OFFICIAL REPORT
AITHISG OIFIGEIL

Equalities and Human Rights Committee

Thursday 27 August 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 27 August 2020

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EQUALITIES AND HUMAN RIGHTS COMMITTEE
14th Meeting 2020, Session 5

CONVENER

*Ruth Maguire (Cunninghame South) (SNP)

DEPUTY CONVENER

Alex Cole-Hamilton (Edinburgh Western) (LD)

COMMITTEE MEMBERS

Angela Constance (Almond Valley) (SNP)
Mary Fee (West Scotland) (Lab)
*Alison Harris (Central Scotland) (Con)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Alexander Stewart (Mid Scotland and Fife) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Arun Chopra (Mental Welfare Commission for Scotland)
Professor John Crichton (The Royal College of Psychiatrists)
Laura Dunlop QC (Mental Health Tribunals)
Karen Kirk (Law Society of Scotland)
Bob Leslie (Social Work Scotland)
Professor Colin McKay (Edinburgh Napier University)
Julie Paterson (Mental Welfare Commission for Scotland)
Professor Jill Stavert (Edinburgh Napier University)
Lindsey Young (Scottish Association of Social Work)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

Virtual Meeting

Scottish Parliament

Equalities and Human Rights Committee

Thursday 27 August 2020

[The Convener opened the meeting at 09:04]

Interests

The Convener (Ruth Maguire): Good morning, and welcome to the 14th meeting in 2020 of the Equalities and Human Rights Committee. We have received apologies from Angela Constance, Mary Fee and Alex Cole-Hamilton.

The committee again pays tribute to all the organisations in the equalities and human rights sector for their continued dedicated service and hard work in what continue to be very difficult and challenging times.

We have a change of committee membership. I thank Maurice Golden for his work and welcome Alexander Stewart to the committee. I invite Alexander to declare any relevant interests.

Alexander Stewart (Mid Scotland and Fife) (Con): Good morning, convener. I am delighted to join the committee. I have no relevant interests to declare.

Covid-19: Impact on Equalities and Human Rights

09:05

The Convener: Our next item of business is our fourth evidence session on how Covid-19 has impacted on equalities and human rights. We will hear from two panels this morning. I am grateful to all the witnesses for their attendance today.

I welcome the witnesses on our first panel: Dr Arun Chopra, the executive director, and Julie Paterson, the chief executive, of the Mental Welfare Commission for Scotland; Professor John Crichton, the chair of the Royal College of Psychiatrists; Laura Dunlop QC, the president of the Mental Health Tribunal for Scotland; Lindsey Young, a mental health officer at the Scottish Association of Social Work; and Robert Leslie, the chair of Social Work Scotland's mental health sub-group.

We will move to questions shortly. I remind members that, if their question is addressed to a specific witness, they should identify that witness by name. Otherwise, we will work to a pre-agreed order for witnesses' responses. If witnesses feel that they have nothing to add in response to a question, they should not feel the need to speak but should simply state that. I will go back to the member for follow-up questions. Once the question is completed, I will invite the next questioner, until the evidence session is concluded.

I expect this panel's session to last for no more than 75 minutes. We have a lot to get through, so please keep questions and answers as succinct as possible. Allow the broadcasting staff a few seconds in which to operate your microphones before you begin to ask your question or provide an answer.

Alexander Stewart: Most of the panel members are on the Scottish Government's advisory group on the emergency coronavirus legislation that deals with mental health. I will ask for specific details about the group. How often does it meet? Who chairs it? What does it discuss? Are there stakeholders or human rights representatives on the group? Are minutes of group meetings publicly available?

The Convener: I ask Professor Crichton to answer those questions first.

It looks as though we are having technical difficulties. Does one of the other panel members wish to pick up on those questions? Julie Paterson, are you able to respond to Alexander Stewart's questions?

Julie Paterson (Mental Welfare Commission for Scotland): I joined the Mental Welfare Commission for Scotland as the chief executive four weeks ago, so it is more appropriate that I refer you to Dr Arun Chopra, who has been the executive lead throughout the pandemic period. He can answer those questions for you.

The Convener: Thank you. That is helpful.

Dr Arun Chopra (Mental Welfare Commission for Scotland): Good morning. Thank you for the opportunity to provide evidence to the committee for its on-going inquiry.

The group meets regularly. In the initial phase of the pandemic, we were meeting fortnightly. The meeting was convened by the mental health directorate of the Scottish Government and brought together stakeholders, many of whom are on this panel: John Crichton, the president of the Royal College of Psychiatrists; Bob Leslie from Social Work Scotland; me or my colleague Alison Thomson, who was the interim chief executive at the Mental Welfare Commission for Scotland until Julie Paterson joined us; and a representative from the Scottish Courts and Tribunals Service.

After the initial phase, we went to slightly less regular meetings. We were meeting on a three-weekly to a monthly basis, and the focus changed slightly from considering what might be needed to trigger the measures, or to think about whether the should be triggered, to looking at how the Mental Health (Care and Treatment) (Scotland) Act 2003 is operating currently, under social distancing measures. We have now resumed fortnightly meetings.

The group is organised by the Scottish Government and brings those people together to present our data. The Mental Welfare Commission for Scotland presents data on how the act is running, which we may speak about later—I have already shared some information with committee members. The Royal College of Psychiatrists talks about how it is functioning, and each organisation talks about the temperature across the sector. There are notes of the meeting, although I do not know whether they are publicly shared. That is the content of the meeting.

Alexander Stewart: That gives a good picture of where we are. As you deal with the unfolding situation, how are the results of your discussions used to make sure that everybody in the group is learning from the process and that lessons are being learned that can help to support individuals and organisations?

Dr Chopra: Is it all right for me to continue, convener?

The Convener: That would be helpful.

Dr Chopra: It is important to reflect on the data that each organisation brings in order to see how things are currently working and to get a sense of whether difficulties are escalating or whether things remain the same across the sector. We look at the data that the commission provides about how many people are being detained and the way in which they are being detained. That information is provided in two ways. We have actual data and numbers that we bring to the meeting—we have a systems analyst and a team working to make sure that that information is contemporaneously available to us. The practitioners on the commission also gather local intelligence, regularly contacting health boards and other authorities to ensure that we have information about how things are working.

We have been compiling data to show us how things worked during the first spike so that, if we have another spike, we will know what pressures there are on the system and how things might work. The group's job is to advise. We represent our organisations and we provide information to the Scottish Government—it probably goes to the chief medical officer or to the minister responsible for making final decisions. Our information will be part of the puzzle; it must be considered in the context of other data sets and information that will be used in making the final decisions.

The Convener: The committee would be interested to know whether the minutes of those meetings are published. Could you follow that up and let us know later?

Are there any human rights representatives on the group?

Dr Chopra: I will relay that request for minutes to our next meeting, which will be the eighth meeting of the stakeholder group. I will then feed back to the committee.

Although I am a psychiatrist, the commission takes the view that it is there to protect the human rights of people with mental disorders or any mental health issues. We have an eye to the professional world, as members of the commission come from practice. Our approach is underpinned by human rights.

