OFFICIAL REPORT
AITHISG OIFIGEIL

Criminal Justice Committee

Wednesday 18 February 2026

Session 6

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CRIMINAL JUSTICE COMMITTEE
7th Meeting 2026, Session 6

CONVENER

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

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Katy Clark (West Scotland) (Lab)
*Sharon Dowey (South Scotland) (Con)
*Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
*Pauline McNeill (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Siobhian Brown (Minister for Victims and Community Safety)
Stephen Gallagher (NHS Scotland)
Nicola Guild (Scottish Government)
Michael Matheson (Falkirk West) (SNP)
Nicky Page (Police Scotland)
Assistant Chief Constable Catriona Paton (Police Scotland)
Dr Robby Steel (NHS Scotland)
David Threadgold (Scottish Police Federation)
Robert Wyllie (Scottish Government)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 18 February 2026

[The Deputy Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Deputy Convener (Liam Kerr): Good morning, and welcome to the seventh meeting in 2026 of the Criminal Justice Committee. We have received apologies from the convener, Audrey Nicoll MSP. Two members are attending remotely: Michael Matheson will be the Scottish National Party substitute for agenda items 1 to 3, and Fulton MacGregor will attend remotely throughout.

Agenda item 1 is a decision on taking business in private. Do we agree to take item 5 in private?

Members *indicated agreement*.

Subordinate Legislation

Antisocial Behaviour (Fixed Penalty Offences) (Miscellaneous Amendment) (Scotland) Order 2026 [draft]

09:30

The Deputy Convener: Our next item of business is an oral evidence session on an affirmative instrument. We are joined by the Minister for Victims and Community Safety. I also welcome, from the Scottish Government, Robert Wyllie, policy lead for safer communities, and Nicola Guild, from the legal directorate. I refer colleagues to paper 1, and I intend to allow up to 15 minutes for the evidence session.

Minister, I invite you to make some opening remarks to set the scene for this Scottish statutory instrument.

The Minister for Victims and Community Safety (Siobhian Brown): Good morning. Thank you for the opportunity to address the committee on this instrument, which makes targeted and proportionate updates to the antisocial behaviour fixed-penalty notice regime. That regime enables the police to respond swiftly and appropriately to low-level antisocial behaviour and so ensure that such behaviour has meaningful consequences. Fixed-penalty systems are well established and the principle of the regime has not, to my knowledge, been questioned in the Parliament.

The draft order makes three updates. First, it removes from the regime two offences for which ASBFPNs were not issued in the most recent year for which data is available, which will help to keep the regime focused on offences for which it is actually being used.

Secondly, it adds to the regime the offence of displaying threatening or abusive behaviour under section 38(1) of the Criminal Justice and Licensing (Scotland) Act 2010. Section 38 is now routinely used for dealing with lower-level threatening or abusive conduct. The offence's inclusion in the ASBFPN regime will align the scheme with current policing practice and the fact that such offences are already eligible for the use of recorded police warnings.

Thirdly, the order uprates the penalty amount from £40 to £70. Using the gross domestic product deflator, £40 in 2005 is equivalent to around £68 today, so the new level will restore the original penalty's value.

The wider review of antisocial behaviour legislation that we have begun will give ministers in the next parliamentary session the opportunity to consider more substantial reforms.

In developing the instrument, officials have engaged with the Crown Office and Procurator Fiscal Service and Police Scotland. The Lord Advocate has highlighted the strengthened guidelines on police direct measures, which set clear limits on ASBFPN use, require consideration of victim impact and provide for monitoring, audit and annual reporting. Police Scotland is also working with Community Justice Scotland on a new referral and signposting pathway for first-time offenders, which aims to reduce reoffending. The pathway is expected to be introduced later this year.

Overall, the amendments update an established regime that operates within a framework of safeguards and oversight. I understand that the Delegated Powers and Law Reform Committee considered the instrument on 27 January and raised no points on it.

I am happy to take questions, convener.

The Deputy Convener: I am grateful. I have a couple of questions, after which I will open up the questioning to colleagues.

As you have just detailed, minister, the instrument would add section 38(1) offences to the fixed-penalty notice scheme. That would create an overlap with the common-law offence of breach of the peace, which is already part of the FPN regime. Given that overlap, what evidence can you adduce that adding section 38 offences is the right thing to do? How will that overlap be dealt with in practice?

Siobhian Brown: I might bring in Nicola Guild on the legal side of things. The order was drafted following discussions with Police Scotland, which has always said that it would welcome the ability to use fixed-penalty notices for section 38 offences. That is why we have introduced it. How the police would enforce matters, and how they would apply the two approaches, would involve following the Lord Advocate's guidelines on fixed penalty notices. Perhaps Nicola Guild would like to add something.

Nicola Guild (Scottish Government): I am not sure that I really understand the question. I suppose that there is an element of overlap between the two offences, but the overlap already exists. I am not sure that the inclusion of section 38 offences in the fixed-penalty notice regime would mean things operating any differently from how they do at the moment.

The Deputy Convener: Section 38 does something that breach of the peace currently does, but breach of the peace is currently part of the fixed-penalty notice regime. By adding in the section 38(1) offence to the regime, you would have two legislative processes, in effect—although dealing with breach of the peace at common law would not involve applying legislation—that amount to the same thing. You would have two tracks running, would you not, for the same end?

Nicola Guild: I think that the same applies in terms of the behaviour, in general. I do not think that the disposal changes the fact that they are two separate offences. In the same way, a person could currently be reported to the procurator fiscal for either offence, and the police would use their discretion in deciding on what the person was charged with. The same applies when it comes to issuing a fixed-penalty notice; that would depend on the facts and circumstances of the case and whether the behaviour constituted a section 38 offence or a breach of the peace.

The Deputy Convener: Minister, the fixed penalty is being raised from £40 to £70, and the thought behind that is that it will provide a deterrent. What evidence do you have that the £70 figure will provide the level of deterrent that the Parliament originally intended?

Siobhian Brown: First, it is not being raised so as to be a deterrent.

We accept that there is sensitivity about the £70 penalty level and that some people could perceive that the increase does not go far enough. Because the legislation has not been updated for more than 20 years, we are just bringing the level up to account for inflation. As we move into the next parliamentary session, I hope that, in future, our penalties for antisocial behaviour can be reviewed annually instead of every 20 years. The penalty level that the order brings in is to reflect inflation. As I said in my opening remarks, it would be about £68 if it were to be brought up to reflect inflation over the period from 2005 to 2026, which is why we have determined that it should now be £70.

The Deputy Convener: I have a further question, but I will bring in Sharon Dowey now to ensure that all colleagues get appropriate time.

Sharon Dowey (South Scotland) (Con): I have just one question on the two unused offences. They have been removed from the regime, so where do those offences now fall?

Siobhian Brown: Sorry—would you repeat that?

Sharon Dowey: Where do the two unused offences that have been removed now fall? I think that you said in your opening statement that, in the final year for which there are figures, two offences had not been used and will now be removed from the regime. Where will they now fall?

Siobhian Brown: It is my understanding that they could still be charged. The offences being removed are

"Disorderly conduct while drunk in licensed premises"

and

"Being drunk … in charge of a child".

The order will keep the legislation up to date, because no fixed penalties have been issued for those offences in the past year. However, the police still have the relevant powers if they want to charge someone for such behaviour.

Sharon Dowey: The police have not used those powers in the past year, so what is the reason for removing the offences rather than keeping them in?

Siobhian Brown: We are just updating the legislation.

Sharon Dowey: Are they now classed as more serious crimes, so that an offender would get a more serious penalty instead of just a fixed-penalty notice?

Siobhian Brown: That would be up to the police, I think. Perhaps Nicola could come in on that.

Nicola Guild: Yes, that would be for the police to decide in the same way as they would for any other offence that is not covered by the fixed-penalty notice regime.

Sharon Dowey: Okay. The figures say that, of all the notices that are given out, 80 per cent of penalties are paid and 20 per cent are not. Do we have any figures on the number of penalties that are not paid?

Siobhian Brown: The number of penalties that have been paid has been stable over the past 10 years, with around eight in 10 being paid in full. That proportion has remained broadly consistent with inflation, even though the penalty itself has reduced in real value over time. Collection of penalties is a matter for the Scottish Courts and Tribunals Service, and it has operational independence in doing so. I do not have specific figures with me, but I will be happy to write to the committee on that point.

Sharon Dowey: That is fine. Do you know what crimes had been committed for which those fines are not being paid? Have you any information on the people who are not paying?

Siobhian Brown: Bob Wyllie or Nicola Guild might have that information, but I do not.

Robert Wyllie (Scottish Government): Collecting those fines is part of the Scottish Courts and Tribunals Service's operational work; we could liaise with it and provide a written reply to that question.

Sharon Dowey: What further action would be taken if people did not pay the fixed penalty?

Siobhian Brown: That would be up to the procurator fiscal.

Sharon Dowey: Would the fine simply be written off?

Siobhian Brown: I will bring in Nicola Guild to answer that. It would not be written off, but I think that any further action would be determined by the procurator fiscal. Is that correct, Nicola?

Nicola Guild: Under the legislation, if a fixed-penalty notice is not paid, the person is deemed to have accepted it, so enforcement action could be brought against them for payment of that penalty.

Sharon Dowey: I appreciate that the level of fine is going up because of inflation, which seems to make sense, but has the Government any concerns that the number of people who do not pay will also go up because of that increase in cost?

Siobhian Brown: No—that is not a reason why we should not increase the penalties.

Sharon Dowey: I agree with the cost going up, but do you think that more people will not pay the fines because of that? Is there a concern about that?

Siobhian Brown: No, there is not.

Rona Mackay (Strathkelvin and Bearsden) (SNP): This might sound like a strange question, but has the offence of being drunk in a pub been removed from the FPN scheme?

Siobhian Brown: Riotous behaviour while drunk in licensed premises has been removed.

Rona Mackay: What about threatening or abusive behaviour in a pub? How is that dealt with?

Siobhian Brown: It would be up to the police to determine, in accordance with the Lord Advocate's guidelines, but my understanding is that the police would still be called and the person could still be charged. The police might simply not be able to give a fixed-penalty notice.

Rona Mackay: So, the fixed penalty would not be applied at that point.

Siobhian Brown: That is my understanding.

Pauline McNeill (Glasgow) (Lab): Good morning. You have answered Sharon Dowey's question, and mine was on roughly the same area. You have removed those two offences because the police are not using fixed penalties for them. Is that right?

Siobhian Brown: They have not been used for those offences in the past year.

Pauline McNeill: In the past year?

Siobhian Brown: Yes.

Pauline McNeill: Oh, right. I presumed that it was from 2004—

Robert Wyllie: And the year before.

Siobhian Brown: Would it be helpful for me to go through some statistics from the past year for offences for which fixed-penalty notices have been issued?

Pauline McNeill: In a second, possibly. What I do not understand is this. Two years is not a long time in the law, really. Did you just accept that the police wanted those two offences to be removed from the scheme because they had not been used for two years? They would now not be able to use them. Did you question the police about why they wanted those offences removed after such a short period of monitoring?

Siobhian Brown: I might bring in Robert Wyllie on that.

Robert Wyllie: If there is a need or a desire from Police Scotland to have those offences integrated into the FPN regime in future, that could be done in the same way as this instrument is doing at the moment. I think that the motivation behind the change was to clarify and make amendments to keep the regime up to date. If the context is that no offences have been subject to the FPN regime for the past two years for which figures are available, it feels as though using it for those offences has fallen into disuse for the moment. However, that

can certainly be kept under review and, as the minister has alluded to—

Pauline McNeill: Is there a policy such that two years is the time after which you would review something? I honestly thought that you would say that those offences had not been used in 20 years—and I could see that—but in two years' time—

09:45

Siobhian Brown: The table of statistics for the year 2023-24 shows that the offence of riotous behaviour while drunk in licensed premises was not dealt with under the scheme. Refusing to leave licensed premises was dealt with 127 times; urinating in public, 765 times; being drunk and incapable, 90 times; being drunk in charge of a child, no times; playing loud music, 43 times; vandalism, 108 times; consuming alcohol in a public place, 1,033 times; breach of the peace, 1,947 times; and malicious mischief, five times.

It was a matter of looking at the list of offences and deciding that we would update it and, as the police had asked, add the section 38 offence of threatening or abusive behaviour.

Pauline McNeill: I understand. For thoroughness, if that situation arose again, perhaps it would be worth asking the police why they were not using the fixed-penalty approach for certain offences. I had understood that that is what it is for. Would that mean that the police would then charge people with those offences in the usual way?

Siobhian Brown: Yes, if they were—

Pauline McNeill: With all the paperwork attached to that, it could be still a fairly low—

Siobhian Brown: Police Scotland raised no concerns about that. For example, the offence of being drunk in charge of a child perhaps does not happen these days as much as it did historically. I do not know—I am just guessing at that. When we engaged with the police on the instrument, it was not an issue that they raised, but they wanted that offence kept on the list.

Pauline McNeill: I will conclude with this question. I would like to think that, if this situation happened again, the Government would ask more questions about why the police were not using the scheme for an offence, so that a committee could make a more informed decision and not simply say, "The police are not using it. Well, that is that—just strike it off, then." The offence was on the list in the first place for a reason, so the scheme was meant to be used. I just make the point that, in future, it might be worth interrogating the police—

Siobhian Brown: I think that it is because—

Pauline McNeill: —about why they are not using it. What happens if, as Robert Wyllie said, two years down the road, the police say, "We would like it back, please"?

Robert Wyllie: I do not know whether it is helpful, but I make the point that the next Government might want to consider a broader revision of the fixed-penalty notice regime in light of developments such as the Sentencing and Penal Policy Commission's report, which suggested different tiers for fixed-penalty notices. For example, some offences would attract a higher level of penalty, a bit like how things are done in England and Wales with penalty notices for disorder. So, there might well be an opportunity for the Parliament to come back and look at the issue more broadly.

Certainly, for our part as officials, we are reviewing the whole of the Antisocial Behaviour etc (Scotland) Act 2004 right now, which gives us an opportunity to tease out some of those points. As the minister has outlined, this instrument just tries to bring things up to date and into line with current practice. We are certainly engaging with Police Scotland as part of our review.

Pauline McNeill: That is very helpful.

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): I suppose that we have to be a little cautious when we are talking about removing offences, which is what we are literally doing in this process. People out there might suddenly think that those offences will not exist any more, but, as you say, they will clearly still exist in law and have legal effect. No fixed-penalty notices have been issued, but are we aware of whether people are still being charged under those offences?

Siobhian Brown: My understanding is that they are not, but Robert might have something further on that.

Jamie Hepburn: Sorry, I mean outwith the fixed-penalty notice scheme.

Siobhian Brown: That issue has not been raised with me by Police Scotland, but it may have raised it in conversations with Robert.

Robert Wyllie: They are certainly offences that can be prosecuted, and this instrument does not change that at all.

Jamie Hepburn: I understand that—that was the basis of my question. Are we aware whether people are still being charged under those offences?

Robert Wyllie: I do not have the figures available to hand, but I can certainly write with the details.

Siobhian Brown: I think that, if it was a concern and people were still getting charged, Police Scotland would have raised it in our discussions, but it did not. However, we are happy to write to the committee regarding that.

