FOI – 202500496472 - Cost calculation

Q4. Any correspondence between the Scottish Government and Police Scotland relating to:

- **mental-health-related demand**
- **repeated crisis callouts**
- **pressures arising from early release or high-risk individuals with complex needs**
- **the development, implementation, or evaluation of "Right Care, Right Person" or any equivalent Scottish model.**

Search time (a)

Requirement for searches of ERDM by case handler and personal inbox searches of two key members of staff (including case handler) to cover this time period. Scottish Government wide folders were required to be searched as this request covers policing, mental health, health, prisons etc. The results from the ERDM searches alone far exceed the cost limit, as such we have only searched the case handler and their teams inboxes for this calculation as an example. However, if a response were to be issued for this, it would require a much wider commission across the Scottish Government, which would further exceed the cost limit.

Case handler searches were approximately five hours using key words searching files known to hold information requested = 300 minutes

One other officials asked to search Outlook/personal storage taking 2 hour each each = 120 minutes.

Total time for searches = 420 minutes

Sift time (b)

*30 seconds to (max) 1 minute per document, we have used 45 second for our calculation. We have broken this down by ERDM results and inbox results and have conducted a sample sift on both for redaction to allow for a more accurate breakdown of time taken.

ERDM

105,410 documents - time taken to sift 105,410 documents at 45 seconds per document = 1,317 hours (rounded down)

Mailboxes

7,333 documents – time taken to sift 7,333 documents at 45 seconds per document = 91 hours (rounded down)

Total Time – 1408 hours

Redaction time (c)

As stated above we have broken down sift sample sift by mailbox and ERDM to make total time calculation more accurate:

- **ERDM:** 3 out of 50 sample were within scope = 6%
- **Mailbox:** 12 out of 50 sample were within scope = 24%

As such it is assumed on this basis that there would be 6324 documents within scope on ERDM and 1759 in mailboxes (just for Police Policy Team). It is assumed that all documents would require redaction as they would at a minimum include personal information.

Total number of documents expected to review = 8083

Number of documents we expect not to require redactions = 0

Time taken to redact (5 mins) x total number of expected documents to redact (8083) = 673 hours

Total resource time = (a) + (b) + (c) = 12h + 104h = 673h = 789 hours

If greater than 40 hours the cost limit can be applied, as such this far exceeds the threshold and qualifies.

Version Control

Mental Health Partnership Delivery Group

Collaborative Commitments / Action Plan

Name and contact details of Author	
Name and contact details of Approver	
Name and contact details of Owner	

Version	Date	Prepared By	Reason for Change
0.1	15/9/2024	[redacted]	Request to include more detail on the MHW Strategy outcomes and priorities.
0.2	18/9/2024	[redacted]	Amending Action Plan
0.3	18/9/2024	[redacted]	Working draft updates for PDG, core group review

Distribution Published versions of this document will be distributed to:
PDG membership
Strategic Governance Group

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Introduction

Mental health and wellbeing is a top priority for the Scottish Government, not only in relation to mental health services for those who need them, but, just as important, in relation to how we improve public wellbeing and help prevent illness.

We know that multiple factors can impact mental health and wellbeing, and that poor mental health and wellbeing is not only detrimental to individuals but also places additional demands on services and supports, and on the people that provide them.

The Mental Health and Wellbeing Strategy: Delivery Plan 2023-2025 and Workforce Action Plan 2023-2025 were published jointly by Scottish Government and COSLA on 7 November 2023. These documents set out the actions that will be undertaken by the Scottish Government and partners including those in Local Government, Health Boards, third sector to make progress towards the outcomes and priorities in the Mental Health and Wellbeing Strategy, which was published on 29 June 2023.

The Strategy recognises the importance of a whole system approach to supporting mental health and wellbeing and provides a foundation for better joint working. It sets out a clear vision for future population mental health, wellbeing and care, and our priorities to help us get there.

> Our shared vision is "*of a Scotland, free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible*".

It contains our blueprint for a high-functioning mental health system, and a set of Outcomes that will enable us to measure our progress and describes the help and support that anyone should be entitled to expect when they ask for it – for any aspect of their mental health, at any level of need.

A fundamental part of our Vision of a high-functioning mental health system, ensuring a good balance between specialist services and activities focused on support and prevention.

The Scottish Government is also taking action jointly with COSLA to reduce the number of deaths by suicide. Creating Hope Together: Suicide Prevention Strategy, Creating Hope Together Delivery Plan 2024-2026 set out the Strategy and Actions being taken to ensures government and local services work together to support anyone at risk of suicide or affected by it, while tackling underlying factors that can lead to suicide, such as inequalities, stigma and discrimination, which have been exacerbated by the pandemic and cost of living crisis. Self-harm is also a risk factor for suicide and the Self Harm Strategy and its Action Plan, are focussed solely on tackling the issue.

In delivering the Vision, we recognise the differing roles, responsibilities and capacity of our respective organisations. We also know wider partnership work will be crucial; achieving our Vision will rely largely on the people who work within and across sectors to improve the mental health and wellbeing of our communities and will need a cross-society approach. This includes local and national government; public bodies

such as the Social Care sector; NHS, Third Sector Police Scotland and Scottish Ambulance Service. This Action Plan will support local partners and partnerships to continue to make local decisions to plan and deliver support and services.

In its thematic review of policing mental health in Scotland, published on 18 October 2023, His Majesty's Inspectorate of Constabulary in Scotland (HMICS) recognised that mental health is a multifaceted issue that requires an effective whole-system partnership response, and set out a number of recommendations for Police Scotland, the Scottish Police Authority (SPA), the Scottish Government, and other bodies.

Police can play an important role in improving the safety and well-being of individuals, localities and communities in Scotland[1], the Vision for Justice in Scotland, sets out the importance of people in contact with the justice system being able to access the correct support. It also recognises that effective partnerships are essential to improving the mental health and wellbeing of those who encounter the justice system.

The Framework for Collaboration (FfC), sets out principles and recommendations for an effective and strong multi-agency collaborative approach to supporting individuals in distress to get the right care they need a person-centred and trauma-informed way.

This Action Plan interconnect with the other Strategies and Plans and is another element of our whole system approach to achieving the Strategy's Vision. It supports the work that is already planned and underway as well as providing more detail on the Delivery Plan's commitment to implement the HMICS recommendations – by taking action to ensure:

- resources are appropriately deployed;
- that those seeking urgent or unplanned mental health support receive the right care, in the right place, at the right time; and
- to reduce unnecessary demand on police officers.

Further information about the outcomes, priorities and actions being implemented to deliver a whole systems approach to improving mental health and wellbeing in Scotland are contained in Annex A.

Governance and Accountability

The Action Plan is split into a series of thematic areas where actions will be taken:

- Communication
- Improved transfer of care between partners
- Timely crisis response
- Building capacity and capability, including improved data and evidence available to partners
- Strengthening community-based provision

[1] Section 32 of the Police and Fire Reform (Scotland) Act 2012

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Delivery of this action plan over the next three years will be taken forward collaboratively across services. The Partnership Delivery Group (PDG), which has supported the development of the Action Plan will continue to advise its implementation. The PDG will report on implementation progress to a Strategic Governance Group, chaired by the Scottish Government, and to the Mental Health and Wellbeing Strategy's Leadership Board. As per the HMICS recommendations Police Scotland have also established an internal Mental Health Reference Group to xxxxxx which will report to xxx. The Scottish Police Authority(SPA) and Police Scotland will also report progress through the SPA Policing and Performance Committee.

The Mental Health and Wellbeing Strategy's Leadership Board, chaired by Scottish Ministers and COSLA, is supporting and ensuring progress towards the stated outcomes and priorities in the Mental Health and Wellbeing Strategy in order to:

Promote positive mental health and wellbeing for the whole population, improving understanding and tackling stigma, inequality and discrimination;

Prevent mental health issues occurring or escalating and tackle underlying causes, adversities and inequalities wherever possible; and

Provide mental health and wellbeing support and care, ensuring people and communities can access the right information, skills, services and opportunities in the right place at the right time, using a person-centred approach.

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Commitments 2024-2027

Theme: Communication						
Action	Description	Lead	Interdependencies/ contributory role of services	Timescales	Outcomes	Measuring Impact
Develop a multi-agency communication strategy to promote access to the most appropriate service/ pathways, highlighting best practice and improve collaboration.	Agencies will improve internal communication to frontline staff, highlighting good practice. Collaborative external communication will take place between partners to raise public awareness allowing persons in crisis/ distress to seek support from the right	All agencies at PDG	Ensure join up and consistency of existing good practice models developed by PDG partners.		• Public and frontline staff have a better understanding of pathways and roles of services within a whole system response. • Improves outcomes for those in mental health distress, through being enabled to access and receive the most appropriate service.	• Qualitative and quantitative feedback from the public and frontline staff • Assessment of call demand to Police/ SAS and the proportion of calls directly made to NHS 24. • Through data and examples, illustrate improvement in person centred support and that staff

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	agency at the right time. Advocate cultural change with the public and frontline staff through this strategy					time is used effectively and efficiently.
Ensure opportunities are identified and progressed to raise awareness of available pathways into support and care	Building on the work of the Mental Health Unscheduled Care Network did on developing a page outlining how to get urgent mental health support, we will explore opportunities to further raise awareness of the available pathways into support and care.	PDG membership	2025	• Improved knowledge and understanding of how to access appropriate support. Reduced inequalities for population groups who may not equally benefit from mainstream forms of communication		Explore opportunities to raise awareness of available pathways into support and care

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	We will develop tailored messaging for specific population and equalities groups.					

Theme: Improved Transfer of Mental Health Care						
Action	Description	Lead	Interdependencies/ contributory role of services	Timescales	Outcomes	Measuring Impact
Develop and deliver an effective handover process for transfer of care in emergency / clinical settings.	Review and improve the current procedures in place for both SAS and Police to facilitate the structured handover of care of an individual in mental health crisis/distress from blue light services to health.	Health/ SAS/ Police Scotland	Partnership Delivery Group NHS Local Health Boards	December 2025	• SAS /Police engagement on scene at mental health distress calls is reduced. • Frontline staff report more confidence in using transfer of care arrangements. • Persons receiving such care are dealt with in a person-centred trauma informed way.	• SAS/ Police Scotland's workforce health and wellbeing survey • SAS/ Police Scotland and NHS data on time spent on scene and subsequent hours saved processing of patients in NHS setting.

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						• Qualitative feedback from persons receiving care/ NHS/ SAS / Police Scotland on trust and confidence that has been built and taking place on handover of care.
Develop and implement a model that allows for direct interaction between police officers and NHS 24 Mental Health Hub when engaging with people in mental health distress (not	Expanding on the development of the Mental Health Index, Police Scotland and NHS 24 will consider the implementation of the SAS Hot Handover process.	NHS 24, SAS and Police Scotland		December 2025	• Services deliver a joint trauma informed approach. • Persons in mental health distress receive most appropriate support from trained professionals. • Officers report more confidence in	• Police Scotland's workforce health and wellbeing survey • Police Scotland and NHS data on time spent on scene and subsequent hours saved

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meeting the triage threshold). Ensuring the on-going support to a person in distress by the right service at the right time.					transfer of care arrangements, and the assurance to leave the scene.	processing of patients in NHS setting. • Qualitative feedback from persons receiving care/ NHS/ SAS / Police Scotland on trust and confidence that has been built and taking place on handover of care.
Implement the consistent use of the Mental Health Index across Police Scotland ensuring officers can effectively access MH	Following the local and national improvements to the unscheduled care pathways across Scotland, all Boards have an unscheduled care clinician for mental health available 24/7 for	Scottish Government/ Police Scotland / Health		Next 3-6 months	• Provide consistent access to clinical advice on the best care outcome for the individual. • Improve, where appropriate, the transfer of care from police officers to clinicians.	• Once the data work with PHS has launched, it will provide a mechanism to monitor referral numbers and referral reasons from Police

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clinician services.	anyone requiring urgent specialist mental health assessment or urgent referral to local mental health services. In most Health Boards, these clinicians are also accessible by emergency services, providing them with advice and support with determining the most appropriate onwards care option. Through the Mental Health Unscheduled Care Network, the Scottish Government developed a digital reference guide called the				• PS officers can return to policing duties whilst ensuring the best support for the individual in mental health distress or crisis.	Scotland to local mental health unscheduled care services. • Evaluation of Mental Health Index to take place within agreed incremental timescales once launched • Explore capabilities of the Mental Health Dashboard in capturing relevant data in respect of MHI pathways.

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	Mental Health Index setting out the 24/7 access arrangements to the Mental Health Unscheduled Care Clinicians; this document acts as a community triage guide and will be quality assured on a six-monthly basis.					
Review of the Psychiatric Emergency Plans	Undertake a national review of the Psychiatric Emergency Plans with the Mental Health Unscheduled Care Network to improve their consistency across the 14 Health Boards in format, roles and responsibilities, and processes,	Scottish Government		November 2024	• A person-centred and human rights-based approach to responding to mental health emergencies. • Clearly articulated roles and responsibilities for each agency involved in responding to and managing a mental health emergency.	• Place of Safety data • Mental Welfare Commission's data on number of EDCs and STDCs • Data from local health boards through the MHUC data

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	while maintaining flexibility to reflect local arrangements and systems. The review will consider the recommendations made by HMICS and the Mental Welfare Commission.				• Provisions to support marginalised and equalities population groups	work with PHS
Develop and publish national guidance and template for Psychiatric Emergency Plans.	Following the review, the Mental Health Unscheduled Care Network will develop guidance and a template Psychiatric Emergency Plan for use by the 14 Health Boards.	Scottish Government		April 2025	• Consistently formatted and easier to use Psychiatric Emergency Plans	• Qualitative feedback from partners on the Mental Health Unscheduled Care Network • Place of Safety data • Mental Welfare Commission's data on number of EDCs and STDCs

						• Data from local health boards through the MHUC data work with PHS

Theme: Timely Crisis Response					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Scope and explore opportunities to work in collaboration around HIU/Complex Needs to develop partnership processes ensuring the public are supported by the most appropriate organisation.	Police Scotland, NHS 24, SAS and other stakeholders/partners will form a working group to assess data and thereafter develop and embed processes, both internal and cross-agency, which ensure those who regularly contact unscheduled care services are appropriately supported in line with care/management plans.	Police Scotland/ SPA? Public Health Scotland/ NHS 24, SAS			• PHS data work • PS MH Dashboard • SAS HIU data

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Theme: Building Capacity and Capability					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Ensure, where applicable, that Police Scotland is in place as a level 1 provider for DBI referrals and training and governance structures are embedded in practice.	Local Authorities and Police Scotland will work together on rolling out training to police division	Local Authorities & Police Scotland	In line with national roll-out/increase of Level 2 providers across Scotland, ensure all local policing divisions are trained in Level 1 DBI referral processes, where applicable. Training will be dependent on capacity of Level 2 providers locally. As and when instructed by H&SCP's	• People in distress who could benefit from non-clinical intervention are better supported • Police officers are provided with the knowledge and skills to support and ease a person's distress, provide a compassionate response and, where appropriate, provide a referral to DBI level 2.	• Data on DBI referrals Add detail on available baseline data
Continue to improve and increase the use of the Enhanced Mental Health Pathway	Fully embed Quality Assurance to consider missed opportunities where EMHP could have been considered.	Police Scotland/ NHS 24	12 months from publication	• Identifying most appropriate agency to support service user •	• Data from MH Dashboard and NHS 24 • Cost effectiveness in

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	• Undertaking QA in relation with service user that came through C3 to NHS 24 • Ongoing analysis to look at other missed opportunities where officers have been deployed (e.g. partner agency requests) – part of exercise to understand demand data and transfer of care				relation to officer deployment time • Police officers deployed vs signposted to appropriate service • Lived experience/user feedback (Mental Health Pathway evaluation reports)
National delivery of Police Scotland Suicide Notification form for information sharing.	Suicide notification form – now live nationally as a consistent model of practice. National template for data sharing purposes. Data sharing is already established within local policing divisions but the amount of information and format in which it is shared currently varies nationally. This new approach will support force wide consistency	Police Scotland		• Measuring reduction or potential increase in suicides – would enable suitable strategic action to be taken. • Supporting national human-rights based approach to information sharing • Enhancing opportunities for pro-active work	• Promoting prevention activity and awareness. • Supporting partnership interventions.

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	and a level of uniformity whilst ensuring compliance with data protection.			in local areas especially around locations of concern • This new approach will support force wide consistency and a level of uniformity whilst ensuring compliance with data protection. • Internal user feedback via the Police Scotland Mental Health Working Group	
Improve Mental Health training internally within Police Scotland for national consistency	This action will ensure officer and staff are trained within a consistent framework to appropriately and effectively respond to MH related incidents. Explore collaborative MH and leadership training opportunities.	Police Scotland (other partners?)	2025		Confident, informed and trained workforce – Staff survey and feedback mechanisms Lived experience feedback via reference group Data extracted from MH Dashboard

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Theme: Strengthening Community-Based Provisions					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Scope alternatives to Places of Safety	Publish a scoping paper to explore the feasibility of implementing safe spaces as an alternative to people being conveyed to an Emergency Department (ED), which are frequently the legal Place of Safety for people in crisis.	Scottish Government	November 2024	• Reduce the need to convey people to ED. • Provide improved support to individuals who may not need to be seen within a clinical environment. • Provided improved support for people who may be in a mental health crisis but due to intoxication cannot participate in an assessment. • Additional service for first responders to convey/refer people who don't meet hospital	• User surveys • PHS data work

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				Outcomes	
				based crisis and can be better supported within an alternative space.	

Theme: Data, evidence, benchmarking, and improvement					
Aim:					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Launch the Mental Health Data Dashboard	The Mental Health Dashboard is accessible via Police Scotland's internal internet. The dashboard draws data from Police Scotland's call recording and management system, STORM. The data is broken down into several themes, specifically: • Mental health related incidents. • Incident repeat • Incident type and Missing person temporal Missing person demand location	Police Scotland	[REDACTED]	• Better understanding of the demand picture for mental health across agencies. • Understanding of incident type and themes to generate appropriate police or partner response.	• Feedback from other organisations on success of data sharing and their interpretation and use of provided data. • Multi agency data groups. Collaborative data platform. • Academic Research
Continue work with Public Health Scotland to collect	The data collected will help us to better understand local pathways, including	SG/PHS	Commence collection in 2024	• Underpin improvements to MHUC	• Data collected

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and report consistent data to underpin Mental Health Unscheduled Care improvements.	referrers to mental health unscheduled care services, how people are accessing services, presenting factors, care outcomes and demographic information.			• Better understand how people are accessing unscheduled care support locally.	
Deliver the multi-agency data linkage project	Professor Susan McVie has been commissioned to undertake a research project to understand opportunities for data linkage across justice system partners and others to understand how data linkage may support earlier intervention to improve outcomes for individuals	SPA	2025	• Improved understanding of opportunities for data linkage • Proof of concept for data linkage principles	
Review insights from existing research to inform new/revised delivery models	Responsive research commissioned through SIPR to understand models for 'transfer of care' in other policing jurisdictions	SPA	2024/25	• Examples of practice to inform design of models specific to Scotland • Clarity on how Scotland benchmarks/compares to other areas	

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The Mental Health Policy and Delivery Landscape

The outcomes and priorities below set out in the Mental Health and Wellbeing Strategy are underpinned by the actions in the accompanying Delivery Plan and Workforce Action Plan.

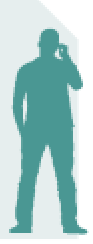
1. Improved overall mental wellbeing and reduced inequalities.

2. Improved quality of life for people with mental health conditions, free from stigma and discrimination.
3. Improved knowledge and understanding of mental health and wellbeing and how to access appropriate support.

4. Better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others.
5. More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.
6. Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
7. Better informed policy, support, care and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
8. Better access to and use of evidence and data in policy and practice.
9. A diverse, skilled, supported and sustainable workforce across all sectors.

Our priorities within the Delivery Plan are to undertake actions which will:

Tackle mental health stigma and discrimination where it exists and ensure people can talk about their mental health and wellbeing and access the person-centred support they require.



Improve population mental health and wellbeing, building resilience and enabling people to access the right information and advice in the right place for them and in a range of formats.

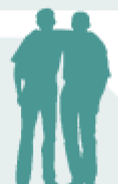
Increase mental health capacity within General Practice and primary care, universal services and community-based mental health supports. Promote the whole system, whole person approach by helping partners to work together and removing barriers faced by people from marginalised groups when accessing services.

Expand and improve the support available to people in mental health distress and crisis and those who care for them through our national approach on Time, Space and Compassion.

Work across Scottish and Local Government and with partners to develop a collective approach to understanding and shared responsibility for promoting good mental health and addressing the causes of mental health inequalities, supporting groups who are particularly at risk.

Improve mental health and wellbeing support in a wide range of settings with reduced waiting times and improved outcomes for people accessing all services, including Child and Adolescent Mental Health Services (CAMHS) and psychological therapies.

Ensure people receive the quality of care and treatment required for the time required, supporting care as close to home as possible and promoting independence and recovery.



Continue to improve support for those in the forensic mental health system.

Strengthen support and care pathways for people requiring neurodevelopmental support, working in partnership with health, social care, education, the third sector and other delivery partners. This will ensure those who need it receive the right care and support at the right time in a way that works for them.

Reduce the risk of poor mental health and wellbeing in adult life by promoting the importance of good relationships and trauma-informed approaches from the earliest years of life, taking account where relevant adverse childhood experiences. We will ensure help is available early on when there is a risk of poor mental health, and support the physical health and wellbeing of people with mental health conditions.

Of particular relevance to this Action Plan is Priority 4 of the Strategy which lays out our commitment to '*expand and improve the support available to people in mental health distress and crisis and those who care for them through our national approach on Time, Space and Compassion*', with a focus not only on improving the response, but also on keeping the person experiencing distress or crisis safe and preventing their situation from escalating further. The Scottish Government have already started to deliver on a number of actions in the Delivery Plan supporting this priority, such as:

- **full national coverage of the Distress Brief Intervention (DBI) programme.**
- **Continue to invest in NHS 24's Mental Health Hub**. The Mental Health Hub started providing 24/7 support in July 2020 and has modernised pathways into mental health services. The Mental Health Hub, which is accessible through the 111 service, is available to anyone who requires mental health and wellbeing support or if they are in distress. Calls are answered by a Psychological Wellbeing Practitioner who offer an empathetic response and will triage people using a psychosocial assessment to either help manage their needs or direct them to the most appropriate form of support. Psychological Wellbeing Practitioners are specially trained staff who are expertly supported by Mental Health Nurses.
- **Continue to invest in the Enhanced Mental Health Pathway and promote partnership working to increase Police Scotland and Scottish Ambulance Service access to local clinical support**. The pathway enables emergency calls received by Police Scotland or SAS where callers are identified as needing mental health advice and support to be directed to the Mental Health Hub. Work is ongoing between Police Scotland and NHS 24 to increase the referrals from Police Scotland's Command and Control Centre (C3) Division to the Mental Health Hub, and we are working on improving the call transfer process with the aim of achieving a warm handover between the two services.
- **Increase awareness of pathways into support and care by developing national awareness raising activity**. Through the Mental Health Unscheduled Care Network, we have developed national messaging outlining how people can access urgent mental health support. This messaging was published on NHS inform in December 2023 with work currently underway to roll-out regular social media posts to signpost people to the page. We are also looking at developing more tailored messaging for marginalised and equality groups.
- **Develop a mental health unscheduled care resource pack by autumn 2024**. The resource will provide a directory of national sources of help and support that the Mental Health Unscheduled Care workforce can connect or a signpost a person to, to complement the support, assessment and treatment that the individual will receive from unscheduled care services.
- **Take an evidence-based approach to our improvement work to better understand how people are accessing and receiving unplanned mental**

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health care. The Scottish Government is working with Health Boards and Public Health Scotland on the lead in work, and this data will measure the impact of the changes to the mental health unscheduled care pathway to date and identify opportunities for further improvements while ensuring that these are underpinned by robust data.