Alison Harris (Central Scotland) (Con): The Mental Welfare Commission has published guidance on Covid-19 for practitioners, which is now on version 13. The guidance includes information on the principles of human rights as well as details on the emergency powers, and it also relates how mental health tribunals are currently functioning. How often is the Mental Welfare Commission's guidance reviewed, and what is the process for that?

09:15

Dr Chopra: Like many organisations, we had an extremely difficult time at the start of the pandemic. We moved rapidly to working from home and embraced that new challenge and all that it brought.

The advice note began as a result of the commission taking multiple phone calls. In answering the question, it might be helpful to outline a little bit of one of the commission's functions, which is to run a phone advice line that is available to service users, carers and professionals. It runs daily, from Monday to Friday. We were gathering information from those phone calls about what people were finding difficult, whether it was the impact of social distancing; the sort of issues that there might be on a ward when someone required to take leave; or community health teams, patients or service users asking questions about what they could expect from their service.

In response to those questions, we started to develop an advice note that was based on those questions and answers. It was largely driven by the calls that our practitioners—the nurses, doctors and social workers who were running the advice lines—were taking. We gathered the questions and brought them together, then the commission, as a group, thought about what we would consider to be a good response. We have a statutory duty to promote best practice under the 2003 act.

I would take some of those discussions to the wider stakeholder group, to reflect across the sector whether what the commission was saying made sense and was applicable across the sector. The practice was reviewed frequently by one of my colleagues, who would collate all the information as and when there were pressures. Rather than set a rigid system of doing it weekly or every two weeks, whenever there was new national guidance or when a new issue came up through our phone lines, emails or local intelligence, we would update our guidance accordingly.

Alison Harris: That is helpful. Thank you. Once you have updated the guidance, do you find that it is quite easy to get it out, so that people know what guidance you are working to and what is most up to date?

Dr Chopra: I suppose that it would be helpful to know what the sector thinks of our guidance and whether it is easy to access. We think that it is. It is on our website, and we are using social media. We have also produced a version that is specifically focused for service users, patients and carers, to make sure that it is easily accessible to everyone, without the jargon that might be used in the professional version. I hope that it is useful and accessible, but it is probably for others to judge whether it is hitting the spot.

The Convener: The committee heard evidence from Kathryn Lyndsay of Social Work Scotland that there have been calls to trigger the powers but that the Scottish Government has "held firm". Are you aware of calls for the powers to be triggered? I am asking that of John Crichton.

Professor John Crichton (The Royal College of Psychiatrists): Can you hear me all right, convener?

The Convener: Yes, we can hear and see you.

Professor Crichton: Excellent. At an early stage, there was particular interest in section 13ZA of the Social Work (Scotland) Act 1968, but there were no calls from the Royal College of Psychiatrists or from stakeholders to activate schedule 9 of the Coronavirus Act 2020. When we were in the exponential phase of the first wave, at the end of March and the beginning of April, there was a point at which I thought we might be a week to 10 days away from not having sufficient staff and not being able to operate under the act in the normal way. Fortunately, however, we did not reach that point. As Arun Chopra said, people quickly adapted to working in different ways, by using telephones, Near Me and video devices. That proved to be very successful in keeping things going.

The Convener: As I understand it, a key reason for having schedule 9 is to ensure continuity of service provision. You spoke about adequate staffing levels. Are you aware of particular local areas that currently have low workforce levels, and can you tell the committee how you measure staffing levels that might result in schedule 9 being triggered?

Professor Crichton: The Scottish Government has a special mechanism to look at staffing levels across health boards, and its monitoring of those is on-going. The forensic estate has a regular mechanism for looking at the number of staff who are absent, and those figures are collated by the Scottish Government. The Royal College of Psychiatrists complemented that source of data by surveying our members on a rolling basis to gauge how they were managing with the constraints on them, and we fed that information back into the legislative oversight group that Arun Chopra referred to.

The Convener: Is there a particular practitioner or role that you are concerned about the staffing levels of? People have been redeployed in the health and care service to deal with the pandemic.

Professor Crichton: It is really about being able to discharge the functions of the 2003 act that

protect the most vulnerable patients and their right to life. Those who are involved with that are those who are involved in detentions, approved medical practitioners, medical practitioners who provide second recommendations for certain orders, and specialist social workers—slightly confusingly we call those people mental health officers—who bring the—[*Inaudible.*]—perspective of social work to the decisions that we make.

In particular, if there were a difficulty in getting MHOs, the provisions in schedule 9 mean that we would be able to continue to intervene to ensure patients' welfare. The schedule also includes second medical recommendation flexibilities. It is really important to emphasise that none of the schedule 9 powers take away from the thresholds or principles of the 2003 act; those remain the same. Also, the powers are permissive rather than prescriptive in that, if they were drawn down, they would enable people to have flexibility about staffing and time limits. However, if people can do the normal thing, they should. Perhaps Arun Chopra will speak more about the oversight of schedule 9 if it is ever activated.

The Convener: You mentioned the requirement to have two practitioners make decisions. For the record, and for information, I ask why that is currently in place. What is the purpose of requiring two practitioners to make decisions?

Professor Crichton: Most decisions are made with at least a member of the medical fraternity and a member of the social work fraternity, thereby bringing together complementary views and skill sets.

If a compulsory treatment order was made, the ideal would be that a specialist mental health professional, an approved medical practitioner, a specialist social worker or mental health officer and the general practitioner would bring a range of views that we could present to the mental health tribunal. It brings complementarity and is all about ensuring safeguard and that we maintain the principles of the 2003 act and human rights to the best of our ability.

The Convener: John Crichton's screen has frozen, so I will just bring in Lindsey Young. I would like her reflections on calls for the triggers to be enacted, on the workforce levels and on the point about two practitioners being required.

Lindsey Young (Scottish Association of Social Work): Whether or not the legislation has been used, we are supportive of it because of the workforce pressures. As John Crichton illustrated, there is pressure on mental health officers. Even before the pandemic, there was a shortage of MHOs across Scotland. However, if we can work in the way we normally work, we will. We will adhere to the timescales and fulfil our duties in making people aware of their rights under the 2003 act to appeal and to have legal representation and advocacy—that will stay the same.

On having two opinions from medical professionals, for me it is much more about having two people coming together with the same opinion, so there is not just one opinion. That gives us a more rounded view of what is going on for a person and it feeds into the process of the mental health officer being able to make decisions about what needs to be in place at that time.

The Convener: The answers seem to be about the practitioners rather than the individual who requires treatment or assistance. From their perspective, what does having two practitioners bring?

Lindsey Young: The Scottish Association of Social Workers is a member organisation, but I can say anecdotally from my experience that having the two individuals there is an opportunity for the person to express how they feel, to be heard by more than one person and to say what they want to say. As John Crichton illustrated, one of the two individuals would ideally be the person's general practitioner, who might know them better and have a more robust relationship with them than someone who has met them for the first time because the person is unwell.

The Convener: Thank you. That is helpful. We have quite a big panel this morning, so if anyone else wishes to come in on any point, please just stick "R" in the chat box and I will bring you in.

