



# Psychiatric Emergency Plan

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<b>Author:</b>	<b>Rhona McArthur</b>
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## NHS Shetland Document Development Coversheet\*

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<b>Author</b>	Rhona McArthur		
<b>Information Asset Owner</b>	Rhona McArthur		
<b>Executive lead</b>	Jo Robinson		
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**Please record details of any changes made to the document in the table below**

<b>Date</b>	<b>Record of changes made to document</b>
28/08/24	PEP review by working group
	MH act 2003 clarified throughout as incorrect dates noted on initial draft
24/09/24	Pg. 12 – clarified that Consultant Psychiatrist has no admission rights to Gilbert Bain as it is not a Psychiatric facility
	Pg. 13 – addition of paragraph which states intensive home treatment in patients home can be utilised as a place of safety
	Pg. 14 – Air transfer – addition of reference to NHS Shetland Air transfer for CMHT, document in draft so not able to hyperlink
	Pg. 14 – clarified roles and position responsible
	Pg. 15 – CAMHS section drafted by Natasha Clubb added and formatted
	Pg4 – Contents table updated and formatted
	Pg. 5 – Monitoring and review arrangements clarified
	Pg. 7 – Abbreviations changed to definition in full
	Pg8 – Act changed to Mental Health Act
	Pg. 9 – Relative detail updated
	Pg11 – Care of an individual during detention – wording added – least restriction
	Pg. 11 – Involvement of Police – paragraph working changed to give examples of when Police might be involved
13/01/25	Section on absconding added RM
15/01/25	LD section update with input from Executive Manager for Adult Services
	Section on Intoxicated individuals added RM
04/02/25	MHO input into 2003 Act, and detention added and revisions agreed RM (version 0.5)
11/2/25	Structure revised to provide clarity around key actions. Detailed procedures and legal background moved to Appendices (version 0.51).
19/2/25	Further restructure and minor revisions for clarity following feedback from MHSLG and Medical Director. Low stimulus room added in Place of Safety section (version 0.52).
28/5/25	Minor revisions including ensuring that all elements of Mental Welfare Commission template were considered; completed template added as appendix (version 0.53).

1/7/25	Revisions to legal framework content on advice of MHOs; assessment section added in response to feedback from AMcD and JW (version 0.6).
31/7/25	Minor revisions throughout for clarity following review by RM (version 0.7).
31/10/25	Minor revision to sections on Assessment and Place of Safety following discussions at ANMAC and Hospital Management Team, and to reflect finalised Physical Intervention Policy.
31/10/25	Minor revision to section on identifying beds for admission following recommendation from Consultant Psychiatrist (version 0.8).
9/12/25	Removed North of Scotland tier 4 Specialist Nurse contact details in Appendix I response to feedback from AMcDavitt (version 0.9).

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## 1. Overview

This Psychiatric Emergency Plan (PEP) outlines the procedures for managing psychiatric emergencies in Shetland. It is designed to minimise distress and disturbance for the patient and to ensure as smooth and safe a transition as possible from the site of the emergency to the appropriate treatment setting.

The Mental Welfare Commission issued “A Review of Psychiatric Emergency Plans in Scotland” on 25th June 2020. This states that:

“Comprehensively developed and locally relevant PEPs are recommended by the Mental Health Act Code of Practice (Vol 2 para 58) as a means to help manage the detention of a patient and aspects of multi-agency working. They are also referred to in the Police Scotland Standard Operating Procedure for dealing with patients who present in mental health crisis. Nationally, one of the strategic priorities for the Health and Justice Collaboration Improvement Board, is to focus on mental health and substance use in their drive to improve health and wellbeing in justice settings which in turn builds on the actions contained within the Mental Health Strategy for Scotland in responding to people in mental health crisis.”