In addition, **the Scottish Government continues to fund the SAS Mental Health Paramedic Response Units**. Action 15 funding was allocated to SAS to deliver the Mental Health Paramedic Response Units in Inverness, Dundee and Glasgow. The ambitions of the project is focused on working collaboratively with local health boards and Health and Social Care Partnerships to provide joined up care to people requiring mental health assessment after they have contacted 999 for ambulance support. The evaluation of this pilot project found a reduction in conveyance to Emergency Departments (ED) for people attended by the MHPRU and anticipated there being potential benefit to the patient by bringing specialist mental health assessment to them, rather than having to go via ED to access this care.

The Scottish Government have also **funded the SAS High Intensity User Pilot**. The project started in 2021 and was later expanded supported by funding from the Scottish Government. The team identified 137 patients over the age of 18 years old who had generated 12 or more 999 incidents in 3 months, and/or 5 or more 999 incidents in a 1-month period. Four clinicians were recruited to support the process development and function as a single point of contact for patients, staff and the wider multidisciplinary team. This person-centred approach aided in supporting patients, by enhancing their confidence in accessing care and enabling the service users to hear their own voice in the process of care planning. Patients received the right care for their needs closer to home or within their local community. In total the number of incidents SAS attended (related to this cohort) nationally, dropped by 55% from 3216 to 1441. This reduction in attendance and conveyance time meant that crews had increased availability to respond to patients who required conveyance, helping to reduce demand on the service and other healthcare providers. As a result, SAS has embedded this model into their service provision and expanded the service to children and young people.

As part of the whole system response the **Communities Mental Health and Wellbeing Fund for Adults**, and the **Children and Young People's Community Mental Health and Wellbeing** have been awarded £15 million each for 2024-25. Launched in 2021, the fund for adults has supported grass roots community groups to deliver programmes for adults which build resilience and tackle social isolation, loneliness and mental health inequalities. Projects focused on connecting people and providing peer support were delivered through activities such as sport, outdoor activities and the arts. The funding supports deliver of community-based mental health and wellbeing support for five to 24 year-olds and their families. Support delivered includes mentoring, art-based therapies, digital services, whole-family support, counselling and sport or physical activities.

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The Mental Health and Wellbeing Workforce Action Plan

Improving the mental health and wellbeing of Scotland's population and ensuring everyone receives the best possible care and support from our health and care services can only be achieved with the right workforce capacity and capability.

The Mental Health and Wellbeing Workforce Action Plan aims to ensure that the commitments in the Strategy are underpinned by a resilient and sustainable workforce, that feel valued and supported to promote better mental health and wellbeing outcomes. The Plan is aligned to the National Workforce Strategy for Health and Social Care placing training, wellbeing, job satisfaction and the principles of Fair Work at its heart. Using this framework, the Workforce Action Plan looks at the whole workforce journey and sets out actions to support how we **plan for, attract, train, employ and nurture** our mental health and wellbeing workforce. However, Workforce Action Plan is not intended to cover all five pillars for the entire mental health and wellbeing workforce. We know that roles and responsibilities for workforce planning, training and regulation vary between different sectors of the mental health and wellbeing workforce, including those of Police Scotland.

The Strategy and Workforce Action Plan considers that the mental health and wellbeing workforce is made up of the core mental health and wellbeing workforce and the wider mental wellbeing workforce.

The core mental health and wellbeing workforce consists primarily of those who provide frontline mental health services and treatments for all age groups and from various sectors. These are staff who are specifically employed in services within statutory organisations, the independent sector or the third sector to support mental health and wellbeing. This includes, but is not limited to, staff in mental health services (such as mental health nurses, psychiatrists, and psychologists), third sector mental health support, social work staff who provide mental health support (including Mental Health Officers), GP's and mental health pharmacists.

The wider mental wellbeing workforce includes roles in the public, third, and independent sectors which, although not directly employed in providing mental health services, support treatment and recovery, have an important role in supporting someone's mental health and wellbeing or play a significant role in promoting good mental health for all. Examples include but are not limited to, employers, wider health, social work and social care staff, police officers and school staff.

As part of the Workforce Action Plan, work is underway to develop a training framework for the wider mental health and wellbeing workforce, volunteers, peer support/ recovery workers and carers. The framework will bring together existing mental health and wellbeing training resources and ensuring that it is on an accessible landing page. This will also support work to embed sustainable trauma-informed approaches using evidence-based training and support available through the National Trauma Transformation Programme, "Roadmap to Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland".

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Other Strategies and Reform Programmes
The mental health policy landscape is complex; and other key strategies and reform agenda also contributing towards the whole systems approach.

The Mental Health and Capacity Reform Programme has been established to look at how we can update and modernise our mental health and capacity legislation. The Scottish Government published the Mental Health and Capacity Reform Programme Delivery Plan in June 2024 - Scotland's Mental Health and Wellbeing: Strategy (www.gov.scot). The Delivery Plan focuses on the work that will be led by Scottish Government between October 2023 to April 2025.

The Delivery Plan sets out our three strategic aims, the first being Law Reform. This aim including those around mental health law reform. Work is being taken forward to prioritise areas of potential change that can be achieved as quickly as possible, within existing resources and recognising the pressure on budgets and services, as well as starting new work to scope and develop options for future reform. One key objective is considering issues around Emergency Detention Certificates (EDCs) under the Mental Health Act. Further detail in the Mental Health and Wellbeing Delivery Plan which links to the work being taken forward to support the implementation of the Action Plan includes:

- Priority 1.12: Ensure there is clarification around the powers of force and detention.
- Priority 2.6: The Scottish Government will work to better understand practice around the granting of EDCs as part of our work to review PEPs confirms that we are working to better understand practice around the granting of EDCs as part of our work to review PEPs and the review will be completed later this year.

Work is also taking place to scope options for reform of the Adults with Incapacity (Scotland) Act 2000.

The Scottish Government is taking action jointly with COSLA to reduce the number of deaths by suicide. Creating Hope Together: Suicide Prevention Strategy, Creating Hope Together Delivery Plan 2024-2026 set out the Strategy and Actions being taken to ensures government and local services work together to support anyone at risk of suicide or affected by it, while tackling underlying factors that can lead to suicide, such as inequalities, stigma and discrimination, which have been exacerbated by the pandemic and cost of living crisis. Considerable progress has been made in 2023/2024 laying strong foundations for ongoing delivery. Key achievements have been:

- Establishing Suicide Prevention Scotland’s leadership team and the wider delivery collective to realise our ambition to create a community of organisations across Scotland
- Establishing strong relationships with local suicide prevention leads and providing the opportunities and resources to support them in their role
- Taking forward work to address inequalities in suicide prevention and building connections with organisations who work with people impacted by

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discrimination, stigma, inequality and wider social determinants of suicide who can support this

- Connecting with a wide range of third sector organisations delivering suicide prevention actions and providing opportunities for networking, sharing learning, and supporting implementation of the action plan
- Building connections with National Suicide Prevention Advisory Group (NSPAG) members and national organisations to create links to sectors and groups where there is a higher risk of suicide
- Refreshing our Lived and Living Experience Panel and Youth Advisory Group, and establishing a Lived and Living Experience Steering Group
- Building on the outcomes framework to develop monitoring and evaluation processes which will help to demonstrate the impact of the work
- Delivering on the broad range of work within the Creating Hope Together Action Plan

Self-harm is also a risk factor for suicide and the Self Harm Strategy and its Action Plan, are focussed solely on tackling the issue.

Scottish Government is working to provide improved access to high-quality and integrated care for people with co-occurring mental health and substance use issues. The Alcohol and Drugs Workforce Action Plan, provides detail how mental health and substance use services should work together to provide high quality care and is aligned to the Workforce Action Plan. It sets out further actions Scottish Government and partners will take including to progress training opportunities, ensuring that services are well informed and fully empowered to support the mental health needs of people who use drugs and alcohol.

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Multi-Agency Partnership Approach to Mental Health Distress

Framework for Collaboration

1. Ministerial Foreword

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2. Introduction and context

We know that multiple factors can impact mental health and wellbeing, that poor mental health and wellbeing is detrimental to individuals and places additional demands on services, supports, and the people that provide them. In its thematic review of the servicing of mental health demand on policing, published on 18 October 2023, His Majesty's Inspectorate of Constabulary in Scotland (HMICS) also recognised that mental health is a multifaceted issue that requires an effective whole-system partnership response, and it set out a number of recommendations for Police Scotland, the Scottish Police Authority, the Scottish Government, and other bodies.

Work has been underway at a national and local level across a range of sectors and partners for a number of years to promote positive mental wellbeing, prevent poor mental health, and provide support, care, and treatment where needed. This includes improvements to the mental health unscheduled care pathway and response, ensuring that people seeking urgent or unplanned mental health support receive the right care, in the right place, at the right time, regardless of where or what time of day they present – there should be no wrong door.

We know that individuals experiencing distress or crisis, and who may need unplanned care, tend to first present at a service that is not best placed to meet their needs; this might be at police, a clinical healthcare service, social care, or wider community-based supports and services. Supporting the individuals to getting the right care they need in a person-centred and trauma-informed way is critical and of high important for all partners involved, and this framework outlines the principles and processes for a multi-agency collaborative approach to distress that will contribute to achieving this.

Building on the work already achieved through the Mental Health Unscheduled Care Network and drawing on the HMICS review as well as feedback from partners delivering services and those with lived experience of the current service provision, we have developed this framework by bringing together and aligning existing and planned improvements to the mental health unscheduled care response. Our aim for this framework is to promote a whole-system and person-centred approach through multi-agency working, with an ambition that partners work in a way that minimalises service-level boundaries and that builds relationships and trust between service to ensure that the individual receives the support they need from the most appropriate agency or provider as soon as is practicable. We also envision that the principles

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and recommendations set out in this framework will provide a solid baseline for the recommendations resulting from the national review of the Psychiatric Emergency Plans.

In this framework we have outlined:

- The current strategic and legislative landscapes to improve mental health and mental health services,
- The principles that underpin a person-centred, whole-system approach to mental health and wellbeing support,
- The roles of key partners in supporting people experiencing distress and their families within a complex mental health system,
- The recommendation for a multi-agency forum in each locality that will support partners to work together in a cohesive and collaborative way in responding to people who need mental health support, and
- Good practice examples to promote and demonstrate the impact of effective multi-agency working.

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3. The Strategic Landscape

3.1 The UN Sustainable Development Goals

The UN Sustainable Development Goals (SDG) are an urgent and universal call to action to create a better world by 2030. The SDGs apply to every country in the world including Scotland and are the responsibility of governments, businesses, civil society and citizens to deliver. Goal 3 aims to 'ensure healthy lives and promote wellbeing for all at all ages' with a specific target (3.4) to 'reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing' by 2030.

3.2 The National Performance Framework

The National Performance Framework (NPF) is developed and published by the Scottish Government and is Scotland's way to localise the SDGs. It sets out 11 National Outcomes to which relevant SDGs are mapped. Each National Outcome has associated indicators which are tracked and publicly reported on. The NPF is for all of Scotland and sets out a vision for collective wellbeing. When developing policy, including this guidance, we use the National Outcomes to tell us what good looks like and the national indicators help us to understand if we are moving in the right direction towards them. While we anticipate that this work will contribute to a variety of the National Outcomes, it will have a particular focus on

- we are healthy and active
- we respect, protect and fulfil human rights and live free from discrimination
- we live in communities that are inclusive, empowered, resilient and safe'.

The main national indicators which this work will contribute to are:

- improving mental wellbeing;
- quality of public services and public services treat people with dignity and respect.

3.3 Mental Health and Wellbeing Strategy

The Scottish Government and COSLA jointly published a Mental Health and Wellbeing Strategy, in June 2023. It builds on the work of the previous 10-year Strategy that was launched in 2017, but has a wider scope, with an increasing focus on wellbeing and prevention as well as a commitment to tackle stigma and responding to underlying social determinants, inequalities, and circumstances that can affect people's mental health and wellbeing. The new Strategy describes what a highly effective and well-functioning, whole-system mental health landscape should look like, with the right support available, in the right place, at the right times, whenever anyone asks for help. To support the delivery of the Strategy a Delivery

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Plan and Mental Health & Wellbeing Workforce Action Plan were also published in November 2023.

People's needs for mental health care vary enormously. Some people may be able to manage their mental health conditions and emotional distress themselves, especially with support from family members, peer support groups, faith-based organisations, or community providers. Many others will need formal interventions to support their mental health conditions, typically offered through a range of daytime services. In most areas, mental health support is also accessible at out-of-hours primary care centres or via NHS 24.

We know that the current system is not delivering as we would wish despite the efforts of thousands of dedicated and skilled people across Scotland. One of the reasons for publishing a new Strategy was to lay out what we think 'good' looks like and move forward with all partners towards that vision. However, the Strategy acknowledges that there are many challenges to delivering sustainable mental health supports and services in Scotland. The Strategy's Delivery and Workforce Action plans set out the specific actions that will be taken through a cross-Scotland partnership approach to:

- **promote** positive mental health and wellbeing for the whole population, improving understanding and tackling stigma, inequality and discrimination;
- **prevent** mental health issues occurring or escalating and tackle underlying causes, adversities, and inequalities wherever possible; and
- **provide** mental health and wellbeing support and care, ensuring people and communities can access the right information, skills, services, and opportunities in the right place at the right time, using a person-centred approach.

3.4 Self-Harm Strategy and Action Plan 2023 – 2027

Scotland's first dedicated self-harm strategy and action plan aims for anyone affected by self-harm to receive compassionate support without fear of stigma or discrimination. It is jointly owned by Scottish Government and COSLA. The approach in the strategy and action plan retains an important connection to the joint work on suicide prevention through the Suicide Prevention Strategy (see below) and to improving population level mental health and prevention through the Mental Health Strategy and Delivery Plan.

Priority 2 of the strategy sets concerns the continuation to build person-centred support and services across Scotland to meet the needs of people affected by self-harm.

3.5 Creating Hope Together: Suicide Prevention Strategy 2022 – 2032

This strategy sets out the Scottish Government and COSLA's vision for suicide prevention in Scotland over the next ten years, with a vision to reduce the number of suicide deaths in Scotland, whilst tackling the inequalities that contribute to suicide.

To achieve this, all sectors must come together in partnership, and we must support our communities so they become safe, compassionate, inclusive, and free of stigma.

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3.6 The Vision for Justice in Scotland

The Vision for Justice in Scotland was published in February 2022 and sets out our vision of the future justice system for Scotland, spanning the full journey of criminal, civil and administrative justice, with a focus on creating safer communities and shifting societal attitudes and circumstances which perpetuate crime and harm. The Strategy is underpinned by four core principles: **equality and human rights; evidence based; embedded person centred and trauma informed practices; collaboration and partnership.** It also outlines two transformational priorities: **'Our services, third sector partners and legal profession must be person-centred and trauma-informed'** and **'we must also strive to work across our public services to improve outcomes for individuals, focussing on prevention and early intervention'.**

While the strategy has a wider focus on the justice system as a whole, its core principles and overarching priorities speak to the ambitions of this guidance and align with its indented outcomes. It focuses on promoting person-centred justice services and highlights the importance of embedding trauma-informed practice. It seeks to ensure that justice services recognise the prevalence of trauma and adversity, realise where people are affected by trauma and respond in ways that reduce re-traumatisation.

The strategy recognises that the population in contact with the criminal justice system is a vulnerable one in health and wellbeing terms, with people experiencing high levels of mental health problems. It also highlights the same key issues set out in the HMICS report: that justice agencies are commonly dealing with situations where the main issues are around mental health and distress, where no offence, or only a minor offence, has been committed; and that Police are dealing with increasing numbers of people in mental health distress and that this is placing significant demand on their services and that of health services. The strategy underlines that we must work with partners to improve the mental and physical health and wellbeing of those who come into contact with the justice system, which is the key focus of this guidance and the ongoing work around mental health and policing.

This document sets out the further detail on the way in which partners can work together to deliver both our vision for improved mental health and wellbeing and the associated outcomes and for a just, safe, and resilient Scotland.

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4. Legislative Landscape

4.1 The European Convention on Human Rights and the Human Rights Act 1998

The European Convention on Human Rights (ECHR; though formally known as the Convention for the Protection of Human Rights and Fundamental Freedoms) is an international convention to protect human rights and political freedoms in Europe. It was incorporated into British law as the Human Rights Act 1998 and came into force into the UK in October 2000. The Act sets out people's human rights in a series of 'Articles' which were all taken from the ECHR.

4.1.1 Article 2: Right to Life

This means that nobody, include the Government, can try to end a person's life. It also means the Government should take appropriate measures to safeguard life by making laws to protect people and, and some circumstances, by taking steps to protect them if their life is at risk. Public authorities should also consider a person's right to life when making decisions that might them in danger or that affect their life expectancy.

Article 2 is often referred to as an 'absolute right' meaning that these can never be interfered with by the Government or public authorities. However, there are situations when this does not apply, for example when the police use necessary force to stop an individual from carrying out unlawful violence or to make a lawful arrest.

A right to life does not include a right to die.

4.1.2 Article 3: Freedom from Torture and Inhuman or Degrading Treatment

This article protects people from mental and/or physical torture and inhuman or degrading treatment or punishment. This means that public authorities must not inflict this type of treatment on an individual. Public authorities must also protect a person where this is being inflicted on them by another person and/or group of people, meaning that, if they are aware that this right is being breached, they should intervene to stop it. They must also investigate credible allegations of such treatment.

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

The Mental Health (Care and Treatment) (Scotland) Act came into force in 2005. It increases the rights and protection of people with mental health conditions. This includes:

- mental illness
- learning disability
- personality disorder

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The Act places duties on health boards, the state hospital, and councils to provide care and support services for people with mental health conditions. It also provides Place of Safety and other related powers to Police Scotland, however these can only be used when particular criteria have been met and not when a person agrees to voluntarily attend a Place of Safety.

The provisions of this Act are intended to ensure that care and compulsory measures of detention can be used only when there is a significant risk to the safety or welfare of the patient or other people.

In 2019, the Scottish Mental Health Law Review was commissioned and tasked with considered ways to better realise and protect human rights through the mental health, incapacity and adult support and protection legislation. The Review also looked at ways to remove barriers to care and support for people currently covered by the legislation. The Scottish Government has considered the report and now intends to establish a new Mental Health and Capacity Reform programme to deliver on the ambitions of the Review.

4.2.1 Psychiatric Emergency Plans

Although not mandated by the Act, it is best practice for all relevant local agencies and service providers who might potentially be involved in psychiatric emergencies to work together to develop and agree on a 'Psychiatric Emergency Plan' (PEPs) as a means of comprehensively addressing the roles, responsibilities, and process in a manner which best reflects local circumstances.

The aim of a PEP is to agree on procedures which manage the transfer and detention process in a manner which minimises distress, disturbance, and risk for the individual and others while ensuring a person-centred and human rights approach.

The professionals involved in the drawing up of a PEP should include, but should not necessarily be limited to, general practitioners, approved medical practitioners, Mental Health Officers, other social workers, social care workers, Community Psychiatric Nurses, ward nursing staff, independent service providers, police officers, and ambulance personnel. It is also important to have input from mental health service users and carers.

A review of the PEPs is currently underway with the aim of improving consistency of the PEPs across all 14 Health Boards and ensuring that the roles and responsibilities of all local agencies and service providers are clearly articulated and as consistent as possible while still allowing for local flexibility. The review will also look at safe transfer of care between agencies, safety and crisis planning, and information sharing guidance, among others, and is expected to be complete by November 2024 with guidance and a national template to be developed in 2025.

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4.3 Section 32 of the Police and Fire Reform (Scotland) Act 2012

Section 32 of the Police and Fire Reform (Scotland) Act 2012 outlines the policing principles, which are:

- that the main purpose of policing is to improve the safety and well-being of persons, localities, and communities in Scotland, and
- that the Police Service, working in collaboration with others where appropriate, should seek to achieve that main purpose by policing in a way which—

  (i) is accessible to, and engaged with, local communities, and

  (ii) promotes measures to prevent crime, harm, and disorder.

5. Definitions

A common theme raised though our engagement and consultation when developing this framework was the need for consistency in the language we use, and what these terms mean. It is essential that we all understand the same thing from the terms we use, this will ensure services are best able to meet the needs of people experiencing mental health distress. The following definitions, which have been taken from a range of sources, including the Mental Health and Wellbeing Strategy, the Mental Health Unscheduled Care Network, and the Children and Young People's Mental Health and Wellbeing Joint Delivery Board, are included to provide a common understanding and a consistent language that can be shared across all agencies:

- **Mental wellbeing** is a person's internal positive view that they are coping well psychologically with the everyday stresses of life and can work productively and fruitfully. Good mental wellbeing means a person will feel happy and live their life the way they choose.
- **Distress** can be described as a sudden change in wellbeing from regular behaviour patterns with expressions of intense emotions (e.g. anxiety, hopelessness, loneliness). It is an emotional pain which may have led the person to seek help, and which does not require further emergency service involvement.
- **Mental illness** is a health condition that affects emotions, thinking and behaviour, which substantially interferes with or limits our life. If left untreated, mental illnesses can significantly impact daily living, including our ability to work, care for family, and relate and interact with others. Mental illness is a term used to cover several conditions (e.g. depression, post-traumatic stress disorder, schizophrenia) with different symptoms and impacts for varying lengths of time for each person. Mental illnesses can range from mild through to severe illnesses that can be lifelong.
- **Crisis** is a state where a person is unable to cope, and they may be a risk to themselves or others. They are likely to require urgent help from others to manage their mental health risks.
- **Mental wellbeing, mental health and mental illness** are linked to a combination of factors covering biology (e.g. genetics, health, and neurodiversity), psychology (e.g. thoughts, emotions and beliefs) and social factors (e.g. culture, poverty and discrimination). These three areas combine with a person's life experiences to impact the state of mind. This impact varies over time, does not progress in a straight line and is specific to an individual.
- **Severe and Multiple Disadvantages** is considered to encompass individuals who present with mental health or distress care needs and at least one of the following: substance misuse, criminal justice, homelessness, and/or

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experience of domestic abuse. However, it can also include asylum seekers or individuals with no recourse to public funds.

- **High Intensity Users** are a relatively small proportion of the overall population who are frequent users of frontline and other services (i.e. often dialling 999 for Scottish Ambulance Service or Police Scotland assistance or presenting at other services). The frequency of their interaction, which disproportionately accounts for numbers of calls to these services, suggests that this group are not getting the appropriate care they require, possibly because they are experiencing severe and multiple disadvantages.
- **Unscheduled Care** is unanticipated, so presentations are unplanned to the services (i.e. where a person did not arrange an appointment). Unscheduled care incidents cannot reasonably be foreseen or planned in advance of contact with relevant services.
- **Urgent Care** is an illness, distress or injury that requires urgent attention but is not necessarily life-threatening, there is therefore an expectation that urgent care is time sensitive.

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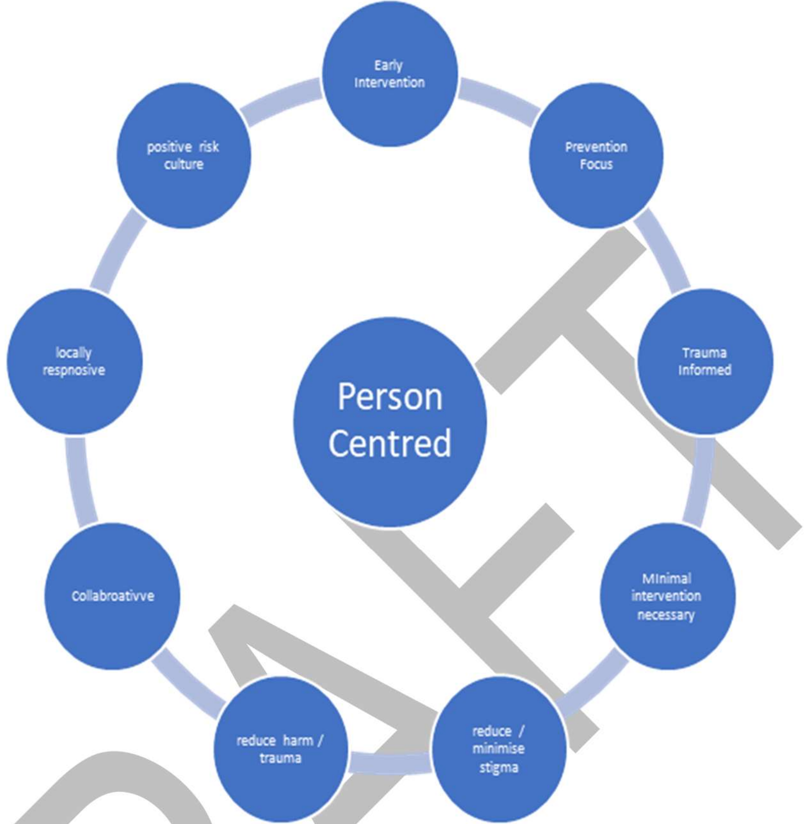
6. Principles

This framework aims to promote a whole-systems approach whereby each of the following overarching principles contributes to creating a person-centred service.