As we ease lockdown and we all begin moving about a bit more and perhaps even socialising, everyone will be a bit more susceptible to the requirement to self-isolate through the test and protect process if they come into contact with someone who is infected. Obviously, that could happen to mental health staff, which was a point that was raised by Kathryn Lyndsay of Social Work Scotland. How much of a concern is that as we move into autumn and winter? That question is for Robert Leslie.

Bob Leslie (Social Work Scotland): We have significant concern about the potential of a second wave coming down the track at us. We have already seen localised clusters reported over the past week or so, which is a developing picture. Obviously, our colleagues in the public health sector are monitoring that closely. I echo what John Crichton said in relation to staffing in the earlier part of the pandemic. Everybody was under significant pressure when we went into lockdown and had to adapt quickly to other ways of working.

On the question of the triggers, I concur with John Crichton's view that at one point we were close in some areas to being short of MHOs, as

some authorities had lost nearly 30 per cent of their workforce through shielding or highly vulnerable staff not being able physically to do the job of going out and assessing individuals who might require to be detained, which is a requirement of the legislation and a protection in the legislation.

The principle of having two practitioners—the approved medical practitioner and the mental health officer—is there because the mental health officer is independent of other health colleagues. We are not employed by the NHS and we provide an independent safeguard and human rights protection for the individual. That is our concern. If there are further lockdowns, even localised ones, or if we lose staff as we begin to open up services around the country, we may not be in a position to respond in the normal way. Having the emergency powers available to be triggered, if required, is very prudent planning. As John Crichton says, that does not detract from the human rights of the individual. The provision is there almost to enhance our ability to respond to a mental health crisis in a pragmatic but flexible way while maintaining the principles of legislation and the protection that it affords.

09:30

The Convener: In a letter from 10 July, the Royal College of Psychiatrists says:

> "The profession is reporting increased demands on not just support services for those with poor mental wellbeing, but also on psychiatric services from people with more severe mental ill health".

Could the Royal College of Psychiatrists expand on that? It would be helpful if the panel could also provide the committee with evidence of current levels of demands on mental health services.

Professor Crichton: In the initial stage of Covid, we monitored the activity quite carefully. One of the best ways to monitor mental health act activity is via the Mental Welfare Commission. Arun Chopra may be able to give some figures on that in a moment. In that first phase, we did not see an increased demand on services, which was fortunate, because that is when there was the greatest pressure on the workforce for both AMPs and MHOs.

The Scottish Government set up an expert group to review the evidence of what we could expect in relation to mental health demand, which was chaired by Professor Gumley. The group predicted an 8 per cent rise in mental health demand across the spectrum. That prediction has been borne out. I get intelligence from my members who feed back to me, and from our medical managers group. There have been substantial increases in activity. No one could anticipate how events would unfold, but what we have seen is that the mental health wave has come after the Covid wave. That gives us a lot of work to do, but had the two things coincided, it would have led to particular pressure on the normal working of the act. I know that Arun Chopra has some helpful, up-to-date figures on the recent use of the detentions under the mental health act.

The Convener: Thank you for sharing those figures with us, Dr Chopra. Unfortunately, I cannot share them on screen, but perhaps you could talk through some of the data for us.

Dr Chopra: It is extremely welcome that things are opening up again and it is particularly helpful that the schools are back—long may that continue. However, there is now a risk as we go into the winter and flu season. We simply do not know what will happen with the pandemic, but we know that it will have an impact on mental health across the community and on the ability of professionals to respond to that.

I will talk through the data that I provided to the committee. There are just a few slides, and I will explain what they mean. The first slide shows the use of emergency detention certificates. Each record represents a very difficult moment for the person who has been detained under an emergency detention certificate. The rolling data from March 2018 to July 2020 shows that things are relatively stable. The lowest point comes around April 2020 and probably represents lockdown and the fact that people were not presenting. Then there is a marked spike, with the curve going sharply upwards. That reflects what is happening now.

To put some numbers on that, in the final three weeks of July this year there were 221 emergency detention certificates. That figure was 154 in 2018 and 174 in 2019, which shows that demand has gone up. As John Crichton said, that probably reflects people seeking help after lockdown or becoming quite unwell. When the furlough scheme comes to an end in October, that may have a further impact on the population's mental health and on the number of people who are seriously unwell. That curve may rise still further. The projections suggest that there will be significant pressures. The slide below that gives the same data on a monthly basis.

The third slide looks at an important safeguard around emergency detention certificates. That is the need for the independent consent of a mental health officer, who would be a social worker who has particular training in mental health. What we can see here is how many of those emergency detention certificates are granted with the consent of an MHO. It would always be best practice to

make sure that an MHO is consulted and gives consent.

I know that those watching the meeting cannot see the slides, but I hope that the preliminary evidence can be made available later on the committee's website. The orange and blue lines on the slide tend to intersect, until we reach the last couple of months when there is a sharp increase in the number of emergency detention certificates granted without mental health officer consent.

That echoes points made by Bob Leslie and Lindsey Young about the significant demands on mental health officers as the situation opens up and as guardianships open up. Lindsey said that the number of mental health officers has always been low. There is now a significant demand for MHOs.

The final slide looks at short-term detention certificates. It shows that fewer short-term detention certificates were granted in March and April of this year than in previous years. Suddenly, in May, June and July, there is a higher number than in previous years. That again reflects an increased demand. That is the tip of an iceberg. It gives data about people who were so unwell that they required support, care and treatment in hospital. It gives a sense of the pressures on mental health across Scotland's population.

The Convener: That is helpful. I can confirm that that information will be made available on the committee's webpage.

Fulton MacGregor (Coatbridge and Chryston) (SNP): I refer members to my entry in the register of interests. I am a registered social worker and my partner is a mental health officer and—although this is not a declaration of interests—is a friend of Lindsey Young, who is on the panel.

The committee is interested in schedule 9 to the Coronavirus Act 2020. The Scottish Government and the Royal College of Psychiatrists are concerned that we are unable to predict whether there will be a second peak. We can understand that, but we could also argue that we are now better prepared to prevent a second peak, or at least are more ready for it, which means that the provisions in schedule 9 are no longer proportionate. When members of the Scottish Parliament were asked to vote on the legislation—by which I mean not only schedule 9 but the whole act—it was probably agreed by all members that we would not keep extraordinary or exceptional powers for longer than was necessary.

We therefore have an interest in schedule 9. I will not ask what schedule 9 does. Instead, what issues would arise if schedule 9 were to be repealed? What impact would that have?

The Convener: Who would like to come in on that? We have not had an opportunity to hear from Laura Dunlop yet. Would you like to respond to Fulton MacGregor's question, Laura.

Laura Dunlop QC (Mental Health Tribunals): I will return to that question, although I am not convinced that it is primarily one for me. I wonder whether I could mention a couple of other things, given that this is my first airing. I have perhaps been rather slow in not chipping in earlier.

The Convener: Yes—please do.

Laura Dunlop: I, too, attend the regular stakeholder meeting that has been referred to. In fact, I have been to all the meetings apart from one, which I could not manage because I was at a hearing. The meetings are useful, because they involve a pooling of information from many different bits of the landscape. For the most part, the information is remarkably consistent, and that means that we are able to keep an eye on what is an evolving picture. The tribunal is really the end of a line, because we are only seeing people in relation to whom compulsory measures are being sought. We are seeing a small subset of people whose mental health is not the best, and we are seeing the most seriously unwell people, who are experiencing the greatest intervention.

