that I had PTSD and needed treatment, so a referral was put in. But was not contacted again. I phoned back them 4 months later to ask about my treatment to be told that the call/info was never triaged, and the referral was never sent

The impact of this entire incident had a profound negative effect on my life and opinion of Police Scotland.

I began having symptoms of PTSD (nightmares, flashbacks, crippling anxiety, panic) a couple of months after the incident, but I did not let it affect my work. I went into work every day after that incident and just got on with my job because there is a culture of 'just keeping going', plus I felt like everyone else had moved on from it, "so why hadn't I?"

In addition, the treatment of that particular sergeant made me wary of asking for help because I didn't want to be forced into doing something I felt uncomfortable doing again.

And the behaviour from one of the highest ranked police officers in my division lead me to believe that I was an inconvenient number costing them money, and as a PC and a human being who dealt with that incident, and did it well, I didn't matter all that much.

18 months of struggling with my own brain, I geared myself up and asked for help from the company that is plastered on the walls of the stations in bright colours saying they could help me. But they didn't do what they said they would they left me in an incredibly vulnerable state. So, what was the point in me asking for help?

After a further 4 months of what can only be described as hanging in hope of a phone call that never came. Which left me feeling alone and, again, like I didn't matter.

From that experience, I will never use The Employee Asist Program, the only help we get, again and would not recommend them to anyone.

From my experience, there is no support provided to officers and staff from Police Scotland. The 'process' is simply there to tick off the boxes so that in the event of an officer killing themselves there is a record to say, 'look we did everything we were meant to'.

The nature of our job is that we go to things that others won't and that of course will never change. However, what I don't understand is why the organisation thinks that asking someone who experiences the likes of the above 'how are you?' a day after it happens and then there is no follow up. And what's more, I asked for support and was left alone.

I'm not sure if this is the kind of thing you are after, but I'm more than happy to clarify anything or answer any questions!

Officer 11

In terms of police dealing with MH crises in the community, I think that overall PSOS does a good job in extremely difficult circumstances. This was borne out by my attendance at a forum for professionals and patients a couple of years ago, where PSOS were about the only government body to come away with a glowing report in terms of patient experiences.

I am [REDACTED] and as such I am the primary liaison with health and social care, as well as 3rd sector agencies. A large part of my job is identifying people who are coming into contact with the police because they are in crisis and working with partners to provide more appropriate support and to divert them away from further police contact.

A significant obstacle to this is the lack of meaningful participation in this support process by acute psychiatric services in the [REDACTED]: Our partners in Community Mental Health Teams and MH Social Work are frequently frustrated by the unwillingness of NHS [REDACTED] to admit patients in crisis, on the basis that they are already supported by CMHTs or GPs, even when it is evident through the patients' presentation or behaviour that their condition is deteriorating and they present a risk to themselves or others. This is particularly problematic with those patients who have a personality-disorder diagnosis and/or whose MH problems are a combination of other psychiatric disorders and an addiction.

It would appear that this is a net result of bed shortages and underfunding in psychiatric services as a whole, however the current approach to demand management adopted by the hospitals (that is denying service to those in crisis) often results in protracted periods

of police contact, sometimes on a daily basis, and generally leading to numerous trips to MHAS, which as you will know can occupy two or more officers for a whole shift at a time. This also leads, albeit less frequently, to those in MH crisis being arrested and sometimes imprisoned whilst awaiting psychiatric assessment.

NHS [REDACTED] are, as far as I am aware, the only NHS Board in Scotland not to provide the assistance of in-patient staff in the management of Compulsory Treatment Orders in the community. This leads to substantial challenges for our community-based partners in managing non-compliant patients (especially those who may require to be detained) as generally community-based staff do not have the training or resources to physically detain patients who have become acutely unwell and who require hospital treatment. Again, this regularly leads to situations where the police become the backstop for the safety of the patient or others and are frequently asked to act well beyond any statutory duties or indeed powers, to get someone to hospital (or custody) long after the ship has sailed for a timely medical intervention.

I hope that this is helpful – please let me know if you need anything else.

Officer 12

Just last night, we dealt with a female, well documented as having long term mental health issues including [REDACTED] and previous compulsory treatment orders within the [REDACTED] {hospital}.

One of her friends saw her yesterday and realised how badly her mental health had declined as she her behaviour was very erratic and she was ranting incoherently. Concerned for her and wishing to get her help, he called the [REDACTED] {hospital} directly, whose only suggestion was to call the police ...?! No suggestion of any NHS involvement or referral to GP or community services.

We attended her home address, where within seconds it was clear that she was a very unwell individual and needed to be taken straight to the [REDACTED] {hospital}. Fortunately for us, she stepped out of her house, and we were able to use our powers under mental health act.

We then spent the next 4 hours with her n the [REDACTED] {hospital}, waiting for her to be assessed and sectioned and then we needed to transfer her to [REDACTED] {hospital} as the [REDACTED] {hospital} had no space and no transport. This incident took us 5 hours and then an additional 1 hour for the follow up paperwork.

From the very start, this was a mental health job that should not have required any police involvement. The very idea that the mental health team's first response at being told that a person already known to have extensive mental health issues should immediately be a police job and not for the mental health services is incredible. I realise they are short of resources too but they repeatedly rely on the police to do their job. As I am sure you are well aware, this is not an isolated incident and is just the incident that happened on the day I got your email!

CJ/S6/22/16/1

Officer 13

As discussed, the other day, I am happy to highlight the issues that I have had with the employer in relation to mental health issues.

In 2015 my father was diagnosed with prostate cancer and then 6 months later my half-brother died [REDACTED] following an accident. At this time, I spoke with my Sgt who appeared unclear of what mechanisms were in place. I took 4 days off work (which was not enough) but I must say, the team I was working with at the time were great and offered great support which helped me.

In 2018, I was having issues with a Sgt who, when I made mention of the stresses and anxieties, I was having in dealing with these events only asked 'do you want to be in the Police?' there was no guidance on support from this supervisor and I did not find them helpful in any way.

In 2019, my new Sgt was very supportive and advised that I call the EAP and have counselling. I took up this offer and I found it to be ok. I was able to discuss things and I have had to use this again in recent months due to stresses of my sons recently diagnosed epilepsy.

I personally feel that other organisations have much better mechanisms in place. Mental health in the police is a problem that is only getting worse. I don't know what the solution would be, maybe a wellbeing day once every 6 months where officers in the same boat can meet over a coffee and discuss things etc.

Happy to speak more on this matter if need be

Officer 14

In regard to the email received today around officer's mental health. I am suffering a great deal at the moment and have recently returned to work after several months off. If someone would like to speak with myself, I am more than happy to discuss my experiences, it's important that the parliament knows the impact policing has on officers and their families.

Officer 15

I have worked on Response Policing in legacy [REDACTED] for the past 22 years. I am currently a Sgt as well as a Divisional SPF Rep. In my opinion, Mental Health cases are continuing to rise, and Mental Health related calls are often the most time-consuming part of a frontline response officer's shift.

One of the main problems is that people suffering from Mental Health issues phone the Police as the agencies who should be helping them aren't able to. This may be due to the fact SAS are unable to resource the persons call or they are unable to get through to NHS24 on the phone. The Police rightly or wrongly don't say no and resource these calls.

Each day in [REDACTED], officers will be sat with people suffering from Mental Health issues at [REDACTED] Hospital, often for the whole shift. A snapshot from the [REDACTED] October 202[REDACTED] shows the length of time officers at three separate stations in [REDACTED] Div. spent dealing with Mental Health related calls;

[REDACTED]
Officers attended a report of a male causing a disturbance in a street in [REDACTED]. When traced, it was established the male was having a mental health episode and he was found to be in possession of a pair of scissors. Once secured in the rear of the Police vehicle, the male who had a known heart condition began sweating profusely and SAS were asked to attend, however their earliest ETA was over half an hour away. The officers took the decision to convey the male to [REDACTED] {hospital} and due to his unruly behaviour had to keep him in their secure van. It was over 6 hrs before the male was medically seen, he did not require any treatment and was then passed on to the Mental Health ward. By the time he was seen by them and deemed fit to be released from [REDACTED] {hospital}, officers had been with the male for 12 hours.

[REDACTED]
Officers attended a report of a 16-year-old female self-harming in a care home in [REDACTED] SAS were instructed to attend, however they requested Police when the female became violent. The female refused to allow SAS to treat her superficial wounds and was then detained under the Mental Health Act by officers. There had been no criminality, and this allowed the female to be taken to [REDACTED] {hospital} to have her superficial wounds attended to. After being seen by the Mental Health nurse the female was conveyed back to the care home some 13 hours later. Care home staff had not been able to sit with her at [REDACTED] {hospital}.

[REDACTED]
Officers attended a report of a male who was apparently trying to kill himself by looking for glass to cut himself with and walking out in front of cars in [REDACTED]. The male was traced, he was drunk and had no injuries. He was unable to be left with any friends and was detained under the Mental Health Act. Due to him being deemed a flight risk, officers sat with him at [REDACTED] {hospital} for 12 hrs until he was assessed by the Mental Health Team who deemed him fit to be released.

These types of calls are now ‘run of the mill’

To try and help cope with the demand, a triage system was set up in [REDACTED] Div. which enables Police officers who are dealing with a person suffering from a mental health issue only, to have a telephone conversation with a member of staff in the Mental Health ward. Providing the person is sober, the officers can phone the Mental Health ward which allows the person to speak direct to the Mental Health nurse who will make an assessment over the phone. This will either result in the Police being able to stand down and leave the person on their own or have the Police attend at the Mental Health ward with the person so they can be seen face to face and normally within the hour.

This system works well, however the one drawback with this is, only the Police are able to access this triage service. SAS have tried getting the Police to attend Mental Health incidents they are dealing with so the triage service can be used. Some members of the public are also aware of this arrangement and will contact the Police direct, knowing that the Police are able to fast track them in speaking to a Mental Health nurse. A recent example of this is;

CJ/S6/22/16/1

[REDACTED]
A female in [REDACTED] phoned Police saying she was feeling suicidal, threatened to jump of a bridge but said she would keep herself safe until Police arrived. Officers attended and noted that the female was drunk, due to this, they were unable to access the Mental Health triage service and advised the female that if she was wanting to speak with someone about her Mental Health, she would need to go through A&E. The female did not want this and then became abusive to the extent that she had to be arrested. When being arrested, the female assaulted both officers who required assistance to restrain her. The female was then taken into custody and later released on an undertaking.

The main problems arise when the person with the Mental Health problem either refuses to engage, has been drinking / taking drugs or is injured and needing medical attention. In these instances, officers can't access the Mental Health ward and must take the person to Accident & Emergency. A&E don't prioritise the examination / treatment of a patient who has been brought in by Police whether voluntary or legislatively. They could do but choose to grade on a medical need and it can appear they downgrade the need of patient who is with the Police knowing that they are being monitored. This results in officers waiting several hours for someone to be seen and who is often turned around in the space of a few minutes. There are no internal protocols between A&E and the Mental Health ward. When the person is then referred to the Mental Health ward, they take no cognisance that the person has already spent several hours in A&E and they will then go to the bottom of the queue to be seen by a Mental Health nurse resulting in an even longer wait.

Another resource intensive part of this is people who attend at A&E on their own accord for a Mental Health issue. They too are subject to the lengthy waits and understandably get bored with the wait and walk out effectively discharging themselves. Once the hospital realises the person has left, they will contact Police to report them as a 'Concern For' / Missing Person. The same goes for patients on time out from Mental Health wards who don't return from their Time Out. The Wards will also report them as Missing Persons. These calls are received on a daily basis in [REDACTED] Div.

I hope this is off some use.

Officer 16

Unfortunately, I have no incident numbers and can only provide anecdotal accounts from memory.

- Multiple cars sitting with someone "feeling low" and listening to one car covering the whole of [REDACTED]. That one car going to violent incidents, large parties etc. with just two officers is a huge officer and public safety issue.

- Repeat callers – members of the community that call in every single day and threaten suicide, leading to officers sitting with them at the hospital, sometimes for whole sets of shifts.

- Arrested male at cells who had attempted to jump off [REDACTED] Bridge – cells demanded a Constant Obs for him because of mental health, despite the [REDACTED] Bridge being slightly inaccessible from [REDACTED] Custody Suite. The drop from the raised sleeping platform to the floor would not, I doubt, be big enough to attempt suicide in a Police cell. This fear of a PIRC enquiry on the back of mental health has become enshrined in Police culture.

- Mental health is not for the Police to deal with. It is tragic and a serious public health risk, however, our responsibility should be to detect and deter criminality (in my opinion). We are completely limited in providing services as a law enforcement agency and this is reflected in public opinion – every member of the public I speak to has a complaint to make that "the police take ages to come" or "the police don't do anything about my stolen van" etc. The public want us to Police criminality, not be Social Workers.

- Partner agencies passing the buck - Other services (especially NHS and Social Work) have the ability to walk away. I have literally seen them walk away from people who have deep self-inflicted wounds because the patient refuses treatment. The Police do not have that same luxury as we would be crucified for it.

- The above has resulted in officers being unable to provide a good service of Policing – it seems to me that many officers on response are inexperienced in dealing with crime and criminals. They are not used to proactive policing or dealing with criminals robustly because they are too busy dealing with mental health. Whether the powers that be like it or not, there are still seriously dangerous people out there and not everything can be solved with a cuddle.