Jamie Hepburn: That would be helpful, as it would give us wider context about the utility of those offences in general.

I will pick up on Pauline McNeill's point and the point that Robert made about officials continually keeping these things under review, as we would expect. I would like to understand a wee bit more about the work that is being taken forward in that regard. I presume that the process of adding or removing offences for which fixed-penalty notices could be issued is as straightforward as the process that we are going through right now—it would just be another affirmative instrument.

Siobhian Brown: As I said, police told us during our conversations that removing the charges would be beneficial for them, and we have been able to work on that in the current parliamentary session through this piece of secondary legislation.

Looking forward to the next parliamentary session, we all appreciate the issues that exist with regard to antisocial behaviour. An independent report came out last year and we have been working with the Convention of Scottish Local Authorities and Police Scotland regarding its recommendations. One of the recommendations was to fully review antisocial behaviour legislation. That will be for the next Government to do, and I hope that it will be taken forward.

Sharon Dowey: I will come back to the two offences that are being removed from the scheme, and my question follows on from what Pauline McNeill asked. It is only in the past two years that the offences have not been used. They are tools in the toolbox, but if they are taken away, the only option left will be to charge, which would take up police and court time and create paperwork.

I still do not understand why we should remove those two offences from the scheme. Would it not be better to keep them in so that the police can use them, rather than take them out and leave only the option of spending more time in court and having more prison sentences?

Siobhian Brown: I will bring in Bob Wyllie to answer that. Police Scotland did not ask for the charges to be kept in the scheme; that is the only reason that we have removed them.

Robert Wyllie: It is important to make the point that a report could be made to a procurator fiscal, and they may decide on direct measures such as fiscal fines that do not involve court appearances, or anything of that nature. Court proceedings would not automatically ensue as a result of removing the charges from the fixed-penalty notice regime.

It may also be helpful to make the point that the fixed-penalty notice is one of two types of direct measures that can be issued by the police; the other is a recorded police warning. The measures are subject to the Lord Advocate's guidelines, which set out the circumstances in which they can be used. The two offences that are being removed from the fixed-penalty notice regime cannot be given recorded police warnings. Again, that is about bringing consistency to the regime.

However, as the minister has outlined, we can certainly continue to clarify and discuss that point with Police Scotland as the review continues. If the police wish for the charges to be introduced to the FPN regime in the future, we can look to do that.

Sharon Dowey: It just seems that removing the offences will add more paperwork to a system that is already under pressure. I still do not understand why the charges need to be taken out of the scheme; I do not think that it would make any difference if they were to be kept in.

The Deputy Convener: As no other members have any questions, I want to clarify something, minister. In response to my second question at the start of the meeting, you told me—I am paraphrasing what I think that I heard—that raising the fine from £40 to £70 is not about providing a deterrent. However, the Scottish Government's policy note on the SSI states in bullet point 3 that

"without revalorisation it no longer provides the proportionate deterrent originally envisaged by Parliament."

That suggests that the raise is about providing a deterrent. Will you clarify that?

Siobhian Brown: Apologies, convener—I may have taken your question as a suggestion that the only reason that we are increasing the fine is to provide a deterrent. All fixed-penalty notices provide a deterrent, but the increase is about bringing the fine up in line with inflation since 2005.

The Deputy Convener: I am grateful for the clarification. As there are no further questions, we will consider a motion to approve the affirmative SSI on which we have just taken evidence. For good order, I remind officials that only MSPs may speak in a debate on a motion. I invite the minister to move motion S6M-20475, in her name, and to briefly make any additional comments that she wishes to make.

Siobhian Brown: I have no further comments to make. I move,

That the Criminal Justice Committee recommends that the Antisocial Behaviour (Fixed Penalty Notice) (Miscellaneous Amendment) (Scotland) Order 2026 [draft] be approved.

The Deputy Convener: Do members have any points that they wish to make?

Pauline McNeill: It is important to draw out the fact that we have heard this morning that two offences will be removed from the list on the basis of monitoring over a two-year period, which I do not think is that long. I will not vote against the motion, on the basis that, as the ministerial team has said, it would be easy enough to bring the order back to Parliament.

However, in the future, there should be a longer period and perhaps more interrogation of the police, who are the ones asking for this, as to why they have not been using the offences. As Sharon Dowey said, the whole point of fixed-penalty notices is that the police can use them for lower-level offences if they think that it is not appropriate to charge someone, as charging them would involve a more formal process that goes to the fiscal—albeit that it is for the fiscal to decide whether it should proceed. We would not want there to be a back and forward situation with the police not using FPNs for an offence this year but wanting to use them next year, or whatever.

I am not going to stand in the way of the draft order, but it might be important to draw that out for future reference.

The Deputy Convener: It is an interesting point. If no other members have any comments, I invite the minister to wind up and respond to the points that have just been made, and to press or withdraw the motion.

Siobhian Brown: I press the motion. I take on board Pauline McNeill's point. We brought forward the draft order following discussions and engagement with Police Scotland about what it thought would be beneficial. As I said, any further changes in the next parliamentary session would involve broader consultation. I am happy to write to the committee with further figures regarding the two offences.

Motion agreed to,

That the Criminal Justice Committee recommends that the Antisocial Behaviour (Fixed Penalty Notice) (Miscellaneous Amendment) (Scotland) Order 2026 [draft] be approved.

The Deputy Convener: Are members content to delegate responsibility to me and the clerks to approve a short factual report to the Parliament on the affirmative instrument?

Members *indicated agreement*.

The Deputy Convener: The report will be published shortly. We will have a short suspension before we move to the next item of business. I thank the minister and her officials.

09:57

Meeting suspended.

09:59

On resuming—

Policing and Mental Health

The Deputy Convener: Welcome back. Our next agenda item is evidence taking from a series of witnesses on one of the committee's priorities for the current session—namely, policing and mental health. By that, we mean how Police Scotland looks after vulnerable people in the community, including people who are in mental health crisis, and how it looks after its own officers and staff, including how it deals with the issue of police suicides. I refer members to paper 2.

Our first two witnesses are from the Scottish Government: Stephen Gallagher is director of mental health, and Dr Robby Steel is principal medical officer for mental health. You are both very welcome. We have up to 60 minutes for this session. I invite either Stephen Gallagher or Robby Steel to make a short opening statement.

Stephen Gallagher (NHS Scotland): I am grateful to have the opportunity to attend today's meeting in my role as the director of mental health at the Scottish Government to respond to the committee's questions on mental health and policing. My colleague Dr Robby Steel, who is the principal medical officer for mental health at the Scottish Government, is also here to offer clinical expertise and insight.

Since the committee last took evidence on the topic back in January 2025, progress has been achieved in a number of areas, and I am sure that this session will provide us with an opportunity to get into the detail of that. I am pleased that that progress has been achieved through the collaborative work of the mental health partnership delivery group to improve our emergency and unscheduled care mental health pathways.

Mental health reform is a priority for me and the mental health directorate. We are working collaboratively to ensure that people who are in distress get the right support, in the right place and at the right time, and tackling unnecessary demand on policing is a critical part of that.

As committee members will be aware, mental health and distress are multifaceted issues that require an effective whole-system partnership response. A range of factors can contribute to our mental health and wellbeing, including poverty, employment, housing, our communities, and many more. That is why I am pleased that our partnership approach to delivering improvements includes the Scottish Government, mental health services, the Convention of Scottish Local Authorities, health and social care partnerships, the Scottish Police Federation, Police Scotland, the third sector and others.

10:00

The Deputy Convener: Thank you. I am grateful to you and to all our witnesses for the submissions that they have sent in.

I will open with a quick scene-setting question before we move to questions from Sharon Dowey. The Scottish Government's submission says that, since 2021, the Scottish Government has provided £84 million for grass-roots projects. The partnership delivery group was set up in December 2023. I am less clear on when the framework for collaboration was set up, but I think that it might have been 2021. In June 2024, we had the formation of the mental health task force. This committee started to get interested in the subject in around May 2022.

What has actually been achieved? Perhaps more important, given the evidence that the committee will hear later today about the significant challenges that are still out there, when will we get to a position in which the right agency deals with the right people at the right time?

Stephen Gallagher: First, the framework for collaboration was published in February 2025, a month after the last committee meeting on the subject, and with that came the collaborative commitments. We are talking about a journey of improvement, and you are right to highlight that it has taken place over a period of time.

Let me talk for a moment about partnership working with the police and the various systems and hand-offs that are appropriate there. I will set that within the slightly wider context of what we are trying to achieve with the mental health and wellbeing strategy, in which we have a focus on combating and reducing stigma, on the prevention of mental ill health and on supporting people in communities, as well as on improvements to services. You are right to highlight that there has been significant investment over a period of time across the whole spectrum of the mental health service offer.

Prevention is an important aspect of all our work. We have invested £164 million, part of which has been spent on investment in services for children and young people in the community—£15 million per year of that money is baselined into the local government settlement—and £15 million goes through third sector organisations, third sector interfaces and down into local communities to support adults with their mental health and wellbeing.

Moving on to stigma reduction, I think that you will be aware of our see me campaign work with

Scottish Action for Mental Health and its impact in reducing the stigma around mental health issues. Finally, there is also the significant development agenda for services.

In the period that you mentioned, which takes us back to 2020, we stood up the mental health hub within NHS 24 and, in recent years, we have extended it to provide 24/7 coverage. The hub now reaches 10,000 people a month. In other words, more than 120,000 people per year use the hub, which did not exist previously, as their gateway into mental health service provision.

The adult prevention schemes that I mentioned reach 300,000 adults in Scotland per year, while the latest figure for children's services is that more than 60,000 children receive support through children and wellbeing support services. We have also been developing services as part of the implementation of the mental health strategy, as well as working through the interfaces between existing services and the new services that we have established. It takes time and partnership working to identify what can be improved and then to work on those improvements, but that is what we are committed to doing.

What have we achieved? I have probably touched on a few of those achievements when I talked about the establishment of the mental health hub. Something that I have not mentioned yet, but which I know is contained in Caroline Lamb's letter to the committee, is the creation of the enhanced mental health pathway, which connects Police Scotland to the mental health hub. Around 300 to 350 calls per month go from Police Scotland contact centres to the hub, through which a range of services can be accessed. I should also say that, under the programme for government for 2025-26, we have a commitment to expand the offer of the mental health hub to allow direct access to psychological interventions, and we hope that that will allow another 1,700 interventions per year.

We have supported the establishment of safe spaces, but I will not go into that in any detail, as I know that the committee spent considerable time talking about the safe space approach at its previous meeting. We have resourced triage car services with the Scottish Ambulance Service in Inverness, Dundee and Glasgow, and those pilots are currently being evaluated. Our review of psychiatric emergency care plans was completed in December, and we are now working on guidance that will go to partners and the NHS.

Our distress brief intervention programme, which is a key facet of the support that we can give to people who appear to be in distress, has reached a landmark 100,000 referrals. Incidentally, the community model of distress brief interventions achieves a 9 per cent referral rate from front-line policing. Policing can also access distress brief interventions through a national pathway that is available as part of the transfer that I mentioned between police control centres and the mental health hub. Finally, more than 2,000 front-line police officers in Scotland have been trained at level 1 distress brief interventions.

I could go on, but I hope that that gives the committee a flavour of some of the improvements that the mental health strategy has brought over the six-year period to which you referred.

The Deputy Convener: It certainly does, and I am grateful for that information, but I am not sure that it quite answers my question about when the police will be able to take a "right people in the right place" sort of approach. I know that colleagues are very interested in that issue, though, so there will be an opportunity to explore it.

I call Sharon Dowey, to be followed by Pauline McNeill.

Sharon Dowey: Good morning. You mentioned the framework for collaboration, in which you say that you are promoting

"a multi-agency collaborative approach to improving local distress pathways, with the person-centred, trauma-informed and no wrong door principles at the heart of the improvement."

That all sounds really good, but the Scottish Police Federation has said that

"the 'handover' between police and health functions is, at best broken, at worst, non-existent".

What are you doing to address that problem right now? You seem to be having lots of meetings, and there are lots of groups, but the police need action right now to ensure that handovers, especially at hospitals, happen on a 24/7 basis, not just from 9 to 5, Monday to Friday. What are you doing to take the pressure off the police force when it comes to people who have a mental health problem? You say that you are trying to reduce stigma, but I do not think that it helps if those people are held by police officers; they would probably much prefer to be with a health professional. What are you doing to address that?

Stephen Gallagher: I will start by talking about the community triage index that we launched in 2024, which is sometimes referred to as the mental health index. It is used by police officers, and there are some good examples of progress that has been made in the use of it. It allows police officers to access a local member of the mental health team 24/7. Assistant Chief Constable Catriona Paton might have spoken to you in the past about the success of the approach that has been taken in Lanarkshire.

Dr Robby Steel might be able to say a little bit more about how that tool operates and speak from a clinical perspective on how the handover between professionals happens.

Dr Robby Steel (NHS Scotland): The number of times that the police are called by the general public to respond to an incident that fits the lay concept of a mental health emergency has not gone down dramatically. It has plateaued and is coming down, but the public's behaviour and their awareness of what options are available will probably be the last thing that changes. People still phone 999 and ask for the police when they are in an emergency.

Where real progress has been made over the past few years—in particular, in the past year, since the collaborative was established—is on the options that are available to the police once they have been called. The enhanced mental health pathway allows the police to say that a person would be better dealt with by the NHS 24 hub. Data shows that that has saved 17,000 hours of police time already. Data is available only for the past 10 months, but, in that period, 17,000 hours of police time has been saved. That means that more than 20,000 hours of police time a year is saved by that one initiative.

The second thing is the distress brief intervention programme, which has now been brought in across Scotland. It gives the police an option that does not involve taking the person to accident and emergency or getting them a mental health assessment. A DBI involves saying that a person would probably benefit from support and advice on how to manage their own distress more effectively, and finding out what the root causes of that distress were. That has now helped up to 100,000 people.

On the issue of police officers arriving with someone at accident and emergency or the mental health assessment service and how they hand them over, there is a very good pilot going on in Lothian, in the Royal infirmary of Edinburgh's A and E department, on how the guidance for police officers can be operationalised and how the handover to clinical staff can be documented and explained. That pilot is still to be evaluated. The evaluation is taking place at the moment, and it will be published this month. The pilot is not perfect—it is a first attempt—but it has the potential to be rolled out.

That work is about giving police officers the ability to structure why it is not appropriate for them to continue to stay with a person and why it is appropriate for them to hand them over to the clinical staff, and to ensure that the rationale behind that is well documented. It is about ensuring that the clinical staff are aware that the patient has been handed over and that the police are leaving. The pilot has the potential to improve that interface. The process will never be perfect, but the pilot has the potential to improve it. I happen to know the people who have been involved in the pilot in Lothian, and it is very promising, so there are reasons to be optimistic.

The collaborative is coming up with real solutions that are making a difference on the ground, even though it has not yet translated into stopping people phoning the police as their first point of contact when they are in crisis. I hope that, as awareness of what is on offer increases, the behaviour of the public will change in response to that.

Sharon Dowey: You have spoken about pilots and trials. Stephen Gallagher mentioned the approach in Lanarkshire, and Dr Steel said that there is a pilot in Lothian, but if the police get called, they will respond. I am more interested in the NHS. This has been an issue for years, so although it is nice that pilots are under way, it is not a new problem.