On the question about data, when I should have chipped in but was a bit slow—sorry—we did a graph, trying to dovetail with the figures that Arun Chopra introduced. He has talked about emergency detention and short-term detention, which are three-day detentions and 28-day detentions respectively. Next in the hierarchy is the compulsory treatment order, which can start with a six-month detention.

Our graph compares two 20-week periods, one this year and one last year. If you look at the graph—I am afraid that it is not available at the moment, although I understand that members all have it—you will see that, in general terms, the line is at a higher level in 2020 than it is for 2019. The overall numbers of applications for compulsory treatment orders are 704 in 2019 and 796 during the same period in 2020. By my calculation, that is an increase of about 13 per cent. By that one measure, there has undoubtedly been an increased resort to compulsory measures, probably for reasons that are multifactorial. That is not really a matter for us, however, as we do not have enough information; we have not done research on that. That is just what we see. Our job is only to operate the system.

I must come back to the question. Perhaps not wearing my hat as president of the Mental Health Tribunal but as a sometime law reformer, having spent some time with the Scottish Law

Commission, I would say that, at a practical level, there would be a drawback. If emergency measures were suddenly required in future, there would obviously be a need to find time for the legislative process. There would be a sense of starting again with something that had been in place but was then prematurely jettisoned. That strikes me as a drawback, but others may have views about other prospective drawbacks.

Bob Leslie: In response to the question, and echoing what Laura Dunlop has said about the law, I think that it is prudent that schedule 9 to the 2020 act is included. Although the focus is obviously on the ability of the workforce to respond and the pressures that we face, it is prudent to have the emergency measures in place. I do not think that any responsible Government would want to remove those provisions mid-pandemic, when we do not know where the trajectory will end up.

As things open up, we are already seeing an increase in activity under the Mental Health (Care and Treatment) (Scotland) Act 2003. My rough calculations show that activity under the 2003 act in the Renfrewshire area, which is where I operate, is up about 30 per cent since the start of lockdown, and the activity is increasing week on week, as MHA data from the commission shows.

09:45

The work with adults with incapacity stopped, in effect, the minute that the lockdown started, because the courts closed, many solicitors had to work from home and things stopped operating in the private legal sector. That work is now opening up again, and the number of requests for activity relating to AWI is increasing. I have said to colleagues in various meetings that, had the normal activity with AWI run concurrently during lockdown, we would be on our knees. I do not think that services around the country would have coped. We might be heading that way again, given the increased business. The pressure is not only on social work and MHO services but on our medical colleagues who provide reports on AWI and so on.

I am not advocating, under any circumstances, the easing of the provisions in section 13ZA of the 1968 act; I am very happy that those changes were not activated, because that would have been a significant override of individual human rights. However, it is prudent to maintain schedule 9 to the 2020 act as a fallback, because if it was revoked and removed from the statute book, as Laura Dunlop has said, it could not be resurrected quickly through the legislative process in Parliament, so we would lose it. We need a service to the individuals whom we are here to protect.

The Convener: The issue is about deprivation of liberty, which sets us parliamentarians on edge, but it is also about people's right to treatment. Do you agree with that?

Bob Leslie: Yes. The provisions in schedule 9 do not have a major impact on human rights. It was a sensible response to a potential crisis. If we were not able to operate under the provisions in schedule 9, were they to be activated, the law might not allow us to detain people and protect them. The provisions are flexible and semi-pragmatic ones that allow the principles of the legislation to be adhered to and allow us to enact the 2003 act in a practical way, given the restrictions that might be forced upon us.

Professor Crichton: I agree with Robert Leslie. Schedule 9 provides a safety net. We do not know what the second wave will consist of or the populations who will be most affected. Students of pandemics know that the at-risk population can change as the virus changes. It seems likely that the increase in demand for mental health services will not suddenly reduce if there is a second wave. Therefore, the two demands could coincide.

What would happen if we did not have the staffing to enable the legislation to function in the normal way? Staff would try to protect patients as best they could, but it is likely that patients would be in the wrong places. They might spend longer periods in police custody, or they might even go into the prison system, but we want people to be treated in hospital. We can do certain things with emergency detention certificates but, if we cannot then get the MHO to go on to a short-term detention, we will be in real difficulty. As Arun Chopra said, we use such measures at extreme moments. They are used to preserve life, for example, when people are thinking about taking their lives. Therefore, as Laura Dunlop said, it would be premature to take away that safety net at this particular moment.

Lindsey Young: I agree with what other panel members have said, but the guidance that comes with the legislation, to which practitioners work, has also been taken away. Although there would be a delay in the legislation coming back in, the guidance for practitioners on the ground would also be affected, which would have a significant impact on the workforce.

Fulton MacGregor: I thank everyone for those helpful answers, which help us to get our heads round what the impact might be. Following on from a question that the convener asked—[*Inaudible.*] Of course, human rights are the committee's key concern, but the changes—[*Inaudible.*]—questions about human rights, but, as we heard, there is also the risk to the rights of those in the community who could be left without support if services were overwhelmed and schedule 9 was removed. Can

panel members say a bit more about the interplay between what are almost competing rights and what they think might have the biggest impact on human rights?

The Convener: I am conscious that we have not had the opportunity to hear from Julie Paterson on this, so I invite her to respond.

Julie Paterson: It is a good question. As John Crichton and other witnesses indicated, schedule 9 is a safety net and an attempt to balance the rights of individuals, including the right to care and treatment without delay in exceptional circumstances, with transparent scrutiny built in as well to protect vulnerable people's human rights. As has been noted, the concern is that, without the backstop of that safety net, people might be at risk.

As Lindsey Young pointed out, if schedule 9 was not in place or there were some changes, not having the guidance for staff would add to the confusion. The risks to individuals, if there is confusion for staff on the ground, are greater in terms of professionals not knowing which way to turn to support those people. People have the right to care and treatment and to life, as John Crichton pointed out, so it is about balancing those rights. We are all committed to not using those powers unless doing so is absolutely necessary and proportionate. However, people have a right to care and treatment and to the services that we provide day in and day out across Scotland. We need to respect that balance of rights—Fulton McGregor has raised a valid point.

Fulton MacGregor: I had further questions, convener, but the responses and discussion so far have already answered them. However, I wonder whether any other witnesses want to comment on the balance of rights.

The Convener: I will bring in John Crichton for any final remarks.

Professor Crichton: We have seen the most extraordinary reduction in our rights as citizens globally, and those have—[*Inaudible*]. My own patient population are mostly living by themselves. It was interesting to see how we were all coping with reductions of our liberties. In terms of balancing rights, we can explore what lawful excuses we can give people with a major mental illness in terms of flexibility, particularly in seeing family members who should be considered part of their care package, the number of times people can get out and have fresh air and so on. I guess that we are talking about a package of measures that is human rights informed and that meets the unfolding situation.