Impact on officer's mental health

- We do not have time to progress enquiries on response. This, unfortunately, does not stop crime so crimes are still being recorded via PAD/CAM team and allocated on UNIFI. Officers are sitting at the hospital/in people's flats who suffer from mental health issues for entire shifts – this leads to stress and anxiety about their own workload. The number of officers going off sick (or worse) because of work stress is increasingly worrying.

- When I was on response, my fuse was so short because of all the above that it did not take long for me to lose my temper. This is unhealthy and impacts the service provided to victims of crime. I know others are the same.

- Morale is beyond rock bottom. People are leaving in droves. Where the Police was once seen as a good career it now seems that it has become a stepping-stone job for people to leave after they have been burnt out by the organisation.

Support provided by Police Scotland

In relation to this I can provide a number of examples of how in practice social work and mental health services struggle to work in partnership with police.

1. one of numerous examples is the [REDACTED] hospital called police to state that they had a voluntary patient whom was about to be made subject to a compulsory treatment order who absconded from the hospital, they went to their home address where they refused to return. The hospital contacted police and asked them to return the patient, police attended, and the patient refused to return, police contacted hospital who stated that they could not attend and a local MHO officer also could not attend, staff at the hospital asked us to arrest the patient. It was explained we had no powers to do so, staff at hospital who annoyed by this and stated they were too busy to attend. The outcome was the patient was left at the address with family pending mental health officer craving a mental health warrant or patient being sectioned.

2. too often police are called out for mental health calls because there is no outs or hours mental health device available to deal with incidents in the community. Officer face transporting persons with mental health difficulties in police vehicles to the royal Edinburgh for treatment. There is such a delay for an ambulance that officers are left with the choice of standing with a mental health patient for 6-8 hours or transporting them to hospital themselves and freeing up police resources quicker to attend other priority calls. Often when officers do attend at the hospital there is no prioritisation of them which results in standing at hospital for hours waiting on assessments.

3. A female patient was experiencing a mental health crisis, she has taken an overdose of prescription drugs and alcohol. She was refusing treatment and violent. Officers conveyed the female to hospital where staff unable to assess her due to alcohol intake (common procedure and accepted). However, she continued to be violent, officer ended up have to handcuff a person suffering a mental health breakdown to her hospital bed and restraining her with leg restraints for her own and staff's safety. No NHS staff were able to medicate or assist with appropriate restraint for the female, this patient who was in mental health crisis was handcuffed and under police watch for 12 hours due to this.

4. there is no joint working protocol between mental health/police/social work to decide on joint procedures going forward consistently, it is very much an ad hoc approach.

5. when joining the police or throughout what can now be a 30–48-year career no training is provided to police on mental health crisis.

Officer 17

When police officers assist mental health officers to execute a warrant under the MHA to detain someone for MH treatment, the warrant usually provides a power of entry for police to put the door in. In my experience at these incidents, the mental health officers then expect police to enter the property and arrest/negotiate with the detainee to bring them out of the house (even though police have no powers to detain in private residence). They are often reluctant to do this themselves. In addition, they usually do not bring a suitable means of transport to take the patient away to hospital - often a pre-booked taxi, rather than ambulance or appropriate patient transport. They expect officers to have a police van that they can transport the patient in, in case of violence.

Police get called to a house where parents are struggling with a violent /uncooperative child/adolescent with mental health needs. Police are always the first call, not the mental health services. On attendance, the police end up negotiating with the patient and usually mental health services will not attend. The only support is to get a triage over the phone with the mental health team at local hospital. The triage team will only deal with adults, the social work team won't come out after hours but say that the person is safe with their parents and the GP won't attend as believes it's the remit of the mental health team. Often the only option is to arrest to ensure the safety of others in the property if violence continues. Police have no powers under MHA to arrest/detain within a private property.

A person detained in public by police under the mental health act and taken up to hospital for MH assessment will have to wait often up to several hours for their assessment. Police officers are being required by MH staff to wait with the patient for all this time – can often be the whole shift sat in a hospital waiting area or longer. Would make sense for there to be a reception "holding area" staffed by hospital staff/nurses to look after the

person until assessed, as this would count as a Place of Safety, and police could be released to continue with their duties.

The Employee Assistance Programme is not of the standard it should be. There have been numerous accounts provided to me of officers not willing to contact the service due to the manner of the person picking up the phone or the comments made to the officer.

The fact that only a small number of counselling sessions are provided is not appropriate when the officer should be getting whatever length of treatment is required for their rehabilitation. It's a false economy to provide only 4-6 sessions, as at the end of that the officer may be making some recovery but will relapse if there is then a lack of support whilst awaiting a different counsellor on the NHS. The absence from work is then more protracted.

Better support is offered from Outwith Police Service of Scotland – by the charity Police Care UK and also the Lifelines Charity. Online welfare packages or intranet sites provided by PSOS are not well regarded and likely to be ignored by frontline officers – they do not have the time to sit and use them whilst at work. Genuine welfare support is required in the form of Face to Face contact – by supervisors having the time to listen to their staff, and the provision of unlimited psychological support services independent of PSOS. Dedicated Welfare officers that could do home visits to those absent on sick leave would be ideal.

Since being a federation rep, I have encountered a startling number of officers that have indicated suicidal thoughts. The reasons behind this appear to include:

1. The workload is just unmanageable and is totally overwhelming, with a sense of not being able to perform their role and being inadequate at their job, with their anxieties not being listened to or taken seriously.
2. Dealing with a number of traumatic incidents in a short period of time, with insufficient therapy to heal them or give them appropriate coping strategies – this includes serious/fatal Road Traffic Incidents, Murder Enquiries (including those dealing with the forensic side of things as well as the actual murder scene), Suicides and Sudden Deaths. Officers often attending and dealing with these incidents in remote areas and single-crewed with little support.
3. Officers are lone-working – either in their own office or at home or covering a huge remote /rural location. They feel unsupported and isolated.

There are a huge number of officers now being medicated for Anxiety and Depression – just about every officer that I support through my role in the federation is admitting to this. It is huge problem.

Officer 18

I have been giving this some thought since reading the email when it came in.

I will try and address the issues point by point and I'm sure you will be well aware of what I am going to raise.

The demand on the police in relation to mental health has grown astronomically in recent years. In the last 10 or so years, as the police service has become more of a political

football and has been under so much scrutiny. Several high-profile social work failings have contributed to the pressure and demand. The vast majority of services, social work, health etc are already stretched by a society where so many seem unable to cope with day to day living. The amount of people calling the police from every avenue to conduct welfare checks has grown. The amount of people in crisis where other services cannot deal with the matter has grown, I cite for example ambulance service not dealing with patients who could be armed or dangerous.

I can say hand on heart when I worked in the control room, we would get calls from the ambulance service that would say, police to attend this as the patient has access to knives. On more than one occasion I called the patients representative back and they would tell me that they were asked about knives and they said no, only to be further quizzed “were there knives in the kitchen”. So, the services use each other to reduce each other’s demand. We would do likewise, using the ambulance service inappropriately.

Police Scotland essentially locks folk up and uses force to make people comply. We are assisted by the NHS in medicating some patients however, on the whole, we are the service who has to step in to help, all the while, our budgets are being cut whilst the health budget continues to grow. Perhaps some health budget could come our way to help with our demand.

I can cite an example from [REDACTED] weeks ago, I as custody Sgt, have a 14 year old girl brought into me under arrest for assaulting the police.

Over the previous 8 days, she had been arrested 6 times and brought to the station. This is highly unusual. Her behaviour had been escalating and I had a genuine fear that her mother or other family member would be killed or seriously injured. The girl’s mother had been given a lock box by social work to keep the knives in, the next night she found the key and threatened her mother (she had assaulted he on numerous occasions previously). Then she moved onto scissors. Only when she dropped the scissors after long negotiations, did she then assault the police. The behaviour had escalated. When she was brought to me, she was being held down by 3-4 officers in handcuffs as quite simply it wasn’t safe to let her go. She was screaming and howling.

The night before the OOH {out of hours} child MH services had detained her, only for her to be released the next day as it was apparently behavioural.

That night, I contacted the OOH child MH services again.

I was advised to have the girl taken to children’s A&E to be assessed there. This was the procedure. I explained that this was not in the best interests of the girl or the other patients (screaming and shouting hysterically). The OOH staff had to call out a manager to seek permission to see the girl in a police cell and not a hospital.... this is what’s wrong... pathways are so inflexible.

Anyway, the staff state that they are of the same opinion as the night before but as the psychologist had released her as behavioural issues, they couldn't detain her again. So, Social work are suggesting I take her back to mum, now that she has calmed down and was sleeping. I'm faced with the decision that as an arrested person, if I release her and she kills her mother, then the police are to blame. SW won't entertain a secure place as there is none. Health have done as much as they can and are adamant the matter should be social works. So, the police are piggy in the middle.

<u>The impact of MH on officers.</u>

This comes in many ways, first of all, how the company treats its officers. The relentless demand of events, many of which are privately funded but have officers cancelled rest days with no recompense, is an outrage. Cancelling days off well in advance for another day back (particularly weekends) is a disgrace. If the police had money for BWV {body worn video}, just imagine the amount of court time that would take away. But we don't, because either we are so poorly funded or we waste it.

Courts have a big part to play in the amount of time wasted at court.

Then there are the general duties, the hypervigilance that you can experience in the urban environment can take its toll. The lack of safety equipment and the type of calls you are being sent to with the belief that you know there is more (taser, shields, firearms) but you, the cannon fodder have to go and check if the maniac is running about with the knife, knowing that you only have an irritant spray and a metal pole to defend yourself.

Then there are the incidents that affect you. I still remember my first sudden death, a [REDACTED] year-old in a children's home who hung [REDACTED]self. I remember trying to open the door and the noise made when [REDACTED] hit the ground. I remember sitting in the room for an unimaginable amount of time and I remember being 19. Strangely, that didn't affect me much. I still remember it with much sadness, particularly when dealing with other care experienced young people.

What affected me the most in my career was the death of a 10-year-old [REDACTED]. I remember the call, driving frantically to the scene and to performing CPR on a 10-year- old, I remember [REDACTED] mother howling and to having to hold her and take her into the hospital when she ran out after being told her [REDACTED] had died. There is so much more to that that will live with me forever. These are the things that first responders deal with daily. Ambulance, fire etc, we all live with these images, sometimes it's the public but in the main it is much more likely it will be the emergency services.

I do consider myself mentally strong, after that call, I drove back to the office, told everyone else to go home, I went home myself and I left a note for my wife asking her to deal with the kids and I would explain when I was ready. I drank myself to sleep that night and again the next night. I had the phone call from the police asking if I was ok. Of course, I would say I was ok. Anyway, after a few days, I noticed that I wasn't right.

I asked for the Trim, I did it, I went there, I told my story, I cried and I left feeling much better. The story doesn't bother me but what bothers me is the thought, what if I wasn't ok. If I needed more help.

The service would get me 6 counselling sessions because that's what they offer. I wouldn't be an NHS priority but I could potentially be off long-term sick. We truly don't offer enough support. Just saying that there is EAP is not enough, the service relies on police officer funded charities to help make cops right. That's not right but we are skint. Society has moved on, as seen by the increased demand on services in relation to MH. The service hasn't really moved on, Trim isn't a treatment, it's an assessment. It helped me but it's not the answer. Neither is 6 counselling sessions, and EAP.

Officer 19

The main gap in legislation exists when we encounter someone requiring mental health assistance in a private environment. We are increasingly being called into folks houses and so end up in a no-win situation where we cannot do anything without the cooperation of the individual. Progress has been made in this respect with the telephone triage system which allows us to remove ourselves from the house comfortable in the knowledge that a medical professional has deemed it acceptable to do so. This is all very time consuming and has a massive impact on our ability to do other work.

The other aspect of mental health matters is that an increasing number of individuals who end up in custody have other issues and end up on constant obs. There has possibly been a decrease in the number of people on constant obs but that isn't because we are getting better at assessing them which is what I suspect custody would claim it is because we are not keeping people in custody for any length of time.

In relation to officers' personal mental health, I do not feel that there is enough support for individuals although it is much better than it was. Our working practices don't help. Supervisors don't stay in one place for any length of time. It is supervisors that should be the ones in a position to pick up on issues and support officers. I spoke to one officer who said that over a period of 3 years they had 13 different sergeants.

We have created a culture where there is no thanks for or recognition of sergeants and inspectors who remain in the one place for a period of time so no one stays anywhere long enough to get to know officers. In addition, a number of measures that a supervisor could employ to look after their troops are not available.

We have no control over time off, who gets sent to events and operations, ensuring that officers get time to do enquiries and paperwork. We are just existing day to day. Shifts are being changed and rest days being cancelled all the time.

All of this has a cumulative impact on an officer (and the supervisor). If someone is trying to juggle issues at home the manner in which we operate will undoubtedly have further negative impact on officers and may well be the straw that broke the camel's

back. I have spoken to a number of sergeants who have left the shifts recently and they have all said that they love the actual job they do however they cannot continue to operate in the way we now do. Sergeants are getting moved about and abused so why would you stay!