Your submission mentions the

"Community Triage Guide … which sets out 24/7 access arrangements to mental health unscheduled care clinicians in every locality across Scotland."

However, we are not seeing that on the ground.

10:15

The police are still saying that they are being called and that there is no handover, so what is being done about that? I still do not understand what the NHS is doing now. If the police respond to a call and it is a mental health call with no risk to life, they do not need to be there. What has NHS Scotland put in place so that the police can safely walk away from that person and leave them in the hands of a clinician?

Stephen Gallagher: The 24/7 access point that has been created—

Sharon Dowey: Sorry—did you say that it is being created? Is it not created yet?

Stephen Gallagher: It has been created, but the practice is not yet consistent across the country.

Sharon Dowey: Why is that?

Stephen Gallagher: That will be for a variety of reasons relating to how different services are configured. Dr Steel has explained to the committee what is currently working and being tested in NHS Lothian. Different models apply in different parts of the country. To give a brief example, in NHS Lanarkshire, the contact would be with a psychiatric liaison nurse, and there is a

protocol with a commitment to a response within a period of time. The person would then, based on an assessment, be directed to the best available point of care for them.

As part of the collaborative commitments, we have agreed to resource a quality-of-care review of practice around the country so that we can look at what is working and what we can roll out. That work will take place through the mental health unscheduled care collaborative to which Dr Steel referred.

We have facilities, or services, in place 24/7 across each health board area in the country, but the way in which those are provided is variable. We are trying to look at what is working, what could work better and whether there is a standard model that we could apply across the country. That is a commitment within the collaborative commitments and within the delivery plan that we are currently working on.

Pauline McNeill: Good morning, and thank you for your introductory remarks about all the work that you are doing. That was useful to hear.

I want to continue with Sharon Dowey's lines of questioning. As the Criminal Justice Committee, we have heard that police officers waiting with people who are experiencing a mental health problem is the main issue that takes up police time—it takes up more time even than police officers waiting in court. I think that we all agree that it has to be resolved.

I will start by talking about the hub pilots. In those cases in which police officers get a call and take the person to the facility in Lanarkshire, for example, do they hand the person over and walk away at that point? Does that mean that the NHS looks after that person from then on?

Stephen Gallagher: Again, I will defer to Dr Steel on that, but I guess that it would depend on the model; what comes out of the assessment and the dialogue about the severity of need; and whether the case involves mental illness or someone who is in distress, for whom another intervention, such as a distress brief intervention, might be more appropriate. It would depend on the nature of the incident and the nature of the engagement with the mental health professional, and then on the diagnosis and the best pathway for that individual thereafter. In some parts of the country, that could be access to a safe space—

Pauline McNeill: Why does that matter? If it is an NHS issue regardless, when the police officer takes the person to the NHS facility where they can best be treated, why would that police officer not simply say, "Well, we've done our job, so it's over to you"? Why would that not be the case in every circumstance? You are saying that you think that the police have some responsibility, at that point, to wait to find out what the diagnosis is.

Dr Steel: A year ago, I was in front of the committee with a different hat on; I was here as a professional liaison psychiatrist—a psychiatrist who works in an emergency department. Now, I am here as principal medical officer—as the psychiatrist who advises the Scottish Government.

The point that I tried to explain last year—I do not know how well I explained it—is that there are essentially two competing models of mental disorder. There is the medical model, which looks at serious mental illness, when someone's brain is not working right; they might have schizophrenia, bipolar disorder or whatever. There is then the lay understanding of mental disorder: that the person is not able to control their emotions or their behaviour, often in response to life events that have happened more recently.

The problem is that the general public, understandably, follow, by and large, the lay perception, and the moment they see such behaviours, they contact the police. The police bring people to the NHS, and the NHS—appropriately—deals largely with a medical model.

There is a gap in between, which relates to people who are struggling to control their emotions but do not have a major mental disorder. The NHS tends to say, "Well, they're not ill," and the police say, "Yes, but they're not behaving as their usual self," and the person falls into the gap between the two views.

Ultimately, the solution to that lies in the area of safe spaces and emergency provision for people who are in emotional distress—in other words, universal provision that follows the lay definition of mental disorder. We are working on that. It will take a shift in mentality regarding what we provide for people in distress to an approach that is not based purely on an NHS model, but which involves a holistic approach across services.

Someone might be in distress because their relationship has broken down, because of debt or housing problems or because of substance issues. We need to have services across Scotland that will embrace that broader definition of mental disorder, and it is not clear that the NHS is where those services should sit.

Pauline McNeill: Does that mean that no progress has been made in filling that gap? It seems to me that you are talking about something that is currently intangible.

Dr Steel: No, I am talking about the big picture. Let me bring it down to the small picture. At the moment, people contact the police when they are in distress. What we have really worked on are the options that are available to the police. They now

have the enhanced mental health pathway—they know who to contact, and it is guaranteed that they will have contact with a mental health professional in their area. We are trying to improve the robustness and the consistency of the handover from police to clinical staff, but, ultimately, the service for people in distress is variable across the country. In the long run, that is a societal issue, and neither the health service nor the police—

Pauline McNeill: But it is not a police issue.

Dr Steel: No, it is not—

Pauline McNeill: That is what I am struggling with. Do we agree that it is not a police issue?

Dr Steel: Yes. Oh—

Pauline McNeill: But you are saying that it is not an NHS issue, so—

Dr Steel: The NHS does not view it as an NHS issue, and that is where people fall down. At present, there is very good provision in some places. In Tayside, there is the Neuk, Hope Point and the Beacon in Arbroath. All of those are open for only 12 hours a day, seven days a week, but they are places that people can go to when they are in crisis, where their distress will be contained and where a solution is likely to be found for the problem that led to the distress. Can that be replicated—

Pauline McNeill: I do not feel that we are getting anywhere with what you are saying, to be honest. Our papers say:

"The taskforce is also looking to build training to give police officers and staff the knowledge, skills and confidence to support that balance around the care, support and monitoring in day-to-day policing."

It sounds to me as if you are still going to rely on police officers to fill that gap.

Dr Steel: The committee is looking at how we have ended up in a position where the police are the first point of call. The police will tell you that they are filling a gap in provision. With regard to what the health service, or mental health services, and police can do on their own, the police increasingly have options—

Pauline McNeill: I do not really understand what you are saying, to be perfectly truthful.

Dr Steel: Okay. Things like—

Pauline McNeill: You have talked about the work to scale things down so that we are making some progress, but that is not in the area where the gap is. It is where there are two competing models when someone has a mental health problem and a diagnosis that needs to be addressed. You have made progress in that area—is that right?—but that is not where the gap is.

Dr Steel: Things such as distress intervention are exactly where the gap is. That has helped 100,000 people so far. The enhanced mental health pathway makes it easier—

Pauline McNeill: I am not asking you about that.

I know that you have helped, and I commend all that work. However, you have your role and we have our role, and we are trying to ascertain, in relation to all the people whom you have helped, at what point the police officer can walk away and give that response—because it is not their job to deal with something that they are not trained to deal with. That is also why I am confused about what it says in our papers:

"The taskforce is also looking to build training to give police officers and staff the knowledge, skills and confidence to support that balance around the care, support and monitoring in day-to-day policing".

It feels like we might be going back to square 1. I am trying to ascertain what progress has been made in allowing police officers to go and do their jobs.

Dr Steel: The enhanced mental health pathway allows the police service to redirect people who contact it to NHS 24 directly, without getting involved. Both the police and the NHS have made good progress in enhancing handover and, as Pauline McNeill said, getting the police out of the case earlier in order to save police hours.

The reason that I point out the gap is that there is a limit to the extent to which the police and the NHS, working together, can solve this problem. It is a broader societal problem. However, there is an appetite to change the nature of the services that we have, with safe spaces and so on, in order to solve the problem.

Since I got involved, I have said that the real proof of the pudding is how much time the police are spending on this. We need to get them out and get people the right help, in the right place, at the right time. At the moment, although we have made progress, we still have progress to make.

Pauline McNeill: Thank you very much.

Rona Mackay: Good morning. I want to clarify a few points that I am a bit confused about.

Dr Steel, you said that, as part of the progress made, police now have contact with mental health professionals immediately in their area. Is that 24/7?

Dr Steel: Yes.

Rona Mackay: That is at any time.

When police get a call, what training do they get to make the assessment that it needs to be redirected?

Dr Steel: A lot of police officers train in what is called distress brief intervention phase 1 training, which is where they learn to assess whether the person is suitable for that. That is one type of training.

However, the fact that they can contact a mental health professional 24/7, wherever they are, to seek advice and run the case past them is probably the most important development, as it places less onus on the individual police officer to make judgments. They can get advice and support immediately.

Rona Mackay: Is that happening in every area, or is it a bit of a postcode lottery?

Dr Steel: Sometimes it is not immediate, simply because the contact is an individual clinician, who might be dealing with another case. Sometimes there is a bit of a wait. I will not pretend that there is always someone at the end of the phone—there is not. However, that route is available everywhere, and it is well resourced.

The Police Federation wants this problem solved immediately. I have a lot of sympathy for it, and I know that the feedback from the police will say that the situation has improved dramatically.

Stephen Gallagher: I can confirm that distress brief intervention is available in every integrated joint board area across the country. The service is embedded across the country. There is also a national pathway into distress brief intervention at the higher level, which we call level 2. That can be accessed through the NHS hub, which, again, is available to everyone nationally as a digital option.

Rona Mackay: Two things have been mentioned, and I am wondering whether they are the same thing. Is the mental health assessment service different from the mental health hubs? Are they two different things?

Dr Steel: Yes, in that mental health assessment services are at health board level and are nurse run. GPs and the police will refer people to those services and people will walk in themselves, whereas the mental health hub is run by NHS 24 and you can phone a helpline. It is a Scotland-wide provision.

10:30

Rona Mackay: The figures that you quoted for the number of people who have used those services and have been helped by them are impressive. So that I can get a clear picture of the referrals to the mental health hub, do those come from the police or from the assessment service?

Dr Steel: Mostly, they come from people phoning 111 when they are in distress. If people phone 999 when they are in distress, the police have an enhanced pathway, which means that they have direct access to the hub if they think that it is appropriate. They are trained to be able to judge whether that is appropriate or whether they need to physically attend. If they have to physically attend a scene, they still have the option of routinely advising people to contact the hub.

Rona Mackay: You also mentioned that a lot of children have been helped by the mental health hub, although I cannot remember the figure. Does it have a link to child and adolescent mental health services? Are those services connected?

Stephen Gallagher: I apologise if I was not clear enough, but I was referring to community-based supports that the Government has invested in for children and young people. Those services are co-ordinated by, and we fund them through, local government. As you have raised the matter, we have been working with our local authority partners and COSLA, through a mechanism that we call the joint strategic board, to create a crisis framework for children and young people. Traditionally, by and large, we speak about adults in the space of unscheduled mental health care, but we want to have a similar framework available for children and young people. We hope to launch that in the near future.

Rona Mackay: I take from that that it is a separate service from CAMHS. I am asking because of the long waiting list for CAMHS, and I am thinking about whether the hub could help with that.

Stephen Gallagher: The framework will guide children, their families and carers to the most appropriate points of care. For some, that may include CAMHS. You will also know that, for the past four quarters, the target of 90 per cent of patients starting treatment within 18 weeks of referral has been achieved, so CAMHS waiting times overall and the size of its waiting lists and backlogs have been reducing across the country.

Rona Mackay: That is the case for some assessments but not for all, and not for autism.

With the new progress that has been made, is there anything that you think still needs to be done? Are there any drawbacks to the current system? Is it very much still a work in progress?

Stephen Gallagher: We need to focus on the commitments that have been made as part of the collaborative framework and the commitments that we have agreed to with Police Scotland and other partners. I think that the building blocks are in place. There is some variation across the country, which we need to understand better. Some of that will be appropriate, because it will be based on either rurality or an existing service model. We need to understand how that can be augmented to

make sense of the commitment in a specific locality. Our challenge is to scale up what works and take it to the next level, so that those outcomes are available for everyone across the country, even if the service model is a little different to suit local needs.

Rona Mackay: Do you think that that can be achieved in the short term? Would it be a long process to balance that out across the country?

Stephen Gallagher: I will defer to Robby Steel on that from a clinical perspective, because it involves changing the way that people work in practice.

Dr Steel: I have been very impressed with the options that are available to the police when they are called. Rapid progress has been made on that since the collaborative framework has been established. I think that it is a case of rolling it out across Scotland and improving it.

The bigger issue is a societal one relating to things being termed mental health problems and the expectation that the health service will solve them. A more holistic view is needed, and we probably need to change the way in which we look at mental health services. We should keep the medical model but expand services to embrace the holistic lay model. That evolution of service will require partnership with COSLA, local authorities and health boards. We intend to embrace that change in what we are calling the target operating model for mental health, which I hope the next Government will support.

Scotland is not the only country that is experiencing that challenge, but it is the right size to solve it. I get the impression that the will is there but we need to reorient our approach, take a more holistic approach and overtly adopt the lay model for dealing with mental distress and mental disorder. If we get there, the police will have their place, but the number of available options for them across Scotland will massively increase and they will need to get involved only when police involvement is needed.

Rona Mackay: Thank you.

Jamie Hepburn: It strikes me that a lot of what you have spoken about touches on a much wider response to supporting people with their mental wellbeing and mental health, which is commendable. Clearly, the NHS should be looking at that, and you have said how it works with Police Scotland to ensure that police officers better understand the processes and the options. Again, that is commendable and welcome.

However, we are here to talk about the impact on Police Scotland. When I speak to officers in my area—indeed, when I met a local inspector not so long ago, we touched on this—the primary concern, which we will touch on when we speak to the Scottish Police Federation and Police Scotland, relates to how much time is occupied when officers feel that they have no course open to them other than to take a person to hospital. If they think that a hospital is the most appropriate place to take an individual, they might find themselves having to wait there for a long time, because hospitals are obviously very busy.

The key question is what more can be done to accelerate the process of assessing whether an individual who has been brought to a hospital needs to be admitted for some form of direct intervention or assistance and then admitting them if that is required. As I said, I recognise that hospitals are busy and deal with multiple things, but there is clearly an issue in the time of other professionals being occupied when they have a wider job to do. They are not able to get back to that job because they feel that they have to wait with the person they have brought to the hospital. How can that process be improved and shortened?

Dr Steel: That point was very well put, and the problem is recognised. In Lothian, a pilot is taking place to improve the handover from the police to clinicians in A and E departments and mental health urgent services by giving structure to the thought process and decision making in that regard. I expect that that pilot will be very well received. We will probably hone the approach, and then there is an appetite for that approach to be rolled out across Scotland. That can be done pretty quickly, so I am optimistic about that.

When I, as a liaison psychiatrist, went into a medical ward at nine o'clock in the morning to see people who were receiving treatment after an overdose, I would often see eight police officers sitting in pairs with four different patients, and it always mystified me why they could not leave. You will be speaking to the Police Federation later, but I know that the police are improving and refining their internal processes. The structured handover will support individual police officers in that regard, so it is a very good development.