I smiled to myself when Arun Chopra was commenting on the frequency of changes to the commission's guidance. We have all been putting out guidance to our practitioners and sometimes changing it more than once a day. The reason for that is that we are in a fast-unfolding situation in which we are all trying to do our best. In that context, people will always try to preserve the principle of the act, the rights of our patients—the rights to life and to treatment, which we must balance with their right to liberty. We do that day in and day out, and we will continue to do that in these extraordinary times.

Laura Dunlop: Listening to John Crichton reminded me spontaneously of something that was said at an event that we held yesterday. The tribunal hosted a service users and carers forum online. We are very new to hosting that kind of event online; that was the second one we managed to do, and we made it using our own video platform.

During the event, we were told about the visiting experience of somebody who is in a secure hospital, As is the case in a number of premises, the visit involved remote visiting through the use of iPads. I do not want to overstate this, but I want to record that it is not all bad news. For some people, remote visiting has been a very positive experience, because they have seen the inside of houses that they know very well but have not seen for a long time. They have possibly seen other family members who are in the house, so it has been more of a kind of group session than would be available to them with the more structured, in-person visiting experience that they were used to in secure hospitals before the virus. I think that that fits with what John Crichton just said.

Bob Leslie: There is another aspect of how individual human rights have been impacted during this period. There are individuals in hospital settings who are progressing through their journey of recovery and heading for discharge, and who require packages of housing support to facilitate that, but those have all kind of dried up—effectively, they have stopped because of lockdown.

Our support providers are not taking on new packages. Housing departments and housing providers are not allocating new properties for tenancies for individuals. Those individuals are having their human rights impinged upon, because, in the normal course of things, they would be progressing through the system.

My colleagues in this meeting will also be aware of appeals against excessive security—in particular, in the forensic estate, where that is causing a logjam in the movement of people between the different levels of security to create vacancies in areas so that people can be moved. People have successfully appealed their detention at a particular level of security or it has been found that they no longer require that and the clinicians

are correctly moving the person through the system.

Even for individuals who are not in hospital, we are struggling on the ground to provide support because of restrictions on the types of services that can be provided. We just cannot purchase them, because the providers are not willing to take on new packages because of Covid. Their housing stock is frozen, whether that is local authority or housing association stocks. We are even seeing people blocked in acute hospitals because we cannot get them discharged to extra-care housing, which is also closed to us at this time.

There are a number of challenges that none of us want to see, but they are unintended consequences of Covid.

10:00

Dr Chopra: I was reflecting on the question and on Laura Dunlop's comments about iPads. With regard to achieving that balance of rights and the new way of working in the digital world, it is important that we do not leave anyone behind. There are people who do not operate the technology well, and they are at risk of digital exclusion in that situation. We also need to champion their rights and think about how any of those changes will have an impact on them. As we go through this situation—and if there are any changes—we need to keep an eye on the people who are digitally excluded as well as on ethnic minority groups, who might be disproportionately affected by any changes; we already know that they are disproportionately detained under the 2003 act.

I am sorry that I forgot to mention Laura Dunlop when I was running through the membership of the Scottish Government's stakeholders group. I am grateful that she reminded me and the committee of her input, because it is always very helpful.

The Convener: Thank you. Professor Crichton wishes to come back in. I will start to draw things to a close, so if anyone has anything that they wish to add briefly at the end, they can do so.

Professor Crichton: I wanted to pick up on Bob Leslie's important point with regard to the current challenges. It would be great if everyone could bear in mind that, because we have difficulties in discharging patients, there will be an increase in delayed discharges. We also have difficulties in transferring people from different levels of security on pre-transfer visits. We need to get smarter about that. Services already—

The Convener: I am sorry to interrupt, but what is a pre-transfer visit?

Professor Crichton: If somebody is moving from Carstairs hospital to a medium-secure unit, it would be normal for them to have a series of testing-out visits to that medium-secure unit, to ensure that everything is going smoothly and that they know what they are coming to. If, because of infection control, that pre-transfer visit entails merely going to a room, the quality of that experience is not great. We asked whether we could do it in a smarter way, using alternative technology. Because of that, we have discovered that we can have mobile phones and iPads within our secure mental health estate, which has enhanced communication as described.

One of the mitigations that services are beginning to plan for is pre-discharge additional units, which will take those people who are entrapped, so that they have the same minimal level of restriction as in-patients but also have the to-and-fro of going into the community and getting used to that. However, that will require additional funding, and I do not know of any place where one of those units has come online yet. If the difficulty in discharging people carries on, I hope that our groups will return to and think about that pressure.

The Convener: Thank you. That is very helpful. Since I do not see any other panel members who wish to come back in, I thank the witnesses for their evidence. We have had interesting and helpful discussions this morning. I understand that this format has its limitations when it comes to intervening to make points, so if, after the session, you think of something that you feel the committee should know or that you wanted to say, please feel free to get in touch with us in writing.

10:03

Meeting suspended.

10:10

On resuming—

The Convener: I welcome the witnesses on our second panel: Professor Colin McKay and Professor Jill Stavert, from the centre for mental health and capacity law, Edinburgh Napier University; and Karen Kirk, solicitor advocate and partner at Kirk Hanlon Solicitors, who is here on behalf of the Law Society of Scotland. I thank you all for coming and for finding the time to answer the committee's questions.

I will invite members to ask questions. If a question is directed to a specific witness, the member will identify that witness; otherwise, we will work to a pre-agreed order for witnesses to respond in. I will then go back to the member for any follow-up questions. Once completed, I will invite the next questioner, and so on, until the evidence session is concluded. We have one hour

for our evidence this morning, so please keep questions and answers succinct. It would be helpful if everybody could give broadcasting staff a few seconds in which to operate the microphones before beginning to ask a question or answer one.

In your submissions, you have expressed concerns about the mental health provisions in schedule 9 of the Coronavirus (Scotland) Act 2020. Can you say a little more about that? We will start with Jill Stavert.

Professor Jill Stavert (Edinburgh Napier University): Thank you for inviting me to give evidence to the committee. I will start with some general human rights comments and leave it to Colin McKay and Karen Kirk to fill in the specifics.

Compulsory care and treatment inevitably impacts on an individual's liberty, autonomy and dignity. In considering whether the emergency provisions should be retained or brought into force, how they are implemented and how the provisions of the ordinary legislation operate during the pandemic, the issues all come down to proportionality. The retention of the emergency provisions must be based on robust evidence such as evidence relating to the likely infection rate, an increase in the infection rate and the impact on services as a consequence of the virus.

The preferred position is that the individual's rights and the safeguards that they provide remain intact. International human rights law acknowledges that, in emergency situations, it may be necessary, where it can be objectively and reasonably justified, to reduce those safeguards. However, it comes down to proportionality—the European convention on human rights and the United Nations Convention on the Rights of Persons with Disabilities are quite clear on that. The UNCRPD enforces this point: when somebody's rights and the safeguards related to those are being limited as a result of an emergency, such as a pandemic, there should not be discrimination and someone should not be adversely impacted simply because they have a particular characteristic, such as a diagnosis of mental disorder or mental disability. That point also relates to the additional support that is provided to an individual to enjoy those rights in the first place.