I have been a sergeant in [REDACTED] Division for 16 years and have done many jobs. I always love being on the shifts as it's what I joined to do but I have consistently found that I have only ever managed about 2-3 years before I have had to move (or have a baby!) just to get a break and then I go back to it. On every occasion it is not the core role that gets you down it is the working practices that have been adopted that begin to take a toll.

In relation to the survey I have not seen any results. I am aware that there have been some focus groups set up very recently but have not heard any feedback. I did ask to be part of a focus group after an invite was sent out to the division however was told that the people had already been selected!!!

Officer 20

The main gap in legislation exists when we encounter someone requiring mental health assistance in a private environment. We are increasingly being called into folks houses and so end up in a no-win situation where we cannot do anything without the cooperation of the individual. Progress has been made in this respect with the telephone triage system which allows us to remove ourselves from the house comfortable in the knowledge that a medical professional has deemed it acceptable to do so. This is all very time consuming and has a massive impact on our ability to do other work.

There have been two changes aimed at lowering the number of calls officer attend and lowering the amount of time it takes –

The first change was the introduction of the mental health hubs. This is a system in place whereby a member of the public can be passed onto a dedicated member of the metal health hub (NHS staff). There are some conditions attached whereby the person can't be injured or threatening injury and should be coherent. If they are passed by the resolution teams at C3, PSOS don't have to submit an IVPD. If officers attend and utilise the service, then the attending officers do have to submit an IVPD.

Pros – Can mean no trip to the hospital, shorter time spent dealing with the call.

Cons – At busy times you can wait forever to get through, at really busy times you have to wait for a call back and despite what the resolution is you still have to submit an IVPD if you attend the locus.

The second change is a test of change I have only become aware of. In the [REDACTED] resolution team, five NHS mental health nurses are working alongside the teams with one on each shift. The initial thought by staff was that they would be

on hand to speak to members of the public direct and basically carry out the role of the mental health hubs.

The reality has been that NHS lawyers have stepped in stopping the nurses from speaking to the members of the public. Instead, they sit beside an officer/staff member who obtains details from the call and from the PSOS systems, they then complete a 7-point clinical assessment which determines whether the call can be closed or if it still requires some further involvement by either sending officers or being dealt with by the resolution teams.

The NHS nurses have no access to the member of the publics patient records so all they have to go on is the details of the call and any previous IVPD's.

Overall, in C3 there is still a high call demand from partner agencies especially around Friday afternoons. Officers when dealing with Mental health calls are still spending a vast amount of time on a single call.

Police Scotland

Police Scotland's submission is structured is response to the particular areas of interest as identified by the Criminal Justice Committee

Introduction

It is well recognised that the police deal with increasing numbers of mental health related incidents which increases demand on Police and Health services.

Previous attempts to evidence this demand on Police Scotland have been anecdotal, unsystematic and ultimately inconclusive despite significant work from various business areas. These attempts have been made difficult by numerous obstacles involving IT systems, recording systems and a dependency upon interpretation of an incident.

Many incidents which transpire to have a link to mental ill health do not always present as such from the outset, and so to accurately record these can be difficult and reliant upon recognition by enquiry officers and updating and insertion of correct disposal codes by control room staff.

Work on a Mental Health Dashboard is underway by Police Scotland's Demand and Productivity Unit in order to more clearly quantify the number of mental health related incidents which impact on the police in terms of quantity and in respect of officer deployment times.

Police are often the point of contact for people in mental health related incidents and this is especially the case in out-of-hours periods when other support services are not available. This can add further demands on Police to safeguard people and provide interim support.

A common situation experienced by officers is when people who they find in significant crisis or distress, often expressing suicidal thoughts, and having spent significant time with them, are taken for assessment and then released back to their home environment and often without an obvious care plan or protective factors either established or intimated to officers. There are many individuals for whom this seems to be a pattern of activity which can be repeated time and time again.

There is also the added impact of officers time involved beyond an on-going incident. For example, the submission of paperwork in relation to referrals, or raising concerns in respect of vulnerabilities due to mental health, liaising with support agencies or Social Work and attending Case Conferences.

In terms of actual demand it is generally accepted that 1 In 4 of Scotland's population suffer from mental health or distress related need at some point in their lives. This is reflected in the 3.4 million contacts to Police Scotland each year, and of the resulting 1.5 million police incidents generated less than 20% result in a crime

being recorded. Demand resulting from vulnerability is increasing year on year and at this time 40% of all persons coming into Police custody report suffering mental health issues. COVID is anticipated to result in a marked increase in poor mental health and distress in communities, as the full impacts of the pandemic are felt.

Access to appropriate services in communities varies significantly across Scotland, with many turning to Police Scotland in their absence. Policing demand in relation to mental health increases between 19:00 – 03:00, when day based services are no longer available. Mental health related incidents routinely take up to 8 hours and involve taking persons to the nearest NHS facility, with a recent evaluation of the cost to Policing estimated at £14.6 million per annum and each visit to A&E estimated to cost the NHS £5000. It is evident that Police Scotland is not the best service to deal with mental health demand, with a policing response often exacerbating the situation for those already in distress.

Area of Interest Identified By Criminal Justice Committee

Data on the number of individuals coming into contact with the police who are assessed as having a mental health issue, and the disposal options used. For example, the number of people: charged and released; charged and remanded; and released without charge

Response

Individuals entering police custody are asked a series of questions as part of a Vulnerability Assessment (VA). This covers all aspects of their health and wellbeing, with specific questions asked regarding their previous and current mental health. These questions rely on the individual providing an honest and accurate response and all responses are recorded on their custody record on the National Custody System. Often individuals entering custody are in crisis and/or under the influence of alcohol and/or drugs, and as such their responses may not always reflect their actual mental health history or current status.

There are a total of 21 questions in VA, which assist the custody supervisor in deciding the bespoke care plan each prisoner requires, the level of care they need and if they require to be referred to Hospital, the NHS Custody Healthcare Professional (HCP) and/or Forensic Physician (FP). Current presentation, arresting officers' observations and any known history of the prisoner are also factored into their care plan.

Three of the 21 VA questions that relate specifically to mental health:

Q.9 Have you ever attempted self-harm or suicide?

Q.10 Do you have any thoughts at present of self-harm or suicide?

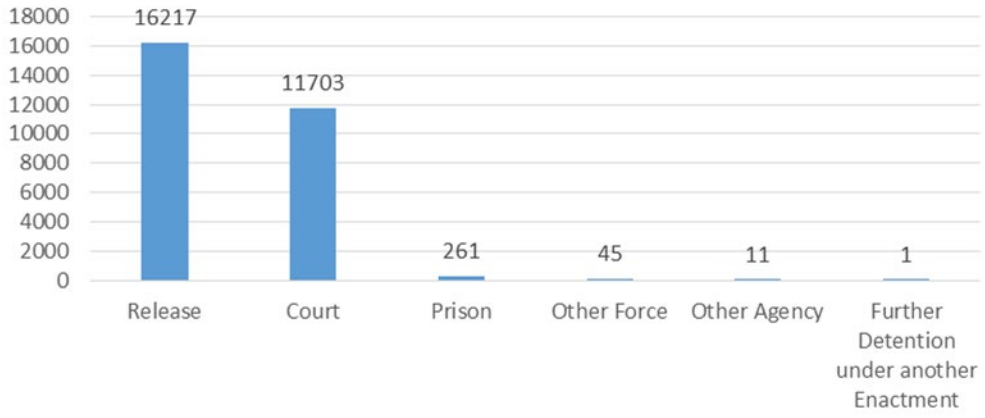
Q.11 Do you have any mental health problems or have ever received treatment for mental health problems?

In 2021 there were a total of 95,038 custody records created, which comprises the throughput for custody. Of these, 93,743 custody records had VA questions completed. The difference of 1,295 not being asked VA questions can be explained by persons who have either had their detention refused or persons attending for a VIPER procedure or voluntary attendance, or been taken direct to hospital and being released direct into the care of NHS. It is worthy of note that the total figure of 95,038 custody records created will invariably include the same person entering custody on more than one occasion (re-offenders).

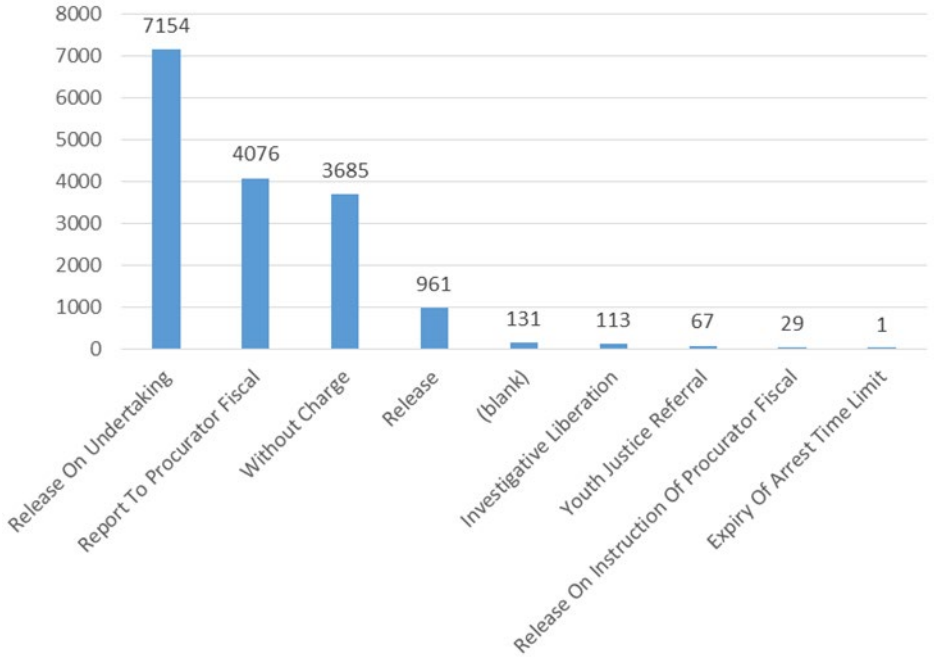
Q.9 Have you ever attempted self-harm or suicide?

In 28,238 records (30.12%) the person responded 'Yes' to this question (compared to 28.87% and 29.84% in 2019 and 2020 respectively).

Disposals for these 28,238 records were as follows:



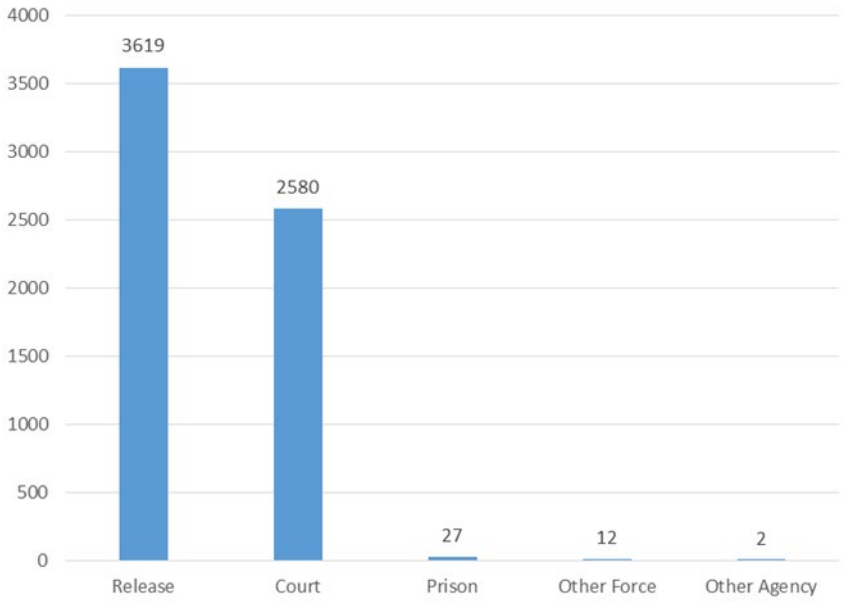
Of the 16,217 records where the person was released, the release disposal was as follows:



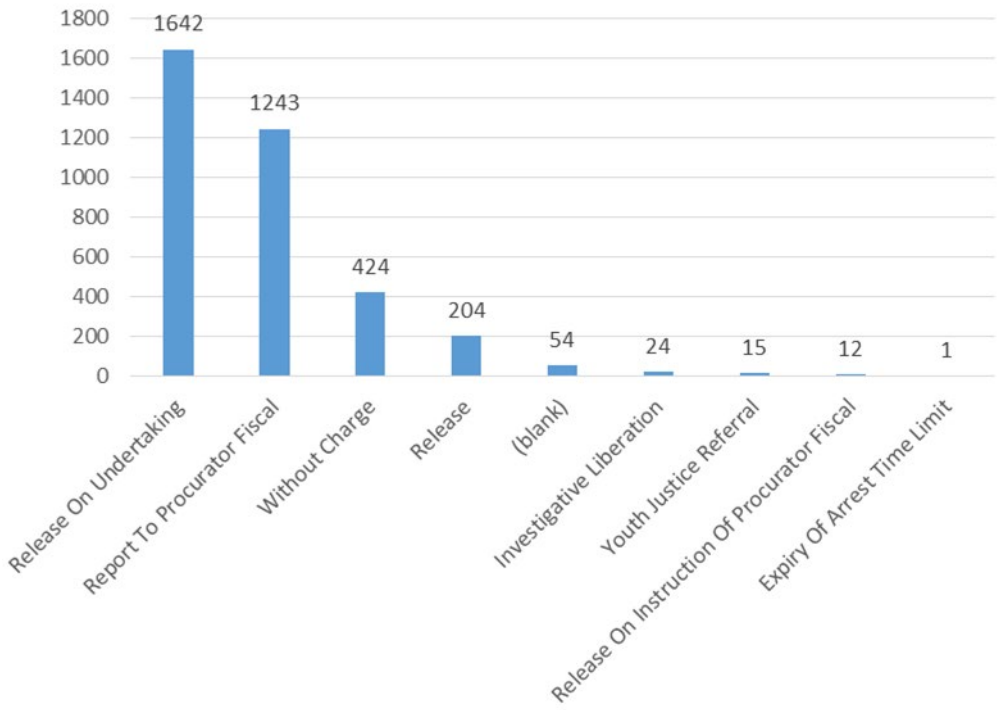
Q.10 Do you have any thoughts at present of self-harm or suicide?