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The following principles provide more detail on how we achieve a person-centred approach and should underpin service delivery. These principles bring together the three areas of focus from the Mental Health and Wellbeing Strategy: **Promote; Prevent** and **Provide**; underpinning them with the four justice principles founded in **equality and human rights; evidence based; embedded person centred and trauma informed practices; collaboration and partnership**.

Principles	MHW Strategic Priorities	Justice Principles
1. Emergency services should only be deployed to respond to an individual in emotional distress and/or crisis when there is an immediate risk of significant harm to an individual or others.	Prevent – stigma/ criminalisation of mental health Provide – a proportionate/ appropriate response to meet needs	Human Rights – minimal intervention in liberty Person Centred / Trauma Informed – proportionate empathetic

Principles	MHW Strategic Priorities	Justice Principles
		response/ avoid escalation
2. Regardless of which service an individual contacts when in crisis, there should be no wrong door. Effective transfer of care should allow individuals to be better, and more quickly, connected to the support that meets their needs in the right settings.	Provide	Trauma informed/human rights collaboration and partnership
3. The duty to share information can be as important as the duty to protect patient confidentiality.	Provide and prevent	collaboration and partnership
4. The transfer of care should be seamless to avoid retraumatising individuals by asking them to repeatedly disclose information.	Provide and prevent	Trauma informed
5. Service providers should work in partnership, to integrate service provision and thus improve the outcomes they achieve. This would mean individuals can be better, and more quickly, connected to the support that meets their needs in the right settings, promoting self-management and avoiding escalation.	Promote, Provide and prevent	collaboration and partnership
6. People presenting in the Out of Hours period should have access to the full range of options available in hours, accepting some options may not be available immediately.	Provide	Equality and Human Rights
7. Services will promote a positive risk taking approach to supporting individuals in crisis that sees services making decisions in the best interest of the individual.	Provide and prevent	Trauma informed/human rights

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Principles	MHW Strategic Priorities	Justice Principles
8. Services will promote and provide access to information about national and local crisis support and services to help individuals access the right care.	Promote	
9. Time, Space, Compassion and Trauma informed principles will underpin how individuals experience care and support, first points of contact should always be compassionate, regardless of whether it is the ‘right’ service.	Promote, provide, and prevent	Trauma informed/human rights
10. Mechanisms for review and evaluation between partners will allow for continuous improvement.	Prevent and provide	collaboration and partnership

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7. Role Of Key Services in Supporting Mental Health

This section aims to provide more clarity on the mental health system and the role of some of the key public services that support those experiencing mental distress and their families. As opposed to prescribing additional responsibility to a specific service, it aims to promote a whole-system approach.

7.1 Support, Care and Treatment Pathway

The Support, Care and Treatment pathway demonstrates the mental health system which can be described as consisting of different tiers. These are defined primarily based on the individual's risk and need. The supports and services across the tiers are provided by a range of partners and this varies in different local systems. The boundaries between tiers can be blurred and people may require input from different tiers at different times or even from more than one tier at any point in time; their path between tiers may not be linear the list of services under each tier is not exclusive to what may be available. The tiers provide a useful way of describing a complex interacting system.

Tier One is targeted at people with low support needs, though they may have previously met the criteria for the other tiers, with the aim of prevention and early intervention, meaning services and support at this level usually support people to stay well and maintain a good level of wellbeing. The services and support in Tier One are generally delivered by local authorities and third sector organisations that have been designed or commissioned meet local needs and are directly accessible without requiring a referral.

Meanwhile, Tier Two provides early intervention and is aimed at people seeking further support with managing their health wellbeing or with improving their situation.

The services and support in this tier are provided by a range of partners, including Primary Care, Local Authorities and Third Sector. Similar to the previous tier, individuals can usually access these services and supports directly, however they may require a referral from Primary Care, NHS 24, or emergency services to access certain therapies and services, such as Computerised Cognitive Behavioural Therapy or Distress Brief Intervention.

It is important to note that while Local Authorities play an important role in providing mental health services across the first two tiers and occasionally the third one, they also provide wider community-based support around the socio-economic determinants of health, including employability, housing, and education. Social Work also plays a key role in providing advice, care, and support for those in need, such as supporting and protecting vulnerable people because of a mental disorder.

7.1.1 Distress Brief Intervention

This world leading programme provides up to two weeks of personalised, compassionate support to people who present to Police Scotland, SAS, and other frontline services in emotional distress but who do not require emergency clinical intervention. The DBI team has also conducted work with the SAS and Police Scotland to introduce national pathways to DBI via their call handling centres. This initiative enables call handling staff to make referrals to DBI instead of sending officers out in response to calls, thus saving key police resources. Independent evaluation has shown that DBI is an effective model in supporting people in distress. Case Studies demonstrate the value of this intervention for individuals and front-line services as well as its ability to connect people to wider services to address the cause their distress[1].

Tier Three consists of more specialist services and require a referral from Primary Care or another health and/or social care professional. The services and supports are usually based in the community and are aimed at people with more severe concerns and may need an assessment, diagnosis, treatment and/or recovery support. These services and supports are usually provided by the NHS though may also include Third Sector.

Lastly, Tier Four is targeted at people who have high and/or complex support needs, and consists of very specialist care and treatment, often requiring inpatient or residential care. These services are usually provided by the NHS and require a referral from Primary care or another health and/or social care professional, though the independent and third sectors may also provide some of these services, such as private rehabilitation facilities.

[1] DBI Case Study extracts

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For the purposes of this framework, we have included a brief description of the role of some of the key health and public services that may be involved in the unplanned care to support a person experiencing distress or crisis.

7.2 NHS 24 Mental Health Hub

The NHS 24 Mental Health Hub (the Hub) is available 24/7 on 111 for anyone in Scotland who is in need of emotional support, in a state of despair or is feeling distressed or suicidal.

The Hub is staffed by Psychological Wellbeing Practitioners (PWPs) who are specially trained advisers who work in mental health and are supported by Mental Health Nurses (MHNs). If a person has an urgent mental health need, the PWPs will help them get the right care in the right place.

Through the development of the Enhanced Mental Health Pathway, the Scottish Ambulance Service (SAS) and Police Scotland's contact centres can safely pass callers with a mental health need to the Hub, provided the caller consents and only where no immediate risk has been identified.

7.3 Social Workers

Social workers usually work for the local authority but may also be located in the community mental health team.

Social workers bring a social perspective to the concept of mental health, particularly mental illness. They work with medical and heath colleagues, as well as with the third sector and others, to provide an effective and balanced service, whilst remaining at the forefront of processes that empower people who use services. Social workers play a significant role in supporting people living with mental illness in the community. Their involvement enables those with complex needs and trauma experiences, including forensic mental health involvement, to live as independently as possible in the community. The role of the social worker in the community mental health team is to try and understand the person's illness in their personal and social context, balancing the rights and needs of the person and others.

Social workers work with the individual, family and/or carers to provide support and education on the illness. They also work across other social work services. For example, working alongside recovery services if someone has a dual diagnosis of substance misuse and mental ill health. Mental health social workers apply their awareness of stigma to mental illness to their work and understand the impact of mental illness across different cultures.

7.3.1 Mental Health Officers

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Mental Health Officers (MHOs) are specially trained social workers who, following a minimum of two years post-qualifying experience, have gained the Mental Health Officer Award which prepares social workers to under the statutory role. MHOs have a unique role in supporting and protecting people who are vulnerable because of a mental disorder, and when a person is required to get care and/or treatment under the Mental Health Act, the local authority must ensure that an MHO is appointed to work with the individual.

MHOs are involved in the assessment of individuals experiencing a mental disorder and may need compulsory measures of care, treatment, and, only where the criteria are met, detention.

The role of the MHO in the individual's care will vary slightly depending on the type of order (e.g. short-term and emergency orders vs. compulsory treatment orders vs. orders related to criminal proceedings). Generally speaking, however, the MHO's role includes:

- Protecting the individual's health, safety, welfare, finances, and property
- Safeguarding the individual's rights and freedom
- Public protection where this concerns mentally ill offenders
- Letting the Mental Welfare Commission and the individual's Named Person know if the person has been detained or where an application is being made for the individual to be placed on a Compulsory Treatment Order.

Although MHOs work alongside medical and legal professionals, they work and carry out their responsibilities autonomously.

7.4 Police Scotland

Police officers are often the first point of contact playing a vital role in supporting communities, individuals in distress/crisis, and victims of crime, and their attendance at mental health incidents can be vital. Police Scotland have been clear that they will continue to uphold the policing principle outlined in Section 32 of the Police and Fire Reform (Scotland) Act 2012 of improving the safety and well-being of persons. However, Police officers should only be deployed when a policing response is appropriate and necessary, and they should have the ability and access to effective and efficient transfer of care, allowing individuals to get the right care, in the right place, at the right time.

7.4.1 The Community Triage Pathways

When Police Scotland consider that an individual calling them may be mentally unwell, they can seek support from Mental Health Services through their Community Triage Pathways. Many people who present in crisis will not require treatment from these services as they are experiencing emotional distress as a result of other social

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factors. The Community Triage Pathway will undertake triage and, if needed, further specialist mental health assessment to determine whether clinical treatment is needed. Urgent Mental Health Assessments should be available to anyone who might need one, regardless of whether Police Scotland are using place of safety powers.

There should be local alternatives available through this Community Triage Pathway to avoid automatic conveyance to the Emergency Department (ED). This not only provides a better response for individuals, it also avoids Police Scotland spending significant periods of time waiting unnecessarily with an individual who is not then admitted to the ED. We know that attendance at ED raises expectations that admittance will be the outcome. This can contribute to the exacerbation of crisis symptoms, and it can often be difficult to achieve privacy within them.

Where the Community Triage Pathways operates well, it guarantees a call back to Police Scotland within the hour, providing them with clinical advice on next steps. In some Health Boards, they also operate missed opportunity reviews between mental health unscheduled care leads and Police Scotland. These reviews could include instances where an individual has been conveyed to ED but not admitted, or when Police Scotland do not feel able to accept the recommendation of mental health unscheduled care clinicians for example because they believe the circumstances suggest that the person will go missing, or the individual has continued to make threat to harm themselves.

7.5 The Scottish Ambulance Service

SAS is a national, mobile health service, delivering services locally and in people's homes within every community in Scotland, 24 hours a day, 365 days of the year, including supporting people with mental ill-health and those in emotional distress. Although they are normally contacted and/or deployed in an emergency when an individual may need urgent conveyance to the ED, they work alongside many other partners, including Police Scotland when paramedic attendance is necessary.

Similar to Police Scotland, in many Health Boards, SAS have access to the Community Triage Pathway to get advice from the Mental Health Unscheduled Care Clinician on the appropriate next steps when caring and/or support a person in mental health distress or crisis – provided that the person does not have an additional medical emergency which would be prioritised.

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8. Promoting Multi Agency Partnership Working through Multi-Agency Fora

In developing this framework, we have worked with partners and stakeholders to explore effective processes, existing good practice, and areas of blockage. Through this engagement it has been identified that a Multi-Agency Forum is an important and effective tool at promoting everyday cohesive, collaborative partnership working by implementing the other themes, outlined below, that have been identified as critical to partnership working.

It is therefore our recommendation that, where these are not already in place, local areas establish a multi-agency forum with representation from local agencies and service providers, with the aim of identifying and agreeing:

- how they will work together, share information and decision making.
- a mechanism for shared input to, and decision making on, care planning and safety planning.
- A mechanism to monitor effectiveness and implement continuous improvement.
- An approach to undertaking joint learning including learning from adverse events/missed opportunities.

Through the multi-agency fora, local agencies and service providers will identify the key roles, responsibilities, and process to responding to and supporting people in mental health distress and crisis on a day-to-day basis. This may align with and form the starting point for the roles, responsibilities, and processes when responding to a mental health crisis or a person with a mental disorder, as outlined in the PEPs.

We have found that the following factors are key to ensuring that multi-agency fora are effective:

- **Who** - the right partners should be represented. We know that people presenting in mental health crisis may have multiple other social factors contributing to their distress, such as, housing, substance use, domestic abuse, bereavement. It is therefore vital that partners who have critical information to contribute or those who can respond to meet a person's needs are represented. This could include but it is not limited to Mental health Unscheduled or Urgent Care Leads, Child, and Adolescent Mental Health Services, Suicide Prevention Leads, Community Mental Health Teams, social work, housing, addictions, and third sector partners (particularly Distress Brief Intervention providers), Police Scotland, and SAS.
- **Dedicated Resource** - Single points of contact should be agreed for each partner to the multi-agency forum to provide continuity/shared responsibility to attend meetings but importantly have the ability to respond to partner

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queries between meetings. It is vital that professionals designated to represent their organisation are appropriately skilled and empowered to make decisions. This doesn't necessarily mean a single person; it could be a team or group of people who can be contacted via a single contact point but where there is shared responsibility ensuring continuity of information flow is critical.

- **When** – Multi-agency meetings should be arranged at regular frequencies (with the frequency depending on local need) to allow timely information sharing and agreed actions to meeting the needs of individuals who require a multiagency response as well as the review of disputes and/or missed opportunities. Regular attendance and engagement is critical for establishing collaborative response.

The fora will have the responsibility for implementing the following themes which have been identified as critical to effective partnership working. However, even where local areas are unable to (immediately) implement dedicated multi-agency fora, they should take steps to embed the below themes. Details on specific practice examples are included at Annex A.

8.1 Behaviours

Partners and stakeholders highlighted that consistent, positive collaborative behaviours are critical to establishing and maintaining strong relationships across agencies. This included:

- Open and direct communication between services, allowing services to have direct contact with the appropriate service/team/individual when necessary.
- Promotion of self-management and avoiding escalation in circumstances where it is not necessary or beneficial to the individual in crisis.
- Trust between services, which promotes a positive risk-taking approach and builds confidence in decision making.

8.2 **Agreed processes**

A key component to ensuring individuals in crisis receive the correct support, is having the appropriate processes and effective systems in place. We have identified that the following promote a collaborative way of working and ensure a more seamless transfer of care to the correct service:

- Structure teams in a way that enables effective communication, so that each service is aware of, and able to contact, the correct teams/individuals across other services or agencies.
- Single points of contact to allow services to quickly reach the correct team/contact to progress individual cases.

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- Dedicated resource to work with other services to build working relationships and identify effective ways of working collaboratively, see examples at Annex A.
- Professional-to-Professional pathways for agencies to use, e.g. the Community Triage Pathway for Police Scotland.
- Missed Opportunity or Conflict Resolution Reviews where partners come together to review a particular case and assess whether an improved care outcome could have been achieved, providing learning and to inform future presentations and continuous improvement.

8.3 Joint Training

A key theme that emerged through engagement was the importance and effectiveness of training, and the potential for joint/ multi-agency training to better support understanding of roles and promote multi agency collaboration.

No single service can provide the support required for individuals in crisis. Joint training allows services to gain a better awareness of the processes and/or role of other services and an understanding of how other systems work. In so doing it provides an environment where services can train together and joined up working isn't something that needs to be contrived but rather becomes second nature. In Annex A, you can learn how Lanarkshire Health Board works with its local policing Divisions and how joint training has helped to facilitate the success of this area.

8.4 Information and data Sharing

It is recommended that, wherever possible, the Multi-Agency Fora develop and implement a data sharing agreement which also includes provisions for mental health emergencies. However, regardless of whether a Data Sharing Agreement is in place, data protection laws and the Caldicott Principles allow organisations to share personal information in an urgent or emergency situation, including to help prevent the loss of life or serious physical, emotional, or mental harm. Sometimes it can be more harmful not to share data.

More guidance to come once the Review of the Psychiatric Emergency Plan is complete.

8.5 Monitoring and Continuous Improvement

The monitoring of processes and working relationships, and commitment to continuous improvement, is essential in order to ensure services are working together in the most effective way possible and providing the best care to those in crisis. This could involve a regular general review of existing processes and outcomes, or 'missed opportunities' reviews to review outcomes when things have not gone to plan or to undertake joint reviews as a result of adverse events. Services

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should be open and flexible to change in order to create and maintain a system/service that provides the best possible care for individuals.

9. Additional Resources

9.1 The National Trauma Transformation Programme

The National Trauma Transformation Programme website provides access to evidence-based training, tools, and guidance to support trauma-informed and responsive systems, organisations and workforces in Scotland. It aims to support everyone, in all sectors of the workforce, to know how to adapt the way we work to make a positive difference to anyone who has been impacted by psychological trauma and adversity.

9.2 The Scottish Information Sharing Toolkit

The Scottish Information Sharing Toolkit which is an evolution of the former SASPI (Scottish Accord on the Sharing of Personal Information 2011) and the former Gold Standard in the direction of minimising personal and non-personal information risks across organisations.

This framework applies to all public sector organisations, voluntary sector organisations and those private organisations contracted to deliver relevant services to the public sector and who provide services involving the health, education, safety, crime prevention and social wellbeing of people in Scotland. In particular, it concerns those organisations that hold health and care information about individuals and who may consider it appropriate or necessary to share that information with others.
The Toolkit enables service-providing organisations directly concerned with the safeguarding, welfare and protection of the wider public to share personal information between them in a lawful and intelligent way. It complements (rather than replaces) important guidance on sharing personal data issued by the Information Commissioner's Office and builds on previous initiatives that have aimed to standardise personal information sharing agreements.

9.3 Time Space Compassion

This introductory guide to Time Space Compassion principles and approach has been developed for use by people and services who regularly come into contact with people experiencing suicidal crisis. However, these principles and approach can be applied more widely to anyone experiencing mental health distress or crisis, regardless of the nature.

Time Space Compassion is about securing better outcomes for people experiencing suicidal crisis. It does this by focusing on people's experience, human connection, and relationships, offering a shared language, resources, and ways to connect and take action together.

9.4 Mental Health Improvement and Prevention of Self-Harm and Suicide

These learning resources will support staff across health, social care, and the wider public sector to develop the knowledge and skills needed to promote good mental health and wellbeing across the whole population and to prevent mental ill-health,

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self-harm, or suicide. It is also about improving the quality and length of life for people who experience mental ill-health and addressing the inequalities people can face.

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Annex A

Scottish Government Engagement Workshops

In conjunction with our partners, the Scottish Government have hosted workshops to develop protocols for safe transfer of care and effective community triaging. These events took place in Highland on 15 March, Forth Valley on 20 March, and Lanarkshire on 16 April 2024. The three areas were chosen specifically to try and draw on existing best practice and identify practical challenges and solutions which could be applied across the country. The following examples demonstrate good practice of effective partnership working, that encompass the themes set out in the Multi Agency Partnership working of the framework, and the positive outcomes achieved as a result:

NHS Highland

- **Triaging:** In NHS Highland, there is a consistent approach to assessment to determine the urgency for treatment and the nature of treatment required. This activity has reduced the number of patients taken to hospital for mental health assessment.

- **Mental Health Unscheduled Pathway:** The police, ambulance service (including the SAS MH Triage Car), NHS 24, and GPs have access to unscheduled care clinicians at the Mental Health Assessment Unit (MHAU) who will carry out a telephone assessment and arrange for an onsite assessment if required. In addition to this, Police Scotland, SAS and NHS 24 also have access to Distress Brief Intervention (DBI) for anyone in distress but not in need of a clinical response. In more rural areas within NHS Highland where accessing the MHAU may be more difficult, Police Scotland are able to access nurses in the localities. The MHAU only covers North Highland, and Argyll and Bute HSCP has its own Unscheduled Care Service. This has reduced the number of conveyances to ED. In addition to this, Police Scotland's C3 Division have access to NHS 24 through the Enhanced Mental Health Pathway, reducing the number of calls that police are dispatched to.

- **Daily Huddle:** Each agency attends a daily multi-agency meeting. This is similar to an IRD meeting and ensures the person receives the right care by the right service. A collective discussion is held monthly to review incidents raised by either NHS or Police Scotland. Through these discussions agencies have been able to review existing process and identify any problems or areas for improvement.

- **Mental Health Response Car:** A vehicle operated by the Scottish Ambulance Service and is deployed when SAS identify that the person's primary concern is mental health related. This currently operational in Inverness on a 24/7 basis and staffed by paramedics who have undertaken advanced mental health training. The paramedics have access to the unscheduled care staff at the MHAU for advice and support. This process has allowed people in mental health crisis or distress to receive the correct support directly and avoided exposure to other responding services where this is not necessary.

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- **Joint Risk Assessment (JRA):** NHS Highland alongside other agencies use JRA when responding to incidents. The questionnaire/risk tool boosts the confidence of the police officer to leave and serves as evidence towards an objective judgement to walk away as soon as a care plan is agreed.

- **Electronic Information Management System for People with Comorbidities:** NHS Highland don't have digital patient records, but a system has been put in place to facilitate information sharing across agencies involved in a person's care. This allow agencies to have a background oversight of the individual that they are responding to. Care plans are shared for high-risk people with the police and weekly tele-conferences are held to make decisions jointly on Vulnerable Person Database (VPD) and such decisions are recorded on each agency's system. This approach allows for data to be shared and easily accessible across different agencies.

NHS Lanarkshire

- **The Community Police Triage (CPT): NHS Lanarkshire's CPT** service is available 24/7, with specific phone numbers operating for different times of the day. In the in-hours (IH) period, calls are filtered through the Flow Navigation Centre (FNC) and picked up by Community Psychiatric Nurses (CPNs) based at acute sites. In the out of hours (OOH) period, calls are directed to the Douglas St Hub where two CPNs aim to respond to any incoming referrals within an hour. Police Officers are provided with a contact card with the two phone numbers.

  The CPT service allows police officers on scene to call a CPN for advice. The CPN will speak to the officers, conduct a telephone triage with the patient, and risk assess the situation before discussing the outcome with officers. Police officers are able to discuss whether they are okay with this approach or not, and if they have strong concerns about leaving a person, the CPN will offer a face-to-face assessment at the Douglas St Hub (or the nearest acute site). Police officers are also able to call back to share concerns/request a face-to-face appointment in the event that the person has expressed the intention to self-harm or suicidal ideations following the initial telephone triage.

  Although Lanarkshire have a dedicated hub for OOH referrals, the CPNs at the hub are part of the Psychiatric Liaison Nursing Service (PLNS) with team members located across the different acute sites, meaning all CPNs have access to the telephone/case records. When the CPNS at the Douglas St Hub are expecting a face-to-face assessment, they will notify their colleagues at the acute sites who will pick up any incoming calls in the interim if needed. The Douglas St Hub can also arrange for a face-to-face assessment at one of the acute sites if it's more convenient than the Douglas St Hub. The CPNs have access to DBI and can refer a person that they have assessed if clinical response is not needed. They can access the OOH social work service if needed, too, as well as other services such as social prescribing.

  The CPT service has improved working relationships between services and significantly reduced mental health related ED referrals over the years,

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however there are instances where an ED referral is unavoidable. In addition, Police Scotland reported having more confidence in their decision making.

- **Missed Opportunities Review:** NHS Lanarkshire and Police Scotland's DBI trainer for Lanarkshire conduct a Missed Opportunity (MO) Review through the data that NHS Lanarkshire collect. Lanarkshire's mental health team have their own data set that is used to produce annual reports of instances where police conveyed a person to ED when this could have been avoided. The information is sense-checked by the DBI trainer in Police Scotland, flagging any cases that did in fact require an ED response based on the police case notes, and investigating any potential MOs.