Some scenarios are intrinsically time consuming, so we are not going to be able to reduce the problem to zero. For example, someone might be too intoxicated to have a meaningful mental health assessment but might still be risky. If they have got into a fight in a pub and a crime has been committed, the police might want to wait there. Should the person sober up in a police cell? That is not appropriate. Should they sober up in A and E? You could argue that that is not appropriate either. At the moment, there is no perfect solution to the problem.

Jamie Hepburn: We understand that there will be circumstances, maybe when violence or criminal activity has been involved, in which it is appropriate for the police to be there. Part of the process is to understand whether the person could be charged and how the police would have to deal with it.

There are cases that I have been told about in which there was no suggestion that there had been any criminal activity—it is just that a person was in severe distress and might have posed a danger to themselves. Those are the situations that we are talking about.

Dr Steel: I am very familiar with those. Historically, it has been frustrating. As a consulting psychiatrist, I would say to police officers, "It's fine. I've got this. The person is in hospital and I'm assessing them—please go," and they would say, "Our inspector says we can't. We've got to stay." That is difficult for both sides. We should put structure around the decision making and have clear guidance so that, on one side, the NHS can meet the police halfway and accept that the handover needs to be structured, well documented, safe and the best thing for the person, and, on the other side, the police can be less defensive in their practice and accept that they have to have faith in the handover to the NHS.

I have heard police officers say that they will not leave someone in A and E because the nurses will not watch them and the next thing that will happen is that the police will be called about a missing person—so it is better for them to stay there than to be called out in half an hour's time for a missing person. That lack of trust and faith in the other side—

Jamie Hepburn: Does that not speak to the point that I am making? I know that it is difficult, because there are a lot of people in A and E and they have to be triaged. Some of them could be in severe physical pain, and that needs to be dealt with. That speaks to my point: if what you have described is the police officers' concern, how can the process of admission be dealt with as quickly as possible, so that the police officers' concern can be addressed, they can see that the person has been admitted and they can leave?

Dr Steel: A structured, well-documented handover will go a long way towards solving that. It will not reduce it to zero, but it will go a long way.

Jamie Hepburn: I appreciate that. It is interesting to hear the evidence that you are giving, which—I know that you will take this in the sense in which it is intended—is anecdotal to a certain extent but is your own experience of telling police officers, "The person is here now. They are safe. We can deal with the situation," and of the police officers still feeling an impediment. That impediment might be their personal perspective or a structural concern about their own procedures, but it means that they do not think that they can leave. That is interesting and we need to explore it further with Police Scotland.

The Deputy Convener: I look forward to doing that, Jamie.

Sharon Dowey: Coming back to availability of services, have you done any assessment of the availability of 24/7 care? You have said that 24/7 care is provided, but there is still the issue with handovers, especially at evenings and weekends, and it seems as though there is a postcode lottery. Has the NHS done an assessment of the facilities that are available 24/7 to enable a handover?

I also come back to something you said earlier, which was that you need to change the nature of the services that are provided and the way that mental health services are looked at. Everybody talks about the holistic approach but, in a round table that I attended more than two years ago, there was a forensic psychologist who said that some people with mental health problems only feel safe in a secure environment and that we probably closed a lot of the 24/7 mental health care facilities because of a knee-jerk reaction. Do you have an opinion on that?

Dr Steel: People can get a mental health assessment anywhere in Scotland, 24/7. Under the Mental Health (Care and Treatment) (Scotland) Act 2003, the health boards have a statutory obligation to provide mental health assessments, so there are mental health services across Scotland. For someone who lives in the Highlands, that will often involve a video assessment with a nurse at Raigmore. If they need a physical environment to keep them safe, is it best to take them to Raigmore or provide a safe space somewhere else?

10:45

The NHS provides up-all-night, 24/7 assessments. What changes at weekends and overnight are the options that are available to the nurses staffing that system. In Lothian, there are often no beds in the psychiatric hospital, so people cannot be admitted to a psychiatric bed to let them cool off, which means that, often, they will stay in the accident and emergency department.

NHS Ayrshire and Arran's psychiatric ward is in the central hospital in Irvine, but the health board is running an interesting pilot that involves having a separate space where people can be kept for up to 72 hours, just to cool off. It is a place where people can be observed and where, without admitting them to medicine, the A and E ward or the psychiatric ward, they can be kept safe until

they have sobered up and daytime services are open. That has been very effective.

If someone has an addictions problem, they need rapid access to addiction support and help, but there is not the critical mass of cases that would be needed in order to make that a 24/7 service. The mental health assessment service, staffed by nurses, is open 24/7, and NHS 24 offers help 24/7, but, often, the options that are available to keep people safe are daytime services, so clinicians and police officers can sometimes find themselves in the difficult position of wondering where there is a safe place for a person to go.

Sharon Dowey: I suppose that that is what I am asking about. Getting a mental health assessment via video screen does not help somebody who may cause harm to themselves or others. Given that we are saying that it is a health issue, what is the NHS doing so that that is a clinician's responsibility and the police can do a handover straight away, 24/7?

Dr Steel: It is important to remember the lay concept of mental disorder. Sometimes the disorder is a health issue, and those are actually the easy cases. When someone has a relapse of their schizophrenia or is manic, the approach is quite easy, as they need to be detained and you need to find a psychiatric hospital bed for them, so that they can be kept safe. The more challenging cases involve people who are intoxicated and emotionally dysregulated. That is not a health problem. We call it a mental health problem, but it is not what the NHS views as a serious mental disorder; instead, it involves acute emotional difficulties that will calm down. I often say that the person needs the very strong medicine of tea and shortbread and a safe place to be kept until they are able to make decisions for themselves again and the emotional dysregulation is settled.

One of the issues with Scotland is the different environments that we work in. In the far north-west, there is not the critical mass to justify having a 24/7 psychiatric facility or even safe space, and it might be that the solution involves having a relative sit with the person in a community hall or some other place where they can be kept safe. In a city, we have triage cars that take mental health nurses out with the ambulance service. That is appropriate in a city, but it is less appropriate in the Highlands, because people would spend all their time driving. The model of care and the solutions will necessarily be different in different places.

The fundamental problem is whether we can provide a place for people to stay safe until they are calm and the crisis is resolved. There is an assumption that that will be a psychiatric hospital, but that is not necessarily the best use of a psychiatric hospital. We have different models in different parts of the community, and they need to be developed. A lot of the safe spaces work is about that.

Sharon Dowey: I appreciate that the model will be different in different areas, depending on issues such as rurality and so on. We are just looking to see what progress has been made. Thank you for your answers.

The Deputy Convener: I will bring in Fulton MacGregor.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Thank you, convener.

I thank the panel for appearing today, and I just want to follow on from other lines of questioning, particularly those pursued by Pauline McNeill and Jamie Hepburn.

The committee has been looking at this situation for quite a long time now—indeed, it very much predates us—but I know that it is a difficult one to get right. That said, I agree with Pauline McNeill that it feels as if things are not really moving fast enough in this area. What are we doing to try something different? The last time that you came in to talk about this issue, I raised the specific issue of having more joint working teams. At the end of your last answer to Sharon Dowey, you touched on the triage system and the joined-up working that is happening, but are there any plans to develop what might be almost multi-agency teams involving police and health professionals to respond to theses sort of situations and ensure that folks are not still working within their silos?

My reason for asking that question takes me back to my own social work experience. I know that, when social work and police worked together in joint teams on child protection issues, such an approach worked really well by bringing all the agencies under the one roof, if you like. Are there any plans even to trial something like that in this situation?

Stephen Gallagher: Thank you for the question. We can see very clearly in our safe spaces work that there is a benefit in taking a multi-agency approach. There are three safe spaces in the Tayside region, and there is also the Woodland View model in Ayrshire and Arran that Robby Steel referred to; they are multi-agency models, and we see advantages in people being together in one place to effect information exchange and handovers and to take a holistic view of all the needs of an individual. Some also have peer support embedded, which is another important feature of mental health support and care. In fact, we have decided just this week to go out to procurement for a research project that will allow us to take an overview of the safe space model

and to work out how we want to take it forward nationally.

It is part of the service gap that we referred to earlier. This is not just about hospitals, or about digital approaches such as NHS 24. Is there another community space that we could, as you have suggested, take forward in a more joined-up and holistic way across the country, to ensure that every area has the notion of a safe space? As Dr Steel has said, it might look a bit different on the basis of geography, but the core principles of how the work is undertaken and how professionals relate to each other, wrapping around the individual, have to be central.

Secondly, it is probably worth mentioning that it is our intention, as part of the strategic renewal framework for health and social care, to establish what we describe in what are, I concede, slightly jargonistic terms as target operating models for the way in which our mental health system works. As part of that, we will be looking not just at what happens where—I am thinking of the conversation that we had a few moments ago about access to beds, for example, and Dr Steel's comment about the acute pressure that some of our bed base is under—but at what else in that spectrum of care we need to provide, and how we would expect and want people to work across boundaries to make the whole system of care happen.

Clearly, that will involve a totally collaborative process. When it comes to policing, we are all in on a partnership approach with the Scottish Police Federation and Police Scotland, and I think that their collaborative commitments show that they, too, are all in on working together to address what is a really significant change in the concept of how people see their lives and how they approach the public services in a state of distress, as well as the preponderance of mental ill health.

Robby, is there anything that you want to add?

Dr Steel: I am very glad to hear a question about more integration of services. Community mental health services have been devolved to local authorities under the health and social care partnerships and integration joint boards.

If we can do that more effectively, with holistic, multidisciplinary services including social care, health and housing services, with lots of peer workers involved, and if we can persuade those services to orientate themselves towards an open front door, with an acceptance that a major part of their work involves dealing with people who are in crisis and who are therefore motivated to change, that will solve the problem in the long run. That service will become the place where people go—or, if they phone 999 and the police are called, it will be the place where the police take them.

Most services will probably not operate 24/7 but, if they work in partnership with the NHS provision, which is up all night—for instance, if there is a peer worker working alongside the nurses, who can get the tea and shortbread until the daytime holistic crisis service is open—that is the medium to long-term solution. If we establish that, we will find that the demand on the police will simply drop away.

In the short term, we are doing all that we can to partner with the police to fix the things that police and health can fix largely on their own. I am really impressed at the progress that is being made on that.

The Deputy Convener: Thank you for that—and thank you, colleagues, for all your questions.

I have a couple of things to ask Stephen Gallagher. Does the Scottish Government believe that the NHS and the wider health system in Scotland have effective provision at the moment to deal with members of the community in mental health crisis?

Stephen Gallagher: Yes, although we would concede that the model will be different in each part of the country. We are committed to ensuring that we have more consistency in our approach and that we follow the principles of the strategic renewal framework, with a people-centred approach, support for people through digital approaches, a focus on communities, less conveyance to hospital—unless it is absolutely required—and services based on strategic needs assessments.

You are asking me a question about mental health or mental illness, and I want to be clear about the definitions and paradigms that we have discussed today. They are clearly and well described on page 3 of the collaborative framework document, which discusses the different ways in which people present to mental health systems and services—whether it is mental distress or mental illness, and how we navigate the right solutions for people, depending on how they present.

If your question to me is whether our mental health services are appropriate for those with mental illness, the answer is yes. Do we have more to do, on the wider spectrum, for people who are distressed in their life circumstances? Absolutely we have more to do. As I set out at the beginning, we can only do that in partnership with our public sector partners.

The Deputy Convener: I am grateful for that.

Police Scotland attends 14,500 mental health incidents every month.

Stephen Gallagher: Yes.

The Deputy Convener: Some 85 per cent of those incidents do not involve a crime. At the outset, you told us that there has been a spend of £164 million in this area.

Stephen Gallagher: Yes.

The Deputy Convener: Do you have metrics showing what the material impact of that spending has been, and the impact of the initiatives that you have both described, on policing?

Stephen Gallagher: Without wishing to trade statistics—

The Deputy Convener: I love statistics. Carry on.

Stephen Gallagher: Perhaps I have picked a strength.

The number of incidents that Police Scotland records as mental health related, based on a full statistical year—2023-24, if I am not incorrect—is about 17.6 per cent of incidents that police are called to. The key words that will be inserted in police systems, as I understand it, will be either "mental health crisis", "mental distress" or "mental illness". In actual fact, a number of calls will also relate to other reasons for which the police are called, such as a neighbourhood disturbance, domestic violence and so on.

It is difficult to fully conceive of an era when that 17.6 per cent will drop to zero, as there will be very valid reasons for the police to be present for other facets of the call or the incident.

Could you repeat the second part of your question, convener?

The Deputy Convener: It concerns all the spend and all the initiatives. What has the impact been on policing? Do you have any metrics that show me, for instance, that the police were spending X hours attending such incidents before that spend, and Y hours after that spend?

Stephen Gallagher: I understand that Police Scotland is continuing to develop a comprehensive dashboard of data. So far, it has been able to share with us the level of incidents, which is what I was referring to in the first part of my answer.

I understand that, in 2024-25, the number of incidents, even using the broad definition that I gave, fell by 1 per cent. Perhaps there is a plateauing effect, but we will see that in the next set of data, which relates to the next fiscal year.

The Deputy Convener: I am very grateful to you both. As colleagues have no further questions, that concludes your evidence for this morning. Thank you for your time.

11:01

Meeting suspended.

11:08

On resuming—

The Deputy Convener: Welcome back. I reiterate my thanks to the first panel. I say to colleagues that we might wish to write to witnesses about points after this morning's meeting, but we can discuss that later.

I welcome David Threadgold, who is chair of the Scottish Police Federation. We have about 45 minutes for this evidence session. David, I invite you to make a short opening statement.

David Threadgold (Scottish Police Federation): Thank you. It is a great pleasure to be here to present evidence to you. I will give you an operational perspective on the impact of demand in the areas that are under discussion today. The first panel discussed the impact on policing, and it is absolutely right to acknowledge the framework for collaboration. A huge amount of work has been done collaboratively between the police and partners, and there have been a huge range of interventions from within Police Scotland.

However, what I will present to you today is the reality that the operational impact on policing and police officers has remained largely unchanged. I have to be honest and say that, after having listened to the witnesses on the previous panel, I am no more confident than I was at the start of that session that we are close to resolving the issues that impact on policing at this time, and doing so to the benefit of those who are trying to deliver policing services across the country.

What it comes down to, and the way that I frame it, is what the public expect from the police. What do they want from an efficient, effective and well-motivated police service? I can tell you the impact of the demand. It is telling that it was acknowledged earlier that, over two years, there has been a reduction of only 1 per cent in recorded calls to Police Scotland that relate to mental health. That is significant, especially when we consider that every other aspect of policing has increased exponentially in that area. I also note the reduction in police officer numbers and the policing of protests that simply did not exist as policing demands a couple of years ago.

There has to be a solution to the problem, and there has to be a fundamental change in the way that Police Scotland approaches the delivery of policing services if we are to remain relevant, visible and effective in doing what I know we are very effective in doing in this country.

The second aspect is Police Scotland's provision for keeping its people well. Again, I acknowledge that a huge amount of work is on-going in that area, and I have been part of a great deal of it. However, there is clearly still much work to do. I have no doubt that some of those challenges will be spoken about today.

With that, I draw my opening remarks to a close.

The Deputy Convener: Thank you. We have heard a lot this morning about the good work that has been going on, which you acknowledged in your opening statement. In its evidence, the Scottish Government has suggested that 20,000 police hours have been saved through initiatives such as the ones that we have heard about. That is a positive impact, one would have thought, but there is also a personal impact on individual police officers. You will correct me if I am wrong, Mr Threadgold, but I think that some 2,300 officers are either off work or on reduced work.