In 6240 records (6.66%), the person responded 'Yes' to this question (compared to 6.64% and 6.44% in both 2019 and 2020).

Disposals for these 6240 records were as follows:



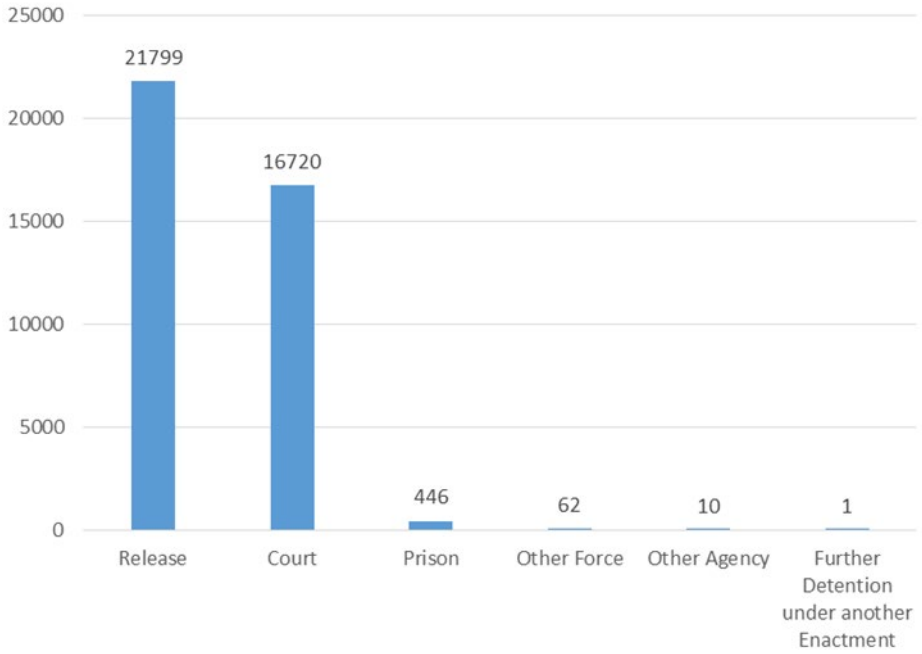
Of the 3,619 records where the person was released, the release disposal was as follows:



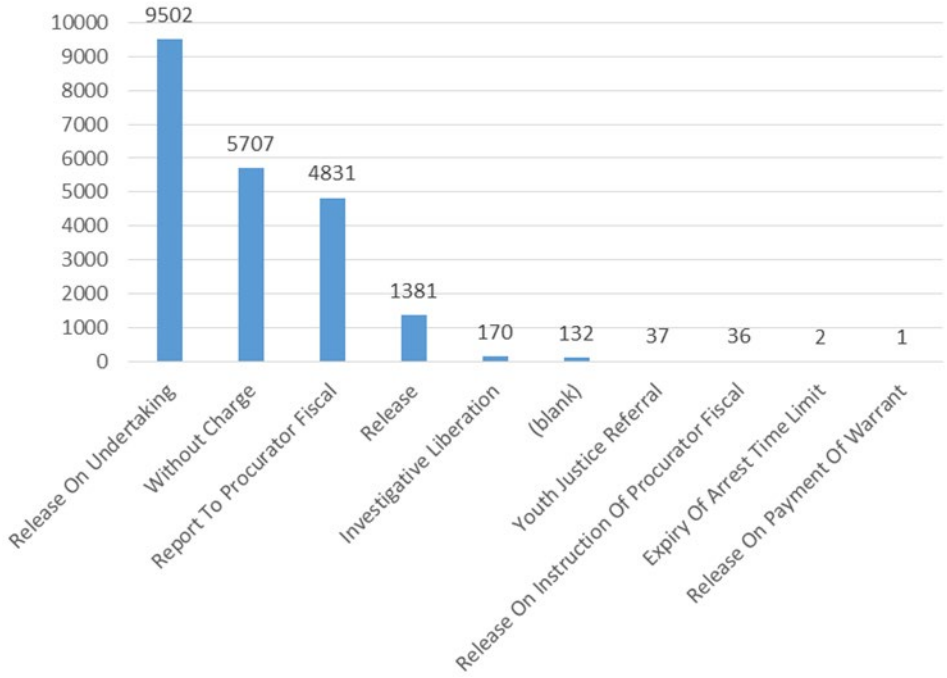
Q.11 Do you have any mental health problems or have ever received treatment for mental health problems?

In 39,038 records (41.63%), the person responded 'Yes' to this question (compared to 40.23% and 41.03% in 2019 and 2020 respectively).

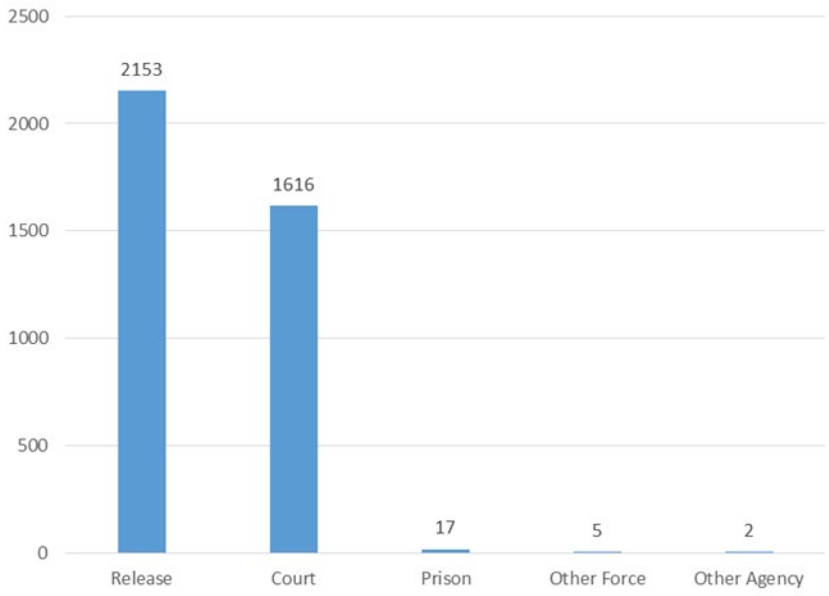
Disposals for these 39,038 records were as follows:



Of the 21,799 records where the person was released, the release disposal was as follows:



In 2021, there were a total of 3,793 records (= 4.05%) where the person answered 'Yes' to Q.9, Q.10 and Q.11 and the disposals for these are as follows:



The vulnerability questions refer to past and present mental health issues. This information is based solely on prisoner's responses to these questions and it is suspected the percentage of those with mental health issues will be higher.

During the person's time in custody and/or during the police enquiry, mental health issues may become apparent. There is no accurate way to draw this information from NCS without a manual search of all records. This is the same for reports submitted to COPFS, as mental health issues are recorded in the free text sections of these reports, therefore the volume cannot be quantified unless there was a manual search of all reports. COPFS are also unable to provide accurate data on the percentage of those who are reported to them where a mental health issue is a factor in the case.

Area of Interest Identified By Criminal Justice Committee

Any legislative barriers to the options available to police officers. For example, in the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003

Response

Custody Perspective

There following two Acts are used by Police Scotland and are relevant:

Mental Health (Care and Treatment) (Scotland) Act 2003

Section 297 provides a power to a Constable where they find someone in a public place. A significant number of interactions take place within a dwelling meaning that

officers are frequently having to consider an arrest for a criminal offence to seek any immediate support for the person in crisis. In an ideal situation, a Mental Health Officer or GP would be available, but the police are routinely at the scene first. An extension to the power to include a dwelling combined with appropriate safeguards such as attendance of a medical practitioner within a reasonable time or the presence of a suitable person to support them could be considered to address this.

Criminal Justice (Scotland) Act 2016

Where a person who has a mental health condition is in Police Custody, where appropriate, they will be provided with the services of an Appropriate Adult. Section 33(2)(c) of the Act provides that the person cannot waive the presence of a solicitor attending for the interview. Whilst it is acknowledged this is a necessary safeguard, it has become common for persons to refuse a solicitor being present for interview. A solicitor cannot be instructed by a third party such as the police and unless exceptional circumstances exist (Section 32(4)), an interview cannot take place. This has been previously identified as a challenge presented by the Act.

Wider Perspective

Being under influence can cause difficulties in health partners accepting people for mental health assessment.

Police officers often come into contact with people under the influence who they suspect have mental ill health which may require a mental health assessment and there is no crime related police involvement required, no urgent medical concerns and no relatives or friends to leave them in care of.

This can leave officers in a difficult position of deciding how best to keep the person safe while balancing with the principles outlined in the Act of imposing minimum interference in peoples' liberty and the maximum involvement of individuals in any treatment, while taking into account the safety of others.

This is particularly so in out of hours periods when regular support services are not available.

There is a gap here which is not covered in the Act and often sees officers spending prolonged periods of time with people in A+E or in a home setting while they await or explore other suitable care arrangements until the assessment can be carried out.

Area of Interest Identified By Criminal Justice Committee

How a person's mental health needs are assessed when they are arrested and how a consistent approach is applied

Response

All Police Scotland officers receive training on mental health and suicide intervention during their probationer training. All Police and Criminal Justice Police Custody Security Officers (CJPCOs) receive mental health training during their Custody Officer Induction Course, which includes an input from NHS Custody Healthcare staff with the following outcomes:

- A brief overview and understanding of mental health in custody
- Common presentations and management while in custody
- Challenges posed in this environment
- Awareness of pathways to divert to mental health services and psychiatric services

This training is not to teach police / custody staff to diagnose mental health issues but rather to identify signs and refer individuals to Healthcare Professionals (HCP) for assessment and treatment as required. Police / Custody staff are also provided online training in relation to Mental Health Legislative Training, Mind-Set – Discovering the Myths and Facts of Mental Health, Mental Health Crisis and Suicide Intervention training, an Appropriate Adult briefing, Protecting Adults at Risk of Harm (3 point test) and Acute Behavioural Disorder which assist when dealing with prisoners and identifying signs relating to mental health and the help/support that may be required.

In addition, some custody staff have been trained in online NHS Trauma Informed Practice and Motivational Interviewing training, to assist them when speaking to prisoners who may have mental health issues related to trauma. This training is currently being evaluated by the Scottish Institute of Policing Research (SIPR).

There are two separate types of mental health provision within police custody. The first is to facilitate the criminal justice pathway, and the second to provide support for persons in custody and/or in the community following release. In relation to the judicial pathway, HCPs will assess prisoners for basic mental health and fitness for detention, interview and release however those requiring more acute assessment are referred to a mental health trained nurse or Forensic Physician or to local community mental health services. Whether a person is fit to plead at Court is for the Court to decide and they use Court Liaison CPNs or other HCPs to carry out these assessments, normally at court prior to appearance.

Mental Health pathways for those requiring acute assessments by community mental health services varies across Scotland. Some health boards will assess those who have been arrested or charged with an offence, but will refuse to admit them and instead, instruct they are returned to custody to attend Court to allow the Sheriff to detain them under a Section 52 Order, leaving the individual in acute mental health crisis in custody sometimes for a whole weekend. This disparity in service provision

creates inequalities in service provision and means arrested persons are being treated differently across the country

Barriers also exist with community mental health wards which will not accept direct referral from a custody HCP as this is not seen as a primary health referral and again this creates delays in persons being assessed.

All arrested persons who are released from custody are asked pre-release questions which include if they have any suicidal or thoughts of self-harm or any thoughts of harming another person. Persons who are deemed as a possible suicide risk are also asked an additional set of questions (Suicide Intervention) prior to release and if they answer negatively to any of these questions, they are referred to the custody HCP prior to their release.

Area of Interest Identified By Criminal Justice Committee

Details of any collaborative work with other agencies to ensure that the person's mental health needs are met. For example, NHS and social work support for those taken into custody

Response

Custody Perspective

All Health Boards have mental health pathways for those in custody to receive acute mental health assessments when required. In some health boards, HCPs/FPs, will also refer prisoners for onward mental health support in the community.

Criminal Justice Services Division's (CJSD) Harm Reduction Strategy has four strands which focus on reducing drug related deaths and assisting those with substance use, mental health and health and social inequalities. This public health approach to policing, delivered through the Arrest Referral process is the means by which custody staff can refer/signpost arrested persons to community support. This process is consent based and driven by a team of volunteer Custody Support and Interventions Champions, who carry out this role in additional to their normal duties and helps promote the services available to arrested persons in their area.