  In addition to the work on the annual report, Lanarkshire and Police Scotland have a single point of contact for any concerns raised by staff in either organisation. Staff are able to raise their concerns with their respective lead, and the lead will discuss the case or concern with their counterpart and agree on outcomes, learnings, and/or way forward. This has been instrumental in identifying further opportunities for improving/enhancing the CPT service.

Police Scotland Workshops

Police Scotland's Mental Health and Suicide Prevention team, supported by Police Scotland Service Design Team, have hosted three partnership workshops on unscheduled care. The third workshop instalment at Scottish Police College culminated in a 'Six Subject Synergy Sprint' aimed to generate actionable responses to the previous two workshop themes. The following objectives were set –

- Objective 1: Build and show MHUC good practice across Scotland.
- Objective 2: Prioritise and link current service provision across Scotland.
- Objective 3: Co-design our MHUC partner pilot(s) for the future of Scotland

Key stakeholders including SPA, Scottish Government, Police Scotland, NHS Boards, Local Authorities, Community and third sector providers, and other emergency responders attended and engaged in these events and discussion. The output from these progressive events was various pilot initiatives proposed which will be reviewed for implementation by Police Scotland Service Design, Scottish Police Authority and Police Scotland's Mental Health and Suicide Prevention Team. The Service Design team produced informative reports post each workshop, which were made available to stakeholders.

The SPA have created a national map highlighting good practice of mental health initiatives across Scotland and work has commenced to explore these innovative practices and their scalability. This will focus on consistent and equitable practice across Scotland taking cognisance of geographical location and taking focus from successful operations like 'The Neuk' and 'Hope Point' in Perth and Dundee respectively.

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Mental Health and Policing – Partnership Delivery Group
6 – 12 month workplan
November 2025

Purpose:

This workplan sets out the priorities and objectives that the PDG will focus on and aim to achieve over the next 6–12 months. It provides a clear roadmap for delivering agreed actions, ensuring transparency around ownership and timelines. The plan is designed to support effective collaboration by outlining what is expected from partners and when updates or actions will be required.

Each item in the workplan is marked with one of the following categories:

- **For Awareness**: Provides members with an overview of relevant information, context, or developments to keep everyone informed.
- **For Discussion**: For discussion on the specified date/forum space for partners to share progress, identify barriers, and explore challenges collaboratively.
- **For Action**: Indicates that partners will be commissioned to undertake specific tasks or deliverables either before or after the meeting.

Date/Forum	Immediate impact	Strategic/ systems impact
20 November - PDG ***Purpose:*** *Focus on shared communications work; agree next steps on performance and baseline metrics.*	**For awareness:** • Transfer of care and international comparison research (SPA) **For discussion:** • [REDACTED] **For action:**	**For awareness:** • [REDACTED] **For discussion:** • [REDACTED] • **ASK:** [REDACTED]

<table>
<tr><td></td><td>[REDACTED]
In advance of PDG in February, partners to review current collaborative commitments, and consider revisions, updates or the requirement for new commitments.
Shape and prepare for the 12 February event by contributing insights, evidence, and ideas that will ensure it delivers on its aims
<u>ASK:</u> Partners to review comms toolkit and task and finish group proposed to work shop future and on-going content</td><td></td></tr>
<tr><td>SGG (Feb/March 2026)

Purpose: Provide feedback to sign off Performance Framework including baseline metrics from PS</td><td></td><td>For awareness
[REDACTED]
[REDACTED]
[REDACTED]
<u>ASK:</u> [REDACTED]</td></tr>
<tr><td>26 February – PDG

Purpose: Provide update on how Collaborative Commitments are progressing identifying barriers; and discuss if any need refreshed.</td><td>For awareness:
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]</td><td>For awareness
[REDACTED]
For discussion</td></tr>
</table>

	• [REDACTED] **For discussion:** • [REDACTED] • [REDACTED] **For action:** • [REDACTED] • [REDACTED] • [REDACTED] • [REDACTED] **<u>ASK:</u>** Partners to consider how good practice examples can be streamlined and shared.	• Review of Collaborative Commitments including repurposing or requirement for new commitments (PDG) – for discussion and action **For action:** • Review of Collaborative Commitments including repurposing or requirement for new commitments (PDG) • [REDACTED] • [REDACTED] • **<u>ASK:</u>** Partners to agree updated or refreshed commitments; [REDACTED]
May PDG ***Purpose:*** *Agree next steps to understanding of the wider strategic landscape and identifying key points of influence, and feedback how the implementation guidance could be applied within local contexts.*		**For awareness:** • [REDACTED] • [REDACTED] • [REDACTED] **For discussion:** • Planning commenced for Framework for Collaboration implementation guidance – to be informed by consolidated understanding of the wider strategic landscape identifying

		barriers and opportunities and avoiding duplication (SG - PD) **ASK:** Partners to understand and consider what the framework for collaboration implementation guidance could look like for local contexts.
August PDG ***Purpose:*** *Agree next steps to drive systems change, focusing on rapid, locally tailored expansion; and review the draft FfC implementation guidance, with partners asked to consider its adaptation for local contexts.*		**For awareness** • [REDACTED] • **ASK:** [REDACTED]
September PPC ***Purpose:*** *Report on progress made since last PPC, and share next steps.*		**For action** • [REDACTED] **ASK:** Partners to share how they will streamline comms of established local forums through existing structures; and support delivery within localities of forthcoming public communications campaign.

Communications action plan

This paper seeks to capture communication activities that are already underway or that should take place to support the delivery of the PDG Collaborative Commitments. As the emerging performance framework is finalised, metrics will be aligned to outcome areas to support a communications narrative underpinned by both qualitative and quantitative updates.

ASK of PDG members – please consider this paper and come prepared to discuss how your organisation could support the activities set out in this paper.

Communication and Awareness

1. **We will develop a multi-agency communication strategy to promote access to the most appropriate service/pathways, highlighting best practice and improve collaboration.**

Objective: Enhance coordination, clarity, and accessibility of mental health service information for services and individuals in distress or crisis

Next 3 months

Outcome	Key activities/ tasks	Output and Timescale
(1) Develop a Multi-Agency Communication Strategy: • Improved internal communication to frontline staff.	Develop multi-agency communication strategy Ongoing stakeholder presentations on PDG and FfC Specific communications/ engagement on repurposing/ establishment of the forums. Agree our collective messaging on the work of the PDG, progress and state of play Agree lines on mental health demand on policing	**Strategy Produced** (live document), 2025 Core presentation available (ongoing)

Next 3 - 6 months

• Improve messaging for front line staff	Create frontline resource on support pathways (e.g., MH reference group contact guidance with Penumbra) Leverage the existing NHS 24 mental health resources (Mental Health Services at NHS 24 | NHS Inform) by encouraging PDG members and partners to amplify its messaging to their service users: - where-to-get-urgent-help-for-mental-health : NHS Inform; and - Mental health services at NHS 24 | NHS inform Relevant NHS mental health and health and social care leads communicate with health boards and health and social care partnerships the principles of FfC and action required to achieve its ambitions. Staff user experience surveys	DG members and partners distribute tailored communications (e.g., flyers, digital posts, or briefings) reinforcing the NHS 24 mental health resources and messaging to their service users, with distribution completed (by Q4 2025?) Completion of input and feedback Baseline survey and completed survey (timescales tbc) Core presentation available, ongoing
• Improved public awareness	Increase awareness with hard to reach groups	**Tailored outreach campaigns (e.g., via third sector**

	Leverage existing digital/social media platforms with targeted key messaging Leverage existing PDG networks, sharing materials and briefings	PDG members to use their own platforms, comms team to disseminate messaging
• Advocate cultural change with the public and frontline staff.	Activities above	
• Improve service experience for those in distress and/or crisis.	Create frontline resource on support pathways (e.g., MH reference group contact guidance with Penumbra) VOX service user surveys (initial + follow-ups) VOX –service user survey about current experience, follow up with surveys further down the line.	Resource rolled out, 2025 Surveys completed, Q1 2026

2. We will increase visibility and uptake of mental health support pathways.

Next 3 Months

Outcome	Key activities/ tasks	Output and Timescale
(2)Raise Awareness of Available Pathways into Support and Care: • Provide clear communication on routes to urgent mental health support, aligned to messaging on NHS Inform	Transfer of Care pilot (E & J policing divisions) Good practice examples/ case studies to be communicated to local services Leverage existing unscheduled care messaging on NHS inform: where-to-get-urgent-help-for-mental-health : NHS Inform	Timescale and implications information sharing / application of learning for other PS Divisions?

	If PDG consider updates are required to urgent messaging, the MHUC Network will consider and take forward.	
• Explore opportunities to further raise awareness of the available pathways into support and care.	Good practice examples/ case studies to be communicated to local services Develop a concise urgent support ‘cheat sheet shared digitally via PDG channels and community platforms.	Case studies distributed, (2025?) Cheat sheet created and shared (2025?)
• Develop tailored messaging for specific population and equalities groups to improve access to unscheduled care services and equity of service experience.	Third sector develops user-focused pathway communications	Materials produced (2026?)

Introduction

As described in the Framework for Collaboration (FfC), we know that multiple factors can impact mental health and wellbeing, and that poor mental health and wellbeing is not only detrimental to individuals but also places additional demands on services and supports, and on the people that provide them. In its thematic review of the servicing of mental health demand on policing, published on 18 October 2023, His Majesty's Inspectorate of Constabulary in Scotland (HMICS) also recognised that mental health is a multifaceted issue that requires an effective whole-system partnership response, and set out a number of recommendations for Police Scotland, the Scottish Police Authority, the Scottish Government, and other bodies.

Police can play an important role in improving the safety and well-being of individuals, localities and communities in Scotland[1], with the Scottish Government's Vision for Justice in Scotland, published in 2022, setting out the importance of people in contact with the justice system being able to access the correct support. It also recognises that effective partnerships are essential to improving the mental health and wellbeing of those who encounter the justice system.

While the FfC sets out the recommendations and principles for an effective and strong multi-agency collaborative approach to distress that will support individuals to get the right care they need a person-centred and trauma-informed way, this complementary Action Plan sets out the actions that we will take to reduce unnecessary demand on police officers and ensure that resources are appropriately deployed. This Action Plan builds on the work already planned or underway across Government and partner organisations in relation to mental health and wellbeing, with a specific focus on mental health and policing and an overarching aim to continue ensuring that those seeking urgent or unplanned mental health support receive the right care, in the right place, at the right time.

Oversight and Delivery

The action plan is split into a series of thematic areas where actions will be taken:

- Multi agency collaboration
- Improved transfer of care
- Timely crisis response
- Building capacity and capability
- Strengthening community-based provision

Delivery of this action plan over the next three years will be taken forward collaboratively across services. The Partnership Delivery Group will oversee the work that is being taken forward, ensuring progress is taking place. The Scottish Government will oversee through a Strategic Governance Group in addition to reporting to Scottish Ministers and via Parliamentary Scrutiny. In addition, the Scottish Police Authority and Police Scotland will report progress publicly through the Policing and Performance Committee. This Governance process will be aligned to the governance process in place for the Mental Health and Wellbeing Strategy.

[1] Section 32 of the Police and Fire Reform (Scotland) Act 2012

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Links with Existing Strategies and Commitments

As previously noted, this Action Plan builds on the work that is already planned or underway across the Scottish Government and key partners.

The Mental Health and Wellbeing Strategy and Delivery Plan

In 2023, the Scottish Government and COSLA jointly published the Mental Health and Wellbeing Strategy and its accompanying Delivery Plan. The Strategy lays out the long-term vision and approach to improving the mental health and wellbeing of everyone in Scotland, meanwhile the first Delivery Plan, covering the period 2023 to 2025, sets out the short-term actions that will be taken to make progress towards the outcomes and priorities in the Strategy. Both documents recognise the importance of local and national leadership, the role of social determinants of mental health, and the importance of prevention and early intervention in supporting the mental health and wellbeing of our communities.

Priority 4 of the Strategy lays out our commitment to '*expand and improve the support available to people in mental health distress and crisis and those who care for them through our national approach on Time, Space and Compassion*', with a focus not only on improving the response, but also on keeping the person experiencing distress or crisis safe and preventing their situation from escalating further. We have already started to deliver on a number of actions in the Delivery Plan supporting this priority, such as:

- **We will achieve full national coverage of the Distress Brief Intervention (DBI) programme.**
- **We will continue to invest in NHS 24's Mental Health Hub**. The Mental Health Hub started providing 24/7 support in July 2020 and has modernised pathways into mental health services. The Mental Health Hub, which is accessible through the 111 service, is available to anyone who requires mental health and wellbeing support or if they are in distress. Calls are answered by a Psychological Wellbeing Practitioner who offer an empathetic response and will triage people using a psychosocial assessment to either help manage their needs or direct them to the most appropriate form of support. Psychological Wellbeing Practitioners are specially trained staff who are expertly supported by Mental Health Nurses.
- In addition to the above, **we will continue to invest in the Enhanced Mental Health Pathway and promote partnership working to increase Police Scotland and Scottish Ambulance Service access to local clinical support**. The pathway enables emergency calls received by Police Scotland or SAS where callers are identified as needing mental health advice and support to be directed to the Mental Health Hub. Work is ongoing between Police Scotland and NHS 24 to increase the referrals from Police Scotland's Command and Control Centre (C3) Division to the Mental Health Hub, and we are working on improving the call transfer process with the aim of achieving a warm handover between the two services.

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- **We will increase awareness of pathways into support and care by developing national awareness raising activity**. Through the Mental Health Unscheduled Care Network, we have developed national messaging outlining how people can access urgent mental health support. This messaging was published on NHS inform in December 2023 with work currently underway to roll-out regular social media posts to signpost people to the page. We are also looking at developing more tailored messaging for marginalised and equality groups.
- **We will develop a mental health unscheduled care resource pack by autumn 2024**. The resource will provide a directory of national sources of help and support that the Mental Health Unscheduled Care workforce can connect or a signpost a person to, to complement the support, assessment and treatment that the individual will receive from unscheduled care services.
- **We will take an evidence-based approach to our improvement work to better understand how people are accessing and receiving unplanned mental health care**. The Scottish Government is working with Health Boards and Public Health Scotland on the lead in work, and this data will measure the impact of the changes to the mental health unscheduled care pathway to date and identify opportunities for further improvements while ensuring that these are underpinned by robust data.

Although not captured under specific strategic actions in the delivery plan, **we will continue to fund the SAS Mental Health Paramedic Response Units**. Action 15 funding was allocated to SAS in 2021 – 22 to delivery the Mental Health Paramedic Response Units in Inverness, Dundee and Glasgow. The ambitions of the project is focused on working collaboratively with local health boards and Health and Social Care Partnerships to provide joined up care to people requiring mental health assessment after they have contacted 999 for ambulance support. The evaluation of this pilot project found a reduction in conveyance to accident and emergency (A&E) for people attended by the MHPRU and anticipated there being potential benefit to the patient by bringing specialist mental health assessment to them, rather than having to go via A&E to access this care.

Lastly, we have also **funded the SAS High Intensity User Pilot**. The project started in 2021 and was later expanded supported by funding from the Scottish Government. The team identified 137 patients over the age of 18 years old who had generated 12 or more 999 incidents in 3 months, and/or 5 or more 999 incidents in a 1-month period. Four clinicians were recruited to support the process development and function as a single point of contact for patients, staff and the wider multidisciplinary team. This person-centred approach aided in supporting patients, by enhancing their confidence in accessing care and enabling the service users to hear their own voice in the process of care planning. Patients received the right care for their needs closer to home or within their local community. In total the number of incidents SAS attended (related to this cohort) nationally, dropped by 55% from 3216 to

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1441. This reduction in attendance and conveyance time meant that crews had increased availability to respond to patients who required conveyance, helping to reduce demand on the service and other healthcare providers. As a result, SAS has embedded this model into their service provision and expanded the service to children and young people.

As a result of the Strategy and Delivery Plan we want to see the following differences or changes:

1. Improved overall mental wellbeing and reduced inequalities.

2. Improved quality of life for people with mental health conditions, free from stigma and discrimination.

3. Improved knowledge and understanding of mental health and wellbeing and how to access appropriate support.

4. Better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others.

5. More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

6. Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.

7. Better informed policy, support, care and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

8. Better access to and use of evidence and data in policy and practice.

9. A diverse, skilled, supported and sustainable workforce across all sectors.

Action plan 2024-2027

	Theme: Multi Agency Collaboration					
	Aim:					
Action	Description	Lead	Interdependencies/ contributory role of services	Timescales	Outcomes	Measuring Impact
Review and consider the role out of joint risk assessment handover forms used between NHS and Police Scotland across Scotland.	This action will ensure the most appropriate service provides timely support to an individual in crisis to ensure efficient transfer of care.	Police Scotland		March 2025	• Services deliver a joint trauma informed trauma approach. • Police engagement on scene at non crime mental health distress calls is reduced • Officers report more confidence in using transfer of care arrangements, providing reassurance that they can leave the scene.	• Police Scotland's workforce health and wellbeing survey • Police Scotland and NHS data on time spent on scene and subsequent hours saved processing of patients in NHS setting. • Service user feedback through advisory group. • Qualitative feedback from NHS and from

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						Police Scotland on trust and confidence that has been built and taking place on handover of care.
Explore possibility for NHS 24 calls on scene	Building on the development and improvements to the Enhanced Mental Health Pathway, and as part of Phase Three of the pathway, Police Scotland and NHS 24 will explore whether it is possible for police officers to hand over a mental health related call to NHS 24 while on scene in circumstances where it would	Police Scotland and NHS 24.			• Services deliver a joint trauma informed approach. • Police engagement on scene at non crime mental health distress calls is reduced. • Officers report more confidence in transfer of care arrangements, and the assurance to leave the scene.	• NHS 24 MH Performance Reporting.

	meet the requisite threshold.					
Promoting confidence and culture change in frontline officers by progressing the Police Scotland communication strategy to share best practice and highlight improvements in collaboration.	Police Scotland will communicate good practice to frontline Divisions that is already taking place. This approach seeks to showcase the benefits of the enhanced referral pathway, the work of frontline officers and the community triage service. External communication will take place with partners to compliment the ongoing work already taking place with the NHS to promote a behaviour change in the public to make contact with	Police Scotland			• Frontline Divisions better understands the whole system response. • Effectively explain Police Scotland's policy on responding to mental health incidents, including the effective dissemination of any updated guidance; training; policy or procedure to internal and external audiences.	• Qualitative feedback from frontline officers • Quantitative measures of awareness before exercise and then compare after exercise. • Deployment of officers on scene • Hours of officers' present at scene • Reduction in call to police and the proportion of calls directly made to NHS 24. • Through data and examples, illustrate

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	NHS 24 rather than calling the police.					improvement in person centred support and that officers time is used effectively and efficiently.

Theme: Improved Transfer of Mental Health Care					
Aim:					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Implement the Community Triage Guide for Police Scotland.	Following the national and local improvements to the unscheduled care pathways across Scotland, all Boards have an unscheduled care clinician for mental health available 24/7 for anyone requiring urgent specialist mental health assessment or urgent referral to local mental health services. In most Health Boards, these clinicians are also accessible by emergency services, providing them with advice and support with determining the most	Police Scotland	Next 3-6 months	• Provide consistent access to clinical advice on the best care outcome for the individual. • Improve, where appropriate, the transfer of care from police officers to clinicians.	• Once the data work with PHS has launched, it will provide a mechanism to monitor referral numbers and referral reasons from Police Scotland to local mental health unscheduled care services. • Evaluation of the digital reference guide.

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	appropriate onwards care option. Through the Mental Health Unscheduled Care Network, the Scottish Government developed a digital reference guide setting out the 24/7 access arrangements to the Mental Health Unscheduled Care Clinicians; this document will be quality assured on a six-monthly basis.				
Review of the Psychiatric Emergency Plans	Undertake a national review of the Psychiatric Emergency Plans with the Mental Health Unscheduled Care Network to improve their consistency across the 14 Health Boards in format, roles and responsibilities, and processes, while maintaining flexibility to reflect local arrangements and systems. The review will consider the recommendations made by HMICS and the Mental Welfare Commission.	Scottish Government	November 2024	• A person-centred and human rights-based approach to responding to mental health emergencies. • Clearly articulated roles and responsibilities for each agency involved in responding to and managing a mental health emergency.	• Place of Safety data. • Mental Welfare Commission's data on number of EDCs and STDCs. • Data from local health boards through the MHUC data work with PHS.

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				• Provisions to support marginalised and equalities population groups	
Develop national guidance and template for Psychiatric Emergency Plans.	Following the review, the Mental Health Unscheduled Care Network will develop guidance and a template Psychiatric Emergency Plan for use by the 14 Health Boards.	Scottish Government	April 2025	• Consistently formatted and easier to use Psychiatric Emergency Plans	• Qualitative feedback from partners on the Mental Health Unscheduled Care Network • Place of Safety data • Mental Welfare Commission's data on number of EDCs and STDCs • Data from local health boards through the MHUC data work with PHS

Theme: Timely Crisis Response					
Aim:					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Explore opportunities to raise awareness of	Building on the work of the Mental Health Unscheduled Care Network did on	Scottish Government	2024	• Improved knowledge and understanding of	•

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available pathways into support and care	developing a page outlining how to get urgent mental health support, we will explore opportunities to further raise awareness of the available pathways into support and care. We will develop tailored messaging for specific population and equalities groups.			how to access appropriate support. • Reduced inequalities for population groups who may not equally benefit from mainstream forms of communication.	
Scoping partnership approach to HIUs	• Police Scotland, NHS 24 and SAS work together to review data and explore opportunities for care and safety planning.	Police Scotland			• PHS data work • PS MH Dashboard • SAS HIU data

Theme: Building Capacity and Capability					
Aim:					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Ensure DBI training is embedded in all policing divisions	Local Authorities and Police Scotland will work together on rolling out training to police division	Local Authorities & Police Scotland		• People in distress who could benefit from non-clinical intervention are better supported	• Data on DBI referrals

				• Police officers are provided with the knowledge and skills to support and ease a person's distress, provide a compassionate response and, where appropriate, provide a referral to DBI level 2.	
Continue to improve and increase the use of the Enhanced Mental Health Pathway	• Continuing with QA to consider missed opportunities where EMHP could have been considered. • Undertaking QA in relation with service user that came through C3 to NHS 24 • Ongoing analysis to look at other missed opportunities where	Police Scotland	12 months from publication	• Identifying most appropriate agency to support service user	• Data from MH Dashboard and NHS 24 • Cost effectiveness in relation to officer deployment time • Police officers deployed vs signposted to appropriate service

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	officers have been deployed (e.g. partner agency requests) – part of exercise to understand demand data and transfer of care				• Lived experience/user feedback
Complete roll-out of national suicide information sharing across Police Scotland	Suicide notification form – awaiting sign off and will result in national form for info sharing with partners through QES.	Police Scotland & PHS		• Measuring reduction or potential increase in suicides – would enable to keep overview of the situation.	

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Develop a new mental health and wellbeing training induction framework	Develop an induction training framework for the wider mental health and wellbeing workforce, volunteers, peer support/ recovery workers and carers. This will bring together existing mental health and wellbeing training resources and ensuring that its is on an accessible landing page.	NHS Education for Scotland (NES)	2026	• Increased education training opportunities to provide the workforce with skills to support people taking into account of protected characteristics and respond to people affected by trauma. • Making it easier for the workforce to access existing education and training resources	• NES evaluation process.

Theme: Strengthening Community-Based Provisions					
Aim:					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact

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Scope alternatives to Places of Safety	Develop and publish a scoping paper to explore the feasibility of implementing safe spaces as an alternative to people being conveyed to an Emergency Department (ED), which are frequently the legal Place of Safety for people in crisis.	Scottish Government	November 2024	• Reduce the need to convey people to ED. • Provide improved support to individuals who may not need to be seen within a clinical environment. • Provided improved support for people who may be in a mental health crisis but due to intoxication cannot participate in an assessment. • Additional service for first responders to convey/refer people who don't meet hospital based crisis and can be better supported within	• User surveys • PHS data work

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				an alternative space.	