If 20,000 hours have been saved, can you help us to understand how many hours the police are actually spending in this area? Is 20,000 hours a lot to save or is it a drop in the ocean? Have all the frameworks that we have heard about this morning and all the good work that has been done really not impacted at all, as you seem to suggest?

David Threadgold: I am always very cautious, and I look at figures that say that the police have saved whatever it is—in this case, 20,000 hours—through a different lens. In reality, the police have not saved anything in that respect, because it was not police demand in the first place. I assume that what people are referring to is the number of hours that have been deferred, in their opinion, based on examples that they multiply by a set number of hours. They then sell that as a saving to our communities.

I can talk about the operational impact and the ability of police officers to deliver policing in this country. I talk to police officers regularly—this comes from the evidence base of a recent survey that we did and, probably, many thousands of conversations with colleagues—and the constables, sergeants and inspectors who deliver the service and make decisions about how we close incidents tell me that between 60 and, in some cases, more than 80 per cent of our operational capacity to deliver policing services is lost because we are picking up the health function. That quantifies it.

To put that in simpler business language, we have a situation, which has become accepted, where we lose 80 per cent of our core capability to deliver policing because we are doing someone else's work. I do not mean to be too simplistic. I realise that we are all part of the public sector. It may come across that I do not have sympathy with the challenges that exist in health and social care, but I am looking at it purely and almost selfishly from a policing perspective, because I see every single day the impact that the current model, for what it is worth, has on our ability to deliver services, but also on our staff.

The Deputy Convener: You talked about operational capacity and public expectations and then, at the end of your answer, you talked about the current model of policing in Scotland. Section 32 of the Police and Fire Reform (Scotland) Act 2012 says:

> "the main purpose of policing is to improve … safety and well-being".

Is that reference to wellbeing an issue? Does it materially impact on how the police carry out their functions? If so, what should be done?

David Threadgold: The simple answer to your question, in my opinion, is yes. It goes without saying that the police abide by the laws that are enacted by politicians.

However, the inclusion of the word "well-being" in that legislation, in my opinion—which is evidence-based, as I have been a police officer for 28 years and have lived through policing since 2012—has allowed policing for our communities to become largely ineffective. The hook that is always referenced by the Scottish Police Authority, His Majesty's Inspectorate of Constabulary in Scotland and the executive in the service, is that we must do what we do because of the insertion of the word "wellbeing".

11:15

How the interpretation of that word has played out in relation to strategic direction and the delivery of operational services is that we now have a risk-averse structure in the organisation, which means that it largely cannot make the simplest of decisions about how it deals with members of our community who are engaged in some sort of health crisis.

I will give you an example. Last week, I was at an event to mark the one-year anniversary of the framework for collaboration, which has been spoken about. Several case studies were presented there, one of which was that the police had taken a lady in our community to a medical facility where she stayed during her care and had then taken her home via the chemist to collect her prescription after she was discharged. I raise that example for two reasons. First, why is it the expectation in the health sector that the police would in any way be involved in that type of activity? Secondly, how have we got to a situation in Police Scotland where that request is being met

by police officers? I think that it is a good example of the situation in which we find ourselves.

I am absolutely clear that, without a different strategic direction from our chief constable that would allow first and second line managers to make different, risk-positive decisions—which would require a different interpretation of the word "wellbeing"—nothing will change in policing, which is something that I simply cannot countenance.

Sharon Dowey: The community triage guide that we heard about in the previous evidence session says that there are arrangements for 24/7 access to mental health unscheduled care clinicians in every locality across Scotland. What is your assessment of the availability of 24/7 care?

David Threadgold: There is no question but that, on paper, that statement is correct. However, although it is an example of progress in our organisation and of that collaborative approach, the operational reality for police officers is somewhat different. I specifically asked the question ahead of this session, and was told that there are too many repeated, regular delays in access to that clinical service to allow my colleagues to make different decisions.

I will extend the answer, if I may, to distress brief interventions. They are a really positive thing. However, it has been mentioned that 2,000 police officers are trained in level 1—where the challenge is initially highlighted and the member of the public will get support for 14 days. However, we have many more thousands of operational police officers, so if the model that Police Scotland wants to use means that only 2,000 officers are trained and we cannot extend the training, those who are trained will feel increased pressure because they are the only ones who can be diverted to those calls. It is progress for sure, but it is by no means the panacea.

Every example is predicated on there being police involvement in the first place, either over the phone or physically, with the police taking an individual to a medical facility or some other place where they need to be assessed. The time element involved and the lack of risk-positive decision making that would allow health services to take those calls on at the very start are so prohibitive for our ability to deliver policing.

Sharon Dowey: Is there still an issue with access to help outwith normal working hours of Monday to Friday and 9 to 5? Are there pinch points in the evenings or at weekends, or have improvements been made in the past couple of years?

David Threadgold: Usually the pinch point is about five o'clock on a Friday—sorry, I do not mean to joke. The service is available 24/7 notionally, but I know from talking to colleagues that it tends to drop off outwith what we would class as business hours from Monday to Friday.

At the event last week, I was struck to hear about the systems that exist in the health service. I really want to keep this focused on the police, but I know from speaking to health colleagues at that event that, although we have 14 health boards and 32 local authorities, computer systems in social work services cannot speak to those in health services. Those problems do not help the police when we are trying to get information in order to make risk-positive decisions about individuals in our community.

The pilot in J division was spoken about—the transfer of care that somehow could be implemented nationwide in the next month or so. That is simply not the case. That change in working practice would require consultation with the federation and for governance in the organisation to go through a huge process. Although I accept that, in principle, the ability to ask questions of an individual and have a clinician or a doctor there to say that that person is safe to leave is progress, the reality—even from within that pilot—is that the lack of availability of medical practitioners to sign off on the health aspect is restrictive. As I have said, it is by no means something that will be put in place quickly.

Sharon Dowey: Are there any best-practice models? In England, there is the right care, right person model. I do not know whether you are aware of that.

David Threadgold: I am.

Sharon Dowey: Is there anything that could be learned from other places about models that could be brought in and implemented quickly so that we can see the benefit?

David Threadgold: The police and the Government have both said that Police Scotland will not adopt a right care, right person approach. Does everyone know what that is?

The Deputy Convener: It would be helpful if you would briefly explain it.

David Threadgold: It is about taking more risk-positive decisions based on the information that has been given by people who are in some sort of crisis. The example that I was given was that, if someone calls the police down in England—this is only in certain areas of England—to say, "I feel suicidal", or, "I have not been for dialysis", the police will immediately divert those calls to a general practitioner or to health services. In Scotland, we might take a different approach to such a call and send police officers to respond to it.

To put it very simply, that is the model. It is more direct and it is almost selfish—I use that word carefully. I do not want the police to appear to be playing a role in the way in which the public sector deals with health issues, and that is simply because of the level of demand and the impact that it is having on our ability to deliver policing.

Sharon Dowey: Is that being selfish, or is it just about directing the call to the correct person to deal with it?

David Threadgold: It might involve saying to the person who is calling, "Thanks very much for phoning the police. However, this is not a police matter. I ask you to divert your call to health", and then putting the phone down—to be blunt about it.

Sharon Dowey: Okay, thank you.

Pauline McNeill: Good morning. You sat in on the previous evidence session, so you will have heard everything that was said. It was difficult to discern what the NHS thinks is the problem, but I think that we got to it. My reading is that the NHS is saying that there is a gap between services and that some cases are no one's responsibility, so they fall to the police. What do you think about that?

David Threadgold: That point was acknowledged by the HMICS in its 2023 report. It is very much the view of operational police officers that we have become the service of last resort, and that the risk aversion to saying to people, "Thanks very much for phoning us, but this is not a police matter" is detrimental to our ability to deliver policing.

As I alluded to earlier, what I took from that evidence session is that I am not confident that any cop in Scotland who was watching the meeting will have any more confidence now that the issues are close to being resolved. Although we have a partnership and a collaborative approach on paper—and there has been some good work—I do not feel that Police Scotland can influence that partnership to change processes within health services for the benefit of policing. I have spoken to health board chief executive officers and general practitioners, so I would consider myself to be informed when I say that the police have become the default option when health services cannot deal with a situation.

The police have responsibilities with regard to article 2 of the European convention on human rights, which is the right to life, but so do health services. Some commentators have told me that it appears that health services can deal with that responsibility by moving calls on to the police, but we cannot do similar.

I frame all that around the impact that the situation is having on policing and on my colleagues and what the public expect from the police service in this country. I am not sure whether that answers your question.

Pauline McNeill: It does, but there is a point that I perhaps did not understand correctly. When I pressed the witnesses in the first evidence session, they explained that there are two competing models of mental health: when there is a diagnosis of a mental health disorder and when there is emotional distress. That is how I would categorise it. They said that the gap relates to emotional distress. I felt that they said that, although emotional distress is not a policing issue, it is not an NHS issue either. So, it is no one's issue.

David Threadgold: The example of safe spaces was given. When I listened to that, it took me back to the time when safe spaces were available for tea and a biscuit—I think that that was the analogy. That was when the police could take members of the public who were drunk or whatever to a facility where they would be looked after. Lo and behold, the funding for those places was lost and so they closed, and now that option is gone.

To be blunt, and if I may be candid, these issues are not for the police to deal with—I think that everyone in the previous evidence session was clear about that. I agree that they were not sure who should deal with these issues, but they agreed that they are not for the police. Although we absolutely have a role to play in maintaining the wellbeing of our communities by keeping people safe, once we get to the point at which it is clear that something is no longer a police matter, we have a challenge in passing individuals on to the right people to care for them.

Pauline McNeill: In answer to Sharon Dowey, you talked about second and third-line managers and risk positives. What do you mean by that? Do you mean that, when the call first comes in, whether it is through 999 or 101—I do not know where they come from—line managers could make different decisions to divert it?

David Threadgold: I know that they could. I was one myself when I was an operational officer. I have spoken to dozens of them who are afraid to make risk-positive decisions for people in a health crisis because they fear being subject to criminal investigations by the Police Investigations and Review Commissioner or the Crown Office, or going through internal processes regarding police professional standards.

I will give you an example that articulates that fear. A young female in Dumfries went into the sea; she clearly had major health issues. She was taken to a medical facility and I am told that it deemed that she could not be dealt with there. Two

cops sat with that individual for four days, and the disposal that the police decided was appropriate was to drive the individual to Northumberland. If we had confidence in our processes, and clear strategic direction from the chief constable, we would make different decisions about such situations.

No one in policing wants to lose the resource to deliver services, but we accept it because of the paranoia that exists about making risk-positive decisions in this area. That will be playing out across Scotland now, and it will have been playing out across Scotland every day since this issue was raised—I can promise you that. I am sorry to repeat myself, but it takes me back to the point that it impacts on our ability to do what we are good at, and on the health of colleagues who suffer the consequences.

Pauline McNeill: We have heard about all the work that is going on and is needed, and that some progress has been made, but you think that it is not enough and that Police Scotland's management needs to make different decisions in the first place.

David Threadgold: We need different strategic direction in my opinion, and that is the opinion of the cops who I represent. The situation has not changed and I do not believe that Police Scotland can change it in isolation. I also do not believe that the priority that Police Scotland places on this work, or the decisions that it has made, have been matched across health in a way that would allow us to free up the demand that currently exists on our services.

Rona Mackay: I want to ask about the health and wellbeing of your members in Police Scotland. During our previous inquiry, what we heard about how things are dealt with was not very encouraging, and the parts of your submission about how officers cope with the trauma that they experience on a daily basis are also quite alarming. There was also an issue with the counselling services that your officers were being directed to. Forgive me, but I cannot remember the name of the service at the moment. The basic issue is that, regardless of the level of trauma that a police officer had experienced, they were being directed to this one-size-fits-all service. Has there been any improvement on that front? Do you think that your officers are being provided with the correct level of mental health counselling at the moment?

David Threadgold: First, I genuinely believe that work is being done to address most of the issues that were raised off the back of our survey, but I cannot say that without also saying that the situation should never have arisen in the first place. Police Scotland has acknowledged that its focus on investment in training and in keeping people well has not been where it needed to be, and we are now dealing with the consequences of that. The convener mentioned at the start the percentage of sickness that we have, and the information that I have is that absences among police officers across the country run at between 7.8 per cent and 9 per cent.

It is also relevant to say that the information that comes from the service's staff surveys shows that the distinction is not always made between the percentages for police officers and police staff. The surveys that I did were for police officers, and it is worth repeating what I said in my submission—our roles are different. If we look at training people, giving them information to stay well and enabling them to identify challenges in their colleagues and deal with the inevitable trauma of policing, only three in 10 police officers who responded to our survey said that they felt that they had had that training. There is a huge amount of work to do.

The training that is provided to keep officers well is not uniform across the service. There is far more emphasis on probationer training and, even in that programme, there are areas of duplication. We could free up capacity in the programme to allow different aspects of training to be given.

11:30

What I see is that the focus on, and provision of, training for first-line managers—I am talking about sergeants, who, in my opinion, have the most important role in policing, because they get it from both the bottom and the top—is nowhere near where it needs to be. That applies to numerous areas, particularly the identification of health challenges, whether within policing or outwith it; we must not forget that police officers are affected by social issues as well. There is a huge area of focus there.

There is some positive news on the offer from Police Scotland. I am told that 120 colleagues a month are now engaging for the first time with Police Scotland counselling services. You could look at that as a really stark figure, in the sense that it is a big number of people, but I try to look at the positive in these things, which is that we are starting to identify colleagues who need help. I understand that 89 per cent of those colleagues benefit from that intervention, which is positive.

However, on the broader question of identifying trauma upstream, I would say that such exposure is inevitable. The long-standing figure that police officers experience 400 to 600 traumatic incidents during their careers, compared with three or four in a lifetime for most people, is relevant here. Trauma is inevitable, and we have much more to do to identify a clear strategy and to provide training. A

lot of information exists; it is just that we are not training people and giving them the opportunity to understand that information and how to deal with trauma.

The model that Police Scotland uses to deliver the training is largely online—there are exceptions, obviously—and that is simply due to cost pressures. However, it does not work. Cops will come up with many ingenious ways to show on a computer screen that they have completed something; they tick that box. That is the phrase that I hear more than any other in this area, but ticking a box does not ensure that we fundamentally understand information that is being provided to us.

Commitment and resource are needed to train everyone, but we must focus on sergeants. There is no second-line manager training for the inspecting ranks, and none as officers progress into the superintending ranks. These are huge issues if the expectation is that those managing the masses—by which I mean constables—will have a positive impact on them.

Rona Mackay: That is really interesting. Did you say that you have had 38 years' service?

David Threadgold: I am not that old—it is 28 years.

Rona Mackay: I could not remember if it was 28 or 38 years.

David Threadgold: I joined when I was five. [*Laughter.*]

Rona Mackay: Apologies.

David Threadgold: No offence taken.

Rona Mackay: You were obviously in it as a young lad and worked your way up.

David Threadgold: Very young.

Rona Mackay: In that time, you must have seen huge changes. In terms of supporting police officers' mental health, including your own and that of all your colleagues, how have things changed? Were services more available back in the day? Obviously, online training would not have been available, but do you feel that you were better prepared then than officers are now?