In relation to mental health support, custody staff are able to refer prisoners to Breathing Space, a national organisation who will speak to the prisoner on the phone whilst they are in custody to provide them immediate support. As Breathing Space is only available at certain times and days, negotiations are currently ongoing with Samaritans to fill the gap and have 24/7 phone support coverage available to all persons in custody.

The Armed Services Assistance Programme (ASAP) is another national agency which provides support to armed force veterans who enter police custody.

There are a number of other Third Sector/ADP organisations around Scotland which also provide mental health support for custody including the Highland Third Sector Interface Custody Link Project in Inverness, an Action 15 funded Crisis Intervention Team in Fraserburgh, the Custody Assessment and Referral Service (CARS) Project in Dundee and the Violence Reduction Unit's Navigator Project in Kirkcaldy.

Work is ongoing in other areas to provide similar support such as Turning Point's Early Help Team in Inverclyde which is now moving from the planning stage to the implementation stage, with a go-live date of 16th May 2022 for e-mail referrals. Once vetting applications have been approved, Turning Point staff will thereafter be based within Greenock Custody Centre to provide greater support via face to face engagement, with a 'no closed door' policy to accessing help.

Police Scotland's Vulnerable Person Database is the process for referring vulnerable people to local social work support but, unlike the arrest referral process, does not require the individual's consent. This process is well established in Local Policing and CJSD are in the process of rolling this out nationally for those identified with additional vulnerabilities during their time in custody.

Wider Perspective

NHS24 Mental Health Pathway (MHP)

MHP is a Scottish Government funded collaboration between Police Scotland, NHS24 and SAS, with a key objective to provide the correct response to mental health incidents at first point of contact. Its aim is to improve outcomes for members of the public who contact Police Scotland suffering from mental ill health and distress by providing a compassionate response via the NHS 24 Mental Health Hub service without the need for front line policing deployments. This was the first National Pathway to health services to be introduced within the UK. In 2020, the first phase was launched which enabled C3 Division officers and staff to effectively assess and refer members of the public in mental health crisis directly to NHS24's Mental Health Hub when they called 101 or 999. In essence when such calls are received by Police Scotland, indicating someone in mental health crisis, they are assessed against a criteria and then referred from the Police Scotland Service Centre to the NHS 24 Mental Health Hub (MHH). Police Scotland Service Advisors provide relevant information and then terminate the call enabling the caller to speak directly to a mental health practitioner and receive an appropriate response.

Phase two of MHP soft launched within the West Command area as part of a 'test of change' on 15 March 2022, following successful completion of joint agency (NHS24 & Police Scotland) training. Five Mental Health Nurse Practitioners are now co-located with mental health trained police officers across all Resolution Teams within Govan, C3 Division. This is a phased proof of concept currently operating in West command only, with a future roll out to North and East Command planned on dates TBC. Each of the Resolution Teams (RT) will have Mental Health Nurse Practitioner

(MHNP) assigned to the team and be based within RT Govan. They will be assisted by Mental Health Resolution Team Officers (MHRTOs).

Through a collaborative process utilising THRIVE methodology and clinical assessment, operational policing incidents that fall out with direct referral criteria (Phase One), and where mental health is believed to be a factor, are triaged to provide professional medical advice to improve outcomes and earlier access to the right care for those in mental health crisis. An outcomes based joint evaluation by Police Scotland and NHS 24 with a four month review period is planned and is likely to be available for review in late summer 2022.

These collective processes are working to reduce frontline demand for Police Scotland, Scottish Ambulance Service and the NHS, but more importantly enabling earlier access to the right care for those experiencing mental health crisis.

Distress Brief Intervention (DBI)

The DBI service provides support to people who are experiencing distress and feeling overwhelmed emotionally. This service provides a quick response which listens and supports with a sensitive, caring and non-judgemental approach and focusses on the individual's needs.

Police can refer to the support agencies Penumbra, Support in Mind Scotland, Scottish Association for Mental Health, The Richmond Fellowship where their services are available, and officers have been trained to refer. Contact is then made by the Level 2 support services within 24 hours and provided for up to 2 weeks. Scottish Government target national roll-out of this service is by 2024.

Local Community Triage Arrangements

There are varying provisions of Local Community Triage arrangements in place in each divisional area allowing contact with local mental health services to assist officers with advice to inform decision making in appropriate courses of action – i.e. in requirement for mental health assessments, considerations prior to use of detention powers under s 297 of Mental Health (Care and Treatment) (Scotland) Act 2003. Out of hours coverage can vary. Contact by officers may include telephone contact directly or attendance at Mental Health Assessment Units. The aim is to provide the best level of service for the individual while reducing time and pressure on A+E departments.

Bereavement Support Pilot

On 12th August 2021 a new pilot Suicide Bereavement Support Service launched across Ayrshire and Arran, Argyll & Bute and Highland and Islands NHS areas. This is a Scottish Government Pilot which will last for 2 years.

This is a rapid-response service, which will offer support for those bereaved or affected by suicide.

The service aims to provide early advice and assistance to bereaved families, practical support (e.g. help arranging a funeral, advice on financial issues, Crown Office and Procurator Fiscal process, an assessment of need, a safety plan and signposting to local organisations that can further assist the family). The service is being provided by Support in Mind Scotland and Penumbra and officers can refer those who wish such support.

Healthcare Improvement Scotland (HIS): Mental Health & Substance Use Pathfinder Programme

Partnerships, Prevention and Community Wellbeing staff are engaged with HIS on this project via the programme & leadership advisory group along with representatives from Local Division. The aim of this Programme is to redesign care pathways to improve quality of care and health outcomes for people with mental health and substance use support needs. Work is already underway within Dundee Health & Social Care Partnership & Dundee Alcohol & Drugs Partnership. Funding has been approved to grow the programme to 4 other localities: Lothians, Grampian Lanarkshire & Glasgow. The programme is embedding a user research approach to the service redesign and transformation.

Public Health Scotland (PHS) Collaboration Framework

Police Scotland and Public Health Scotland signed a collaboration framework in July 2021. With the strategic ambition to work together to improve the health and wellbeing of communities.

As Scottish Public Bodies both PSoS and PHS have important contributions to make to deliver the National Performance Framework (NPF). In particular, the national Public Health Priorities, which align to the NPF, represent a consensus on where we need to focus our collaborative efforts if we are to improve community wellbeing and reduce health inequalities. Both organisations are committed to working with partners to deliver on these. This Strategic Collaboration Framework, between two key national public bodies, provides the opportunity to engage and convene other partners and strengthen our collective efforts across the system to build on the learning from the collective COVID-19 response to deliver Scotland's Public Health Priorities.

Local and national focus: Both organisations have a role in working across both local partnerships and nationally, and a shared ambition to improve the effectiveness of local and national systems focused on improving community wellbeing. As relatively new organisations, there will be learning to be shared on how best to develop and utilise this dual role.

Common causal factors: Many of the factors which contribute to poor health and health inequalities are also recognised as factors which contribute to the risk of offending, reoffending and becoming a victim of crime. These foundations of community wellbeing include experience of poverty, access to education, good quality employment and housing. Strengthening collaboration between policing and public health to build stronger foundations for our communities to thrive will contribute to the delivery of shared outcomes.

Shifting to prevention: Public health is fundamentally about preventing poor health outcomes within communities. There has been growing interest in transferring skills, methods and approaches developed and utilised by public health to a policing context. In part, this interest recognises the shared territory we have outlined above, but also recognises the value of applying public health approaches to improving outcomes by supporting a shift towards prevention.

Our collaboration framework sets out 3 priorities:

- Mental Health & Wellbeing
- Supporting local systems
- Data & Analysis

Mental Health & Wellbeing is a shared organisational priority. We are working together to develop a will develop a shared programme of work with key areas of development including shifting action towards prevention, better utilisation of data and intelligence and strengthening the focus on staff wellbeing. We will also seek to mobilise the wider system of partners to work together more effectively.

A winter learning exchange event took place virtually on 21st January 2022, which was co-hosted by DCC Kerr & Angela Leitch CEO of PHS. The attendees were Executives and Delivery Leads from both PSOS & PHS. The focus of the event was on Mental Health, moving from strategy to practice and putting a Public Health approach into reality. Supt Ian Thomson (now retired), who was on secondment to the Royal Foundation, provided an overview of the Blue Light Together Programme and the Mental Health at Work Commitments and Pledge. One of the main actions from the event was to "Develop 12-18 month action plan. To include development of a Prevention toolkit to support interventions at officer, divisional, and corporate/national level based on mapping of top 5-6 call categories at Primary, secondary and tertiary levels of prevention." Work is progressing on this with further follow-up workshop with Healthcare Improvement Scotland, SAS re the High

Intensity User work programme and the Mental Health Pathway project on the 18th May 2022.

Area of Interest Identified By Criminal Justice Committee

Details of any challenges faced in accessing the necessary support, and how these are, or could be, overcome

Response

As stated elsewhere, some of the mental health pathways make it more difficult for those requiring more specialist acute mental health assessments whilst in custody. There is also a mixture of different custody healthcare operating models across Scotland some with having on-site 24/7 HCPs, others with a HUB model, with HCPs covering several custody centres and others with an on-call FP/GP model. Some health boards have advanced mental health trained nurses working within some of their custody centres, some of which have been funded by Action 15 monies.

Ideally there would be a nationally agreed mental health pathway, which all persons in custody could access. This could be achieved by enabling custody HCPs to refer individuals requiring specialist mental health assessments or care direct to the local community service without the need to attend an Emergency Department or other route. The fact the individual is in police custody, arrested and/or charged with a crime or offence should not affect the pathway as their mental health may well be the reason behind their offending and should take primacy. This would ensure equality was delivered across Scotland and individuals received the right level of mental health care at the right time.

In relation to CJSD's Harm Reduction arrest referrals for community based mental health support, there is a mixed landscape of what Third Sector/community support is available across Scotland.

Approximately 60% of persons entering police custody have more than one complex need, so their mental health problems may overlay drug/alcohol use and or other health and social inequalities. Addressing only one complex need is less likely to have a positive outcome than trying to address all the complex needs in a person-centred way. Medication Assisted Treatment (MAT) Standards to help reduce drug deaths recognises this and will include the provision of mental health support and trauma informed care along with the prescription of medication.

Each individual Third Sector organisation to which persons in custody can be referred requires an Information Sharing Agreement to be in place. Conversely, when referring to the Navigator Project in Kirkcaldy, this requires only one ISA but they will then be able to refer on and provide support for all of that person's complex needs, which includes onward mental health, drug, alcohol, housing and employment support, which is more person-centred. Unlike some other Third Sector

organisations, no person is exclude from referral, however it is recognised that funding does restrict the services that other organisations can provide.

Aspirationally, a single referral portal for each Local Authority area would be ideal. This would mean any person in custody requiring support could be referred through this single portal, where Police Scotland can submit one referral, whether it is for community health support and/or multiple complex needs, with an open door policy with no set criteria. This would create a person centred approach where a single referral would offer community based support for all the person's complex needs with a 'care plan' type approach to all Third Sector support available.

Area of Interest Identified By Criminal Justice Committee

The support provided to police officers and staff

Response

Custody Perspective

All training provided to police officers and staff highlights that support is also available to them in relation to their own mental health and wellbeing.

CJSD Business Support has introduced monthly Continuous Professional Developments (CPDs), designed to support staff. These have covered attendance support, wellbeing maternity leave and flexible working and have been made available to all but have been particularly targeted at line managers to empower them to lead the discussion and give them the right tools to do so.

The CPDs coincide with national awareness raising campaigns for various issues, for example, LGBT+ Awareness month, Autism Awareness week and the forthcoming Mental Health Awareness Week (9th -15th May 2022). The information shared with staff is brief, easy to read and focuses on how the subject matter may affect people within the organisation, so staff can support one another. Where staff are willing to share their lived and living experiences, this is also included.

Wider Perspective

The examples below outline some of the support mechanisms available to officers and staff and the ongoing developments in this area.

24/7 HELP Employee Assistance Programme (EAP)

Officers and Staff have access to our 24/7 HELP Employee Assistance Programme (EAP). The programme offers professional support and guidance via a team of trained wellbeing and counselling practitioners who offer confidential, independent and unbiased information and guidance. Officers and staff can call HELP EAP and discuss in confidence any concerns they might have. EAP can offer support and

information on a wide variety of areas including health and wellbeing matters, money worries, caring responsibilities, consumer and legal issues, family and home concerns and work/life concerns such as job stress or bullying/harassment.

Trauma Risk Management (TRiM)

The Trauma Risk Management (TRiM) process is in place to support officers and staff affected by potentially traumatic incidents at work. Understanding and processing reactions and emotions immediately following exposure to traumatic incidents can help to prevent mental health difficulties further down the line. TRiM can be requested through a line manager referral or officers and staff can self-refer. Following TRiM support sessions if is identified that additional mental health support is required an immediate referral to the HELP Employee Assistance Programme is made.

Your Wellbeing Assessment

Officers and staff have access to a 'Your Wellbeing Assessment', delivered through Police Scotland's occupational health and HELP EAP providers Optima Health. Your Wellbeing Assessment has been designed to spot the early signs of potential difficulties before they become problems. It should be seen as an MOT, but for mental health.