This PEP sets out clear guidance for staff who may be involved in various functions under the Mental Health (Care and Treatment) (Scotland) Act 2003 (hereafter referred to as the 2003 Act), including the use of compulsory measures. The guidance contained is applicable to and has been agreed by senior management in all healthcare and local authority, police, and ambulance services. As a means of comprehensively addressing these issues in a manner which best reflects local circumstances, in drawing up this PEP those consulted have included: Police Scotland, the Scottish Ambulance Service (SAS), Mental Health Officers (MHOs), Consultant Psychiatrists, Children and Adolescent Mental Health Managers and Team Lead, Community Mental Health Team Lead, General Practitioners, Chief Nurse Community, Community Psychiatric Nurses (CPNs), hospital nursing staff, and independent service providers.

For the purposes of this document any reference to mental health and learning disability services covers the following services:

- All adult mental health services.
- All learning disability services.
- Child and Adolescent Mental Health Services (CAMHS).
- Older adult mental health service

## 2. Key Principles

This document is designed to describe best practice when assessing patients with a mental disorder in a psychiatric emergency. It will contribute to good joint working and, by so doing will help to minimise the distress that patients, their family and friends can experience when compulsory admission is being considered.

- All statutory services will act in the best interests of patients, to deliver high quality care
- Patients will be treated with compassion, respect and dignity at all times.
- All procedures will be based on the principle of minimum necessary force or action to achieve the desired outcome.

- Treatment will be delivered in a safe, professional and competent manner; interventions will take a person-centred approach and be trauma-informed
- A person-centred approach will help ensure the smooth running of any function discharged under the 2003 Act, with good communication being essential.
- In all psychiatric emergencies clinicians should be mindful of the application of Adult Support and Protection legislation and Child Protection procedures. See: <https://www.safershetland.com/resources/resource-library/shetland-inter-agency-adult-protection-procedures> and <https://www.safershetland.com/resources/resource-library/shetland-inter-agency-child-protection-procedures-2024>
- Managing a psychiatric emergency will require a multi-disciplinary team approach. This should ensure that staff are not put in a vulnerable position where their safety is compromised, and that patients receive the most appropriate care in a timely and compassionate manner.
- Staff will have access to appropriate training to support them in their roles.
- The principles of the 2003 Act **must** be applied at all times when assessing a person or discharging functions under the Act (please see Appendix C).

The PEP is based on the ability to safely assess and manage a situation.

Where individuals cannot be safely assessed either due to environmental or physiological factors influencing the presentation, e.g. acute intoxication of unknown substances, careful consideration must firstly be made in relation to the appropriate placement for the individual in the immediate term. And secondly, as to whether follow up assessment or support is required in the longer term.

For complex situations, this will likely require a whole team approach. Immediate and longer term considerations must be based on each individual's needs.

### 3. Definitions and scope

A psychiatric emergency is defined as: "An acute disturbance of behaviour, thought or mood of a patient which, if untreated, may lead to harm, either to the individual or to others in the environment" (Sudarsanan et al, 2004). The Oxford Dictionary (2024) defines an emergency as: "A sudden serious and dangerous event or situation which needs immediate action to deal with it".

Throughout this document there is reference to "mental disorder". The definition of mental disorder is found in section 328 of the 2003 Act and refers to any mental illness, personality disorder, or learning disability, however caused or manifested.

The scope of this plan is emergency situations where there is a psychiatric emergency. It will reference how to seek support if a situation is de-escalated from an emergency but it will not set out how to support this.

### 4. Geographical context

Shetland is an island community located 170km off the north east coast of Scotland. The largest island in Shetland is the mainland where the highest proportion of the population live,

followed by Whalsay, Yell, Burra and Unst. While some outlying islands are connected by bridges the majority are serviced by interisland ferries.

Managing psychiatric emergencies in a remote and rural setting like Shetland is particularly challenging due to the spread of population across mainland and outlying islands. The vignettes contained within Appendix B provide examples of the use of the 2003 Act in detention from community.

Local provisions for unscheduled care are limited and all inpatient based care for a mental disorder is provided off-island. Inpatient care for those over the age of 18 years is mostly provided by the Royal Cornhill Hospital in Aberdeen and by Dudhope Hospital in Dundee for those under the age of 18. As a result, compared to the Scottish mainland, more agencies are likely to be involved in psychiatric emergencies and on-island contingency plans have to be in place in case adverse weather conditions delay transfer of the patient off island.