Another thing to bear in mind is that the state has a positive obligation to protect life. That needs to be carefully balanced with individual rights to autonomy and liberty. However, it should never be taken that the positive obligation to protect life automatically allows the state to ride roughshod over an individual's right to autonomy and liberty. That takes us back to the simple principles of proportionality and non-discrimination. I hope that that answers your question.

The Convener: As you rightly say, any of those restrictions would need to be proportionate, time limited and in place for as short a time as possible. Although the measures in schedule 9 could have been considered necessary and proportionate at the beginning of the crisis and the peak, do you think that they remain necessary and proportionate?

10:15

Professor Stavert: I am not really in a position to comment on that. As I said, the decision must be based on data about rates of infection and the impact on services as a result of the pandemic. That is not really within the knowledge of the centre; it would be a matter for the stakeholder group, based on the data that is available to the Scottish Government.

The Convener: Colin McKay, I will bring you in for your reflections on the concerns in your submission.

Professor Colin McKay (Edinburgh Napier University): I have a couple of comments. I generally agree with Jill Stavert on how we should think about the issue and what a human rights-based approach would involve. The provisions are not currently in force, so when we talk about whether they are still necessary, we are talking about whether we should keep them on the books just in case they turn out to be necessary. Obviously, we place great significance on the evidence from the Mental Welfare Commission, the Royal College of Psychiatrists and social work representatives about concerns that the system could become overwhelmed. There are a couple of things to say about that.

In your first session this morning, Dr Chopra gave evidence about the rise of emergency detentions and so on. It is perhaps difficult to answer this question at this stage, but we would ask, "What's going on there?" Some of that may be about the pandemic having a deleterious impact on people's mental health, but it might also be about people requiring to be detained because services have been reduced. If the support that people have been receiving in the community has been reduced, that could have led to their mental health getting worse.

The Mental Health (Care and Treatment) (Scotland) Act 2003 is a kind of safety net at the far end of the system. In terms of human rights, it is important to go upstream a bit and think not only about the right to due process if you are detained but about the right to health. The UN Convention on the Rights of Persons with Disabilities contains the right to the maximum possible support for mental health. In that context, it is important that we look at what is going on with not only the

operation of the 2003 act but the support that people might not be receiving, which might be causing their mental health to worsen.

If we are keeping the measures in schedule 9 as a contingency in case things get much worse in the future, what is the plan for services? One accepts that we cannot do everything as well as one might like in the middle of a pandemic, but it is important to be thinking about the resilience of the system and people's right to health, and the right under the convention for people with disabilities to be protected in national emergencies. Those questions are important.

We are encouraged that the stakeholder group is monitoring the issue, although we are not in the stakeholder group, so I do not know all the details. It does feel slightly like insider tennis, to use an American phrase. Other than the commission, the issue is really about providers. There is a human rights expectation that people with disabilities have the right to have a say in policy, including in how we respond to emergencies. There might be things to think about around how that group operates, how transparent it is and how much the people affected by the work are involved, but I say that without knowing everything about how the group operates.

The Convener: I will bring in Karen Kirk.

Karen Kirk (Law Society of Scotland): On behalf of the Law Society, I thank you for inviting me to join you this morning.

The Law Society is concerned about the fact that, if schedule 9 was brought into effect, it would remove safeguards. We call them safeguards, but removing them could cause a violation of a patient's human rights.

The legislation was introduced at an acute time when a lot of the information that we now have was not available. In a sense, it was emergency legislation. The consequences of some of the provisions in schedule 9 are therefore quite serious. For example, under the criminal procedure provisions, a final disposal could be made on the basis of one medical report, which would have a lasting effect on an individual who, for example, was placed under a compulsion order that might last for a significant period of time. The society is quite clear that the provisions were created at a time of emergency.

That being said—I think that other panel members have made this point—there has been a lot of adaptation and adjustment by existing legislative measures that has allowed the current safeguards to continue during what has been a difficult phase. On the basis that more information is known and more planning can now be done, the Law Society suggests that the balance of human rights could be placed not on convenience but on protecting the human rights of patients under the system, with the caveat that, as Jill Stavert said, in the absence of the figures and the information that the politicians will have, we recognise that there are arguments both ways and that the decision has to be a political decision about whether to repeal or retain.

The Convener: I would like to press you a little on the Law Society's opinion. You indicated that, at the time when they were introduced, the provisions could have been considered to be necessary and proportionate. If they are no longer necessary and proportionate, what measures should we be using to take those political decisions about whether to repeal?

Karen Kirk: Again, it has to be a political decision. However, looking at the legislation and making changes to it could be another option, because, as I said, the provisions were made during an emergency and some of them are quite significant in respect of a patient's human rights. For example, taking away the reviews of a patient's detention and allowing two short-term detention certificates, which last for 28 days each, would mean that someone could be under a short-term type of detention for a period of eight weeks. A number of measures within the legislation could be looked at, but, again, that would be a political matter and the solution is, fortunately, not one for the Law Society.

The Convener: Turning that around a bit, the committee heard from the Scottish Association for Mental Health that there is no clear trigger point for bringing schedule 9 measures into force. That has been followed up by further evidence from the Scottish Government and the Royal College of Psychiatrists that the trigger point would vary according to health board or healthcare setting and depend on staffing levels.

What do the panel members think the trigger points for those measures should be? I will go to Jill Stavert first.

Professor Stavert: I can only reiterate what I said earlier: it is really a political decision. The trigger points will come when the impact on services as a direct consequence of the pandemic requires that those measures are adopted, and not before.

I am sorry that that is rather general, but it all has to be based on the information and data that are available at any given time.

Professor McKay: We cannot prescribe in advance what exactly the circumstances would be that would necessitate the measures coming into force. One assumes that it would have to be related to the capacity of the workforce to deliver the service and do the reviews.

It is important that there are different professionals involved in different bits of regulation. For example, if there were a shortage of mental health officers—whether all the regulations needed to come in at once or only some—would be an issue. It is difficult to be precise. Such a decision would have to be the result of a fairly catastrophic loss of availability of professionals. If all the mental health officers in an area were self-isolating, one can see why it might be necessary to introduce the measures locally and for a limited period.

The important point is about the process of justification. It is extremely important that the measures are not brought in just because we are all really busy and would rather not have the hassle of doing things. There has to be a pretty high bar that people would need to get over before it could be said that it was impossible to safely deliver a mental health service and carry on with the normal requirements of the 2003 act, or that we physically could not get people a mental health officer or second doctor within the timescales of the act, which would be legitimate justifications. That order of seriousness would have to be justified. It is important that there is a process of elucidation and justification, especially in relation to local lockdowns.

Thinking ahead, the measures might have to come into force in an area where there is a spike. If a lot of professionals were unable to participate in the process and other people could not be brought in because they were not allowed to travel, those circumstances might justify it. However, it is very important that, if and when these things are ever introduced, there is a very transparent process of explaining why they are justified and when they will no longer be justified. That means saying what needs to be done to mitigate whatever the current pressures are and ensure that the measures are enforced for as short a time as possible.

The Convener: It is interesting that—this is not a criticism of what you said—we seem to be framing this whole discussion around services and practitioners rather than individuals. I guess that, if we are saying that the measures are necessary for individuals to get the emergency health treatment that they need, perhaps we need to think about things from their perspective rather than purely from the perspective of practitioners.