The main features of 'Your Wellbeing Assessment' include:

- Open to All Officers and Staff
- It is voluntary, secure and confidential.
- A secure online screening tool
- Assessment is reviewed by a member of the Optima Health clinical team
- The assessment can provide early identification of issues and the provision of tailored support
- Telephone and/or face to face follow ups are carried out after completion

Lifelines Scotland Project

Police Scotland are currently working closely with Lifelines Scotland, a tri-service project part run by the team at NHS Lothian's centre for Traumatic Stress which focuses on promoting wellbeing and addressing psychological risk. Training from Lifelines has been provided to various Divisions/Areas throughout Police Scotland on staying well, understanding resilience and self-care, supporting colleagues and post trauma support, involving providing psychological first aid.

Police Scotland sign up to the Mental Health at Work (MHAW) Commitment & Standards – Dec 2021

Police Scotland have placed mental health as a priority for some time which is highlighted both through the People Strategy and the inclusion of 'Psychological' as a key area within 'Your Wellbeing Matters'.

The commitment standards and actions as detailed below form part of the Blue Light Together package of mental health support, which has seen The Royal Foundation working together with emergency service leaders and partner charities to change workplace culture with regards to mental health and provide specialist support to emergency responders and their families.

1. Prioritise mental health in the workplace by developing and delivering a systematic programme of activity
2. Proactively ensure work design and organisational culture drive positive mental health outcomes
3. Promote an open culture around mental health
4. Increase organisational confidence and capability
5. Provide mental health tools and support.
6. Increase transparency and accountability through internal and external reporting

Work to align current support and to develop new initiatives and frameworks commenced in January 2022.

Psychological Issues and Long Term Absence

An intensive deep dive into the evident link between long term absence and the prevalence of psychological issues is currently being led by Police Scotland's Head of People, Health and Wellbeing.

The deep dive will consider organisational data from the last 5 years and will aim to:

• Further understand the correlation between long term absence and psychological issues

• Identify the primary causes of the psychological issues and trends amongst our workforce.

• Inform the development of 'fit for purpose' support pathways and services i.e. EAP and Occupational health service provision.

• Inform the future direction of our mental health in the workplace activity i.e. a more preventative approach.

This work is underway with findings and recommendations to be presented by September 2022.

Area of Interest Identified By Criminal Justice Committee

The response to the findings of the 'Your Voice Matters' survey of officers and staff

Response

Background and key findings

A study by independent researchers from Durham University Business School received 7,389 (31.2% response rate) responses for the main survey, which were collected over a four-week period in March 2021.

Durham University Business School has worked with over 30 police services and their experience and expertise enables credible, meaningful and comparable insights.

The results suggest individuals within policing in Scotland are highly motivated to provide meaningful public service and are personally committed to serving the wider community. High levels of job satisfaction were also reported by officers and staff across Police Scotland.

Other key findings of the survey include -

- Integrity identity was reported at an extremely high average level across the service, with officers and staff scoring an average of 6.35 out of 7 (officers 6.37/staff 6.28).

- Commitment to the public was high across the service at an average of 5.46 out of 7 (officers 5.53/staff 5.29).

- Job satisfaction was at a high level across the service at an average of 5.05 out of 7 (officers 5.03/staff 5.1).

Organisational response

The Chief Constable's Commitments 2021-22 include a promise to act on the findings of the survey which will be delivered through synergy of both national and local activity.

The 'Your Voice Matters' Steering Group has overseen the development of the organisational implementation Plan, which focuses on tangible activity within 5 key themes:

- Leadership;

- Wellbeing;
- Behaviours;
- Hindrance Stressors; and
- Enablers.

In alignment with the organisational response, local Implementation plans have been developed and agreed via Divisional/Departmental Senior Management Teams.

Area of Interest

Data on the number of days of police officers and staff absences due to mental health issues, such as stress, over the last 5 years and any trends

Response

The first two tables below provide the number of WDL due to psychological disorders broken down by employee type and year for the past five years.

The subsequent two tables detail this information as a percentage of total working time over the last two years.

It should be noted that as Police Scotland's People and Development Division continue to refine and mature their data sets, the absence reporting protocol has significantly improved since April 2021. Therefore, when comparing this data with earlier years some variance may be attributed to this.

Psychological Disorders - Officer WDL					
YEAR	2017/2018	2018/19	2019/20	2020/21	2021/22
TOTAL	43326	44414	52103	44975	51421

Psychological Disorders - Staff WDL					
YEAR	2017/2018	2018/19	2019/20	2020/21	2021/22
TOTAL	19457	20403	24418	24156	25427

Psychological Disorders – Officer WDL% of Total Working Time		
YEAR	2020/21	2021/22
TOTAL	1.3%	1.6%

Psychological Disorders – Staff WDL% of Total Working Time

YEAR	2020/21	2021/22
TOTAL	1.8%	1.9%

Area of Interest

An update on Police Scotland's plans to issue a survey to police officers and staff to assess their wellbeing and mental health

Response

Health and Wellbeing Programme Evaluation and Review

The Health and Wellbeing team are currently under taking an organisation wide evaluation and review which aims to:

• Understand the current health and wellbeing (HWB) needs of officers and staffs, and identify any emerging needs throughout the organisation.

• Engage with stakeholders, both internally and externally, to gain a depth of qualitative and quantitative insight. At present the HWB team have engaged with all ACC's areas to include local policing (East, West, North), all departments, SPA, SPF, ASPS, Unison, Unite and all Diversity Staff Associations.

• Measure the impact of the overall Health and Wellbeing Programme against its objectives; and more specifically 4 key services and projects within the wider programme, namely TRiM, Wellbeing Champions, Employee Assistance Programme (EAP) and Occupational Health (OH);

• Evaluate the extent to which the objectives of the Health and Wellbeing Programme are pertinent to the needs, problems and issues it was designed to address;

• Evaluate the efficacy of the Programme and identify its most efficient and its most inefficient aspects;

The Health and Wellbeing team plan to present a draft framework of priorities and actions at the Wellbeing Governance Board in June 2022, from which they will seek approval to proceed with the roll out and implementation of the Health and Wellbeing Action Plan and Evaluation Structures.

Scottish Government

10 May 2022

Dear Convener

Thank you for the opportunity to contribute prior to the evidence session taking place on Wednesday the 18th of May on the issue of policing and mental health.

The Scottish Government takes very seriously the responsibility to ensure that those going through the criminal justice system who may have mental health issues are appropriately supported, treated and cared for, while ensuring their rights are maintained.

We know that people in custody present higher levels of risk and vulnerability than the general population as a whole and often have complex mental health needs. We are therefore committed to ensuring that everyone who requires swift and effective emergency mental health and wellbeing care is able to easily access it.

As you may be aware, the **Scottish Government's Mental Health Strategy 2017-2027** provides more details on our continuing plans for an integrated approach to providing help to those in need.

Action 15 of the Strategy outlines our commitment to funding 800 additional mental health workers in key settings, including all A&Es, all GP practices, every police station custody suite, and to our prisons, ensuring that local provision and support is at the heart of our plans. These additional health professionals will provide increased capacity to deliver support in key locations where people may need help the most, including police custody suites. This resource works alongside **Police Scotland** to provide support to individuals coming into custody and is over and above other avenues of mental health support that are available to individuals in police custody[3].

The Scottish Government is committed to reviewing and refreshing the Mental Health Strategy in 2022. We want to ensure that our future strategy is evidence based, data and intelligence driven, outcomes-focused, underpinned by equality and human rights; and informed by lived experience. The Mental Health and Wellbeing Strategy is one of a suite of strategies currently being developed in the Mental Health Directorate. It will be progressed alongside strategies on Mental Health Workforce, Suicide Prevention, Self-Harm and Adverse Childhood Experiences (ACEs) & Trauma.

To date, a number of stakeholder engagement workshops and events have been held over recent weeks to help us define the scope, and shape the aims, of the strategy. We are also working with our Mental Health Research Advisory Group to bring

[3] An Action 15 example is a funded Crisis Intervention Team who will soon be co-located in Fraserburgh Custody Centre. They will be providing mental health support to persons in custody, which will extend in the community with follow up support, onward referral and signposting also available.

together the latest evidence on mental health and wellbeing in Scotland to guide the strategy. A formal public consultation will take place over the summer.

A **Cross-Portfolio Ministerial Working Group** to explore solutions to some of the urgent issues surrounding mental health (and substance use) issues in regards to those in the criminal justice system has been taking place since December last year. My officials will continue to work with Police Scotland, the **Scottish Health in Custody Network** and **third sector** representatives to drive forward progress to ensure the wellbeing and human rights of detainees in police custody are properly considered and action is taken where required.

In 2021, we also expanded operational hours for the NHS 24 Mental Health Hub, which is staffed by mental health practitioners, to ensure a 24/7 service for anyone seeking mental health support.

These clinicians will be able to access national and local routes to ensure people in emotional crisis or distress and those in need of urgent care – are assessed and supported, regardless of how they access services.

In addition, through the re-design of the Urgent Care Programme, the Scottish Government is working with our partners, including Police Scotland, to ensure that people with urgent mental health care needs get the right help, in the right place, at the right time.

With regards to the Committee's evidence session on the 18th of May, I would like to pick up on some of the specific matters this session will cover.

The demands placed on the police service when dealing with people with poor mental health

I want to start by expressing my appreciation of the extremely valuable work that all police officers, police staff and key partner agencies carry out every day of the year, serving the needs of *every* individual who enters the criminal justice system.

Police Scotland plays a vital role in assisting work across the public and third sectors to alleviate numerous public health issues, a position made even more evident by work in the last two years to support the response to the COVID-19 Pandemic**.**

I am aware through my regular meetings with the Chief Constable, that vulnerability-related 24/7 call demand into Police Scotland (which is typically non-criminal in nature) remains high and that his officers and staff are being required to attend many incidents which involve persons in mental health crisis and/or in distress.

These incidents impact throughout all business areas of Police Scotland including Contact Command & Control Division (C3), Criminal Justice Services Division,

Public Protection Unit, Professional Standards Division and Local Policing.

Police Scotland is fully committed to working with partners to identify criteria to fully assess the demand brought to the system as a result of individuals' mental health issues and work is underway between Police Scotland and Public Health Scotland (PHS) to consider how best to measure this demand.

Work continues to build on the opportunities created by Police Scotland's **Contact Assessment Model (CAM)** in order to provide the most appropriate investigators or responders at point of first contact, lessening the burden on victims and reducing overall police demand in the process. This is being achieved through the Contact, Engagement and Resolution Project (CERP), which includes three workstreams.

The first, Direct Partner Referral Pathways; provides mental health practitioners inside C3, increasing the proportion of calls diverted directly to the NHS whilst providing expert support to officers dealing with such incidents.

It is clear that direct joint working is necessary to address issues that cut across numerous areas of society and do not sit wholly within the remit of any one organisation or sector.

In recognition of this, regular sessions are held between Police Scotland and the PHS mental health team, with the ambition of developing a joint delivery plan, including shared priorities and key activities to be the responsibility of both agencies.

One primary work stream within this role relates to improving the mental health of our communities, through enhanced data sharing and collaboration. Work continues to join Police Scotland, PHS, the Scottish Suicide Information Database (SSID), the Convention of Scottish Local Authorities (COSLA) and the National Suicide Prevention Leadership Group (NSPLG) in creating national data sharing processes around suspected suicide figures, allowing the rapid dissemination of information, increased suicide prevention awareness, and ultimately saving lives.

Since 2020, the Scottish Government have provided £564,188 to Police Scotland to support the development of an **Enhanced Mental Health (EMH) Pathway** for those in distress or in need of mental health support who come into contact with Police Scotland. This pathway enables emergency calls received by Police Scotland where callers are identified as requiring mental health advice to be directed to a dedicated Mental Health Hub within the NHS 24 111 service[4].

[4] Police Scotland's Healthcare and Interventions Team works with all 14 Health Boards to ensure a safe public health approach to persons in custody continues to be delivered. Mental health pathways are being reviewed with each Health Board to facilitate a smooth journey through the CJ process for every person, whilst receiving the support they need through the Arrest Referral Programme.

As part of Police Scotland's **Modernised Contact and Engagement Programme**, on Tuesday 15 March 2022, a number of Mental Health Nurse Practitioners (MHNPs) from NHS24 began work within C3. In conjunction with police officers from C3 Division's Resolution Teams, the MHNPs will triage and support mental health related incidents throughout Scotland as part of phase 2 of the Pathway.

An online survey has been made available to officers and staff, seeking views on how Police Scotland currently deals with mental health incidents. Insights from the survey will be considered as part of the ongoing evaluation of this initiative.

How Police Scotland deal with people with poor mental health who are taken into custody

Police (and indeed prison) custody provides an opportunity to connect with individuals who traditionally do not engage with community health and social care services.

High quality healthcare, social care and health improvement services provided by NHS, **Health and Social Care Partnerships**, **Local Authorities** and the Third Sector in police custody and prison can:

- Enable people to access a range of clinical services and social care services in police custody and in prison.
- Reduce the disparities in the availability of and access to health services for these people compared to people in the community.
- Provide pathways into community services from police custody and prison, enabling access to community services previously unavailable to them and ensuring continuity of care.
- Ensure the health and human rights of people in police custody and prison, limiting discrimination and stigmatisation and removing impediments in access to health promotion and preventive and curative interventions.
- Minimise the negative impact of incarceration on health outcomes by considering health risks specific to the prison setting.
- Improve the health and wellbeing of people in police custody and prison.
- Assist in reducing reoffending; health and social inequalities experienced by some people in the justice system may be contributing not only to their offending but may also leave them trapped in a cycle of harmful behaviours that they cannot break on their own.