## **5. Initial contact**

The PEP is structured to reflect the usual flow of events in responding to psychiatric emergencies that could happen anywhere and in many different situations. Guidance has been developed for the most common psychiatric emergency situations and included in the appendices.

It would be assumed, for most situations, that the Community Mental Health team would be the lead service in a psychiatric emergency. It is vital however that all services work collaboratively to support the individual and their family or named persons.

### **Police / Scottish Ambulance Service (SAS) / Accident & Emergency (ED) / Primary Care:**

For professional partner agencies the single point of contact within the hours of 0900 – 1630 is the Community Mental Health Team duty CPN (Tel 01595 74 3006). Further detail on arranging assessment is provided in Appendix A.

### **Members of the public:**

If any members of the public or third sector partners are concerned that a person is presenting with a mental health crisis warranting urgent assessment, the first point of contact is now standardised as NHS 24 (Tel: 111). As for other health conditions there is a matched triaging process to facilitate access to appropriate support. If the presentation is an emergency or involves threat to life, 999 should be utilised.

### **For self-referral in crisis:**

It is possible for patients to seek support through NHS 24 (Tel: 111) as above. Similarly if the crisis involves an emergency or threat to life 999 should be used. There is no direct access to secondary mental health services, unless you are already a patient within the service. For patients within services, direct contact can be made to the duty CPN (Tel 01595 74 3006).

Where a person presents to a service which will not be providing ongoing input, there remains a duty to respond to the distress and re-direct to appropriate service. Where a person is not experiencing a psychiatric emergency but remains in distress, there are local services, including Distress Brief Intervention, which can be accessed by signposting or referral:

<https://www.nhsshotland.scot/right-care-right-place/mental-health>

A mental health unscheduled care resource for staff that outlines additional sources of support is also available for reference: <https://www.gov.scot/publications/resources-mental-health-unscheduled-care-services/>

## 6. Assessment

Assessment requires specific professional involvement and agreement.

An Approved Medical Practitioner (AMP) is required for assessment under the 2003 Act. An AMP is a registered medical practitioner who is approved by a Scottish NHS Board for their special experience in the diagnosis and treatment of mental disorder – usually a Consultant Psychiatrist. In a psychiatric emergency, the Responsible Medical Officer (RMO) is the AMP in charge of a patient's treatment under the 2003 Act. The RMO has the authority to make decisions regarding leave, discharge, and ongoing care while the patient is subject to compulsory measures.

A Mental Health Officer (MHO), a Social Worker who has specific training, qualifications and experience in the use of the 2003 Act, is also a key team member in the use of the 2003 Act. MHO approval is required for detention under the 2003 Act as set out below.

## 7. Legal framework

### 7.1. The Mental Health (Care and Treatment) (Scotland) Act 2003

The 2003 Act provides the legal framework for providing care and treatment to individuals who are diagnosed with a mental disorder who may require compulsory measures. Being detained under the 2003 Act is a serious infringement of a person's liberty and should only be considered where there is no other alternative way to support a person who is unwell, at risk and in need of care and treatment.

The 2003 Act applies to all ages, including children under the age of 16.

When considering any detention, the principles of the 2003 Act (see Appendix C) must be taken into account. The principles are legally binding.

### 7.2. Key compulsory measures under the 2003 Act:

- **Short Term Detention Certificate (STDC)** is the preferred option in an emergency and allows for detention in hospital for up to 28 days. This can only be granted by an Approved Medical Practitioner (AMP) with the consent of a Mental Health Officer (MHO).
- **Emergency Detention Certificate (EDC)** allows for detention up to 72 hours and can be granted by **any** fully registered medical practitioner if waiting for an AMP would be impractical.

The medical practitioner **must** attempt to contact an MHO. An MHO's role is to ensure the patients' rights and welfare are protected. A doctor can only proceed with an EDC without MHO consent where it is too urgent to wait for an MHO to attend or where an MHO cannot be contacted. Where an MHO is not consulted the doctor must provide a valid reason for not doing so on the EDC form.