David Threadgold: I tend to look forward, not back. However, to answer your question, I note that, when I got promoted, there was a two-week residential course for newly promoted sergeants. That has gone—and I think that is one of the areas that needs to be revisited. I do not think that the challenges of policing have changed, and we still dealt with pretty horrific things every day. However, there are different challenges now such as protest activity—stuff that was not there before. The awareness of mental health and mental wellbeing is far greater now than it ever was before.

I will try to merge together the two areas of this discussion. When I was a newly promoted sergeant in Aberdeen, I was able to manage my team by having peer-to-peer interactions with colleagues and knowing that I had colleagues close by to assist me with whatever. That is the biggest change that I see: there is a lack of peer-to-peer support, because Police Scotland has closed more than 140 stations—some quite rightly, there is no question about that. However, I cannot accept that those decisions were not largely based on finance and the financial pressures that exist in the service.

My opinion is that the biggest thing that needs to change is that we need to return to having an internal focus. We need to switch the lights on inside and start to look after ourselves, so that we can get more cops back to work and provide a greater resource to deal with what it is that we should be doing.

When I talk with communities—I talked with a community council yesterday—they tell me that the police are not relevant. People who would fundamentally be on the side of the police are now not bothered. They say that they cannot get through to report crimes. Yesterday, people in Kirkwall in Orkney told me that the police station is never open, and they wanted a view on that.

Those are the effects not only of the financial pressures that the service is under but of our ability to deliver policing, because we are simply tied up for so much of our time with other activities. The 80 per cent figure that I gave on operational impact comes from Inverness. It is staggering to me that we would lose that much capacity and almost accept it in policing. It has become the norm, and that has a real impact on the health of people.

Rona Mackay: That is a fundamental change from two decades ago when you started out—demand has increased and increased.

David Threadgold: Demand has gone up and resource has gone down. I do not suggest for one second that the service does not have the backing of its officers, but the focus has been allowed to shift away from policing towards servicing mental health provision due to, in my opinion, the word "wellbeing". That must stop. The police have done everything that they can to play their part in this partnership and collaboration to deliver change in the way that we police, but that effort has simply has not been matched by partners in a way that would allow that change to happen operationally.

Rona Mackay: I have a final question. Do you want to say anything about the impact of the new employee assistance programme and the new

occupational health service contracts? Have those made a difference?

David Threadgold: Yes, they have, but there are still challenges. The provision is better than it was, for sure. In relation to officers with ill health, the timescales regarding that particular process have increased. There was a blip during Covid, obviously.

We are aware of the issues, and one of my colleagues in the federation deals with that area of work. She provided me with information showing that the process is taking too long. Some of the disposals from the process have concerned us in respect of retaining officers in the service. However, I would need the opportunity to give you a written response to that particular question, rather than making it up here.

Rona Mackay: That is absolutely fine. Thank you. That has been helpful.

Jamie Hepburn: Good morning, David. You listened to the previous evidence session, and I am interested in following up on some of the areas that I explored there. You set out one of the main challenges, which relates to officers taking a person into hospital to see whether they can get assistance and perhaps finding a lack of appropriate clinician expertise or personnel.

I thought that Dr Steel made an interesting point in the previous session. He has encountered, and it has been reported to him, that some of the challenges—he was not saying this in a critical sense—might also be at the Police Scotland end and their protocols, which, I am sure, have been put in place for good reason. In that scenario, clinicians might be saying to individual police officers, "You've brought this person to hospital. We've got this person—they are in the hospital environment—and we can now deal with this." However, for whatever reason, the officers are saying either that they do not feel that they can leave the person on their own or that they are being told not to leave the person on their own. Clearly, there will be circumstances in which that is sensible—for example, the person might have committed a crime—but that scenario included instances in which that was not the case.

Can you say whether you recognise that as an issue? If you do, can you speak to what any of those processes might be and whether they need to be looked at?

David Threadgold: My previous answers fundamentally address your question. I do not feel that supervisors who make difficult decisions about all sorts of things every day are applying the same risk aversion when it comes to decisions about people. The cover-your-back scenario is to take that person to hospital, or wherever, because we simply will not make that decision ourselves due to the fear that I spoke about earlier.

Interestingly, the issue of missing persons—and of not leaving people at hospital because we are afraid that they may go missing and, for example, harm themselves—always comes up. That is a real consideration, but I am not aware of any data that suggests that we have left individuals in hospital who have then gone missing.

From a policing perspective, the pilot in J division is an initial step. I saw the document for the first time last week, and there are real challenges with it. We have to start utilising existing technology. We are now in possession of body-worn video, and we have hand-held devices on which we can electronically record decisions that have been made in order to expedite decision making within policing. That might play out like this:

"Mr Hepburn, you're at the hospital now. Are you fine? This is all being recorded."

"Yes, I am."

"The police are now leaving. Do you have any issues at all?"

"No, I don't."

"Okay—see you later".

That is a very simplified example of what I think could eventually happen in policing. Again, however, that example—

Jamie Hepburn: Can I just ask something? You have posited my name, so let us just use it. In that scenario, am I, Mr Hepburn, the person you brought into hospital or am I the clinician who has said that it is safe?

David Threadgold: You would be the person who we had taken there.

Jamie Hepburn: Okay. Please carry on.

David Threadgold: However, that example, and every other situation that has been discussed, is still predicated on the police taking the person to the facility in the first place.

To tie that back into the wellbeing aspect of the legislation, as was mentioned earlier, is it to the benefit of somebody's wellbeing to sit with the police for an extended period waiting on a decision through the pathway, a decision on a DBI or a decision to take someone to a health facility? Is that good for that person? The answer clearly has to be no. I find it frustrating that we try to sell success—I hear about the selling of success—in this area of policing, based on the fact that the police have still taken that initial course of action, which can take hours.

To illustrate the point further, I go back to the Woodland View facility down in Ayrshire, which was mentioned. It is a tremendous facility within a hospital to deal with people who are going through an unscheduled mental health crisis. The numbers that I have show that 1,200 incidents have been dealt with there, 1,100 of them successfully. The facility has a 72 per cent referral rate from the police.

You think that that is a success and that it will take demand away from the police, but when you ask about the impact on operational policing as a result of the 100 cases that could not be dealt with by that service, it wipes it out. From an operational perspective, therefore, we are no better off than we would have been previously—do you know what I mean?

It is a challenge, but I think that the solution—having listened to what was said earlier in the meeting, I am even more resolute in this opinion—is that we have to start doing things differently in the police. In my opinion, there is no prospect of the broad situation changing any time soon, and if we do not do things differently, we will just continue to have the same discussion in three years' time as we did three years ago when I started this job.

Jamie Hepburn: It sounds to me as though this is part of the equation. You have taken the person to hospital, presumably because you think that that is the environment in which they will be safest and is the appropriate place to go to. I understand that an officer is accountable to, and will take their orders from, the superior officer—the supervisors, as you described.

However, I am thinking about what happens if a qualified clinician says, "You've brought the person here; it's now safe." How do we get to a place whereby officers, including supervisors—it sounds like they might be the key players here, from what you have said—are confident enough to say that they, or the officers on the ground, have been told by an appropriately qualified medical professional, "You can go now—you've brought them to the right place"? I can understand that the human instinct, in any profession, is to say, "I've got to cover my back here". What needs to be done to get to that place? It sounds as though you are saying that some of the issues are at the operational end of Police Scotland.

David Threadgold: Yes. It is very simple: you give police officers the confidence and the structure from the top to make those decisions and to be confident that, if the person subsequently leaves the hospital and completes suicide or harms themself, the officer will—quite rightly—be scrutinised for the decisions that they have made, but they will not be subject to extended processes and periods of investigation by the PIRC. Those might be appropriate, but it is that fear that prevents what I can see you consider to be fairly basic decision making from taking place.

That has to come from the top. There are many examples from within the PIRC in which it has looked at deaths following police contact and decided that there was no issue whatsoever with the decisions that were made by the police, but that culture is not ingrained across policing in Scotland. It is that fear that prevents that basic decision making from taking place.

The Deputy Convener: I have a final question, to bring together some of the evidence that you have talked about, Mr Threadgold. It leads on from Mr Hepburn's point. You said earlier in the session that these issues are not for the police and therefore they need to be passed on. In the previous session, Dr Steel told us that, "The NHS does not view it as an NHS issue". That raises some questions. Where, in your view, is the blocker here? What is preventing the handing on? Who, therefore, has agency to make things better?

11:45

David Threadgold: As we spoke about at the start of this session, the hook at the moment is the legislation that refers to wellbeing, and the fear of making decisions that would, I would argue, be risk positive for the benefit of policing.

The police will make operational, instinctive decisions in every set of circumstances that they find. However, if somebody is clearly going through a health crisis, I am not sure that anyone—certainly no one at the table that I was sitting at when the case studies were presented during the event last week, which was full of health professionals and academics—agreed that any of them were the role of the police.

If you accept that what we are being presented with as evidence, from both within and outwith policing, has nothing to do with the police, there has to be a process within the public sector in Scotland that provides a mechanism to allow people to stay well and get the help that they need. Extended exposure to the police is not that mechanism for that individual, because we are not trained to deal with it. We would strongly argue against any suggestion that we should receive enhanced training to identify and deal with those who are going through some sort of medical crisis because, unless that is what the public want, it is not our function.

The analogy is that we have the fire brigade policing at Pittodrie because they might as well just do it. That is the situation that we currently have. However, we do not see the fire brigade in surgical wards performing operations, because it is not their role in the public sector jigsaw. We have

found ourselves picking up much of the health function, and the thing that frustrates me the most is that everybody acknowledges it. One of the witnesses in the previous session—I think that it was Dr Steel—offered his sympathy to police officers. We do not want sympathy from the NHS—we want an effective public sector that allows us to play our part in the delivery of services across Scotland. We are hamstrung in doing that, for all the reasons that we have spoken about.

The Deputy Convener: I understand.

Pauline McNeill would like a quick extra question.

Pauline McNeill: From reading the submissions to the committee, the situation is exactly as you just said: we will soon be going in the other direction and training police officers to do some of that other work.

A final question just occurred to me, on something that I have dealt with myself. In 101 cases, where a person is in distress and they are not answering the door, the police officer would need to attend in case the door needs to be broken down. Is that the kind of risk-assessment decision that you are talking about? I see the need for a police officer to attend that call, because no one else has the authority to kick down the door. Would that be right?

David Threadgold: Yes—the first function of the police is to preserve life, and we are always going to do that. We will always attend emergency calls, whether they involve road accidents or members of the public on the street who are going through some sort of health crisis. We will go there in that situation. My view is that the handover—as has been discussed—between us and the health service is either broken or non-existent, and it is that which is inhibiting policing so much.

With a call like the one you describe, where someone is unsure whether the person on the other side of the door is alive, of course it is appropriate that the police attend that incident. However, it is how that scenario plays out, and what happens next, that would be of particular interest to us, if what we found was clearly a health matter.

The Deputy Convener: Mr Threadgold, I thank you very much for your evidence. One area of our inquiry that we have not managed to get to today is police suicides. That topic is very important to us, but we have been stymied by time. I wonder whether you might be amenable to writing to us on the issue after this session. Would that be okay?

David Threadgold: Of course. If you let me know the exact question that you wish to be answered, I will certainly do that.

The Deputy Convener: I am very grateful.

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

11:48

Meeting suspended.

11:51

On resuming—

The Deputy Convener: I welcome, from Police Scotland, Assistant Chief Constable Catriona Paton, the lead for the policing together programme, and Nicky Page, the temporary director of human resources. We have up to 60 minutes for this session.

I invite ACC Paton to make a short opening statement.

Assistant Chief Constable Catriona Paton (Police Scotland): Thank you. It is good to be here. I am grateful for the opportunity to share with the committee in my role as assistant chief constable for policing together, particularly in my role in leading and supporting the organisation in relation to our policing of mental health demand and how that impacts our staff.

As members might remember, I gave evidence to the committee a year and one month ago, just ahead of the launch of the framework for collaboration, which was mentioned earlier. During that session, I gave an overview of the work that we had been doing across the organisation to reset and rebalance policing's roles and responsibilities relating to mental health.

Foolishly, I set myself a deadline during that session. In my optimism, I said that, if I was here in a year's time, the real test would be whether tangible progress had been made. One year on, the question about what has been progressed remains.

For the benefit of time, I will emphasise only a few things in my opening statement and leave the rest for my answers to questions from the committee. It is important that we reflect on the context and role of policing, because that brings understanding and reassurance that our activities are focused on where they should be.

In April, Police Scotland will become a teenager. As you have heard, Police Scotland was created by the Police and Fire Reform (Scotland) Act 2012, and the importance of our purpose, which is to improve safety and wellbeing, has been drawn out. Those are two small words, but they describe a vast array of activity in relation to place, personal and physical safety.

I want to be clear with the committee—because this has also been mentioned this morning—that, in order to understand our purpose, you need to look at it through the lens of our role. The 2012 act is clear on our role, which is to prevent and detect crime, to maintain order, to protect life and property and to bring offenders to justice. That is our core purpose, that is why we exist, and that is what the public expect of us. “Core” means the basic and most important aspect of what we do.

When we consider what we do in policing, we do that through the lens of our purpose as well as the lens of our role. Our chief constable has provided greater clarity on that through our 2030 vision. She has been clear that the role of policing is to ensure that we have safer communities, that there is less crime, that victims are supported, and that we have a thriving workforce.

This morning, we have heard a discussion about who owns mental health and where some of the challenge around mental health demand sits. Let me be clear to the committee that mental health is a health problem and not a justice problem. Of course, there are complexities, and mental health is multifaceted, but people who are in mental health distress or crisis require care, compassion and, sometimes, clinical intervention. They do not need control, criminal courts, or convictions.

That said, the behaviours of people who are experiencing mental health distress and crisis require policing to have a role and purpose in that because, of course, our responsibility is to protect life. We will always deal with threat, risk and harm. However, when that has subsided and when there is no longer a threat to life, policing must be able to step back and return to our core purpose, which I have outlined to the committee. As you have heard, officers continue to attend a significant proportion of incidents where they are not best placed to attend and/or to remain with individuals without it impacting on and being a deviation from our core purpose. When the crisis is over, we need to be able to return to our core purpose. Our chief constable has also been clear that we cannot continue to fill the gaps.

As you know, we have committed to a significant amount of work to re-address the balance of our policing response in relation to mental health incidents. Through my answers to your questions, I will be happy to draw out some of the progress that has been made, because that is the exam question. I also want to be clear that much more needs to be done, and will provide examples of that.

The committee has heard from David Threadgold, so I will finish by saying that, ultimately, policing exists only when our officers and staff are thriving. That is why having a thriving workforce is one of the key elements of our 2030 vision. Therefore, we have a continued commitment to develop our process, practice and interventions to ensure that our staff continue to feel well when they come to their work and that they are equipped to do the job that we are asking them to do.

I thank the committee for allowing me the time to make my statement.

Pauline McNeill: What you have talked about is exactly why the committee is conducting its inquiry. However, the truth is that not much progress has been made. This morning, we have heard from witnesses that a gap exists, which has fallen to our police force to fill. That is what David Threadgold said. Do you agree that not very much progress has been made?