Theme: Data, evidence, benchmarking, and improvement					
Aim:					
Action	Description	Lead	Timescales	Outcomes	Measuring Impact
Launch the Mental Health Data Dashboard		Police Scotland		• Better understanding of the demand picture for mental health	•
Continue work with Public Health Scotland to collect and report consistent data to underpin Mental Health Unscheduled Care improvements.	The data collected will help us to better understand local pathways, including referrers to mental health unscheduled care services, how people are accessing services, presenting factors, care outcomes and demographic information.	SG/PHS	Commence collection in 2024	• Underpin improvements to MHUC • Better understand how people are accessing unscheduled care support locally.	• Data collected

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Mental Health and Policing Partnership Delivery Group

FfC and Commitments Implementation Approach

Background

The Mental Health and Policing Partnership Delivery Group (PDG) was established in November 2023 as a mechanism for coordinating the range of activities underway at that time in response to increasing mental health distress related demand on the policing system.

Since that time the membership of the PDG has grown to reflect the range of services and organisations involved in providing a response to increasing unscheduled demand related to distress and crisis.

During 2024 the PDG developed a Framework for Collaboration(FfC) and linked series of Collaborative Commitments, outlining the partnership and collaborative actions being progressed to enhancing the current activity underway across the system, and build on the wider commitments and improvements being made through the national Mental Health and Wellbeing Strategy.

The Terms of Reference for the PDG outline key responsibilities around the coordination of a partnership response to mental health distress related demand; coordination and reporting of current activity; identification of opportunities for collaboration; development, delivery and oversight of distress specific guidance; identification of interdependencies and synergies; and creation of specific products for use across distress response.

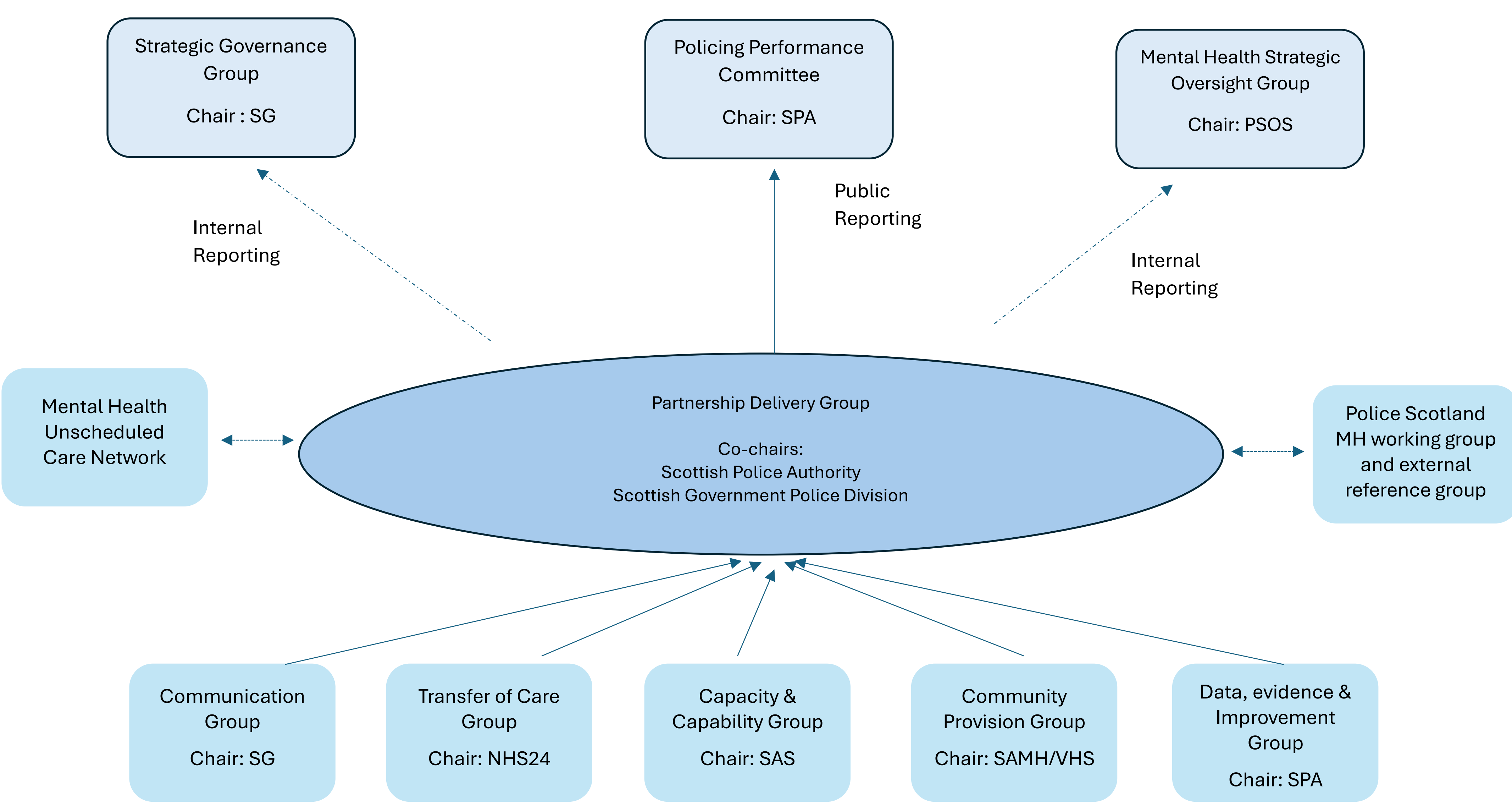
The PDG has, to date, reported internally through existing organisational structures within member organisations as well as more formally through COSLA boards and the Policing Performance Committee of the Scottish Police Authority. Additionally Scottish Government established a Strategic Governance Group to provide oversight and direction for the work of the group.

Way Forward

The PDG has focused on development of the FfC and commitments documents, which are now in final design ahead of publication in January/February 2025. The workplan for the PDG for 2025/26 onwards requires a refresh to ensure a focus on implementation of the commitments and identification of further opportunities for collaboration.

To support this refocus on the PDG it is recommended that a series of implementation sub groups are established, as shown in the graphic below, led by members of the PDG itself and drawing in wider membership as required, to drive delivery of agreed actions. The proposed structure of these groups reflects the key themes identified in the collaborative commitments and proposes, for discussion and agreement, a lead agency for each. The responsibility of the lead / chair for each group will be to drive progress and report on this through revised quarterly meetings of PDG.

The development session in February will allow us to develop workplans and structures for each of the implementation sub-groups.


Strategic Governance Group
Chair : SG
Policing Performance Committee
Chair: SPA
Mental Health Strategic Oversight Group
Chair: PSOS
Internal Reporting
Public Reporting
Internal Reporting
Mental Health Unscheduled Care Network
Partnership Delivery Group
Co-chairs:
Scottish Police Authority
Scottish Government Police Division
Police Scotland MH working group and external reference group
Communication Group
Chair: SG
Transfer of Care Group
Chair: NHS24
Capacity & Capability Group
Chair: SAS
Community Provision Group
Chair: SAMH/VHS
Data, evidence & Improvement Group
Chair: SPA

Mental Health Demand and Policing Strategic Governance Group

Terms of Reference

The Mental Health Demand and Policing strategic governance Group (the Group) is a strategic level sponsorship and governance focused group of key partners and stakeholders involved in responding to mental health distress demand from the communities of Scotland. It provides collaborative oversight, scrutiny, direction and support for the delivery of collaborative action being taken through the multi-agency Mental Health Demand and Policing partnership delivery group.

The Governance Group's core purpose is to

- Ensure strategic alignment and delivery of key commitments around responding to mental health distress related demand
- Consolidate the joint commitment to, and priority status of, the partnership response
- Support a focus on understanding and improving impact of collaborative work
- Consider risks to delivery and provide a platform for resolving challenges

The Group will focus on:

- What does success look like/What are the tests for success?
- How do we scale local initiatives up?
- What is the impact of the current workstreams?
- Mapping of current activity
- Improved options available to police for handover, onward referral
- Intervening where the operational group encounters barriers

Membership, Frequency and Secretariat

Name	Role	Organisation
	Safer Communities	Scottish Government
		Police Scotland
	Mental Health	Scottish Government
		Scottish Police Authority
TBC		NHS Board Chief Executives
		IJB Chief Officers Group

Meetings will be attended by officers and staff supporting this work across Police Scotland, Scottish Police Authority and Scottish Government.

Secretariat support will be provided by the Scottish Government Police Division team.

Meetings will be held on a six-monthly basis, with additional meetings or deep dive thematic sessions scheduled at the discretion of the Chair.

A record of the meeting and action log will be produced and circulated to Group attendees following each meeting.

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Mental Health Distress and Policing
Partnership Delivery Group

Wednesday 29 January 2025
1400 -1530
MS Teams

		Agenda item	Lead	Purpose
1400	1	Welcome and apologies		
1405	2	Update on design and publication timeline		
1410	3	Communications Plan update and action planning **Discussion Item**		Discussion on specific actions by each organisation on publication day. Plans for sharing, internal and external cascade.
1440	4	Next steps and Implementation Proposals **Decision Item**		Proposals for supporting structures for oversight and delivery of commitments, updated TOR for PDG.
1500	5	Update from PSoS Mental Health Working Group **Discussion Item**	**Police Scotland**	Update on key delivery areas including data dashboard and local practice examples
1510	6	Development of Performance Framework and Baselines **Discussion Item**		Discussion on metrics, indicators and available data to support reporting of progress
1520	7	Partner updates **Discussion Item**	**All**	Reflecting on the discussion having taken place during the meeting, partners are invited to provide an update on any relevant activity they are undertaking as an organisation.
1525	10	AOCB	**All**	For discussion
1530	12	Date of Next Meeting 25 February 2025 1000-1330 in person meeting		Planning / workshop session

PDG stakeholder map and engagement plan

Organisation or group	Stakeholder status	Key contact	SPOC from PDG	Engagement type	Most recent engagement	Next steps
Scottish Government	Critical	[redacted]		Direct	Member of PDG, regular updates and engagement	
Police Scotland	Critical			Direct	Member of PDG, regular updates and engagement	
SPA	Critical			Direct	Member of PDG, regular updates and engagement	
BTP	Critical			Direct	Member of PDG, regular updates and engagement	
SAS	Critical			Direct	Member of PDG, regular updates and engagement	
NHS24	Critical			Direct	Member of PDG, regular updates and engagement	
Lived Experience (via VOX)	Critical			Direct	Member of PDG, regular updates and engagement	
SFRS	Critical			Direct	Discussion re membership of PDG	
SWS (CJ specifically)	Critical			Direct		
HSCP COG	Critical			Direct		
COSLA	Critical			Direct	Member of PDG, regular updates and engagement	
NHS Scotland	Critical			Direct		
Community Planning Improvement Board	Critical			Direct		

Organisation or group	Stakeholder status	Key contact	SPOC from PDG	Engagement type	Most recent engagement	Next steps
MHUC Network	Critical			Direct	Member of PDG, regular updates and engagement	
Unions and Associations	Critical			Direct		
SCTS	Important			Email		
SAMH	Important			Direct		
Samaritans	Important			Direct		
HMICS	Important			Email		
PIRC	Important			Email		
Mental Wlefare Commission	Important			Email		
SPS	Routine			Invite		
Scottish Health in Custody Network	Routine			Invite		
National Police care Network	Routine			Invite		
HIS	Routine			Invite		
SHRC	Routine			Invite		
SCVO	Routine			Email		
TSI network (?)	Routine			Email		
COPFS	Routine			Invite		

Status:

Critical

Important

Routine

Engagement type:

Direct contact & discussion

Email engagement

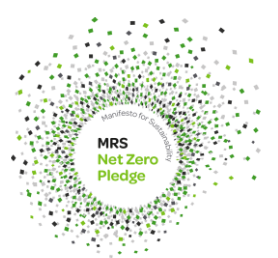
Invite to respond

Police Scotland

Mental health demand and response

Report

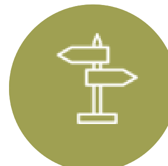
June 2023



Contents

Project background

Objectives



Method

Sample

Summary of findings

- Understandings of mental health
- Distress and its presentations
- The emergency response system
- Experiences of responding to people in mental distress
- Future challenges and goals for the emergency response system

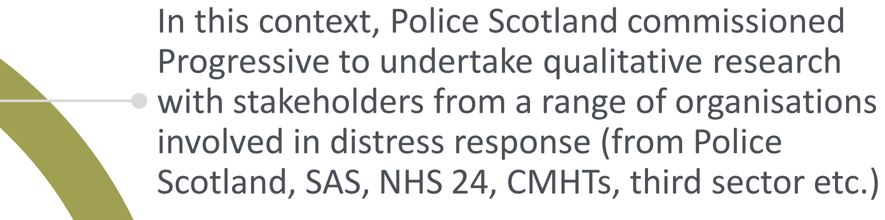
Conclusions

Project background

Responding to distress incidents in the community absorbs a significant amount of Police Scotland service advisor and officer time.

Sometimes police deployment is necessary, but there are other instances where individuals in distress would be better supported by qualified professionals in mental health response, or by other services (e.g., third-sector distress mgmt. services).

Understanding more about the network of organisations that respond to emergency distress incidents is vital for developing more coherent responses to those in distress.



In this context, Police Scotland commissioned Progressive to undertake qualitative research with stakeholders from a range of organisations involved in distress response (from Police Scotland, SAS, NHS 24, CMHTs, third sector etc.)

The overarching purpose of the study was to gather insight from stakeholders as to how well the emergency response system is managing distress incidents in the community, and what improvements could be made, both from an individual and system-wide perspective.

This document reports on key findings from the study, from the perspective of the different responder groups (and as a whole).

Project objectives

progressive

- To understand how stakeholders feel about the response of emergency services to people in mental distress.
- To understand what is successful about the current response process/what improvements could be made.
- Gather insights on stakeholders' views as to why people in mental distress call the police.
- Journey mapping – how could the 'user journey' of people experiencing mental distress be improved.

Method and sample

Depth interviews with stakeholders from key responder groups

50 one-to-one depth interviews

Up to 60 minutes in length

Videoconferencing (MS Teams)

2nd May – 2nd June

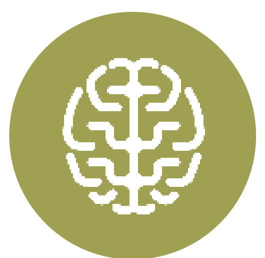
Offered £60 but many decided to donate incentive

Responder group	*Interview breakdown*

Police Scotland (x16 interviews)	• x8 with 101/999 call handlers
	  • Mix of C3 service advisers
	• x8 with police officers who have been called out / have experience of dealing with citizens in mental health distress
	  • Mix of staff from V, N, Q, E Divisions (as per sample)
	  • Mix of rank across all Divisions

Scottish Ambulance Service (x10 interviews)	• x7 with ambulance staff • Mix of job role (emergency call handlers, paramedics, ambulance technicians) • x3 with mental health triage car staff (mental health paramedics)
The NHS (x14 interviews)	• NHS 24 111 staff (mix of job roles – PWPs, MH Nurses, Senior Charge Nurses) • Mix of other NHS staff – CMHT staff (inc. Occupational Therapists, Consultant Psychiatrists, CPNs etc.), addictions services staff
Community/third sector responders (x10 interviews)	Including: • Social workers • Crisis Centre staff (Penumbra) • Distress Brief Intervention staff (Penumbra e.g., MH & Wellbeing Practitioners) • Helpline staff (Samaritans, Breathing Space)

Please note that, due to the small sample sizes involved and the methods of respondent selection, qualitative research findings do not provide statistically robust data. However, this type of research does facilitate valid and extremely valuable consumer insight and understanding.



Mental health in Scotland

Understanding mental health

Mental health considered a broad, nebulous idea by some, but recognition that everyone has mental health, and it can vary over time.

- Recognition from responders that mental health is an individual's emotional and psychological wellbeing; it can vary throughout an individual's life and mental health issues can impact on an individual's ability to function in their everyday life, especially if untreated.
- Mental health **encompasses a variety of conditions** – there were common mentions of depression, anxiety, schizophrenia when defining the term.
- Recognition from some that everyone has mental health (similar to physical health in this sense), and it can be **good and poor** (and can swing between these states), but only some people have mental health conditions or mental illnesses.
- Recognition that mental health challenges can be difficult to explain and identify what might be affecting an individual.
- Recognition that **more acute mental health conditions/illnesses can lead to more frequent crisis**; some drew from the crisis incidents they attend on a regular basis.
- Lot of factors can affect/exacerbate mental health, notably **drugs and alcohol.**
- Few mentions of **stigma** around mental health **still existing**; although recognition that it tends to be a more open topic of conversation than previously.
- A few found mental health a **difficult concept to define**, either not knowing where to start or how to tie it all into one definition.

> *"Everyone has mental health, it's just a sliding scale. Some people have poor mental health, some people have good mental health, and this can fluctuate over time, over people's lives, it's more up and down for some people than others."*
>
> **- Community/Third Sector Responder**

Understanding mental health

No common understanding of mental health between responder groups

Consensus between respondents was limited

- Participants defined mental health in a range of ways – a key distinction in responses being whether responders drew on experience of responding to mental health/distress incidents in their role or took a medical approach (focusing on accepted definitions of the concept)
- This tended to reflect responders' training on, and knowledge of, mental health – SAS, NHS and community/third sector responders were more likely to think of mental health in a holistic sense (that it can be good/poor, that it can change dependent on a range of circumstantial and historic factors etc.) than Police Scotland responders who tended to focus solely on poor mental health/distress.
- Police Scotland responders were more likely to focus on the impact of alcohol/drugs on mental health than other responders which might also reflect the type of incidents they encounter in their role.
- Community/third sector were more focused on the everyday experiences of individuals and how people manage their mental health differently.

"It is an individual's thoughts and feelings and opinions. It can be both a feeling of wellbeing but also a diagnosis and a specific condition that affects somebody through either through structural changes in their brain and can impact on or be impacted by a wide range of different things, physical health, addiction, socioeconomic factors, things like that."

- Scottish Ambulance Service Responder

Factors affecting poor mental health

Multitude of individual and systemic/societal factors can affect someone's mental health – and it is often a combination of these factors.

The majority felt that **mental health in Scotland had got worse in recent years, with many citing the COVID-19 pandemic lockdowns as having a significant impact** – during this time, the availability/accessibility of support services decreased, and individuals/communities were left feeling isolated with fewer paths to support and advice. However, they also noted that prevalence of mental distress had been increasing pre-COVID due to dwindling resources for care provision.

Two broad categories of factors affecting poor mental health: **individual factors and systemic/societal factors**.

Many individual factors impacting poor mental health, including:

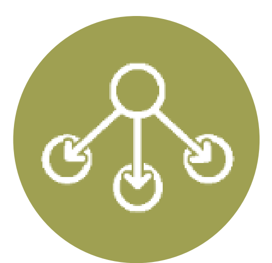
- **Financial hardship or socioeconomic issues** – a commonly mentioned factor, which has been exacerbated by the cost-of-living crisis.
- **Drugs and alcohol** – commonly cited as factors contributing to poor mental health, but non-medical responders did not tend to consider the underlying reasons for substance abuse (e.g., trauma/PTSD).
- **Childhood trauma** – the impact adverse childhood experiences can have on individuals can be profound if they haven't been able to address/process these experiences.
- **Relationship breakdowns** – this was felt to be a particularly prominent for poor mental health among young people.
- **Isolation** – loneliness was considered a 'silent' killer by many, affecting younger people as well as older people.

Systemic/societal factors impacting poor mental health included:

- A **lack of resources**, leading to **long waiting lists** for a variety of services – responders felt people continually left 'in limbo', not knowing where they can get support – this can lead to increased demand on emergency services, particularly during 'out of hours' (when community services aren't available).
- **Stigma** – some felt stigma around mental health is still prominent, a barrier to some seeking the help and support they require. (Although it is also worth noting that many felt people are more open about discussing their mental health than before – which can put additional strain on services.)
- **The pressures of modern life and how this is affecting young people** – many responders reflected that young people are struggling with their mental health and lack emotional resilience of older generations. They are negatively impacted by factors such as social media.

Responders from all groups mentioning a range of individual and systemic factors affecting poor mental health. However:

- Community/third sector and NHS participants tended to focus on individual factors over systemic factors whereas Police Scotland and SAS focused on systemic factors (e.g., the lack of resources affecting mental health service provision).
- All Police Scotland and SAS responders mentioned the increasing occurrence of crisis incidents.



Mental health response system: how it operates

Current way emergency response operates

Police Scotland taking the form of backstop for mental health crisis. Access to mental health services records are often blocked to police.

Key perspectives from Police Scotland responders:

- Tasked primarily with keeping people safe but often find themselves in a position of 'babysitting' (i.e., sitting with someone in distress in A&E).
- Police often the first point of contact, but support can be requested by other services and responders (especially if risk to life). Staff find this challenging:
  - Often dealing with individuals in distress which requires sensitive handling, especially when related to suicide.
  - Lack of integrated communication means referrals from third party services often don't include all the relevant information required (i.e., what their state of distress is, what the response from Police Scotland should be – e.g., welfare check, transportation to MH assessment).
- Sense from some service advisers and uniformed officers that other services (SAS, NHS, third sector) divest themselves of the responsibility of dealing with people in crisis. On the flipside, these services claim lack of effective communication means services don't understand each other's role and remit and so Police Scotland responders don't understand the limitations on services.

Partners Police Scotland responders work with:

- Officers work very closely with hospitals/A&E where there isn't a dedicated mental health assessment service or dedicated psychiatric hospital, but they feel the process is flawed. NHS and police equally recognise the flaws in sending a person in mental health crisis to A&E, but there are few alternatives if situation is serious – triaging via A&E service might be only option for critical distress incidents.
- Officers and service advisors also work closely with the NHS (e.g., NHS 24 Mental Health Hub referral pathway) and SAS, but they feel access can be difficult/slow at times due to waiting times associated with these services vs. the police, as well as the different types of people being referred.
- Referral to third sector is limited, although DBI pathways and local crisis centres are used by police sometimes.
  - *"So, it generally falls down to us because obviously ambulance crews don't have the capacity, NHS don't have the capacity, that we are the only other 24-hour service that people can call to say, 'I have concerns about such and such.'"* **- Police Scotland Responder**

Current way emergency response operates

SAS works closely with police and values their support but recognises police not trained to support those in mental distress

Key perspectives from SAS responders:

- Tasked with saving life of those in distress and their work largely stays true to role, although call handlers often assume '*the role of counsellor*'.
- Paramedics not trained to deal with all types of mental distress – two days of mental health training vs. three months on physical health.
- Very aware of the role that Police Scotland play in emergency mental health and sympathetic to the idea that Police Scotland is not designed to deal with mental health issues.
- Also, aware that police presence at scene of mental health emergency can escalate the situation:
  - *"Generally, when people see police, they assume there's been a crime. Then there's a stigma attached again that they've done something bad. In my experience, we find a lot of the time the presence of police can exacerbate the situation. There's been nothing done to cause any exacerbation, it's how just people see police and then they think criminal. They go down that line of thinking and then they're worried about what other people think about them."* **– SAS Responder**

Partners SAS responders work with:

- Work very closely with police in life-threatening cases – the latter typically first on scene to ensure safety of all parties.
- Rely heavily on Police to respond because wait time for ambulances can be too long (and SAS downgrade incidents if there is no sustained injury which leads to police being called because they are considered a more mobile service):
  - *"And Police Scotland will attend a mental health related call where a person is an immediate risk as a grade one call, I think they call it. So that's their highest priority call. So, they're going as a grade one, we are going as a low priority. So, they're there first, they're waiting so long for us, they're getting frustrated."* **– SAS Responder**
- In non-life-threatening cases, work with NHS, Distress Brief Intervention and third sector in terms of handovers and future care packages.
- Paramedics work very closely with internal mental health team and are accompanied by mental health nurses in Glasgow and Dundee; Inverness triage into mental health team over the phone.
- Call handlers don't have direct pathway to Mental Health Hub which can be challenging for non-life-threatening cases.