An EDC cannot proceed if an MHO is consulted and does not consent to the granting of the order. In such situations the MHO must consider alternative arrangements and provide a report to the doctor detailing their reason for not consenting.

- **Warrants** – an MHO can apply to a Sheriff for warrants that permit entry to premises, medical examinations, or removal to a place of safety under certain circumstances, for example, if a person with a mental disorder is believed to be at risk.
- **Mental Health Nurses' holding power (s299)** - additionally, a Registered Mental Health Nurse has the power to hold a patient in the in-patient setting for up to three hours while awaiting a medical examination.
- **Compulsory Treatment Order (CTO)** is not a solution in an emergency, as it can take around two weeks to complete the application and for a tribunal to be held. Where a patient is already on an Interim CTO and CCTO or a Compulsion Order and not complying with an attendance requirement, S112 allows the Responsible Medical Officer to compel the patient to attend a specified place at a specified time to be given medical treatment for a mental disorder. If the patient does not comply the RMO can arrange for the patient to be taken into custody and conveyed to a specified place or hospital.

The 2003 Act provides additional safeguards to ensure a person's rights are upheld when they are too mentally unwell to make decisions about treatment or keeping themselves safe. A person should not be 'de facto' detained in hospital e.g. told they will be detained if they attempt to leave.

In some circumstances a person may be treated under a S47 certificate via the **Adults with Incapacity (Scotland) Act 2000** where they lack the capacity to consent to medical treatment. However, it should be noted that "wherever there is resistance or objection to treatment for a mental disorder or for a physical disorder that is a consequence of the mental disorder this treatment...should be under the MHA 2003". (MWC Right to Treat – Good Practice Guide p.13)

Detailed guidance on the above measures are provided in Appendices D (Compulsory Measures) and E (Warrants).

Where there are any differing opinions between professionals on whether detention is appropriate, the decision should be discussed with the admitting Consultant at Royal Cornhill Hospital, and consultation should be sought with the Head of Mental Health and the Team Leader - Mental Health (Social Work). In the absence of a qualified MHO, the Executive Manager - Adult Social Work could be involved if there is concern about risk in the community.

### **7.3. Duty to inquire**

Section 33 of the 2003 Act places a duty to inquire into the situation of a person, over the age of 16 years who is suspected of having a mental disorder and who is living in the community. This duty to inquire is triggered when the person is suspected of being at risk of neglect or ill-treatment or their property may be at risk of suffering loss or damage because of their mental disorder or the safety of others is at risk. The Local Authority must comply with this duty where the criteria in Section 33 is met. The duty to inquire may be carried out by any officer of the local authority.

Where this occurs, the duty MHO should be contacted to clarify if intervention should be taken under the 2003 Act. Section 34 of the 2003 Act requires other agencies to cooperate with the

local authority in the process of it making inquiries, including the Public Guardian and Health Board.

#### **The duty MHO can be contacted on:**

Office hours (Monday to Friday 9 am to 5 pm) – 01595 744 400 / 744 460

Out of hours and public holidays – 01595 695 611

### **7.4. Involving the Police**

#### **Entry without Warrant**

A constable is empowered at common law to enter any house or building without a warrant:

- (a) On hearing the noise of a serious disturbance in the premises in order to enquire into the cause or to suppress the disorder;
- (b) When in close pursuit of a person who has committed or attempted to commit a serious crime
- (c) In order to fulfil their duty to protect life and property.

If, during a consultation with the police while attending a property at the request of an MHO for a spontaneous and unplanned event, an individual is experiencing an ongoing mental health crisis that necessitates immediate entry under these powers due to the urgency of the situation - i.e. **where any delay would pose a significant risk to the life of the individual or others in the property** - officers should proceed with entry using the relevant powers rather than waiting for a mental health warrant to be granted.