Assistant Chief Constable Paton: I do not agree that not very much progress has been made. As I said last year, no one has a magic wand in this, and we need to have patience, perseverance and hope to see it through. It is important that it is recognised that progress has been made. We have given some examples of that.

From what David Threadgold mentioned, I understand that the frustration may be that policing should not even be called in the first place. If we take the mental health pathway as an example, we see that more than 15,000 calls that police would have attended are now being diverted to NHS 24. That equates to 76,000 staff hours. True success in the mental health pathway will be when we do not have any calls to divert, because people will know to call 111 and not 101. There is more to be done on that.

By the same token, we have an opportunity to refer people into distress brief intervention services across the country. There are two local authority areas in which we need to see that being mobilised in practice but, as has been mentioned, policing alone has referred 7,000 people to DBS services. Why does that matter to policing? The evidence shows that when people are referred into that system, we reduce repeat calls and we reduce escalation, which is important progress.

I spoke to you last time about the mental health index. It is now in practice across the country. The challenge, which has already been mentioned this morning, is in the inconsistency of that practice. More needs to be done there.

12:00

There has been progress against the collaborative commitments, although much more needs to be done there, too. That “much more”

needs to involve a recognition of what we are doing to fill the gap if we agree that it is not down to the police.

Dr Steel gave an example involving clinical requirement for assessment and intervention: the 80 per cent of incidents that do not require clinical intervention. They are still health related, however: some elements will involve a health issue.

Earlier, convener, you mentioned the statistic of the approximately 14,500 mental health incidents that we attend each month, and you said that 85 per cent of them do not involve an element of crime. For clarity, a lot of them will still have a policing purpose of a missing person or a suicide intervention, so we still attend a lot of incidents where the police absolutely should be there.

However, your point is absolutely right, in that more needs to be done in relation to the transfer of care and the strengthening of local provision available 24/7 across the country. You heard some good examples the last time I was here, but the progress in that regard has not been as fast as I or others would want it to be.

Pauline McNeill: David Threadgold talked about second-line and third-line managers making different decisions. He talked about them being risk positive. Do you agree with that? What is the barrier to that?

Assistant Chief Constable Paton: David Threadgold reflected his views and his perspective on that. In my role in leading this work, I have been clear that having policy, strategy and guidance is one thing, but how is that translating into practice at an operational level? Part of my work, since I last met with the committee, has been to go on visits to every single division—as I have done personally—to sit down with their senior management teams and understand the practical implications of the work that we are trying to do as it relates to mental health and the barriers.

David mentioned the narrative around the fear of making decisions and the results of those decisions. That has been explored. My position is that we have been absolutely clear with line managers that they have both the authority and the responsibility to make those decisions and to step away when it is safe for them to do so, because the person no longer requires a policing response. Is that happening on every occasion? I recognise that we have to continue to do more.

One area of work that has been drawn out in the collaborative commitments involves our training. We have been giving our officers and staff learning bites in relation to a number of things linked to mental health. The next two that will be going online relate to risk assessment and transfer of care. Further to the discussions and the empowerment that we are trying to give our supervisors, staff and line managers, supported by our guidance and our strategy, there is on-going training and support, so that they make those decisions knowing that they are doing do with the support of the organisation.

The Deputy Convener: I am grateful—thank you for your contribution this morning, Pauline.

I will ask the next question, and I will then move to Sharon Dowey.

ACC Paton, the Scottish Police Federation said that there was an ever-increasing demand on Police Scotland to look after vulnerable people for ever-longer periods. That is in a context of resource going down. What does the chief constable propose to do about that? Might the right care, right person model, which we heard about earlier, be part of the solution?

Assistant Chief Constable Paton: I will take those questions in reverse order, starting with what the chief constable is going to do about that, and I will come back to discuss right care, right person in a second.

In her statement to the SPA, the chief constable was really clear about what she has done about that: we need to reset the balance as it relates to our policing demand and policing's role in responding to mental health. Those are not just words. She has invested in resources at chief officer level and a team of people through the mental health task force to support us to drive forward on the practical implications—the governance structures, strategic visibility and awareness—and she has invested in systems to provide insights and engagement, such as our mental health dashboard. The chief constable has been really clear on the need for us as an organisation to shift the balance, and she remains utterly committed to the progress that we need. As I said earlier, policing is doing all that it can and it continues to work with partners, but we need more progress in some of the other areas. I specifically mentioned the transfer of care and strengthening local provision.

You mentioned the right care, right person model. We spoke about that last time I was here, but the reality is that nothing has changed, and I will tell you why. When the right care, right person model was brought in, it provided the option to step away, but I mentioned the piece of legislation that you have mentioned, deputy convener. We have a responsibility to police in a way that is collaborative, which is part of our core purpose and our core role. That is critical to the work that we are discussing, because mental health is multifaceted and no one service has all the answers. Policing has therefore been really clear that, when there is

a risk to life, we will not step away until there is a safe alternative.

As I mentioned last time I was here, we have been down and looked at the right care, right person model. We have brought into our organisation anything that we think will add value, but that is not the right model. Some of the evaluations of the right care, right person model down south have shown that to be the case.

We are comfortable that the model that we have with the partnership delivery group and the work that we are doing through the framework for collaboration and the collaborative commitments is the way forward. It is about everybody playing their part. However, as I mentioned, we need to see swifter progress in some of the other areas.

The Deputy Convener: I will bring in Rona Mackay in a moment to ask a quick supplementary question, but I have a further question for you first, given that you brought up section 32 of the 2012 act and the wellbeing issue.

You talked earlier about your core role and you set out your four priorities for policing. You talked about the chief constable's 2030 vision for safer communities, less crime, supported victims and, crucially, a thriving workforce. However, when we heard from the federation earlier, it said that section 32 is the key issue. We heard that, because it includes wellbeing, it is fostering a culture that is risk averse and that includes an expectation that, as I think you have just said, the public do not necessarily have of their police.

If that is correct, and if the federation is correct that a different strategic direction is needed from the chief constable, nothing is going to change unless that wellbeing issue changes. How does Police Scotland respond to that? What do you think the chief constable can and will do?

Assistant Chief Constable Paton: This time, I will take the questions in reverse order. The chief constable is really clear on our purpose, and our vision sets that out really clearly. Underneath the four priorities of safer communities, less crime, supported victims and the thriving workforce are a number of milestones and objectives that we are working towards.

As they relate to the legislation that I mentioned earlier, improving safety and wellbeing—two small words—can have a vast array of interpretations. However, the reality is that, if we deliver the chief constable's vision of safer communities, less crime, supported victims and a thriving workforce, we will improve wellbeing. Society thrives and has positive wellbeing when there is safety and a justice system that is fair and equitable, so it matters. It is a by-product, it is relevant and it is important.

As I said, it is important to understand the lens through which we understand improving safety and wellbeing. There are aspects of safety that are not for the police to deal with. People will understand what the 2012 act means only when they look at our role, which is to deter and prevent crime, to maintain order and so on. It is not about water safety, to give an example, because that is not part of our role. In the same way, when we talk about improving wellbeing, that must be seen through the lens of our core role.

If we do the things that the public expects us to do, we will see improved wellbeing. I accept that the challenge has been in others misinterpreting the role that policing has to play. That is why, since the start of her time at Police Scotland, the chief has been really clear that we need to reset the balance and the parameters of policing's role as it relates to mental health and mental health demand.

I will finish by putting the point about demand in context. The committee heard earlier from David Threadgold about the number of incidents and the 1 per cent reduction. That is still progress but, to put it in context, in the previous year there had been a 4.5 per cent increase. We have stabilised that and seen some reduction, and progress has been made. However, I go back to the point that I made at the outset that much more needs to be done, which is why the chief is committed to further engagement with NHS board chief executives and others to discuss moving into those areas around transfer of care and strengthening local provision that we have spoken about and that the committee explored in detail with the first panel of witnesses.

The Deputy Convener: I understand. To reflect that back—these are my words, so if I am not reflecting it correctly, do challenge me—you would argue that the focus on wellbeing under section 32 is a red herring. It is the wrong end of the telescope. Police Scotland would say that the wellbeing objective can be achieved through day-to-day operation and that it is about the outcome, rather than saying that wellbeing has been part of day-to-day operation. The chief constable wants to make it an outcome, rather than a day-to-day thing.

Assistant Chief Constable Paton: We still have a role in wellbeing. I have mentioned incidents of threat, risk and harm, such as someone who is suicidal, for example. Policing still has a role to keep that person safe in that moment.

There is a direct transactional response for policing in relation to wellbeing. The same would apply when we deal with children. We might not be preventing or detecting crime, but there is a direct link to improving wellbeing from a threat-to-life perspective. My personal opinion is that the two go

hand in hand. If we do one well, wellbeing is improved, but there are times when we still have to focus on wellbeing even if there might not have been a crime. That comes back to the point that I mentioned earlier. A number of the incidents that we attend do not have a crime related to them, but it is still right that the police attend, because a person might be missing or someone might be suicidal. There might be a whole range of elements that do not require justice, but do require police.

Rona Mackay: You have talked about resetting the balance in relation to the mental health duties that you are performing. You are saying that progress has been made, but there is a lot more to be done. We heard from David Threadgold that the balance has not been reset, because your figures show that 85 per cent of such call-outs did not involve a crime, so they were for a mental health issue. That is clearly an issue that needs to be resolved.

Assistant Chief Constable Paton: Can I clarify those figures? It is helpful to say that, even though an incident is not a crime, there can still be a requirement for police to be there, because there is a threat to life.

Rona Mackay: Yes, I heard you say that—you talked about when attempted suicide is involved, and I understand that.

You also said that success could be measured when you do not have to take any calls about mental health issues or distress. Would it help to have a public awareness campaign about who people call if they are having an extreme mental experience incident, so that the public know? Obviously, people might phone the police as a first responder, but could they be directed to phone another number, for example, if that is happening to them but they are not being threatened?

Assistant Chief Constable Paton: That is why numbers 1 and 2 of the 19 collaborative commitments in our framework relate to communication. The short answer is yes, and that work is being progressed in partnership.

12:15

Rona Mackay: I am thinking about a Government public awareness campaign, not an internal one, because that is how people get to know these things. Frankly, the public will not have a clue what you are talking about—they do not know about all the collaborative interactions—but if they hear something on the telly or read something online, they will know who to call.

Assistant Chief Constable Paton: Our communication plans have already started that work. When I spoke to the BBC in December, I was clear that there is success when the public know to dial 111, and we can continue to expand that work. However—this is where the collaboration element comes in—we need to work at a pace and scale that means that, when people phone that number, the call is answered because resources have been provided. As you will appreciate, a number of elements are needed in general society, irrespective of where we are—

Rona Mackay: The system needs to be fit for purpose.

Assistant Chief Constable Paton: Exactly. You heard about calls being diverted to our mental health pathway. We are also—this touches on what David Threadgold said—looking at other methods, such as voice messages that ask people some questions so that they know to hang up from the police number and phone 111. We should also be clear that, if someone does not want to use the mental health pathway, we will hang up anyway if it is not a police matter. We are doing lots of things to try to address at the first opportunity the issues that David Threadgold raised and to give us the best chance to say, “This is not for the police,” and stop at that point.

Rona Mackay: You have used the phrase “thriving workforce” quite a lot. Would you say that the workforce is thriving at the moment?

Assistant Chief Constable Paton: As a strategic leader, my answer is no—not until 100 per cent of the workforce are thriving. The chief constable included that phrase as part of our vision because that it critical to our ability to deliver our service.

Nicky Page, as the head of HR, can get into some of the practicalities and set out the outcomes from our survey that tell us that there are green shoots of hope and that some of the work that is being done is starting to have an impact on our staff.

Nicky Page (Police Scotland): I will answer the question straightforwardly: we have a lot of work to do. We appreciate that. As ACC Paton outlined, there is an absolute strategic commitment to that goal, and there are three levels to it—the prevent aspect, the support aspect and the restoration aspect, which relates to people who need far more support because they are already ill.

On the prevent aspect, our primary focus is on addressing barriers in the workplace, and we are listening to our workforce so that we know what those barriers are. There are numerous barriers, but the predominant one relates to resources. That factor has been mentioned in our submissions and by David Threadgold. We cannot get away from that.

However, we can consider those barriers and how we create capacity with the resources that we

have, and the chief constable is focused on that, because it is in her gift. She has done that by working with partners to reduce court abstraction, and we have seen the benefits of that in relation to rerostered rest days, for example. That factor is an absolute hindrance for our workforce, because it is not good if people's rest and recuperation time is disrupted. We have seen a drop of about 10,000 in that space, which shows that there are green shoots of hope—

Rona Mackay: Sorry, but what do you mean by a "drop"?

Nicky Page: The number of rerostered rest days is coming down. We have a reduced requirement to change people's days off, because we are managing, with partners, things such as court attendance that require us to reroster and bring in officers during their time off. That is one positive aspect.

Another aspect relates to big events that require front-line capacity. The chief constable has commissioned work to look at remodelling our workforce so that we can put more people on the front line during busy times to relieve some of the stress on resource complaints. Internal work is being done at the primary stage to try to support the workforce and answer the question of, "What are you doing about resources for us?" There is an absolute commitment on that. The chief constable has done far more in that space than I have seen in the past 13 years.

I noted your questions earlier to David Threadgold about whether the secondary support at individual level has improved—yes, it has. We have focused on a number of improvements and are doing far more on training and lifelines, and we are training our probationers as they come in to the service. We are making them aware not only of trauma in its wider sense and how officers support society but of what trauma means for them. David Threadgold mentioned that police officers are exposed to roughly 300 to 400 serious incidents of trauma during their policing career, based on a 30-year career. Of course, the changes to pensions means that our workforce are working beyond that and, therefore, they are exposed to more trauma. Our ability to manage the impact of it, make our officers aware of that and to get into the prevention space is an absolute focus.

We are pushing the trauma impact prevention technique. Previously, we used trauma risk management processes, or TRiM, which you have probably heard of, which are used across policing as well as armed services. That process is about what happens after the incident, how we deal with it and how the officers cope afterwards. The prevention aspect is about upstreaming it and saying, "How do you deal with a traumatic incident? How can we give you tools to manage it better so that it has less impact on you?" We have a big push on those areas.

We are also engaging with the workforce. Again, it is about the prevention aspect and asking them, "Do you understand where your mental health is at?" We do mental health assessments for our staff. Although we have had good engagement on that since we introduced it, indicators still show that we have to push that and do more work on it. Those who are rated as red in the assessment almost all go on to get support. We would like 100 per cent of those who are rated as amber to say, "I need to engage further and do more," but we are about 50 per cent there. The survey that the federation conducted showed that some of that relates to stigma and it is about staff thinking, "Do I want to get further support? The support is there, but do I want to access it, because I am scared of what colleagues or others might think?" We have a lot of work to do on that, but we have significant communications in that space.

By training probationers on the impact of trauma, we are normalising it for the workforce at the inception of their career but—I am looking to you, Catriona—officers who have 30 years or more of experience would not have been as trauma aware at the inception of their career as they are now. They would not have been aware of the life journey and the need to look after themselves for 30 years. We are trying to ensure that our new workers are aware of that. Frankly, there is a gap between officers who have longevity of service compared to new probationers, which we are trying to close.