Professor McKay: Absolutely. That is one of the other reasons why the bar has to be quite high. A mental health officer or second doctor is involved in the process not only to comply with legal requirements; it is part of the process of deciding what is necessary and appropriate to care for and support a person. If we stop doing those things, people might not get the care and support that they require.

You are absolutely right that the focus has to be on individuals. I said that the decision relates to the availability of services, and the justification for taking important rights away needs to be framed by how we provide the care and support that people need.

10:30

Karen Kirk: What struck me during the first panel was the focus on what the provisions mean to a patient and what reassurance and confidence in the independence of various parts of the 2003 mental health act would be provided if the provisions were repealed.

The Law Society recognises that there are strong arguments going both ways. However, for a patient, getting a second opinion from a second doctor, who may know them very well, may be a crucial part of the process. That would apply, in particular, to the process for getting an order, which would make a huge difference to the patient over the medium term, for the next few years of their life. The right to a second opinion is not something that is, or should be, easily taken away.

I recognise the point about services; we are discussing services because there is a recognisable justification in that respect. Colin McKay's point about the process being transparent and fair is key, because it has to be understood by those vulnerable patients who will be detained under the 2003 act. There needs to be an understanding of the reasons for the changes to the trigger points. The bar has to be set very high, because of the potential for infringement of someone's humans rights.

I do not want to reiterate the same points, but the extent of the changes to the legislation are pretty significant. We need proportionality in relation to each local area. We take the point that there will be some changes to our mental health officer workforce. All those provisions require to be put in place, and that requires us to give patients confidence that their human rights will continue to be protected despite the changes that have had to be made.

Fulton MacGregor: Good morning, panel. I will stick with questions about the repeal or otherwise of schedule 9, following on from the earlier discussion. I asked the previous panel about competing rights. Schedule 9 is an exceptional measure but, on the other hand, the rights of folk may be impacted if they do not receive a service or are not admitted to hospital due to service shortages. What is the biggest impact? I would like to hear the Law Society of Scotland's view on that dilemma.

Karen Kirk: In terms of—[*Inaudible.*]

The Convener: We will give Karen Kirk a few seconds for her microphone to come on; we missed the first bit of what she said. Karen, there is an icon on your screen. If it does not have a line through it, that means that it is on, and we will hear you loud and clear.

Karen Kirk: I am from Glasgow—I just come in really quickly.

The biggest impact that we, as the Law Society's mental health and disability committee, have seen relates to a point that has been raised: there has been a significant change in services. In my practice, I now see a lot of cases that have new features or factors whereby certain services cannot be introduced, restarted or adapted because of difficulties in purchasing and changes in the care companies. I have been involved in a lot of cases in which services have been a major factor—[*Inaudible.*]—impacts.

I am also a mental health tribunal chair, and I see that factor coming through in some of the detention work. Unfortunately, patients have not had the support that would normally allow them to maintain their life in the community or, conversely, enable them to be discharged at an earlier point. There has been a huge impact across the board as a result of the difficulties with services.

The Convener: Do other panel members wish to respond to that question? Does Colin McKay have any reflections on the matter?

Professor McKay: I do not have many reflections, but I have one thought about unpicking the different provisions in schedule 9. Some of the effects of those provisions are quite short term, in a sense. For example, although the extension of the emergency detention period from 72 hours to 120 hours is significant—it means five days in hospital instead of three days—there is no long-term impact.

Some of the other provisions that Karen Kirk pointed to—for example, those relating to criminal procedure measures—could have a much longer-term impact on a person and would require a greater degree of justification. If the process of passing an order that might impact on a person's life for months or years is going to be attenuated, that requires justification.

I will make a technical point—this might not be the right time to bring it up, but I am quite concerned about it. Karen Kirk mentioned that the provisions were passed quickly. I still have a question about whether they work legally. Paragraph 9 of schedule 9 is about how compulsory treatment orders are renewed. It suspends the requirement to review a compulsory treatment order. After six months, the doctor does not have to go through the process of deciding whether the order is continued before it is renewed.

That provision has a potentially serious long-term effect, but it is not clear to me that it works in law. The mental health act sets a time limit of six months for the first order, and it is not obvious to me that that has been removed by the provisions. In our response to the original provisions, we raised the concern that we do not know that the provisions actually work. I could be missing something, but I am interested in the Government's response to that.

The Convener: The committee can certainly follow that up.

Fulton MacGregor: We are giving the issue quite a good hearing. We have heard a lot about the concern that we do not know whether there will be a second peak or how big that peak might be. We have heard quite compelling evidence from the two panels that, so long as we are still in a pandemic and coronavirus is still a threat, schedule 9 should be kept. We might need it because of the concern that our services might become overwhelmed.

If the threat of coronavirus is eventually taken off the table—we all hope that that will happen sooner rather than later—but services are still overwhelmed as a result of the pandemic, will schedule 9 be required in that situation, once the pandemic is over? Does the panel have any thoughts on the longer-term situation?

Professor Stavert: That is a really good question. My view is no, because that is a completely different situation.

Professor McKay: I agree. I understand that the provisions were brought in specifically because of the impact of the pandemic. You are right. Afterwards, people may be dealing with a huge tail of mental health problems and services that are picking themselves up off the floor but, other than for maybe a couple of weeks, I cannot see any justification for continuing the provisions beyond the crisis period of the peak of the pandemic.

Obviously, mental health law is currently under review. Jill Stavert and I are involved in the review of mental health law by John Scott. There may be longer-term issues. Earlier, a point was made about the general shortage of mental health officers and the practicalities of what they are expected to do under mental health legislation and under adults with incapacity legislation after the pandemic. That might be something for the Scott review to pick up on. However, I do not think that the provisions should continue beyond the pandemic.

Karen Kirk: I totally agree. The Law Society is clear in its response that the infringement of human rights that might be caused by schedule 9 is in response to a public health emergency. I would leave it at that. If we had a different set of affairs at the end of the pandemic, schedule 9 would not be justifie despite the fact that it might be a solution to some difficulties. The Law Society's view is that schedule 9 was justified due to a public health emergency.

Fulton MacGregor: Those answers are reassuring and have helped to focus my mind on the point that the agencies and bodies that are dealing with such issues are thinking about them now, despite being in the midst of a pandemic, as we all know, although we are easing lockdown restrictions.

Alison Harris: The most recent letter from the Scottish Government to the committee, which is dated 16 July 2020, states:

"Even if the temporary provisions contained within Schedule 9 are commenced, the expectation is that current legislation will continue to apply until the point when services are not able to cope with significant staff shortages or when adhering to the current mental health legislation is not practicable or would cause an undesirable delay."

Is it possible to commence the provisions in schedule 9 while still applying the current legislation until services cannot cope with, for example, significant staff shortages? How do we ensure that people's rights are respected?

Professor Stavert: That is a good point. If the emergency provisions were introduced, the default position would probably be that they would be used instead of the ordinary legislation. Obviously, the preferred position is to use the ordinary legislation, because it provides greater safeguards for the individuals concerned. It would be very difficult, in practice, to delineate between the two. That needs to be clarified.