Current way emergency response operates

Pathways to getting support are often complicated and differences exist between health authorities

Key perspectives from NHS responders:

- Mental Health Hub responds to calls from police, ambulance, mental health officers, and social workers and if the patient becomes aggressive or there is any threat to life the police are called.
- Aware of the role that Police Scotland play in emergency mental health and most are sympathetic to the idea that Police Scotland is not designed to deal with mental health issues
- View from some that cases can incorrectly lead to police officer deployment because call handlers from emergency services (SAS, Police Scotland) are not trained in mental health and do not transfer regular callers often enough to Mental Health Hub or work to a set of guidelines/protocols that would be beneficial in terms of triaging someone to the correct service.
  - *"Maybe they're hearing voices, like somebody's trying to get into their house. But [Police Scotland call handlers] don't know that at the time. They're not mental health trained, and they don't have the history of the person. And it's not a criticism towards the staff, [but] it's what you ask them [the person in distress] as well. But yeah, it's maybe people that are maybe phoning them most of the times, and potentially they could put it to us, and we could try and settle them from that night."* **– NHS 24 Responder**
- Often, lines of communications between police/other agencies aren't clear, and police can refer to social services when it should go directly to the Mental Health Hub.
- In contrast to some ambulance and police staff, a few medical practitioners believe that having a police officer in uniform is often enough to diffuse a situation where a patient may become violent and aggressive.
- A few claimed that GPs are not always aware of what support services are available in their area and that they do not refer effectively.
- Mental Health Assessment Unit set up in Glasgow gives much more direct pathway to the right care – similar services are available in Edinburgh (Mental Health Acute Assessment and Treatment Service) but services like this are not available in all hospitals.

Current way emergency response operates

Distress Brief Intervention (DBI) reported to be working well. Some concern about police presence escalating situations.

Key perspectives from third sector/community responders:

- While recognising the need for Police Scotland in an emergency situation, some felt that police presence at scene of mental health emergency can escalate the situation especially in the case of children:
  - *"Police should step back sometimes, as they can escalate situations - it can put people into flight mode. Often kids come direct to us as they know it's a safe place and they can deescalate."* – **Community/Third Sector Responder**
  - *"Police need to be more wary of what a person's mental health constitutes and have extra training to deal with mental health incidents. Police shouldn't be overly involved because it's scary for a lot of people when people appear that creates the stigma that deters people away from being open and honest about their mental health."* – **Community/Third Sector Responder**
- Some community/third sector responders of the opinion that the cases referred to them are too complex to deal with and that they are picking up where specialist NHS care is needed.

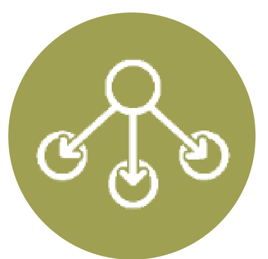
Partners third sector/community responders work with:

- Work with a broad range or organisations in the community (e.g., signposting to aftercare support) as well as first responders (emergency services, NHS 24, GPs etc.).

Current way response operates cont.

Pathways to getting support are not clear to all users and can be circular which leads patients back to where they started which wastes responder time/resources.

- Responders from different groups recognised that circularity can be an issue (i.e., examples of bottlenecks):
  - GP is gateway to many community mental health services/medication, but because people struggle to get an appointment with GP, they go direct to MHH who send them back to GP.
  - SAS and Police Scotland can refer someone in distress to Penumbra's Distress Brief Intervention, but because the person's distress situation may have deteriorated in the time between SAS/Police Scotland responding to the incident 'on scene' and the individual being contacted by Penumbra, there is no guarantee they will engage with DBI; in this event, referrals sometimes must be re-referred to Police Scotland/SAS.
  - SAS can refer to NHS Mental Health Hub and sometimes those cases get repassed back to emergency services.
  - There is an option for police responders to refer to the Mental Health Pathway through NHS 24 but they often can't get through to them as they have limited staff and strict criteria for referral – e.g., service users still have to be on the phone to you as you refer.
    - *"I think the people that are getting referred to us from SAS are usually in quite a lot more crisis than people from NHS 24, for example. So, when we speak to them, often that crisis hasn't been resolved yet and they are still quite actively suicidal or have plans to act or have potentially self-harmed. So, if... somebody says to us that they have an active suicide plan and they're not willing to engage in safe planning with us, then we obviously have to phone the police for a welfare check. If they have already acted on that plan, if they've harmed themselves in any way, then we obviously have to get an ambulance out for them as well."* **– Community/Third Sector Responder**
- Related to the above, another key issue is a lack of consistent care throughout the process – individuals get passed around services and often have to 'retell' their traumatic circumstances to multiple people before accessing the appropriate care.



Mental health response system: how well it's working

How well the system is operating

The biggest issue for Police Scotland is lack of training and not being designed to provide mental health support

- Police typically believe the mental health emergency response system is not working well due to:
  - **Appropriateness of service:**
    - They are not trained in dealing with mental distress.
    - Many officers believe many mental distress incidents are out with their remit.
    - People in crisis are often frightened by police presence; police presence can escalate a situation especially if the officer has not been trained in mental trauma and does not understand the best way to manage a person in mental distress.
    - Often police are not needed because there is no real threat to life.
    - They encounter many ‘regular’ callers who do not receive follow-up care from mental health professionals.
  - **Lack of connectivity:**
    - Lack of effective communication with other responder organisations.
    - Connection across police divisions can be fractured and divisions have different priorities.
    - Police feel they are held to higher degree of accountability than other responders (although it is worth noting that in many incidents, police are the only responders with the appropriate powers needed to manage a situation where there is threat to life).
- Resource is limited at best and usually scarce (also true for the NHS) which leads to poor, delayed service and frustrated police officers who spend a significant proportion of their time attending mental distress incidents.
- Additionally, recognise that service provision is very different across the country:
  - Dedicated psychiatric hospitals or assessment units more prevalent in large conurbations.
  - Services in rural areas particularly limited / stretched (most notable in Highlands).

How well the system is operating

Strong sense with this group that community mental health services are inadequate, and they are having to provide support that isn't available in the community

- SAS responders typically believe the mental health emergency response system is not working well because of:
  - **Issues with service provision**
    - They believe service provision around the country is unequal; some mental health assessment units have an 'open-door policy' whereas others are closed; Glasgow has clinical advisor role that gives paramedics access to patient information that can be useful to road crews
    - Believe Islands have limited support services; West coast has very little
    - Health boards working in different ways which makes service provision and communication between responders more challenging
    - Not enough paramedics trained in mental health in general
    - Services so stretched that SAS is providing support that should be provided in the community and not as an emergency response
  - **Poor communication**
    - Patients are often confused about where to get support.
    - Communication between police and SAS not always clear – SAS responders feel police don't collect or hand on sufficient information to SAS about patient.
    - Emergency services don't communicate with other mental health support services such as GPs, mental health teams and CPNs.
  - **Lack of training**
    - Recognise that police not trained to deal with mental health issues which can exacerbate crisis situations.
    - Paramedics not trained enough in dealing with mental health or suicide risk which makes them fearful of making a catastrophic mistake.

How well the system is operating

Similar themes emerging among NHS responders

- Some NHS responders believe the mental health emergency response system to be flawed because:
  - **Public behaviour**
    - Members of the public know that calling emergency services will elicit a response and they can get urgent help.
    - ‘Regular’ callers are a challenge that CMHTs should help manage.
    - Communication between police and NHS services (NHS 24 etc.) is poor because the remit of each service is not made clear to all parties involved.
  - **Lack of resources**
    - The social systems required to keep people well looked after are compromised.
    - The waiting times for community and hospital services are elongated because resources are so stretched.
    - Model of hospital care is to return people to the community quickly, some say too early which increases pressure on community.
    - Inequity and variation of services across different regions means that support in a crisis is a post code lottery.
    - No out-of-hours GP cover and limits on CMHT coverage out of hours.

  - **Not wanting to accept call**
    - Feeling among some that police and SAS don’t always accept duty of care for mental health crisis:
      - *“When we tell somebody we're going to call an ambulance, what I'll say to them is, "Based on what you've told me, I'm going to arrange an emergency ambulance." I'm going to hang up now and then I'm going phone an ambulance. [Then I] give them [the ambulance service) the details and they maybe say, "We're extremely busy tonight. It's going to take maybe three or four hours to get to that patient." Okay, that's it. I can't say, "No, you need to update that," whatever. I've just got to accept it.”* **– NHS Responder**

How well the system is operating cont.

Some see great improvements in the way NHS manages mental health

- Police do not understand health professionals' limited ability to detain individuals under the Mental Health Act, but NHS responders also recognise there is too much red tape involved in getting people detained when this is the most appropriate and safest (in terms of preservation of life) option (e.g., NHS CMHT responders need Sheriff warrant to detain someone).
- Emergency services act in a responsive, not preventative, way and so they can only act once a person has acted on suicidal ideation.
- There are innate issues with vulnerable older people leaving home and getting lost which takes up a lot of police time and can lead to the police in a constant loop of getting called out to older people (e.g., those with dementia).
- There are programmes in place (e.g., in SAS) to build trained mental health teams but they are small in comparison to the wider services.

Some recognised positive steps that had been made:

- A few thought it was working well in Scotland compared to other areas in UK and considering how under resourced the NHS is:
  - *"We're not like London where it takes hours for someone to get there."* **– NHS Responder**
- A few thought it was much improved compared to ten years ago, main innovations including the formation of the NHS 24 Mental Health Hub, mental health triage cars (SAS), increase in community mental health hubs/crisis centres and better connectivity with emergency services having mental health nurses based in Police Scotland call centres and the ability of call handlers to refer to NHS 24.

How well the system is operating

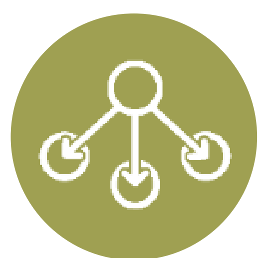
Community/third sector services work well in the case of distress but not so well in the case of mental illnesses which is a common referral situation

Third sector/community responders felt the system is not working well for these reasons:

- **NHS doesn't have capacity to manage all acute cases of mental illness in the community.**
  - *"The police need the option to refer people to more mental health specialists. It is important that the police are involved but they need extra mental health training as sometimes we get referrals that aren't appropriate for us but is more a hospital matter. This can include people who are actively suicidal, we can put safety plans in, but we are out of their depth to monitor that situation. People with severe mental illness like schizophrenia, psychosis etc. we aren't equipped to deal with that. I recognise the police and SAS aren't either, but they have no choice."* **– Community/Third Sector Responder**
- **Waiting list for longer-term support can be too long** (and they also rely on the individual not dropping out of services – which can be hard to do when someone is experiencing mental distress).
  - *"I think that's when the waiting lists really kick in, that can be weeks or months for people. So, there is definitely a gap between first responders, our service, and then that longer-term mental health."* **– Community/Third Sector Responder**
- **Lack of resource** in the system to deal with mental health crises. Some felt that NHS, community mental health providers and police are all under resourced. Schools are also reportedly not resourced well enough to deal with mental health crises. A few community/third sector responders believed teachers to be at the forefront of dealing with children's mental health, yet they are not trained to do so. Reportedly many refrain from discussing mental health in school because they think it could trigger children when in reality young people need someone to listen to them.
  - *"The system is working at capacity, which works when it's at equilibrium, but if there's an overspill then it's not good. It's too close to capacity."* **– Community/Third Sector Responder**

But felt it does work well when:

- Well-suited cases enter DBI and forward resource is available.
- Often, elements of the system work well together and hospital can be avoided but this works when a person is in distress situation and not facing a more serious mental illness related distress.



Mental health response system: accessing support

Accessing support

Public access police and ambulance because they know they will get a response

Police Scotland

- Following 999 calls, a police response is often sent as a precaution and service advisers are not trained to talk to callers about accessing alternative support (although some are able to). So, when a caller doesn't articulate what service they want, it defaults to police deployment even if ambulance is better option.
- Some responders feel some members of the public play the system and use Police Scotland to gain fast-track access to mental health services (although there is recognition that mental health assessments made by services would prevent unsuitable access – i.e., for those who don't need community mental health services).
- Police Scotland response more often accessed out-of-hours and at weekends (drink and drug abuse at weekends increases calls).
- First time callers thought of as more serious than 'repeat and regular' callers by some call handlers (cynicism exists in some factions).
- Police called because they have a duty to respond:
  - *"If they [people in distress] can't get a GP appointment, then they're going to phone 999. That's what they do. This means people are 'clogging up' the system adding to long ambulance and A&E wait times."* **– Police Scotland Responder**

SAS

- Some think accessing support is problem with signposting – the public need more information; others think ambulance is called too often because of lack of choice. For these responders, the public call 999 out of desperation because they have nowhere else, not because an ambulance is the most appropriate place.
- They believe 999 and 111 are most-used access routes to support. First port of call because it is a health service.
- Mental health triage cars are considered to be the most effective at responding to mental distress incidents, but their limited geographical scope and shift hours (not 24/7 service) means their potential benefits aren't being maximized.
  - *"There should be [a mental health triage car] running 24 hours in every city because it just is such an amazing thing and the people that work on them are always just great people. It just saves us time and resource and it means that the person that's dealing them is equipped to deal with them."* **– SAS Responder**

Accessing support

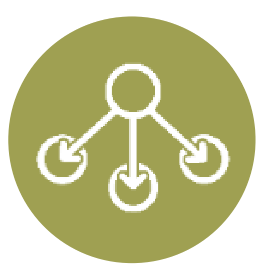
Pathways to getting support out of normal working hours need to be advertised to the public and all responders (who will then be able to signpost)

NHS

- GPs and NHS 24 are key routes to access help during normal working hours. Lack of access to GPs often leads to people presenting at A&E, some said.
- A&E is too often used to get help out of hours; people go direct to A&E or through emergency services. A&E is recognised by HCPs as not being the best set up to deal with mental health crisis because of the length of time it takes to see someone and the scarcity of mental health specialists in A&E departments (although they may be available elsewhere in the hospital setting).
- Some said pathways to getting support out of normal working hours are not well known and the public needs more signposting. Others said the same needs to be done for accessing support in normal hours:
  - *“There are a robust amount of services available but people don't know how to navigate [to] them.”* **– NHS Responder**
- Those who have an established need and support team already access CMHTs during normal working hours, but many feel there are some patients that wouldn’t be satisfied even if they had round-the-clock CMHT support.
- Dementia patients are often referred through third parties (family members/neighbours etc.) which often escalates the response, as third parties may not be fully aware of the most appropriate support someone in distress needs.

Third sector

- There is an issue with NHS 24 re-referring people to third sector services because they don’t keep records of previous referrals – this means services like DBI see the same individuals and there is a sense from third sector responders that these people need to be ‘caught’ by the established care system after their distress is under control. This is despite notes being sent by third sector services to GPs and CMHTs.
- Services such as Penumbra and Lighthouse are getting better known but more needs to be done to inform potential referrers and members of the public of what is available. Lighthouse is a one-of-a-kind service that offers crisis level support to 100 teenagers a week in Perthshire. Other areas are keen to offer similar services but don't have the resources in place yet meaning there is a mostly unaddressed mental health crisis among young people across Scotland.



Mental health response system: ideal route(s) to support

Ideal route to support

Direct access to a mental health professional at the point of emergency response is regarded as the best way to care for people

There are many good routes to support:

- In the case of suicide or harm to others, Police Scotland is required to attend.
- Ideally members of the public would call NHS 24 if there is no risk to life; and a smooth transfer to Mental Health Hub where a trained specialist professional can help is the ideal if Police Scotland staff are able to de-escalate (over the phone or on scene).
- A dedicated mental health emergency line or mental health team within Police Scotland would free up resources and mean individuals would receive tailored support from trained professionals
  - *"I suppose an ideal route in an ideal world would be to have the fourth emergency or the fifth part of the emergency service for mental health, because it's definitely prevalent in Scotland, it's a major issue that media was saying it's become almost normalised that we almost need a separate mental health emergency service"* **– Police Scotland Responder**
- Suggestion from some to increase remit of Mental Health Hub so that they can physically see a patient or more mental health paramedics that can see patient in person.
- Model of warm transfer from Police Scotland to NHS Mental Health Hub that exists in Glasgow (and has been extended) works because often people just need to talk.

Ideal route to support

There is a need to train call handlers better in responding to mental health distress and to give them better ability to refer people to a mental health team

- The triage cars in Glasgow, Dundee and Inverness were held up as an ideal route to support and a 95% discharge rate on scene was quoted. This is because they are trained medical professionals who de-escalate the situation and have strong knowledge of onward pathways for individuals:
  - *"They [people in distress] get one of my colleagues coming out to them, one of the mental health paramedics in Glasgow where one of our cars are. They have a mental health nurse on board that car. They go out and they will deal with the physical health and the mental health of the person on site, and if appropriate, discharge the person on site and give them all the support they need there and then. Or if required, then they can refer them onto other services or admit them to hospital. So best-case scenario, they can have somebody sitting there with them in half an hour and within an hour and a half have an outcome."* **– SAS Responder**
  - *"I think Police Scotland would benefit from a service like what we do. A nurse and an officer to not just drive, but who's interested in mental health, I think it can benefit, massively help, they would take so much strain off the service."* **– SAS Responder**
- Some commented on the need to train call handlers in better triaging (via increased awareness of alternative routes to support, and reduced NHS 24 wait times) as well as creating a more nuanced/sensitive protocol system (e.g., SCENE surveys) that doesn't automatically transfer patients to ambulance response if they are feeling suicidal.
- Almost all commented on the need for better preventative care in the community to minimise the number of people who reach crisis point.

Ideal route to support

Many felt that the first call should be taken by people with better training and more ability to refer to care team as this would result in fewer emergency call outs.

NHS SCOTLAND

progressive

- Some argued a strong case for a dedicated service for mental health emergencies where people would get fast access to a mental health professional.
- Triage cars were held up as an effective way to provide emergency support
    - *The mental health triage cars should attend with trained professionals who can administer medications if needed. There should be a separate line to call for mental health emergencies. They should get assessed straight away then be supported until they can move onto the community team.* **– NHS Responder**
- Some commented on the need for better resourced social services and better ability to discharge people from hospital
    - *A lot of patients in a rehab ward, who are suitable for discharge aren't, because they would be homeless, losing all of the progress that they've made due to drugs and alcohol.* **– NHS Responder**
- It is essential that when a person calls Police Scotland or SAS that they feel heard. Call handlers should be better trained to assess and respond to mental distress and need more regular training and support related to negotiation tactics.
- Many felt that call handlers need to be given better access to notes of previous calls and the outcomes as this would help them identify the best course of actions
- Many commented that best practice would mean that police are not as involved as individuals would receive medical support as a priority and police would only be present in situations until the risk of harm is gone.
    - *Best practice within the whole system is someone in distress being able to walk into a service and be seen immediately by someone who can support them (e.g., addiction specialist, psychological wellbeing specialists etc.) - they don't want to wait on the phone for ages to speak to GP / NHS 24. Edinburgh crisis centre is a good example of the type of service on offer that people could access*

Ideal route to support

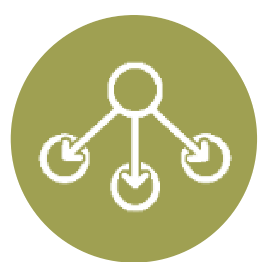
There were many comments about the lack of suitability of an A&E ward as a place for assessment and place for care.

NHS

- Many said that A&E should be avoided if possible and that self and community care programmes are the better option.
  - *"One of the things that we always ask someone is, when you're doing a suicide risk assessment is yes, you might have ideas about harming yourself, suicidal kind of thoughts coming into your mind. But actually, we really try and explore what is the real risk of you acting on them? Because we can all have suicidal thoughts. I've had them in my life where you think, oh God, life's not really worth living and what's this all about?... I've spoken to people over the years who will say things like, "Oh, I'm feeling terrible and I'm going to kill myself." And then they happen to throw in the conversation, "But I'm getting my hair done tomorrow"."* **– NHS Responder**

Third Sector organisations

- Ideally people in distress would be directly referred to third party support agencies more often and reduce unnecessary call outs from SAS and Police and bypass A&E.
- Some commented that it is often harder to deescalate referrals by police and SAS as they are often in greater crisis and are less prepared for or willing to engage in safety plans.
- Some felt there is no set right route for referral as all cases are individual.



Mental health response system: bottlenecks to support

Fluctuation and bottlenecks

The biggest contributors to bottlenecks in the system are increases in OOH and weekend usage of emergency services for mental health issues

Police Scotland

- The number of calls to police has increased over the years, some put this down to increased understanding of mental health issues and a greater willingness on part of the public to seek help. Most put it down to dwindling resources in NHS and mental health support.
- Call levels increase out of hours when mental health teams are not available and weekends when people self-medicate with drugs and alcohol.

SAS

- Calls to service start to build after 4pm and peak at 1am. Weekends are busier than weekdays; usually busier when community services are closed.
- Drugs and alcohol reportedly a big contributor to demand.
- Bottlenecks occur when demand levels for ambulance are high and members of the public call the police because the ambulance has not arrived. The reverse is also true – when the police are called first, attend an incident, but medical assistance is required, but they need to wait for an ambulance.
- A&E was regarded as the biggest bottleneck in terms of accessing service when there is no direct pathway to a mental health team and a person needs to be in a place of safety and clinically assessed. This is often because MH triaging is lower priority than physical assessments for A&E teams, and MH assessment teams in hospitals are very busy.

Fluctuation and bottlenecks

There are high demand times which often occur when community services are not available.

Demand-led bottlenecks

- Lack of community services at weekends and out of hours was also commonly commented on by NHS staff:
  - *"Demand peaks on Friday night as CPNs work Monday to Friday then people have a crisis when they have to face the weekend without support. Mondays can be busy as people wait for us to be in after the weekend."* **– NHS Responder**
  - *"[We] don't get many calls during working hours, 9-5. Demand increases after 10pm, more on the weekends too and also public holidays. Increases when GPs and MH teams are at home and not working."* **– NHS Responder**
- Mondays and Tuesdays were regarded as bottleneck days by some, when demand is high due to 'comedowns from the weekend'.
- August/September were also felt to be busy periods – when the school term starts, teachers, students/pupils tend to self-refer as a result of stress.
- Demands from acute patients often put appointments back for less acute patients which can lead to deterioration in mental health.
- Patients don't like to leave the care of community services and so discharge can lead to a deterioration in mental health.
- Too much demand on GPs because people don't understand/think about other pathways to getting help.
- Also, GPs can incorrectly refer patients to CMHT as urgent cases; when they are assessed, they are deemed not urgent and so are re-referred to GP or helpline services.

Fluctuation and bottlenecks

There are systemic issues with poor lines of referral and a scarcity of resource which all contribute to bottlenecks.

System-led bottlenecks

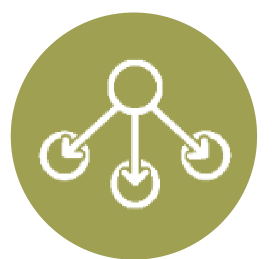
- A&E was identified as a bottleneck and understood as problematic for Police Scotland who can be tied up for hours waiting with patients for the right help because MH welfare/psychiatric incidents in A&E are lower priority than 'life-threatening' conditions (e.g., heart-related conditions/incidents).
- Access to CHMT support is limited – only GPs, social workers, other health professionals (e.g., those in MH assessment units/services within hospitals) can refer to more intensive community support.
- SAS sometimes not able to respond immediately so re-refer to NHS 24 service for re-assessment or to keep the service user 'on hold' until SAS can respond.
- Lack of secure tenancy for patients who would be homeless if they were to be discharged from hospital leads to capacity issues within in-patient wards.
- There is an issue in terms of who is able to refer to particular services. E.g., Forth Valley MHAATS – Mental Health Acute Assessment & Treatment Service – needs to be clinician with mental health background; whereas other (ostensibly similar/same) services (e.g., Glasgow MHAU – Mental Health Assessment Unit & Royal Edinburgh MHAS – Mental Health Assessment Service) allow for self-referral, police escort etc.