Highly dedicated and specialist **Custody Officers** have overall responsibility for the care of all detainees entering police custody centres. They take the decision to authorise or refuse the detention of the individuals presented before them and are ultimately responsible for the effective and efficient completion of the whole custody process. A vulnerability/risk assessment is carried out in respect of each detainee and the Custody Officer will react to and address any welfare and medical needs

identified. This officer will then ensure that the **Arrest Referral** process is offered.

Arrest Referral is an intervention aimed at people who have been arrested with a view to reducing drug deaths, supporting those involved in harmful substance use, those with mental health issues and those suffering social inequalities which is part of the **Criminal Justice Services Division's Harm Reduction Strategy**. It capitalises on the opportunity to help people engage with all available interventions including drug use treatment services, reducing the likelihood of involvement in offending behaviour in the future. It takes place in the police custody centre.

The intervention may range from the giving of information to assessment and referral to appropriate services. Custody staff will offer advice and help with a view to referring the individual to a service as quickly as possible. If the person agrees, custody staff will carry out an assessment of the person's needs and arrange a contact with an appropriate service either directly or by email referral.

Over 160 **Custody Support and Interventions Champions** have been identified across the custody estate to drive the Arrest Referral Programme at an operational level. This has resulted in a significant increase in the number of arrest referrals being offered and also accepted by persons in custody.

Work continues to promote the Programme across the country with an Interventions Sergeant having visited almost every Primary Centre to speak with Champions, staff and supervisors about the Harm Reduction Strategy.

In addition, these Champions have received NHS training packages about **Motivational Interviewing and Trauma Skilled Practice** and two new types of posters have been placed in custody centres to remind staff and arrested persons of the support available.

There are different **Navigator** and **Peer Mentor** models operating at local level in custody centres across the country - some examples of which are;

- Positive Outcomes Project (POP) is a joint initiative by Police Scotland, Glasgow Health and Social Care Partnership and Aid & Abet.
- Change, Grow, Live (CGL) is a drug and alcohol addiction support service which currently works in partnership with Police Scotland covering the City of Edinburgh, the Lothians and Forth Valley regions.
- 'We are with you' in the Scottish Borders.
- Third Sector Interface Link Workers, based in Inverness custody centre.
- Dundee (City) Custody Assessment and Referral Service (CARS).

Navigators can facilitate a pathway into harm reduction, treatment and rehabilitation services aimed at reducing the risk of reoffending and Peer Mentors can give detained persons the opportunity to access support specific to their needs.

In some areas of the country, Police Scotland has secured further commitment

from support organisations, whose vetted staff will now attend custody centres to speak with arrested persons face to face. There is also ongoing engagement with several local authorities and third sector organisations to plug gaps which have been identified in support services across the country.

It is acknowledged that where such services are available, **referral criteria and/or inclusion criteria** can be complex and work is ongoing to try and alleviate this and to bring **more local, regional and national cohesion**.

It is also acknowledged that the Pandemic affected the services available to persons in police custody. Detainees were processed and released much more quickly and alternative measures were used far more widely to reduce the number of individuals being held for court the next lawful day. Support agencies struggled to physically attend custody centers to meet face-to-face with (potential) service-users and telephone engagement generally had to take place post-release. It is anticipated that as we continue to emerge from the Pandemic, all related restrictions will be lifted.

Police Scotland is one of the first police services in the UK to implement **mental health and suicide intervention training** for all officers, up to and including the rank of inspector. This benefits the police workforce, as well as the public they serve.

In addition, police staff working in custody suites receive an input in mental health awareness as part of their **custody officers induction course**. It is vital that this training is provided to frontline officers and staff to ensure they are receiving the right knowledge and skills required to assist in identifying, engaging and supporting those experiencing mental ill health.

With cross sectoral partners, the Scottish Government have developed the innovative **Distress Brief Intervention (DBI) Programme** over recent years. DBI is a 2 level approach provided for presentations of distress (including self-harm) to frontline services that have an emotional component and do not require alternative emergency service involvement. Current funding for DBI is £4.1m per annum.

The intervention has a clear vision of providing "connected, compassionate support". The DBI has two levels: Level 1 is provided by trained front-line staff (**including police officers**) and involves a compassionate response and offer of referral (where individuals are assessed as appropriate) with confidence, clarity and guarantee of support within 24 hours. Level 2 is provided by trained third sector staff who contact the person within 24 hours of referral and provide compassionate community-based problem solving support, wellness and distress management planning, supported connections and signposting for a period of up to 14 days – connecting people to the supports that help them over time. It is not possible to self-refer to DBI. The model is to allow frontline staff to refer people in distress, who they encounter in the course of their duties, to a support option which was not available prior to the development of DBI.

The initial pilot phase was developed in Lanarkshire, Scottish Borders, Aberdeen and Inverness; but with the incremental addition of new DBI "associate sites" in other areas, DBI is being rolled out towards our PfG target of having DBI available in all NHS Board areas by March 2024.

Currently 17 of the 31 Integrated Joint Board areas in Scotland have DBI in place, with more to go live across Summer 2022 and more in earlier stages of discussion. These "associate sites" form a key building block towards the 2024 target.

In addition to the growing provision of DBI in local areas, DBI also has three national pathways. In Spring 2020 as part of our wider response to Covid, we worked with NHS24 to open up a new pathway to DBI, which meant that people contacting NHS24 in distress, anywhere in Scotland, could, where assessed as appropriate, be referred for DBI Level 2 support.

Earlier this year, new pathways to DBI became available via **Police Scotland's and the Scottish Ambulance Service's national call handling centres**. This means that people who contact these call handling centres can be referred on to DBI without a patrol car or an ambulance crew being sent out to see the person. The Police Scotland and Scottish Ambulance Service call centre pathways therefore not only provide support to people in distress but also free up police and SAS crews to deal with other tasks. Initial referral numbers via the police and SAS call centres have been relatively small but this is expected to grow over time as more staff receive DBI training.

Since launch in 2017, over 26,000 people have been supported by the DBI programme. This includes some 2,705 referrals from Police Scotland. An evaluation of the initial DBI pilot, and an evaluation of the NHS24 pathway extension, are due to be published this Spring; these will help inform the detail of the continuing rollout process of DBI.

We are also committed to ensuring that the recommendations set out in **Dame Elish Angiolini's Independent Review** of Complaints Handling, Investigations and Misconduct in relation to policing in Scotland are progressed to ensure that the efficiency and effectiveness of the whole system approach to mental health is reviewed and that NHS accident and emergency facilities are designed to be able to deal safely with mental health care and acute crises.

Work with colleagues from the **National Police Care Network** is also ongoing to introduce **Medication Assisted Treatment (MAT) Standards** into custody during 2022. Existing support agencies are being rolled out to additional custody centres and new support agencies also introduced, to increase the support available for persons in custody suffering from substance use, mental ill-health, physical health and social inequalities.

The impact on the mental health of officers due to the demands being placed upon them in the course of their duties

The wellbeing of police officers and staff is a matter for the Chief Constable, and Scottish Government welcomes the range of initiatives being undertaken by Police Scotland to support its workforce, keep them well and prevent mental illness.

Police Scotland has been clear that maintaining and supporting the health and wellbeing of their workforce is a key priority and officers and staff can access a range of services to care for their physical and mental health through the "**Your Wellbeing Matters"** programme.

They also have approximately 200 **Wellbeing Champions** across the organisation to offer peer support and officers and staff can download a **Backup Buddy app** to their mobile devices which has been specially developed in recognition of the need to support the mental health of those in policing.

Police Scotland also recognised the impact of the Pandemic on the wellbeing of officers and staff, and quickly set up a **Wellbeing Hub** to coordinate information on support services that their workforce can access

With regards to help for officers they have access to Police Scotland's **24/7 HELP Employee Assistance Programme (EAP)**. The programme offers professional support and guidance via a team of trained wellbeing and counselling practitioners who offer confidential, independent and unbiased information and guidance. Officers can call HELP EAP and discuss in confidence any concerns they might have.

The **Trauma Risk Management (TRiM)** process is in place to support officers affected by potentially traumatic incidents at work. Understanding and processing reactions and emotions immediately following exposure to traumatic incidents can help to prevent mental health difficulties further down the line.

In addition, the Scottish Government has provided funding support to extend the **Lifelines Scotland** wellbeing programme. This is a project which supports the wellbeing – and recovery - of emergency responders in the "blue light" services (professional, voluntary and retired – and their families) who have had challenging or distressing experiences in the course of their work. SG Mental Health Division has provided some support funding to Lifelines in the last three financial years, and they also receive funding from Police Scotland, Scottish Ambulance Service, Scottish Fire and Rescue Service and the Fire Fighters Charity. Although based at NHS Lothian, the project provides support to emergency responders from across Scotland.

Scottish Government funding in 2022-23 was £97,864, to support a range of subheads across training, staffing, evaluation and development of online support and advice modules. This funding ended in March 2022 but we are currently considering a proposal from Lifelines for further funding support in 2022-23.

The Scottish Government does not hold related **crime data** and suggest that Police

Scotland is better placed to provide the evidence you request.

Keith Brown

Association of Scottish Police Superintendents

9th May 2022

Dear Mrs Nicoll

CRIMINAL JUSTICE COMMITTEE – POLICING AND MENTAL HEALTH

Thank you for the invitation to submit written evidence to the Scottish Parliament's Justice Sub-Committee on the above matter.

From the correspondence welcoming comment from ASPS, it is my opinion that much of what the Committee seeks will come directly from Police Scotland. The Service is much better placed to provide quantitative measures of mental health impacts on operational policing, as well as legislative and procedural barriers to service delivery. The impact that mental health matters has on the public and public services cannot be overstated. It is widely accepted that the overwhelming majority of calls into Police Scotland do not relate directly to crime. A considerable proportion of contact from the public has a mental health aspect to it, and this translates to increased demand in areas such as response policing and public protection.

What I would be pleased to offer are views on the impact on the mental health of our members and the wider policing community; opinion based on feedback from our members (directly or via the staff survey) and the lived experience of police officers who are either currently serving or have recently served Scottish communities. Concern calls, be it missing persons, those threatening self-harm, or even those misusing the contact systems, represent some of the most challenging and high-risk work police officers, staff, supervisors and command teams face. Whilst there is no argument that it is right that the Police play their part in safeguarding those at risk due to a mental health crisis, the impact of this demand must be examined.

A strong collaborative relationship with our partners in the health and social sectors must be maintained in order that appropriate resourcing and allocation of responsibility in dealing with matters arising from mental health issues. Policing cannot be expected to deal with these events unilaterally, when there is a wealth of knowledge, and experience in other areas. The immediate management of crises, quite correctly, often rests with policing, however policing alone cannot be expected to tackle the causes of the mental health challenge Scotland faces.

Over the years, a number of groundbreaking programmes and pilot schemes have been undertaken by Policing and our partners; such as having Community Psychiatric Nurses in custody suites, and taking clinicians out operationally with mobile units. The problem with these trials is they require resource and a commitment to funding to make them sustainable, so despite their success they have often failed to be mainstreamed. The Association hopes that this is all acknowledged by the Committee and the Services.

As senior leaders in Policing, ASPS members are acutely aware of the consequences our job has on our own mental health, as well as that of our peers. Through the staff survey of 2020, it is quite clear that our people are undergoing some significant strain and pressure which takes it's toll on their mental health. The phrase "emotional fatigue" regularly featured in responses to the survey, and it is vital that the Service addresses the cumulative effect of a career exposed to volatile and stressful incidents as soon as it can.

Our Association recognises that not only serving officers experience their own challenges emotionally, but that members who have since left the service still undergo support. We believe that whilst the Service has a number of procedures to deal with significant post-incident trauma (e.g., TRiM and PIP), the organisation is still slow to respond to the continual "topping up" of many years of exposure to crises and trauma- a "death by a thousand cuts" type scenario that many officers face. This has as insidious an impact on an individual and their loved ones as involvement in any one single event.

ASPS has, and will continue to, provide as much welfare and support to our members (and by extension their families) as we can. Through our Panel of Friends network, we seek to provide peer support to any member of the Association looking for additional welfare during misconduct investigations, or grievance procedures, or just when they feel unsupported by the Service; all this helps ease the psychological burden on our members during highly stressful times and lessens the risk of further tensions and pressures at home and at work. We are also aware of how disrupted rest can have a massively negative impact on our members and their recovery time from the challenges of their roles, and we actively encourage our members to take their rest when possible.

We have also been keen to support the work of Ian Thomson, a former ASPS Executive member who has been working with the Royal Foundation of The Duke and Duchess of Cambridge. Mr Thomson has been developing strategies to provide a package of mental wellbeing products to emergency responders, particularly in Policing. This approach to supporting all emergency services is reflected in our burgeoning relationship with Lifelines Scotland, with whom we have a series of Continuous Professional Development events planned, to help our members self-check their wellbeing and to help identify when their peers need that same assistance.