**There may be exceptional circumstances where Police will be required to provide assistance to medical teams, nursing staff and ambulance crews involved in the transfer of patients who are deemed high risk of harm to themselves or others, who may be displaying high levels of distress, aggression or violent behaviour.**

Contact should be made with Shetland Police on 101.

Where police involvement is required, the use of force and restraint should be minimised and the response should avoid criminalising the patient.

## **8. Detention**

### **8.1. Detention in a community facility**

Due to the varied nature of service delivery, there will be occasions when persons who require detention will be within community facilities such as day centres or care homes. The preferred gateway order is the Short Term Detention Certificate, but the Emergency Detention Certificate may be used in circumstances (as noted above) where the use of the Short Term Detention Certificate is impracticable. The mechanism for their use is the same as those described above and outlined in detail in Appendices D and F.

There may be occasions when staff will be unable to contain a situation within a community resource. If there is a clear threat to their personal safety, they should request the assistance of the police. The decision to involve the police may be taken by any member of the team involved in the detention.

In cases of urgency Dial 999 to ensure an immediate response.

## **8.2. Detention in a general hospital**

When detaining a person in a general hospital under emergency conditions an EDC may be used by any fully registered medical practitioner if the person meets the criteria. It should only be used where the use of the SDTC is impracticable, for example, when an Approved Medical Practitioner and a Mental Health Officer are not immediately available and the situation has a degree of urgency where waiting would result in harm.

It should be noted the 2003 Act exists to safeguard the human rights of individuals who have a mental disorder, and it is important that efforts are made to contact an Approved Medical Practitioner and Mental Health Officer before proceeding with an EDC, where possible.

Where a registered medical practitioner is not available, the Registered Mental Health Nurses' holding power (s299) can be used to detain a person for a holding period of up to three hours to allow a medical practitioner to attend. See Appendix D for further details.

## **8.3. Care of an individual during detention**

It is incumbent upon all statutory services to act in the best interests of persons to deliver high quality trauma informed care and to treat persons with respect and dignity at all times. Trauma-informed systems and practice, where the impact of trauma on those affected by it is understood by staff, and systems are adapted accordingly, can result in better outcomes for people affected by trauma. Trauma-informed practice is not designed to treat trauma related difficulties, it seeks to address the barriers that those affected by trauma can experience when accessing the care, support and treatment they require. Further information on trauma informed practice and tool kits can be found at:

<https://traumatransformation.scot/app/uploads/2023/09/nationaltraumatrainningframework-final.pdf>

All support and any interventions should be directed towards the best overall interests of the person, being based on the principle of least restriction, minimum necessary force or action to achieve a desired outcome, and to be carried out in a safe, professional and competent manner. The underlying principles of the 2003 Act relating to the care of the person should be observed at all times. A pragmatic approach should also be taken to ensure the smooth running of any function discharged under the 2003 Act with good communication being fundamental.

## **9. Identifying available beds for admission**

When a person has been detained in a community setting, locating a suitable bed is a priority. It is recognised that the transfer of patients to the nearest Psychiatric facility is in itself significant due to the requirement to undertake a road and air transfer to access an inpatient psychiatric facility at Royal Cornhill Hospital (RCH). If there is a delay in accessing an inpatient bed, this will prolong the period of time the patient will spend in an acute or community setting.

Any admission to RCH must be discussed by the Consultant Psychiatrist in NHS Shetland with the Duty Consultant, who will be the admitting Consultant at Royal Cornhill Hospital (RCH). Once a referral for admission has been accepted, then either the Consultant Psychiatrist in Shetland or the Consultant Psychiatrist at RCH will inform the Grampian patient flow team that admission has been agreed. The patient flow team will then identify a bed, if available, at RCH and inform the Consultant Psychiatrist in Shetland. Notification of an available bed can be made via telephone but should be followed up with an email which details date and ward of admission.

Where a person has a Learning Disability and is believed to be suffering from a mental disorder, the admission protocol to psychiatric care would be followed.