Fluctuation and bottlenecks

Generally, less exposed to bottlenecks as other organisations, but services becoming more stretched

Demand-led bottlenecks

- School can be a safe place for some children and so end of holidays and beginning of new terms can cause spikes in demand for children's services/charities as extended time at home can affect mental health.
- The current mental health crisis is creating a spike in demand for services:
  - *"The demand is manageable but there has been a massive increase in the amount of referrals over the last few months. Hard to deal with the amount, emotionally challenging as well."* **– Community/Third Sector Responder**
- First responders (Police Scotland, SAS staff) sometimes lack required level of training which leads to delays in people getting the most appropriate help for their need which can be a big issue for those who have contacted the police in a high state of distress – risk that their situation escalates.
- Demand for Breathing Space can outstrip ability to support people – only answer c. 50% of calls, so need to hope people continue to call back to access support. (But there is a risk that people will call the police because they can't get through.)
- Some feel a lack of appropriate social care can place delay in getting support (as it can take a long time for people's deteriorating MH to be noticed by services).



Mental health response system: improvements

Improvements to the system

Several things noted: consistency of services across the country, more training, out-of-hours service for mental health and better access to mental health support teams.

- More training for service advisers to help them de-escalate/diffuse crisis situations, which would avert emergency response and allow for referral to alternative pathways to support (NHS 24 MHH, or Breathing Space, Samaritans etc.).
- More training for police officers (in de-escalation in order to reduce unnecessary trips to A&E):
  - *"We all do our best and we've all got experience of life but certainly, my younger colleagues are coming across terms that they've never heard in their lives before… [people in distress] will be using terms like schizophrenia, bipolar, things like [that]."* **– Police Scotland Responder**
  - *"The police have to be there because there might be violence or weapons, but all they have is physical training. They don't have mental health training… In person training is needed."* **– Police Scotland Responder**
- Uniform service (and referral process) across the country – in terms of acute assessment services, hospital in-patient services, intensive community services etc.
- Follow up with individuals to ensure they are getting the support they need in the hope that it will prevent future call outs.
- Better signposting for people to mental health experts (e.g., NHS therapy services), NHS Mental Health Hub and third sector support etc. as police too often the go-to response option for people in distress.
- Increase/expand out-of-hours services in the community so pressure on police over evenings/weekends is alleviated.
- Belief that joint response (from police and a mental health professional working in conjunction) would be best as MH professionals could authorize sectioning at the scene, relieving pressure on A&E and psychiatric hospitals (in terms of wait times, assessment etc.):
  - *"When the concern-for calls go in, rather than having to do a phone call triage [via] the mental health crisis team or whatever, there [should be] a mental health specialist there and then to deal with that person. And if that person is deemed to be requiring to be sectioned, then it can get done there and then...Why are they [mental health specialists] not out with us to deal with it frontline, to stop us getting to that stage of having to take them to the hospital to tie up more resources? Because it not only ties us up, it ties them up as well… because there's a queue at Accident & Emergency."* **– Police Scotland Responder**

Improvements to the system

Very high levels of consistency with comments from Police Scotland employees.

- Belief from some that mental health needs its own multidisciplinary emergency service:
  - *"I think there's definitely more that could be done. I think mental health needs its own emergency service. It needs to be a separate service. Obviously, there's a lot of debate around who mental health calls should be going to, should be going to police or ambulance. But really, I think it's a multi-agency effort because some scenes need different resources that we can't provide."* **– SAS Responder**
- An increase in triage cars that can deal with incidents on scene (belief that these have been successful). Feeling is that triage cars could be extended across all cities in Scotland.
- Better sharing of information between the police and ambulance service. (E.g., police records of a person's danger levels are often more up to date than ambulance, lack of knowledge can lead to delays in attending – e.g., attending a residence where ambulance service believe there is a threat, but this threat is historical, not current.)
- More staff training in recognising needs and determining the best pathway for callers (e.g., greater understanding of OOH services like NHS 24 MHH and other helplines).
- Better exchange of information between mental health services, GPs, police and ambulance (about individual callers, how different services work and what type of referral is most appropriate for each service).
- Some called for dedicated out of hours mental health care support teams (outwith NHS 24, hospital-based services).

Improvements to the system

NHS staff called for greater consistency in diagnoses and referrals, and better connectivity and information sharing across organisations.

- As with SAS staff, some NHS employees also called for a mental health to have its own its own multidisciplinary emergency service:
  - *"There should be mental health nurses and teams, operating 24 hours a day to speak to people. If someone is having a crisis, someone should be available to manage that. There should also be a team that people can see face to face, available 24 hours a day. The police can then just do police work."* **– NHS Responder**
- Many thought that early intervention is the only way to reduce the number of emergency situations.
- Some suggested there was a need to locate mental health professionals within GP practices:
  - *"[We] need MH professionals in GPs or GP training [on MH]. NHS 24 don't have access to people's care plans or patient notes. Also, if they [the caller] don't give consent, NHS can't inform GP that patient has called in a MH emergency."* **– NHS Responder**
- Linked to the quote above, some responders pinpointed the need for better information sharing between organisations (e.g., NHS 24 access to management plans for 'regular' callers/CMHT records, access to GP notes etc.). This would help with determining pathways and would lead to more consistent advice being delivered.
- Greater consistency across health boards in terms of services offered, IT systems used, and communication channels – this would make information sharing much simpler.
- Psychiatric nurses cannot assess a person who is drunk and so there needs to be a **safe holding place** for people until they sober up and can then be assessed. (However, some recognition that can be difficult to get people to engage with services once they sober up.)

Improvements to the system

Training in mental health would improve referral pathways, reducing pressure on Police Scotland

- A common framework/understanding of risk level for all responders to work to would likely lead to more consistent referrals:
  - *"We had a lady that had been in contact with the police for… I think it was 5 weeks or something… and they'd been out 2 or 3 times a week… over that 5 week period and on the 5th week they called me and said, "look we've been called here, have you heard about her?", "no we haven't heard about her before", "she's screaming in her house, it's like she's talking to people", I was like, "okay", I said, "it doesn't sound like it's an emergency tonight but I'll get people out tomorrow to see her". The woman was floridly psychotic, and they hadn't picked up on it."* **– NHS Responder**
  - *"We need a more consistent way of GPs referring, some go straight to CMHT, others go to police in emergency situations."* **– NHS Responder**
- More experienced staff and better trained staff to work across the NHS:
  - *"I think at the moment we are bringing in a lot of inexperienced staff, and that would never have been heard of 10 years ago. We would never have brought in that level of inexperience to community [mental health support] because you do need to have a knowledge base, and I think we're trying to do it on the cheap."* **– NHS Responder**
- Some called for better training of call handlers so that they can assess and triage to the most appropriate service.

Improvements to the system

Improvements largely centre around a need for more resources in mental health support; closer communications also mentioned

- Schools should be better equipped to talk about, educate and support on suicide and self harm with their students (particularly as the waiting list for CAMHS is *'two years long'*).
- Many called for more resources to be pumped into the 'system' in the form of staff, training and funding:
  - *"More staff, more funding, more training. Things are always changing so it is it good to keep up to date. Good to keep everyone, including first responders, in the loop for this knowledge and training."* **– Community/Third Sector Responder**
  - *"There needs to be more money and resources as there are a lot of overworked services struggling to cope with the demand."* **– Community/Third Sector Responder**
- The loop of re-referral should be closed and could be if people got enough support in the community and also if NHS 24 kept a record of who they have already referred to third-sector organisations:
  - *"Often, they do have quite a team around them of other like professionals involved maybe social work or CPNs, psychiatrists, all that sort of thing. It is difficult. They're all quite different as well, I feel. I don't think there's like a kind of common theme between them all, other than they don't feel like they're getting the right support from somewhere."* **– Community/Third Sector Responder**
- Some felt the public should be better educated in understanding that police are there to support in cases of mental health crisis if it a life-threatening situation, but they tempered this by saying that the police can escalate distress incidents, so people might still refuse to call the police service.
- It would help third sector organisations if the police could furnish them with more details of the individual when they refer them, such as past mental health history/current issues they are facing. Referrals from the police to third sector services (particularly DBI) often lack detail.
- Some called for closer communication between organisations and remarked on the need for emergency response services to have better contact with community and social services (such as CMHTs, social work etc.).

Mental distress – understanding it and its complexities

Responders' understanding of distress

Distress manifests in many ways and people in distress have a range of different emotional presentations

Distress generally understood as when a mental health, illness, wellbeing situation becomes **unmanageable for the person experiencing it**. It is the point at which someone cannot cope.

Distress can present in a range of ways:

- Some very upfront – will share their distress in detail from the outset of the contact
- Some share their diagnosis – can be helpful in determining the appropriate response
- Some will call about a separate issue and the distress will become apparent during call
- Some unable to articulate what's happening for them (but obvious they are overwhelmed)
- Observing language and behaviour critical if presentation not obvious
- Range of emotional presentations – from quiet/determined to teary/frenetic
- Emotional presentations can vary during a call – from calm to heightened (and vice versa)

"There's certain [people] who don't present that obviously... maybe ring about another matter, but during the conversation it becomes apparent that there's something else going on. For example, they might say, someone came into my room and stole my money. But as the conversation goes on, it becomes apparent that that person that came into the room may or may not exist..."
SAS Responder

Differences between responder type?
Generally, **call handlers** (at NHS 24, Police Scotland and SAS) will encounter people at the height of their distress during their first point of contact with services. Services might have an informal log of regular callers, stating their mental health presentations and third-party contact(s), but this information could be more detailed / kept up to date (and be more widely shared).
Secondary responders (officers, paramedics etc.) rely on referral notes.

Complexities of distress

Distress does not always require a medical response and it does not always mean there is a suicide risk – a more nuanced understanding of this will lead to more appropriate responses

The research highlighted the complexity of distress and what we mean when we talk about different levels of distress (low, moderate, high, critical) – and the importance of meeting each level of distress with an appropriate response.

Working towards **a common framework for understanding distress** (inc. definitions of each distress 'level') might be beneficial in this regard. It could help inform decision making based on how someone is presenting and what is known about each individual.

However, more training would be needed to ensure emergency response staff understand this complexity.

These are some of the key factors to be considered when making correct response to someone presenting in distress:

- Distress does not usually necessitate a clinical/medical response – often preferable to respond via combination of psychological wellbeing activities (risk assessments, safety planning, self-care tips) and de-escalation techniques.
- Distress can be short or long term. It could be a 'trigger' on a particular day, or a slow buildup of stress (e.g., bereavement often involves a longer period of distress).
- Distress does not always mean there is a suicide risk. Ascertaining someone's level of risk (whether they have a plan, the means etc.) is critical to avoiding a disproportionate response from services.
- The impact of alcohol / drugs on distress mgmt. is profound – it seriously impinges on responders' ability to de-escalate, and intoxicated vulnerable people are more erratic/unpredictable in terms of their emotional response to support.
- Distress response is highly variable, and no two individuals will respond to the same external factors in the same way – emotional resilience, support networks etc. come into play.
- Important to take time to establish someone's experience with distress – is this the first time they have felt dangerously overwhelmed or is it a consistent thing? What has their approach been before?

Distress and de-escalation

De-escalation is crucial in preventing emergency service response to distress and reducing hospital admissions

Some first responders (i.e., NHS 24, SAS and Police Scotland call handlers) spoke about occasions when they were able to 'talk someone down' by staying on the line and taking the time to understand the factors that had led the vulnerable person to contact the mental health/emergency services. However, others felt less comfortable doing this and felt they lack the necessary skills/training.

Additionally, emergency service telephone scripts/protocols can be risk averse (a tension with the 'positive risk-taking' espoused by some NHS responders) which leads to categorizing callers as a suicide risk (and ultimately an emergency response).

Reducing distress via de-escalation can involve any of the following:

- Affirming people that they've made the right decision in reaching out for support
- An empathetic tone
- A candid line of questioning to ensure people reflect on/are cognisant of their intentions
- Reassuring people that the right support is on the way
- Distracting someone by focusing on aspects of their story that would suggest they are unlikely to do something dangerous ("I'm getting my haircut tomorrow.")
- Working through how someone is feeling – the factors at play and the impact they are having

Responding to people in distress – experiences and learnings

Types of people in distress

Regular callers absorb a significant amount of emergency service time and supporting them to manage their distress without contacting emergency services is critical

First-time Callers

- This group of callers need support to manage their distress.
- Typically, first time they have experienced period of heightened, unmanageable distress – and they often do not have the tools to manage their distress.
- Typically, do not have support for their mental health from clinicians in the community (e.g., CMHTs) although this is not always the case.
- They generally lack understanding of the system (and what response their level of distress requires).
- Can be uncertain about what they need – in their case, distress = paralysis. They need guidance to the right support for their presentation.

"I think first and foremost, [people in distress need] compassionate support. They need a person who is going to listen to them in a non-judgmental way, whatever the situation is. And I mean whatever it is."
Third sector responder

Regular Callers

Regular callers repeatedly contact services for support (in extreme cases, on a daily basis). Respondents described different presentations, including:

- **The dishonest caller** – 'knows what to say' to get a response from emergency services. Dishonest about overdosing, self-harming, or accesses other services (e.g., crisis centres) as an indirect route to emergency service response.
- **The demanding caller** – distrust of services/clinical experts, a lack of willingness to change behaviour (wants an immediate fix).
- **The lonely caller** – contacts services time and again (sometimes everyday) to talk about how they're feeling. Often not deterred by frustrated responders. Needs emotional support.

All these callers need more support – for underlying health/addiction issue, trauma etc. – but emergency response is not suitable. Responders are cynical about these types of caller.

"We had a lot of callers that would use our service [Crisis Centre] as a way of accessing immediate mental health support. So, they would potentially say that they've had an overdose, for example, so that an ambulance would get called and they would go to a hospital, but they actually hadn't."
Third sector responder

Crucially: <u>being able to distinguish between these types of callers</u> would be hugely beneficial in terms of effective resource mgmt. between services. Up-to-date records of 'regular' callers should be held and shared between services so callers can be better triaged.

Needs of people in distress

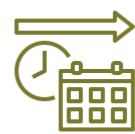
Short-term needs are what emergency responders need to focus on, but long-term needs (via appropriate signposting) need addressing to avoid 'cycle of distress'

- Fundamentally, vulnerable people are individuals with unique mental health needs/emotional triggers – key to have a tailored approach (as much as practically possible) and treat the person as an individual.
- Important to think about the **short-term and long-term needs** of people in crisis – the short-term needs are dealt with during the crisis, but long-term needs require post-crisis care.

Short-term needs

Often common among people in crisis:

- **Crisis management** – how do responders de-escalate a crisis? Key considerations:
  - Negotiation tactics
  - Distraction tactics
  - Talking through/unpacking individual's feelings/emotions
- **Safety planning** – how do responders keep the vulnerable safe in the immediate? Key considerations:
  - Anyone the person in crisis can turn to/call for support
  - Anywhere the person in crisis can go (family/friends, crisis centre)
  - Anything the person in crisis can do (self-care)
- **A listening ear** – allowing person in crisis to vent/share frustrations/offload etc. (has potential to diffuse crisis)



Long-term needs

Often varied/multifaceted among people in crisis:

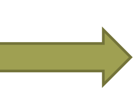
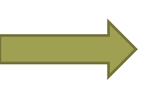
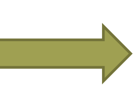
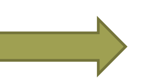
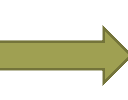
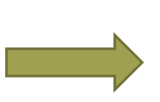
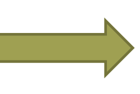
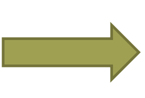
- **Tackling loneliness** – ensuring people are guided to relevant community resources/groups (walking, gardening groups etc.); initiating conversation with vulnerable person to establish network of people to support them in crisis (inc. 'named contact' to call).
- **Tackling underlying health issue** (addictions, undiagnosed neurodiversity, mental illness) – ensuring people are linked in with community mental health teams and/or addiction services.
- **Tackling underlying trauma** – ensuring people are linked in with relevant NHS/private counselling/therapy services.
- **Stabilizing mental illness** (psychosis, bipolar, schizophrenia etc.) – ensuring people are linked in with community mental health teams that support the individual to increase medication, .

Responsibility is key – aftercare following period of distress must be supportive.

Responses to presentations of distress

Although any type of distress can require emergency service response, there are more suitable, less resource intensive alternatives for most who present in distress

The chart below summarises the principal types of distress responders have encountered. It shows the type of distress and (ultimately) the most appropriate service for that type of distress. However, it is worth noting that these can overlap and be more complex, so individuals may need a more tailored response.

Type of distress		*Possible response(s) to distress*		*Most suitable service(s)*
Life circumstances/events (e.g., bereavement, relationship breakdown, financial struggles)		Self-care tools & processes; counselling; practical distress mgmt. planning; access to services – e.g., debt mgmt.; possible emergency service involvement (if threat to life)		
Drug/alcohol-induced distress (possibly disguising underlying mental health issue / trauma)		Possible medical attention (if physical impact); possible emergency service involvement (if threat to life); access to longer-term addiction/health & social care services		
Deterioration in mental illness (i.e., someone becoming increasingly unwell – personality disorder, psychosis, schizophrenia)		Escalation of support (increased dose of medication, enhanced CMHT support); possible hospital admittance via emergency services if threat to life		
Habitual distress (the 'problem callers' – present continually in the same way)		Self-care tools & processes; someone to talk to/to listen to their problems; community group support		Community groups
Perceived lack of support from services (CMHTs, addiction services, GPs, care home provider)		Enhanced community-level support from specialists / primary care providers; possible emergency service involvement (if threat to life)		

Responding to mental distress incidents

(By responder group)

Headline: service advisors and uniformed officers don't typically feel confident responding to incidents involving distress (particularly the most acute cases – or those involving mental illness). Many are cynical about the frequency of regular callers ("*people threaten suicide and next minute they're asleep in bed*").

Incident types responded to

Experience with whole range of distress incidents – suicide, self-harm, drug & alcohol induced distress, mental illness related distress:

- **Suicidal people (life/circumstantial distress, habitual distress, deterioration in mental illness)** – both first-time callers who haven't contacted services before and 'regular' callers. There are those who currently have a suicide plan and those who express suicidal ideation e.g. 'I don't want to be here anymore'
- **Missing persons in crisis** – often more mobile and quicker to respond than other services (e.g., ambulance service / CMHTs – most services are remote, and ambulance can only respond to a call with an address).
- **'Out of hours' service (perceived lack of support from services)** – service users frequently contact the police on weekends as their weekday support (from community services) is not available on the weekend.
- **Intoxication (i.e., drug/alcohol-induced distress)** – most services (addiction services, MH assessment in hospitals, NHS 24 etc.) won't work with vulnerable people under the influence of alcohol/drugs, so officers required to keep people safe.

Experience/skills responding

Evidence some call handlers have developed skills to diffuse potentially dangerous situations 'on the hoof':

- Distraction techniques (stalling someone in distress)
- Use of call history to determine likelihood of someone acting on their words

Lack of training makes decision-making (both over the phone and on-scene) very challenging – particularly when the call handler or officer on the scene is believes the presentation to be behavioural rather than a genuine mental health issue (as they don't feel as able to take positive risks with people as they are the last-resort responder).

Generally, signposting is limited; little knowledge of local services and pathways to support (e.g., local community services) although MH assessment services in hospitals and national services NHS 24, Breathing Space, Samaritans etc. are used frequently.

Responding to mental distress incidents

(By responder group)

Headline: typically respond 'after the event' (i.e., after someone has overdosed, after they have self-harmed) due to demand for services and won't typically get involved in triaging process because they arrive when a situation is desperate – the person needs medical attention.

Incident types responded to

Experience with self-harm (overdosing / cutting etc.) particularly common for SAS responders (as threat to others' lives due to distress would be a policing/criminal matter).

Responders reported a simple way of separating call types – 1) those who have taken action based on their mental health, and 2) those who have suicidal ideations but have not acted on these.

Some also mentioned the impact of alcohol / drugs on response insofar as there can often be a physical medical matter to attend to before SAS on-scene staff (paramedics etc.) are able to diagnose a mental health crisis and respond accordingly (either take someone to hospital for a MH assessment or refer onward to alternative services like DBI).

Experience/skills responding

Generally, more confident at responding than police (e.g., suicide awareness training, ASIST training) – particularly the MH trained paramedics – but there are still training gaps. For instance, negotiation skills (for people 'about to jump') and better MH / de-escalation training for call handlers. Some staff rely on personal interest in MH support / suicide prevention (e.g., through voluntary roles) which help them in their day job.

Long response times means the service isn't as well equipped to deal with MH crisis – and physical health crisis (e.g., cardiac arrest) tends to take higher priority than suicidal ideation/intention because one has happened, the other hasn't.

An issue with awareness of pathways / knowledge gaps in terms of triaging people in moderate distress (i.e., not in act of suicide) – some paramedics unaware of pathways for people feeling suicidal who need someone to talk to (e.g., NHS 24, Breathing Space).

Responding to mental distress incidents

(By responder group)

NHS SCOTLAND

progressive

Headline: NHS responders (CMHT staff, NHS 24 MHH practitioners, in-patient services) always try to deescalate a distress/crisis situation and manage it in-house (emergency services as last resort), but due to services being stretched (huge caseloads) and an increasing backlog of 'new' patients to assess, people in the community can reach a crisis point that is unmanageable for services. Additionally, after-crisis support is generally stronger in NHS settings if the person in crisis has a dedicated CMHT (e.g., CMHT crisis team).

Incident types responded to

In crisis:

The incident types NHS staff respond to is highly variable and tends to reflect the nature of the service they offer. Those working in CMHT teams with older adults in the community will tend to see distress incidents related to dementia (e.g., not recognising your partner and seeing them as a threat) or as a result of physical health issues. Those working with working-age adults will tend to have more physically threatening crisis situations to deal with. NHS 24 staff have experience with all distress types (low to critical).

Post crisis:

Two types of people: those known to services (on a local CMHT register – with a dedicated CPN / social worker etc.); those not known to services (experiencing distress, but no diagnosed condition/illness that needs additional support). For those known to services, response after distress is always to try and review the crisis incident and change the support package someone is receiving. For those not known to services, getting them to engage with services is critical.

Experience/skills responding

There is a vast amount of experience that Police Scotland & SAS responders could draw upon which would suggest that more cross-sector training is needed. For instance, the concept of 'positive risk taking' was advocated by many NHS responders as a way of managing what they described as 'challenging callers' (e.g., people who have been presenting to services for the same way for 20+ years).

Notable complexities associated with responding to certain demographics – e.g., older people and younger people. CAHMS services are underfunded with large waiting lists – which means distressed young people (LGBTQ+ issues, undiagnosed neurodiversity etc.) are contacting services that aren't as appropriate for them. At the other end of spectrum – older people are more likely to have physical issues (UTIs etc.) and underlying mental health conditions (dementia) that cause distress/erratic behaviour, and not all of these need emergency response but better diagnosis by GPs/care home staff etc.

Remote working (e.g., NHS 24) has limitations in terms of having to trust how someone is presenting on the phone – difficult to address 'problem callers'.

Responding to mental distress incidents

(By responder group)

progressive

Headline: typically shielded from people presenting in distress (people typically referred onto community/third sector services), but their role is critical in terms of safety planning, de-escalation, equipping people with tools to help them manage distress in future. They typically have more time to support people in distress than emergency services (and people who want to vent are given this outlet), but there is a risk that 'immediate access' services (DBI, Crisis Centres, Suicide Helplines) become waiting-list services due to demand.

Incident types responded to

Third sector and community responses are more likely to encounter low to moderate distress/crisis situations – i.e., those where there is no imminent threat to life, and someone is in a position where they can benefit from distress mgmt. and helpline services.

They do, however, sometimes still encounter people who are actively suicidal (referrals that usually come from emergency services) so there are occasions when they need to re-refer someone to the emergency services - although these can typically be managed in time.

As with other responders, they encounter a full range of mental health and distress circumstances – addictions, psychosis, suicidal ideation, emotional crisis. Their role is to give everyone the support they need and tailor their support accordingly – incorporating different approaches to talking about distress and what is causing the distress.