Rona Mackay: Are you able to tell the committee about the drop-out rate or the retention rate of new probationers? Is it improving or going backwards?

Nicky Page: National patterns of retention show that the risk component is between three and five years. If people stay beyond that time, it plateaus. At the moment, Scotland has one of the best rates of retention across policing in the UK at the three to five-year mark. However, with an ageing workforce and a reducing working population, we will be competing to make policing attractive.

Rona Mackay: What I was trying to get at is whether that situation is improving or you are getting more drop-outs. If you do not know the numbers, can you give an approximation?

Nicky Page: I would be able to provide you with those numbers after the meeting, if that would be helpful. There has been a small percentage rise in those numbers in the three to five-year range. The numbers are extremely small, so I would not want to say that that was a statistical pattern or to give false assurance on it. However, we keep a close

eye on it for the reasons that I have just outlined: we have to remain attractive to applicants. We get far more applications to join Police Scotland, in comparison to the numbers received by colleagues in England and Wales, so it seems as though it is still an attractive career.

Rona Mackay: It is the retention element that I am interested in—obviously, whether we have enough police officers in the future will come down to that.

Nicky Page: Absolutely. I will provide those figures after the meeting.

The Deputy Convener: Before we move to questions from Sharon Dowey, I note that we are starting to run out of time. I ask colleagues to be tight on their questions and witnesses to be similarly concise.

Sharon Dowey: How can Police Scotland improve the handover at hospitals? That is my initial question. Also, are there things that might make it possible to not take the call in the first place? We have talked about various things, including using 101. ACC Paton, you said that, if there is no threat to life, police must be able to step back. What is it that police officers are scared of? Are they risk averse? Are they scared that they will not get support from higher-up officers? Is it that, if something were to happen, they would get the blame for it? How can we improve the handover, and how can we improve the confidence of police officers to leave someone whose life is not at risk?

Assistant Chief Constable Paton: Thank you for the question; I will try to be brief. We are focusing on that area. You have heard about the pilot scheme that is happening—that is one element.

What are the mechanical elements that will support the decision making at a practical level so that officers and staff have the confidence to do that part? As I have mentioned, line managers and supervisors make risk assessments every day, and part of that is to understand whether there is an on-going and enduring risk. If there is not, and we have fulfilled our responsibility up to that point, we should have the confidence to step away. What will help with that is the things that I have mentioned in relation to continuing to empower our people, and continuing to deliver training around risk assessment and the transfer of care, which is helpful to decision making.

That said, policing is a caring profession. Two things can be true at the same time: it can be true that we should walk away, and there can be an element of our wanting to make sure that the person is getting the right care. If officers are in an establishment and—like you heard about in a previous panel—NHS staff think that it is not a case for them to deal with at that time, there is a gap. We need to address that gap collectively and collaboratively. There are opportunities to do that in the work around safe spaces and other places where people can go when they are in mental health distress, rather than the police having the responsibility to pick them up.

Through a combination of all those things, we will start to see progress being made. The pilot that went on in the J division finished yesterday—17 February—and is being evaluated. We will be looking at the practicalities of rolling that system out. Early indications and anecdotal evaluations are saying that that system saves a number of hours. It does not change the reality of staff having to attend the scene in the first place—they have attended and have taken the person there. That goes back to the improvements that we need to see, such as in the mental health index.

There is inconsistency across the country: in some areas, staff always get access to a clinician and an assessment and are able to step away; in other areas, they are being told to take the person to A and E. We are highlighting that inconsistency with partners. Next week, I will be at the partnership delivery group. We need to see consistency of practice. I was heartened to hear the director for mental health mention that they would review the community triage mental health index to see where it is working and what will need to be done. We need to see consistency across the country.

Sharon Dowey: It is still confusing. You have said that, if there is no threat to life, officers must be able to step back. You also said that you cannot step away until there is an alternative. That is basically tying the hands of police officers. What would you like the NHS to implement right now that would help you?

12:30

Assistant Chief Constable Paton: We were talking about the right care, right person approach. I was saying that we would not devolve our responsibility to protect life and support people in crisis when there is not an alternative. We will encounter people in mental health distress or crisis in a whole range of scenarios, whether in domestic situations, whether in situations of criminality or whether it is to do with missing people. My position is that, until there is an alternative, we do not step away from that element of responsibility.

We want to empower our staff to be able to step away from a situation where we have taken someone to an A and E department, for whatever reason, if we are comfortable that the person is safe. We are dealing with behaviours, not DNA or forensics. Everything is continually assessed in

terms of the level of threat, risk and harm that the person poses to themselves and other people.

As you heard from Dr Steel back in January 2025, part of the issue is that police officers and even some medical staff are not trained to diagnose mental disorder. Asking police officers to understand whether someone is in mental health distress, crisis or disorder is really difficult. That is why we need the support of partners—so that we can say that we are comfortable that we now have an understanding of the risk, and the person can remain with us. That is why there has been the transfer of care pilot. If the person leaves, they will not be a high-risk missing person, or there would not be an increased risk. Those are the practicalities. The evaluation will be important for us in rolling things out when we have a better understanding of the impact.

Sharon Dowey: Effectively, we are still no further forward. Your officers will still not be able to leave somebody without there being an alternative. The NHS has not really made any progress, then.

Assistant Chief Constable Paton: Much more progress needs to be made by the NHS. There is no doubt about that.

Sharon Dowey: Because it is a health issue.

Assistant Chief Constable Paton: There is absolutely no doubt about that.

Katy Clark (West Scotland) (Lab): I appreciate that we do not have a huge amount of time.

It would be helpful if you could give us a great deal of detail on the retention issue, which is concerning both in the fact that the number of police officers is dropping and in the recent statistics showing that a disproportionate number of quite young police officers and officers with not many years' service seem to have left. It would be helpful to get an understanding of that over a wider period and of whether that has changed over the past 10 or 20 years, say. If you can provide that detail when you write, it would be very useful.

I wanted to ask mainly about the work that is happening with individuals and agencies other than the NHS. A great deal of the evidence today has related to the national health service and the transfer of care—and to what happens in hospital or in similar settings. Many of the scenarios that the police have to deal with are clearly not in those settings. Could you say a little bit more about what work is being done now? Are other agencies or individuals working to ensure that the police can transfer individuals outside those settings? There have been a number of mentions of other agencies and other partners.

Assistant Chief Constable Paton: I assume that you are referring to services such as the Nook.

Katy Clark: I am really asking what you mean and what work you are involved in. I do not want to make a presumption. There is obviously a wide range of other agencies. Perhaps you could talk about some of the work that you are involved in. If you want to talk about the Nook, that would be fine.

Assistant Chief Constable Paton: We have the partnership delivery group, which brings together the Scottish Government, local authorities, other emergency services and the third sector. Those emergency services include our NHS colleagues, of course. A big part of it involves working with the NHS and NHS 24, through the mental health pathway and so on.

Katy Clark: Yes—you have spoken about that.

Assistant Chief Constable Paton: Linking to what Dr Steel was speaking about, we also need to think about who is best placed—if not the NHS—to consider the support that is available. In support of the partnership delivery group, there is also a partnership reference group with third sector and lived experience voices that let us understand the wider support that is available. Through the framework for collaboration and the collaborative commitments, that work supports our understanding of the alternatives to A and E.

One of those alternatives, as I mentioned, is the Nook, which has just opened in Glasgow—and there are more such facilities due to open. It is a walk-in centre, so people who are experiencing mental health distress and/or crisis can walk in to the service and immediately get support. It is an alternative to A and E where our officers in Glasgow can take people who are experiencing mental health distress.

We are working to understand the benefits and the implications of that alternative for policing in relation to reducing demand and finding a better place than an A and E department to help somebody to understand what they need, what has caused their distress and what support is available. There are examples of that across the country.

Katy Clark: I appreciate that we do not have a huge amount of time.

In broad terms, what proportion of the types of scenarios that we are talking about are non-NHS—that is, scenarios in which the NHS is not the right place—but are scenarios in which the police should still be able to hand over? I am asking that to get an understanding, because so much of the evidence has been about the NHS.

Assistant Chief Constable Paton: I will mention a couple of things in response to that

question. Part of the work of the partnership delivery group and the framework for collaboration involves the creation of a performance framework, which will pull all of that together. There is a draft performance framework that will examine a whole suite of measures and include aspects that relate to the time and the response.

One point that would be helpful for this committee to understand is what Dr Steel said in the evidence session that I attended with him in January 2025. He said that about 80 per cent of those who go to A and E do not clinically require the NHS. That suggests that those 80 per cent of people require an alternative. However, sufficient alternatives are not consistently available across the country—that is the point that I made in January last year. There still needs to be more support across the country to provide alternatives to A and E for people, such as the Beacon in Arbroath, the Edinburgh Crisis Centre and the Nook.

Katy Clark: If there is any further information that you want to give us in writing, that would be helpful. I know that we have an issue with time.

Assistant Chief Constable Paton: I would be more than happy to do that.

Katy Clark: Thank you.

Jamie Hepburn: I want to pick up on an area that I explored with the other witnesses, which you have touched on already. It is the bottleneck whereby officers will take someone into a hospital environment—more often than not, A and E—and then feel that they have to wait there with them for a long period of time. David Threadgold talked about the issue sometimes coming down to a superior officer not enabling officers on the ground to leave. You touched on that, ACC Paton—by the way, is your name pronounced Pay-ton or Pah-ton?

Assistant Chief Constable Paton: It is Pay-ton.

Jamie Hepburn: That is what I thought. You said that officers and staff should have the confidence and be empowered to leave a person in a hospital or a place in which they are comfortable. We heard directly from Dr Steel—I do not know how frequent an occurrence this is—that there are circumstances in which a qualified clinician will literally say to officers, "You can go now. You have brought this person to this place, and it's safe to leave." Yet, for some reason, they will not do that.

If officers have taken a person to hospital, they presumably think—or, at least, they thought in the first instance—that it is an appropriate place to leave them in the care of someone with professional expertise. That begets the question, at what stage should the officer think, "Well, that's enough for me. I feel confident, now, that this person who understands mental health challenges better than I do is saying that I can go"? Why does the officer not leave at that point? Why are they not thinking, "This is the juncture at which I can leave"?

Assistant Chief Constable Paton: I would need to understand the individual case, but the committee can be reassured. I have been a police officer for 35 years, as Nicky Page mentioned, and I remember, as a hostage and crisis negotiator, scenarios in which we would take people we had been speaking with, who were on a bridge contemplating suicide, to accident and emergency—as we did in those days; it was a number of years ago—and be told, "You can leave them, but they're not going to get an assessment. We're quite comfortable and you can leave." However, we would still be reluctant to walk away, because we had just spent hours with somebody on a bridge, protecting their life. It is really difficult to make those decisions.

Jamie Hepburn: That speaks to human instinct. I think that it is an understandable human instinct. However, we are hearing about challenges that mean that officers are not able to be diverted to other forms of activity that we would expect them to be doing. I suppose the question is how we get them to move beyond what would be an understandable human instinct—I know that it is hard—and say, "Right. I've got a job to do, so I now need to trust this person who has told me I can leave," so they can then do so.

Assistant Chief Constable Paton: I could not agree more, which is why our focus is on equipping and empowering. That is why, for example, I went round and did all the divisional visits—to ensure that there is nothing lost in translation when it comes to the expectations of us as an organisation. It is why, supported with our guidance, we are doing the learning soundbites, which look specifically at risk assessment and transfer of care. That is about giving people confidence by saying, "If you make decisions in this way and in these circumstances, you will have support."

The sad reality, as we all know, is that people may choose to take their life. That is horrendous and we want to prevent it, but we have to enable and support police officers who have done everything in their gift to then walk away. You mentioned a scenario. If that scenario was brought to my attention, I would be able to say, "Let's look at that, and let's give support—what would change that?"

As I have said from the outset, we do not have a magic wand that enables us to change a pattern of behaviour, either among our officers or among

our partners, overnight. However, the question for the committee is, are we starting to see progress? I have been clear that, yes, there is progress, but I have also been clear that much more and much quicker progress is needed in a number of areas.

Jamie Hepburn: I wonder whether it is about how you actually make it structural. There must be a way of recording it when someone says, "I've been told by a clinician that I can go."

Assistant Chief Constable Paton: That is part of the transfer of care. We are involved in a collaborative risk-assessment discussion and agreeing, as a collective, that, "You're happy to take and we're happy to give," and we can then walk away.

We also cover the consequences of "What if?" for someone who is concerned about what may happen if they leave. Even if they leave, we are agreed. That is not the answer, because we are talking about the sum of all these parts, but it starts to give staff the confidence that they have something tangible that allows them to say, "I did everything that was in my gift."

Jamie Hepburn: Okay. That is helpful.

The Deputy Convener: Finally, we go to Fulton MacGregor, who joins us online.

Fulton, you are on.

Fulton MacGregor: Yes—that should be me now. There is a slight delay—[*Inaudible*.]

The Deputy Convener: Fulton, can I ask you to start again? Your connection is really bad. You can start the question again, but we will have to move on if you remain unclear.

Fulton MacGregor: Okay. Thank you. There do not seem to be any wifi problems here. Can you hear me better now?

The Deputy Convener: Yes, I can.

Fulton MacGregor: My question is on some of the themes that others have already explored today, around joined-up working. I want to dig into that a wee bit further, because I asked the witnesses on the first panel about it.

It strikes me that there are quite a lot of situations in which we hear the NHS and other services, such as social work, saying that these issues are not in their remit. We also heard from David Threadgold that there are a lot of situations in which the issues are not for policing either and are diverting police attention away from other things.

Is there an argument for having an assessment phase when workers go out together? There are a lot of situations in which there may be a risk and it is therefore appropriate for the police to be there, but whether the situation itself is a police matter after that might be disputed. Does more work need to be done on having an assessment carried out by both police and other services, such as health, in that particular scenario? Is work being done on that? If so, what form is that taking? Is there more that could be done?

12:45

Assistant Chief Constable Paton: Thank you for your question. I will keep my answer brief. Yes, that is considered. We have the option to work with the triage cars in Dundee, Glasgow and Edinburgh—they are in those three locations at the moment—which continues to help because that involves a joint assessment and understanding of risk. All such interventions and opportunities form part of the partnership delivery group, as I said, and we are able to understand and evaluate their impact, which is particularly important, and look at whether we would want to scale something up or down, depending on its effectiveness.

The Deputy Convener: Do you have another question, Fulton, or are you done?

Fulton MacGregor: In the interests of time, convener, I am happy with that. We have had three panels today and we are considering quite a big area, so I am happy enough with that.

The Deputy Convener: I am grateful for that—I appreciate your consideration.

That concludes our evidence taking for this morning.

For committee members and for your own purposes, ACC Paton, I note that the committee will seek a written update after this meeting—as we discussed with Mr Threadgold earlier—on progress on tracking whether work-related stress and mental health issues contribute to cases of police suicide. That subject was explored in the session that you attended last year, but the data was not being tracked at that time. We will also want to know what improvements have been made to the duty-of-care system for officers and staff. We will be in touch about that following this session.

That concludes our marathon evidence taking this morning. I thank all the witnesses who have attended, as well as everyone else who has attended and asked questions. We will now move into private session.

12:47

Meeting continued in private until 12:59.

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