Professor McKay: That is right. As a matter a law, it is not that there is a second set of rules and that we can choose which set of rules to follow; the provisions in schedule 9 change the rules. The law currently says that emergency detention can last for 72 hours. If we introduce the schedule 9 provisions, the law will say that emergency detention can last for 120 hours. I do not think that the provisions can be introduced locally—perhaps they can—but, once the schedule 9 provisions are introduced, the mental health act has changed and the emergency provisions apply.

Guidance could be introduced to say that, even though a second opinion is not needed, it is still good practice to get one if you can, and that, even though people can be detained for 120 hours, they should be released more quickly if they can be. However, that would only be guidance; the law would be what the schedule 9 provisions say.

Inevitably, there would be a tendency for services to say, "We'll work to what the law tells us. If we can get away with detaining for 120 hours, that's what will happen." The provisions would have been introduced to deal with pressure that the services would be feeling. That is a concern about the justification for introducing the provisions. However, we have to assume that, once they are introduced, that is what will happen.

Karen Kirk: I agree with Colin McKay and Jill Stavert. In many cases, we are talking about deprivation of liberty under the legislation, and there has to be certainty in law with regard to that. As Colin McKay said, once the schedule 9 provisions are introduced, the law has changed. It is important to note that, under the legislation, a number of professionals make decisions for a patient, including nurses, those who work for mental health tribunals, consultant psychiatrists and mental health officers. A lot of professionals apply the provisions. Even if a trigger—which would need to be legislative—was very transparent and clear, in practice, it would be difficult to run two types of legislation. In my view, the law would have changed.

10:45

To pick up on Colin McKay's earlier point, there is doubt about how schedule 9 would affect the law. With regard to his point about reviewing someone's detention, the 2003 act says that, on certain occasions, there has to be a mandatory review by the doctor in order to renew the detention. Schedule 9 takes away that review but, in some ways, the standing provision about reviewing and renewing detentions still exists and that has not been affected by the schedule. Therefore, as well as there being uncertainty if that procedure was followed somehow—[*Inaudible*.]—there would be uncertainty about how schedule 9 would apply where people have been detained for some time and the detentions have become renewed.

It is not easy. Schedule 9 was brought in in an acute phase and was an immediate response to a pandemic. I am not criticising but, now that we have had a chance to consider it fully, those are the Law Society's concerns.

The Convener: Thank you. That is helpful.

Alison Harris: A key concern of the Scottish Government and the Royal College of Psychiatrists is that they are unable to predict whether there will be a second peak. However, it is possible to argue that we are now better prepared to prevent a second peak and therefore the provisions of schedule 9 are no longer

proportionate. What would be the impact of repealing schedule 9?

Professor Stavert: I cannot comment on the impact on services but, if it is considered necessary to repeal schedule 9, we will use the ordinary legislation, with all the safeguards that it provides, and operate in the normal manner. How difficult that would be in practice if there was some impact on services as well as on access to services that are outside the use of the legislation to support people with mental health issues is another matter. As we mentioned earlier, that is a wider, on-going issue, which is not confined to the pandemic and which the Scott review will have to consider.

Professor McKay: The experience of the pandemic, the fact that we have did not have to use the provisions even at the height of the first wave and our hope that we are better prepared give us some comfort. We can be more hopeful that the legislation will never need to be used. However, that is a judgment call based on evidence about how much we know about what might happen to services in a second wave. Ministers and the Parliament have to take cognisance of the experience of professionals. Although we did not need to use the legislation the first time round, from the evidence that we heard in the first session, it feels like it was sometimes a close call.

Given that we do not know what a second wave might be like, we can understand an argument that says that we are still not so confident about the future that we can safely do away with the provisions. I accept the argument that it might be worse to repeal them and have to bring them back in again. It is a finely balanced judgment. I hope that the provisions will never have to be used. I think that it is unlikely that they will ever be needed, but whether it is now safe to say that we should just get rid of them is a political judgment.

We note that the Government is proposing regulations in relation to some of the other provisions on adults with incapacity and removing some of them on the basis that it has assessed that they are no longer needed. I suppose that we have to acknowledge that there is a thought process going on about what is needed and what is not needed, and that it is for the Government to justify that. However, I do not think that we would accuse the Government of not thinking about whether the provisions continue to be needed.

Karen Kirk: In short, we have not required the provisions to date. There has been a lot of discussion about them, but we have not used them, so there would be no change. There would be no change to or impact on the operation of the current act, which is a human-rights-based-approach act, and its general principles would continue.

We have dealt with a lot of the consequences of the pandemic under the current legislation, such as covering or shielding mental health officers. There have been quite a lot of circumstances in which the operation of the current act has been appropriate, so there would not be any change.

In our submission, the Law Society says that retaining the provisions when they were not required during the first wave could be seen as a cautionary response. At the start of my remarks, I said that, if you are balancing a cautionary response in being prepared with an infringement of the human rights of an individual, which can potentially happen under schedule 9, the balance ought to tip on the human rights side approach. Again, however, the information that is available to politicians is finely balanced. There have been arguments on both sides of the Law Society's relevant committee for retaining and repealing. That does not make the job for the politicians any easier. However, I am here to represent the Law Society, and there has been a mix of views from various individuals about the best way to proceed.

The Convener: Thank you. That was very helpful. Are you content, Alison?

Alison Harris: Yes, thank you. I am content with those responses.

The Convener: That concludes our questions. However, I will go back to the panel members to check whether there is anything that we did not ask them about that they want to share or any further points that they want to raise in closing.

Professor Stavert: I do not think so. I think that we have covered everything. I listened to the earlier panellists, and I think that everything has been fairly well covered. There are some wider issues around moving people from hospitals into care homes and the legal basis for that, but I am not sure that this is the forum in which to deal with those issues on this occasion.

Professor McKay: As Jill Stavert said, we have some significant concerns not so much about the provisions that we have discussed but about other deprivations of liberty that might have happened without any kind of legal process, particularly in relation to moving people into care homes. We were quite struck by the fact that the Government is looking at removing some of the other emergency provisions around the adults with incapacity legislation and saying that they may not be needed because delayed discharges from hospitals into care homes have greatly reduced. That means that lots of people have moved from hospitals into care homes, and we have questions about whether that is lawful. That is in the same broad area as the deprivation of liberty, but we

accept that that issue is slightly different from the schedule 9 issues, which have been quite well covered this morning.

Karen Kirk: I have had a chance to make the Law Society's points, and I am grateful for that. The society's further concerns are the same as those that Jill Stavert and Colin MacKay have raised about how, especially at the beginning of the pandemic, adults might have been moved to situations in which they experienced deprivation of liberty without appropriate consent. However, the society's points about schedule 9 have been raised, and I thank the committee for that.

The Convener: I thank you all very much for taking part in the meeting. That was another very interesting and helpful session.

That concludes the public part of the meeting. The next meeting of the committee is scheduled to take place next week—we expect it to be on Thursday 3 September. We will take evidence in the race equality, employment and skills inquiry. In the meantime, any follow-up scrutiny issues will be dealt with through correspondence, which will be published on our website.

As previously agreed, we will now move into private session.

10:55

Meeting continued in private until 11:17.

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