Experience/skills responding

As not (typically) clinical roles (often volunteers), community/third sector services have their limitations – in terms of the types of people they can adequately support (those with acute mental illnesses / at the height of distress not always appropriate).

Well of empathy among these third sector audiences – wanting people in crisis to be heard etc. – NHS staff much more cynical (as they've been working in the sector for years/are at the 'thin end' of the problem):

"I can only speak for myself here, but I don't feel like it matters what comes through the letter box. I don't deal with them any differently. I signpost them differently, I respond differently, but you take what you're given, and you help them as best you can. And again, if you're going into this in a completely non-judgmental way, then it shouldn't matter what the person is presenting with, you should be completely supportive to what it is."

- Third Sector Responder

The best-case scenario for people in distress

Critical that the right decisions are made for people in distress, which is reliant on key factors including an in-depth knowledge of the patient and an understanding of MH support pathways

progressive

The research has shown that there is no 'one-size-fits-all' best-case scenario for people in crisis, but it is critical that the right decisions are made for vulnerable people in terms of determining the *most-appropriate response* and connecting people with services.

There are several key factors that increase the likelihood of the right decisions being made:

- **De-escalation techniques** – talking someone 'down from the ledge' is vital in terms of reducing frequency of emergency services response (and a solution to this could be training for all emergency service call handlers on de-escalation techniques).
- **Knowledge of the patient** – keeping detailed, up-to-date records about individuals that contact services (and sharing this with other organisations where possible) is vital for effective response. Information sharing between organisations can help reduce the impact of 'regular' callers (e.g., *'the chronically suicidal'*) as certain services will be aware of individuals, their history (addictions, social support networks etc.), how they present and the best way of managing their presentation.
- **Understanding of distress and how someone might present** – distress encompasses a range of experiences, and a deeper understanding of distress will help first responders to triage effectively – e.g., just because someone is suicidal does not mean an emergency response is needed.
- **Knowledge of alternative pathways to support** (that might better suit the individual caller) – Breathing Space; NHS 24 111; DBI services; local crisis centres; drunk tanks. Awareness of both local and national services/pathways is vital for effective triaging.

Ultimately, though, it is about people feeling listened to and supported **in crisis and post crisis** (to avoid a repeating 'cycle of crisis').

> *"So, I'm not, I don't like to blow my own trump, but eight times out of 10, I can probably talk the person down and they're totally calm by the time we get to hospital, just through understanding where they're coming from and.... just from sort of talking to them and understanding where they're coming from, understanding the sort of background behind [their] mental health."*
>
> **- Police Scotland Responder**

Challenges of supporting people in distress

Catching people coming out of crisis is a huge challenge for the 'emergency response' and 'established care' systems in terms of breaking the distress cycle

There are several core challenges associated with supporting people in distress that need to be carefully managed by emergency responders:

Supporting people in crisis is fraught with risk as certain actions / words can be triggering (e.g., emergency responders who do not act in a trauma-informed, sensitive manner with people in crisis)

Police deployment in distress response is a double-edged sword: for some people in distress, it is helpful in 'sobering people up' (making them understand the seriousness of a situation), but for others, police presence can heighten distress

People in distress can be volatile and/or abusive to responders, and they may tell different stories to different services in terms of their level of distress (e.g., NHS 24 vs. Police Scotland) which can be challenging in terms of providing a suitable response.

There is also a significant challenge around people in distress who aren't in a position to engage in conversations about what might be causing their distress (particularly prevalent in trauma / PTSD distress cases) – this causes issues in terms of readiness to receive support from distress services.

Catching people coming out of crisis is a huge challenge for the 'emergency response' and 'established care' systems in terms of breaking the distress cycle. Signposting & aftercare support are essential parts of distress response but maximizing the probability of people accessing longer-term services (NHS psychological services, community groups, addiction services etc.) is a serious challenge.

Alcohol/drugs can be problematic during the distress phase (e.g., erratic behaviour) but it also negatively impacts engagement with services after the distress – and people become caught in a cycle

"I would say where it falls down is… your alcohol and drugs is a big factor and it all basically comes back to, 'Well, we can't do anything. You need to be kept safe, so we're going to take you to accident and emergency.' That's probably the biggest part for me where it doesn't really work… [because] once people sober up, they're either regretful or they don't really access that [support]. They go and do it again and they get caught in this vicious cycle."

- Scottish Ambulance Service Responder

Considerations for the future of emergency distress response

Challenges facing the system

Growing concern about perfect storm of more open discussion about mental health in society, and lower ‘emotional resilience’ among the public, increasing pressure on services

There are many (ongoing and forthcoming) challenges facing the emergency response system, including:

- **Societal factors:** principally the cost-of-living crisis and post-pandemic Scotland; respondents claimed these factors are likely to have a huge impact on distress levels in Scotland – e.g., increasing numbers accessing services who can’t afford to pay their bills.
- **‘The tip of the iceberg’:** some in addiction and voluntary services believe those accessing services represent just the tip of the iceberg (i.e., those willing enough to open up about their distress/mental health). This group worry about the ‘floodgates opening’ and whether emergency services will be able to cope.
- **Public resilience:** linked to the above, NHS responders, in particular, were concerned about what they perceived to be a lack of emotional resilience among the public, particularly younger people.
- **Positive risk taking:** this relates particularly to the ‘problem callers’ who present repeatedly and regularly to services in what many NHS and emergency service responders consider a waste of emergency resources. Balancing positive risk taking with the potential grave risk to life will be critical going forwards.
- **Staffing and cuts to services:** responders from all parts of the emergency response system (but particularly NHS responders) were concerned about staffing levels and cuts to services and the impact this would have on **early intervention** – a vital aspect of distress mgmt. – as well as distress response. They were concerned about vacancies in their services that hadn’t been filled, ex-colleagues who had left NHS services for more lucrative, less stressful private healthcare roles.

"Some of them [the people who call NHS 24 Mental Health Hub] you could give them 24 hours a day and still wouldn't be enough, which is crazy.”

- NHS Responder

"I think it is more… societal education. It’s normal to break up with your partner and feel like crap… that’s how you know that relationship had value… because you feel rubbish about it. You go out and get drunk… and move on with your life. That’s a normal coping thing. You don’t struggle and think about ending your life and start taking steps towards that."

- NHS Responder

Is there a role for police in distress response?

Unanimous feeling that the police have a role to play, but that they need greater authority to leave situations of distress if they feel it isn't a police matter

Responders from all groups (Police Scotland, SAS, NHS, community & third sector) felt there was still a role for policing in distress response but there was broad agreement that its role should be reduced.

There was consensus among responders in that they felt that Police Scotland's core role in relation to emergency distress response should consist of **incidents where there is an imminent threat to life (either self or others) or when the distress incident involves criminal activity.**

Some people also felt that the police's role could extend to the following, although there was less consensus here:

- Negotiation (in suicide cases)
- Missing persons cases w/ suicide risk (inc. those absconded from hospital, and where there is a suicide risk but someone's location is unknown)

Some felt the police should have the authority to say whether a distress incident is a police matter or not. And vice-versa: ambulance and NHS staff felt that they should be able to make the call when they feel safe to take over and for the police to step away.

However, mental health training and greater awareness of services were considered vital – so that police officers and service advisors could understand the limitations on healthcare professionals (in terms of legislation around mental health restraint).

"I'm a firm believer in that the police don't need to be involved unless there's a physical threat to life. I don't believe that the police should be involved in any way, shape or form unless they are physically threatening, if there's a weapon involved, if they're threatening to throw themselves off a window"

- SAS Responder

"In general, it [mental health] should be something… they [police] need to have a good understanding of it. They'll be dealing with a lot of incidents and emergencies that stem from mental health, ultimately, so I think just keeping that understanding, that empathy with people"

- Third Sector Responder

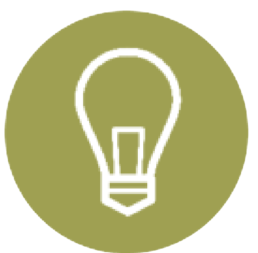
Public's knowledge/understanding of system

Many things the public need education on, but critical that they are made aware of alternatives to GP practices and emergency response services

The emergency response system faces great pressure due to the public's use of services and educating the public on correct and incorrect use of services is vital for efficient delivery of support.

There are several areas where change in public knowledge / understanding is needed, including:

- A general lack of understanding about the most relevant service for the type of distress being experienced – e.g., critical, life-threatening distress requires a response from emergency services, whereas moderate distress could be managed via helpline services, NHS 24 MHH triaging and local community services (NHS therapy services and third sector organisations).
- There remains an overreliance on GP surgeries as the main channel to support, particularly for people experiencing distress for the first time. Contacting dedicated mental health services (e.g., hospital based mental health assessment units, the NHS 24 MHH) will likely result in a quicker and more suitable response.
- The public also generally lack knowledge about local pathways to support when they are struggling – pathways that would help both in terms of early intervention and at the height of distress (e.g., free/low-cost counselling services, crisis centres - Chris' House in Glasgow, Edinburgh Crisis Centre etc.).
- Educating the public about the importance of early intervention (and self-care in terms of regulating emotions, managing distress, sharing distress with trusted friends/family etc.) is another vitally important piece of the puzzle. And crucially recognising that it is a holistic effort – involving schools/teachers (for young people), workplaces etc. to provide opportunities for people to share how they're feeling.



Conclusions and recommendations

Conclusions

The mental health landscape

- Most felt that the mental health state of the nation is worsening and is not set to get any better soon.
- Most felt that support for mental health is under resourced.

Police Scotland

- There was a general feeling especially amongst those working for Police Scotland that the current way of responding to people with mental health crisis is unsustainable.
- Most agree that Police Scotland, in its current state, is not best suited to providing support to people experiencing a mental health crisis.
- Many felt that Police Scotland staff need training on managing mental health crisis:
    - Call handlers need to better understand mental health and be trained to better triage people (this is true of SAS call handlers as well).
    - Officers need to be trained in de-escalation and trauma informed responses (to avoid triggering people in distress which would lead to even more incidence of emergency services needing to respond).
    - Consideration should be given to having plain clothed and specialist mental health police responders to reduce potential for intensifying a distress situation.

The system as a whole

- It is better than it once was in that services are more sophisticated/dedicated to MH (and there are pathways available), but worse than it was because service providers do not have enough staff to give people in crisis the support they need (and early intervention is also challenging due to capacity issues).
- There is a lot of empathy among responders – different responder groups tend to understand the pressures on other services (although they might not necessarily understand the detail of these pressures and the affect that might have on service provision).

Conclusions

System as a whole cont.:

- Out of hours mental health provision needs to be increased in the community because mental health crises can occur at any time.
- There is a need to 'level up' service provision across different regions (particularly in rural areas).
- Certain initiatives are working well and should be more widely known about and available to responders in terms of referral routes (e.g., Distress Brief Intervention, Breathing Space, and the clinical adviser role that gives paramedics access to patient information and triage cars).
- People in mental health crisis ideally would see a mental health specialist in person at the point of crisis.
- The focus should be on reducing admission to A&E, as there is typically a more appropriate alternative – by using local crisis centres for people needing a 24-hour respite period or phone / face-to-face services with mental health and wellbeing staff.

Communication

- Clear pathways of communication need to be created inside and between organisations:
    - Clearer information of each patient's background (how often they call etc.) given to call responders (SAS, Police Scotland, NHS 24 Mental Health Hub responders).
    - Need for better open access to patient records so that appropriate referrals can be made more quickly.
    - More information on 'regular' callers provided to all services.
- Members of the public need to have pathways clearly communicated to them and need to be advised about where to get help outside normal working hours.
- Any changes to the way the system operates should be discussed fully with all parties involved as not all parties see things in the same way (e.g., having uniformed police on a scene; the extent to which Police Scotland should be involved in certain non-life-threatening incidents – negotiation cases, people in distress who are missing).

Solutions and recommendations

There are several potential solutions/recommendations to consider in terms of both how distress responders operate internally and how they work together. These ideas are covered below based on the main findings/conclusions of this project. We welcome comment on these and we recognise that while actioning all of them might not be possible at the current moment, they could be considered in future. We have put them in order of priority (i.e., the things most likely to improve emergency mental health response in Scotland), not necessarily feasibility (in terms of financial cost etc.).

1. Commission a largescale public education piece, covering:
    - Key national mental health pathways (NHS 24, national helplines, hospital/community-based mental health assessment units where people can self-present) to divert people from GP practices and emergency services.
    - Availability of local mental health pathways and third sector services – focusing on how these pathways would help people both in terms of early intervention and at the height of distress (e.g., free/low-cost counselling services, crisis centres - Chris' House in Glasgow, Edinburgh Crisis Centre etc.). This would not necessarily cover specific services (as these are likely to be area specific), but it could give a flavour of the types of support services available to people, or signpost people to directories of mental health support services (such as iThrive in Edinburgh).
    - The availability of weekend mental health support services (i.e., when GPs and CMHTs are not available) – again, this would cover some of the national mental health pathways (e.g., NHS 24, Breathing Space) as well as local services that are open 24/7 (e.g., crisis centres).
    - Choosing the most appropriate service based on level of distress (e.g., life-threatening distress requires a response from emergency services, whereas low/moderate distress could be managed via helpline services/NHS 24).
    - The importance of early intervention and self-care techniques (in terms of regulating emotions, managing distress, sharing distress with trusted friends/family etc.).

    It is, however, vital that any support covered in any public comms is immediately available to people. As we have covered in the report, there are many services that are becoming inaccessible due to ongoing waiting lists as well as the sheer volume of people contacting services (e.g., Breathing Space – that is only able to answer 50% of the calls the service receives). Without available services, there is a risk the public could be angered/despondent.

Solutions and recommendations

2. Develop a comprehensive, cross-responder mental health awareness/response training programme (and possibly a semi-regular training 'forum' for ongoing updates) to ensure all responder groups are 'on the same page' about mental health, distress, and the wider mental health system. This might improve understanding of the pressures each responder group faces, particularly if mental health training was delivered to Police Scotland staff by NHS staff (as they tend to have a better understanding of the individual and social factors that might be affecting someone's mental health). This training could involve several 'modules', including:
    - What is mental health and what affects people's mental health (looking towards a holistic understanding of mental health and trauma-informed responses).
    - What is distress, how does it present, and the different types of support that people in distress might need.
    - National pathways available to different responders (and what might be the most appropriate pathway for different types of distress).
    - De-escalation training for call handlers (promoting alternatives to emergency service response by diffusing a crisis incident over the phone). This is linked to wider point that the first point of contact has significant influence on the 'final' outcome for people in distress. Call handlers at all levels have a significant role to play in terms of reducing the knock-on effect on services (emergency services, A&E departments).

    This training would also present an opportunity for internal peer-to-peer learning, particularly for police officers who can bring their personal experiences with mental health to delivery of the training (e.g., more mental health-informed police officers could teach their fellow officers). Related to this, we would recommend implementing mental health services that police officers and services advisors could access to help them work through the stresses of their job and ultimately provide a better, more informed service to people in mental health crisis.

3. Develop an information-sharing agreement between responders – this is critical in terms of knowing the most appropriate response for an individual (particularly 'regular' callers who continually present in the same way). Collating information on service users (specifically, a chronological account of service users' engagement with services) from all services (GPs, NHS 24, Police Scotland, SAS, third sector) in one place that all responder groups would be able to access would be helpful in terms of taking 'positive risks' with certain individuals or suggesting different/more appropriate pathways than they have previously been directed towards. This would greatly reduce the burden on services caused by the 'cycle of distress' but would also be helpful in terms of ensuring the distressed person does not need to repeat their story/presentation to multiple services.

Solutions and recommendations

4. Develop a 'common distress framework' that all responder groups would sign up to. This could include a matrix covering the various 'levels of distress' (e.g., low to critical) – inc. how these should be defined, the 'criteria' of each, and what particular actions should be taken in response to each.

5. Create a national referral map (see Appendix 2 as a starting point here) so that all responder types (primary care, secondary care, Police Scotland, SAS, third sector etc.) understand what is available (and where), and the best pathway available to the individual depending on their presentation. This national referral map could also be tailored to different health boards as local pathways will be region specific. This would also need to include 'post-crisis' referral/signposting routes, again depending on an individual's presentation.

6. Extend / expand the remit of mental health triage cars and 24-hour crisis centres to other cities in Scotland. Widespread belief that these services have been successful in reducing burden on A&E and other emergency services.

7. Develop a 'post-crisis support service' in order to 'catch' people leaving crisis services – inc. following up with people who have been signposted onto local support services to check if they have engaged with these services. The research has shown that aftercare needs to greatly improve for people admitted to A&E/hospital or triaged into third sector services (DBI) etc. who aren't on social service registers. Post-crisis mgmt. plans (to understand how mental health services can prevent distress from happening again) are relatively commonplace in CMHTs, but there is a need for a similar service for people coming out of crisis who aren't supported by CMHTs.

Solutions and recommendations

8. Consider taking steps to increase coverage of social services (addiction services, counselling services, CMHTs etc.) OOH (evenings/weekends) as this is when emergency services receive higher call volumes. Often, people will contact emergency services because they can't reach their dedicated community mental health practitioners – this has a knock on effect on services, particularly.

9. Consider developing a fast-track, intensive counselling/therapy service for 'regular' callers who take up emergency services' time. Ensuring regular callers are given direct access to longer-term, 24/7 NHS or third sector mental health support services (e.g., CBT) will be helpful in terms of reducing the burden on emergency services. They would be able to access this service whenever they want, for as long as they want – for a chat, to air frustrations etc.

9. Consider extending powers of security staff within hospitals (e.g., A&E departments or MH assessment services etc.) who could look after vulnerable people instead of the police. Or alternatively, could position dedicated mental health-trained police officers in hospitals who could take over from 'on-street' staff.

10. Consider creating a dedicated '999' phone service for mental health response (i.e., 'press 4 for mental health services'). This service would be staffed by mental health professionals who would have access to call histories of the individuals contacting mental health services – how they have presented, what they have requested etc.

11. Consider establishing a cross-responder protocol covering the handover/responsibility of crisis incidents between responder groups. This would cover things like the 'criteria' which would need to be satisfied for handover between police staff and medical professionals/third sector staff. This would hopefully mean there is clear demarcation between police-related and non-police-related distress incidents.

Thank you

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Appendix 1: Technical Appendix

Technical appendix

Qualitative: method and sampling

- The data was collected by one-to-one depths interviews.
- The target group for this research study was responders to situations of emergency distress/mental health crisis from organisations such as Police Scotland, SAS, NHS 24, and Penumbra.
- The sampling frame used for this study was a list of stakeholders compiled by Police Scotland colleagues and transferred to Progressive via secure transfer.
- In total, 50 depth interviews were undertaken.
- Fieldwork was undertaken between 2nd May and 2nd June 2023.
- Respondents were recruited by the Executive team working on the project.
- An incentive of £60 compensated respondents for their time and encouraged a positive response – some responders chose to donate their incentive.
- In total, four interviewers were involved in the fieldwork for this project.
- It should be noted that, due to the small sample sizes involved and the methods of respondent selection, qualitative research findings do not provide statistically robust data. This type of research does however, facilitate valid and extremely valuable consumer insight and understanding.
- All research projects undertaken by Progressive comply fully with the requirements of ISO 20252.

Appendix 2: Mental Health Response System Decision Making

Entry points to system

Emergency services

POLICE SCOTLAND

NHS 24

NHS 24

GP Surgery

Single-call helplines

ACE

SAMARITANS

BREATHING

Local CMHT (inc. via care providers)

Local crisis centres

Hospital / A&E

Hospital visit: A&E / MH assessment unit

Short-term distress mgmt. programs

dbi

Self-care (de-escalation)

Emergency services

POLICE SCOTLAND

Self-care (de-escalation)

Local CMHT recovery

Hospital admission

Discharged

?

Hospital admission

Local CMHT recovery

Discharged

?

Self-care (de-escalation)

Hospital visit: A&E / MH assessment unit

Local CMHT recovery

Discharged

?

Discharged

?

progressive

Local CMHT recovery

Hospital admission

Discharged

?

Exit points of system

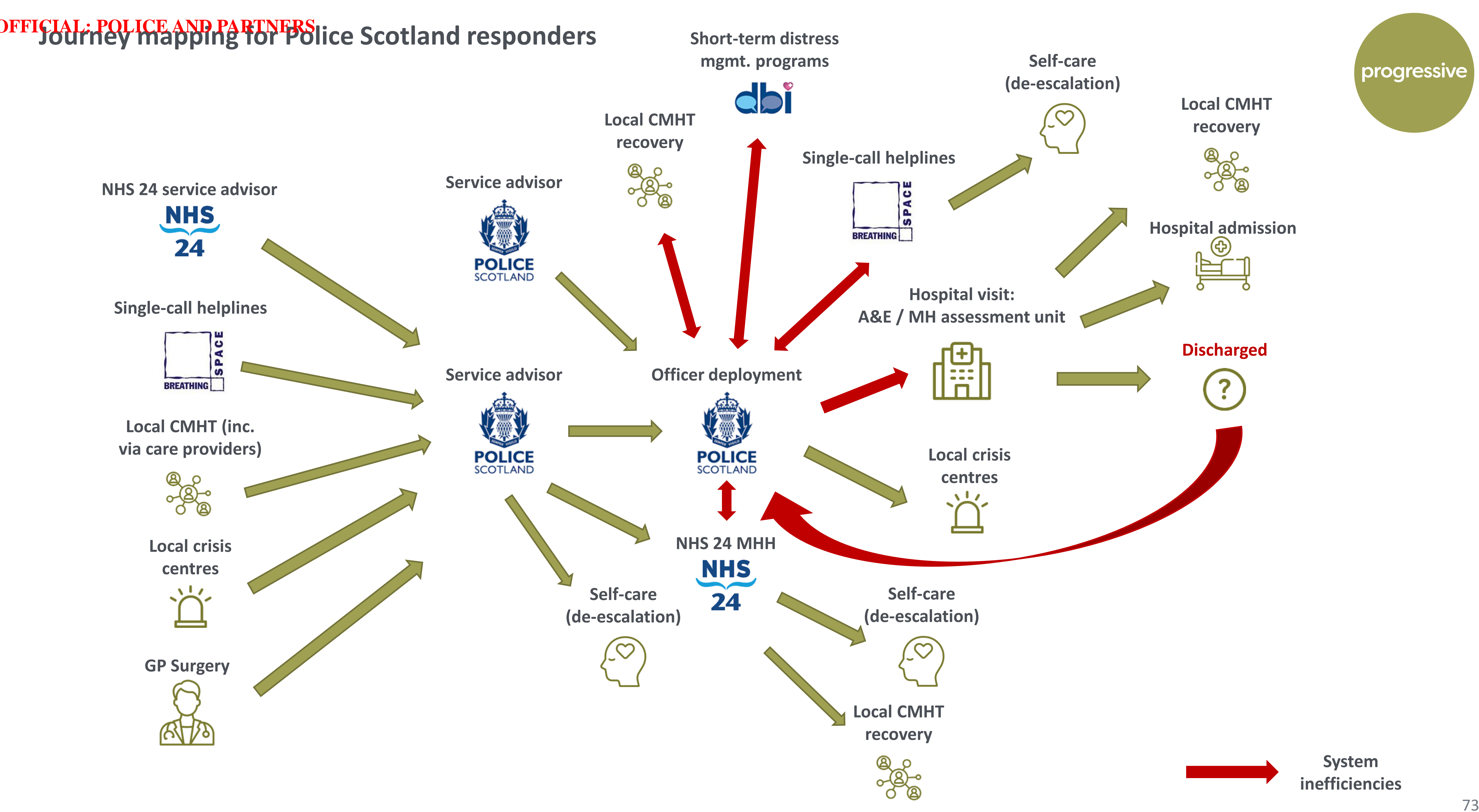
First phase decision-making

Second phase decision-making

Third phase decision-making

Appendix 2: Journey Mapping for Police Scotland Responders

Journey mapping for Police Scotland responders



Policing and Mental Health – Local pathway/partnership mapping

[Redacted]

	Police/MHUC collaboration	Good Practice Examples	Opportunities for Improvement
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
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