Wellbeing, particularly emotional, is a key priority of our Association, and we believe the Service are prioritising this, as the recent staff survey has clearly indicated that staff and officers throughout the organisation experience what they believe to be poor levels of wellbeing care. ASPS are keen that the plan to remedy the findings of the survey is implemented as soon as practicable, and we will endeavour to provide Police Scotland with whatever assistance, guidance and participation is needed. From recent discussions, I am confident that the Service will make the necessary changes imminently. The Wellbeing Agenda within Police Scotland has been taken seriously, and with the recent appointment of a new Wellbeing Manager, we are encouraged by

their desire to change the welfare agenda of Police Scotland with some innovative thinking. They do, however, need the wholehearted support of the Service, in terms of resource and autonomy. The Association feels it is absolutely essential that Police Scotland addresses some of the hindrance factors that prevents our senior leaders (and all staff) from valuable recovery and family time, such as minimising the amount of on-call duties an individual takes, allowing people to take uninterrupted leave without the fear that they will return to the workload that has been left dormant whilst they are off, even small things such as ensuring that no meetings are scheduled for one hour a day to allow staff to take a break from their screens, refresh and deal with correspondence.

In conclusion, the Association will be pleased to participate in further consultations and discussions on Policing and Mental Health. I have previously commented in writing to the Committee that I believe Police Scotland has taken a mature and welfare centred approach to providing a service to Scottish communities, and I am confident that with the support of our membership, the Service can deliver.

Yours sincerely,

Suzie Mertes
Chief Superintendent
President of ASPS

HM Chief Inspector of Constabulary in Scotland

Dear Criminal Justice Committee

Written Evidence on Policing and Mental Health

HM Inspectorate of Constabulary has a three year scrutiny plan to inspect Police Scotland and the Scottish Police Authority. Within this plan is an intention to inspect the policing of mental health demand. The plan states the following:

Servicing Mental Health Demand
This was the area discussed most by officers and staff who took part in our consultation. There was a feeling that demand for policing has shifted significantly over recent years and that more incidents relate to mental health than crime. We will seek to examine this position and to use benchmarking with other services to establish options for alternative approaches. We will seek to examine the role that policing has in responding to mental health related incidents as well as where other services may be more equipped to provide the appropriate level of support to the public. We will also look at preventative approaches and the support available from partner organisations, to identify alternatives that will offer the best possible outcomes for the public.

It is intended to undertake this work later in 2022 and publish in 2023. At this point in time it would be inappropriate for HMICS to offer any further comment on the demands placed on Police Scotland in relation to managing mental health incidents.

Joint Inspection of Healthcare in Custody
In addition HMICS will be working in partnership with Healthcare Improvement Scotland on a baseline assessment of the provision of healthcare services to police custody centres in Scotland. Our objective will be to map out healthcare provision to custody centres including governance arrangements, models of delivery and level of service provided. We will publish a joint report on the findings from the assessment and will utilise our findings to inform the subsequent onsite joint inspections of custody centres that will take place thereafter- a key element of this will be understanding mental health issues within the custody environment.

Officer and staff wellbeing
Between 2020 and 2021, HMICS published two reports in to the training and development capability within Police Scotland (HMICS | HMICS Thematic Inspection of Police Scotland Training and Development - Phase 2). Within the first report the following recommendation is made:

Police Scotland should develop a systematic process to record wellbeing conversations and considerations in support of its Wellbeing Strategy- work is ongoing in relation to this recommendation however, HMICS continues to see the value in the recording of wellbeing conversations and enabling audit of steps taken.

In the Training and Development Phase II report the following comment was made:

"Police Scotland has invested significantly in the wellbeing of its workforce over recent years. Wellbeing is a consistent theme throughout Police Scotland's People Strategy 2018-2021. The Chief Constable has pledged to "Implement new initiatives to support wellbeing and understanding of mental health issues" and this can be seen in the creation of a Health and Wellbeing Team, who release regular newsletters to staff promoting initiatives and support services that are available to officers and staff. A cadre of approximately 200 Wellbeing Champions has been established throughout Police Scotland, with the remit of providing confidential wellbeing support and guidance to officers and staff by signposting them to the most suitable services. These Wellbeing Champions have received Scottish Mental Health First Aid (SMHFA) training, along with a signposting course to build awareness of the different support available. Further training is also being piloted, in the form of NHS Mental Health Learning Bytes. Police Scotland has also invested in the Employee Assistance Programme (EAP), which provides officers, staff and their household family members access to a confidential support service, including counselling support and practical information and advice. The availability of the 87% App also allows users to input data to determine their current mental health status and then provides personalised guidance to improve aspects of wellbeing, such as advice, exercises, life coaching and coping strategies. A number of these initiatives have been developed following the results of a previous staff survey.

The welfare, wellbeing and morale of staff was also highlighted in the survey that was carried out to assist our inspection. Many felt affected by the culture and conditions within which they worked. This related to the themes of working culture, line management and senior leadership, opportunities for development and progression, harassment and discrimination, and a lack of opportunity around flexible working and reasonable adjustments."

It is clear that wellbeing of officers and staff is a high priority for Police Scotland and is recognised as challenging and complex by the force, staff, officers and the associations that represent them.

Yours sincerely

Craig Naylor
HM Chief Inspector of Constabulary- Scotland

Families Outside

Policing and Mental Health

Families Outside is a national independent charity that works solely on behalf of children and families affected by imprisonment in Scotland. We do this through provision of a national Support & Information Service (Helpline and online support) for families and for the professionals who work with them, as well as through development of policy and practice, delivery of accredited training, and face-to-face support.

Families Outside welcomes the opportunity to feed into the Criminal Justice Committee's call for evidence on policing and mental health in Scotland. We welcome the approach the Scottish Government is taking to ensure that human rights are respected at all times. We agree that everybody deserves to be treated with dignity and have their human rights respected.

Demands placed on the police

Families Outside recognises the intense demands on the police as a result of non-offence related calls from people in distress. Such calls can result in hours of police time spent providing crisis support and accompanying people to Accident & Emergency units, or in placement of people in police custody and in some cases on to custodial remand. We valued the important Community Triage programme Police Scotland tested with the NHS in recent years via local CPNs (Community Psychiatric Nurses) and would commend this model to be revisited, evaluated, re-established, and fully funded if confirmed as the positive model of support it was deemed to be[5].

We also recognise the high proportion of people who come into contact with the police who suffer from mental ill health. These issues may not always be recognised and even less frequently have a formal diagnosis, especially in the case of people with more hidden issues such as learning difficulties or learning disabilities. In such cases, the police may not be equipped to provide the most appropriate response. Established supports such as Appropriate Adults are not always used when they should be, which again leaves people who require it without the necessary support in place[6].

Mental health and wellbeing of officers

In order to have a well-equipped police force to be able to respond effectively, we feel it is important to recognise the demands placed on the police and the impact this has on the mental health and wellbeing of police officers. In order to support this, it

[5] http://scottishjusticematters.com/wp-content/uploads/Pages-from-SJM_5-2_PolicingAndCommunityMentalHealthTriage.pdf
[6] https://www.emerald.com/insight/content/doi/10.1108/JIDOB-08-2015-0023/full/html; https://www.gov.scot/publications/appropriate-adults-guidance-local-authorities/

will be vital that the key areas surfaced in the Your Voice Matters Survey 2021[7] are taken forward and committed to as stated in the implementation plan [8], Ensuring a focus on tackling mental health stigma and having appropriate things in place to support mental health and wellbeing. Although not directly linked to policing, much of this links to what Families Outside and other key partners found in the Independent Review of the Response to Deaths in Prison Custody 2021[9]. It highlighted variability in terms of support practices for staff and, that seeking support can be challenging for some staff, as it can be seen as a sign of weakness.

Support for people with poor mental health who are taken into custody

The expectation that police will be adequately trained to recognise mental ill health when they see it, to know how best to support people with mental ill health (especially those in crisis), and then to have the capacity to provide that support, creates unrealistic expectations and considerable pressure on the police. Forensic nursing assessments such as those conducted in the custody suite at St Leonards' Police Station in Edinburgh[10] provide much-needed support for the police and for people with mental ill health alike, but this service appears to be the exception rather than the rule. Proper assessment is crucial if people with mental ill health are to be diverted from criminal justice processes to receive the support they need.

Arrest and detention in police custody is likely to be distressing to anyone, even when they do not have underlying mental health conditions. Police are therefore responsible for supporting the general wellbeing of people in their care, recognising that they may be distressed, in crisis, suicidal, or likely to self-harm. Ensuring that people in police custody have the opportunity to reach out to a family member or friend, and to make contact successfully, is a basic right. Police also have a duty to inform the family that they can provide a change of clothes, books, etc. to their family member in police custody to help them feel settled and supported.[11]

2003 Act provisions

The Mental Health (Care and Treatment) (Scotland) Act 2003 Part 8 contains provisions for people in the criminal justice system who are displaying symptoms of a mental health condition. The process outlined in the 2003 Act reflects Scotland at the time; Scotland's understanding of mental health has improved since. We now have a

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[7] https://www.scotland.police.uk/spa-media/0s0diex1/your-voice-matters-survey-2021-summary-of-findings-report-issued.pdf

[8] https://www.spa.police.uk/spa-media/lwyhwiva/rep-c-20220221-item-6-1-your-voice-matters-doc.pdf

[9] https://www.prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/Independent%20Review%20of%20the%20Response%20to%20Deaths%20in%20Prison%20Custody%20p6%20%281%29%20WEB%20PDF.pdf

[10] https://www.google.com/search?q=nursing+assessment+women+custody+st+leonards+police+edinburgh&rlz=1C1GCEB_enGB995GB996&oq=nursing+assessment+women+custody+st+leonards+police+edinburgh&aqs=chrome..69i57.11431j0j7&sourceid=chrome&ie=UTF-8

[11] https://www.familiesoutside.org.uk/content/uploads/2021/10/Family-Framework-Document-Oct-2021.pdf, at 1.17; and https://www.familiesoutside.org.uk/content/uploads/2021/10/Supporting-Document-Oct-2021.pdf at 1.17.

better understanding that many people who have been arrested or committed a crime suffer from a mental health condition. As such, Scotland's approach to treating mental health within the criminal justice system should not be 'clear-cut'.
In taking a human rights approach to mental health legislation, Families Outside believes that the provisions set out in the 2003 must be more flexible to ensure that anyone going through the criminal proceedings receives the care and treatment they require at the earliest possible stage – in this case, at the point of arrest or even before.

Training

Police officers have an important role to play in supporting the positive mental health of people who enter the criminal justice process and should be trained to do so. All too often, police are first to notice symptoms of mental ill health or are the first people to whom someone will make a mental health disclosure. Again, the evidence available shows that mental ill health is more prevalent in custodial populations than in the population at large. Police officers should therefore have a minimum level of skill in recognising mental ill health and supporting mental wellbeing, and why legislative provisions should extend beyond medical professionals.

Family Involvement

Families Outside has long argued that family members should have a greater role in the medical support and treatment provided to people in custody. In most circumstances, it will be the family member who has an understanding of the symptoms experienced and the treatment given by various health professionals.
The Charter of Patients' Rights[12] sets out clearly that family members should be engaged in discussions about care arrangements of an adult they care for (formally or informally) subject to Mental Health law. Families Outside works with a number of families who struggle to share or discuss their concerns about their relative in custody or to have an input to the care they receive. Families Outside supports the Charter and believes it sets out the minimum level of care and support to which people with mental ill health are entitled. We support extension of the Charter, especially in terms of family involvement, into criminal justice settings: currently the Charter is limited to mental health settings.

Under current mental health legislation, healthcare professionals are required to engage with a person's carer to inform and involve them in their care. However, the police do not currently have to engage with a person's carer, demonstrating a lack of parity between care in justice and health settings. We have highlighted above that mental illness is more prevalent in the custodial population than the population as a whole, highlighting the need to involve family members more in the care of those in custody, including police custody.

Family members are likely to be aware of the history of mental ill health of the person in police custody, any current treatment or care provision, and potential triggers. By

[12] https://www.gov.scot/publications/charter-patient-rights-responsibilities-2/

extending the provisions in the Charter and reflecting the Charter within mental health law, greater family involvement could be achieved to enable better outcomes for those suffering with mental health conditions.

A call for the increased need for family involvement and, greater multidisciplinary working and sharing of information, has also been highlighted within the recommendations of the Mental Welfare Commissions report into 'Mental Health Support in Scottish Prisons 2021'[13]

Case Study

We have permission to provide the case study included in our email,[14] which we feel illustrates some of the key themes we highlight in this paper, in relation to lack of proper assessment at earliest possible stage, lack of training around mental health for officers and significant failings around family involvement, partnership working and communication. This case study unfortunately highlights just one example of the devastating impacts and knock of effects this can have to individuals and to the wider family network.

Families Outside is grateful for the opportunity to feed in to the Criminal Justice Committee's call for evidence on this issue. We look forward to working with Committee members over this Parliamentary Session in tackling the issues facing Scotland's justice system and ensuring the engagement of and support for families affected by imprisonment. We are more than happy to discuss the issues raised in this response further.

[13] https://www.mwcscot.org.uk/sites/default/files/2022-04/PrisonReport-April2022.pdf
[14] The case study was provided to Committee members but has not been published.