## 10. Place of Safety (POS)

The definition of a place of safety given in section 300 of the 2003 Act is:

- a hospital;
- premises which are used for the purpose of providing a care home service (as defined in section 2(3) of the Regulation of Care (Scotland) Act 2001 (asp 8));
- any other suitable place (other than a police station) the occupier of which is willing temporarily to receive a mentally disordered person.

Police Scotland may remove a person from a public place to a Place of Safety, under Section 297 of the 2003 Act, where they believe the person may have a mental disorder, may be in need of immediate care and treatment and where it is necessary in the interests of the person or the protection of other people. The police are required to complete a POS1 form to notify the Mental Welfare Commission of any person held under section 297 and provide: details of the date and time of the removal from a public place, the circumstances giving rise to this, the address of the place of safety and, if the removal was to a police station, why this was done. The local authority must also be notified, along with the person's nearest relative, unless impracticable to do so.

The 2003 Act outlines the clear requirements for places of safety to be identified for persons in an emergency situation to go to. It is explicit that Police Stations should not routinely be used for this purpose. **Appropriate Places of Safety (POS) in Shetland include:**

- Accident and Emergency departments
- Hospital wards
- Community Mental Health Team premises
- Registered care homes

Within Shetland, hospital-based POS are located within the Gilbert Bain Hospital as there are no on island inpatient psychiatric facilities. The POS should be utilised for short-term placement unless there is an underlying medical requirement for admission. In cases where there is an underlying medical condition which requires treatment, the medical condition should be treated. The POS in Shetland are spaces within the hospital that provide adequate privacy and safety:

- Emergency department – side room / cubicle
- Ward 3 GBH – side room

The Gilbert Bain Hospital has a designated Low Stimulus Room (LSR), located on the ground floor of the hospital and away from clinical areas. The use of this room for any mental health patient must follow the guidance outlined in the NHS Shetland Physical Intervention Policy, which includes the requirement for an individual risk assessment. Approval should be made by agreement between the most senior CPN, AMP, Admitting Consultant, and Nurse in Charge of the hospital – with the Head of Mental Health made aware of the decision to review impacts (reprioritisation of resource to support). During out-of-hours periods, this will include Silver

Command – Acute. Any decision to use the LSR should trigger an adverse event report to explain the decision making and context and support learning.

The Consultant within Community Mental Health Services has no admission rights to the Gilbert Bain Hospital as it is not an inpatient psychiatric facility and so any patients admitted are admitted with medical consultant agreement. However, NHS Shetland has a responsibility to accommodate until a safe transfer to a psychiatric hospital can be made.

Police Stations should only be used as the place of safety in exceptional circumstance, where it is the best option for the individual, and when local Police Officers' judgement (based on specific case circumstances) may deem that a Police Station is an appropriate POS. Police Officers have the power to take a person, who is in a public place, to a POS if:

- They reasonably suspect that a person in a public place has a mental disorder;
- That person requires immediate care or treatment;
- That it is considered in the interest of the person or protection of any other person to move the person to the place of safety;

The removal to a POS is to enable:-

- examination and assessment by a medical practitioner
- the making of arrangements for onward transfer to an inpatient facility, if required
- other arrangements/treatment that the medical practitioner feels necessary (e.g. continued detention in hospital) within 24 hours

If there is no ongoing requirement for Police presence once a person is in a POS, Police can be dismissed. If stood down, Police should communicate with the senior clinician in the POS.

In specific cases, it may be possible to support a patient in their own home which would significantly reduce the impact of acute hospital admission prior to transfer on to an inpatient facility. However, a person's home cannot be classed as a POS in terms of S300 of the Act. At home care remains under the Consultant Psychiatrist, who would be responsible for deciding whether this is appropriate. Where home is an agreed place for the patient to remain prior to planned transfer to RCH, this will be risk assessed. Support at home is for short term only and cannot be supported overnight, and any agreement would be for not less than 2:1 staffing in order to ensure safety of staff and patients. If rapid tranquilisation is needed for safe transfer, transfer to hospital will be necessary.

## **11. Advance Statements**

Doctors and other professionals supporting a person with a mental disorder have a duty to take into account an individual's Advance Statement. The 2003 Act means that, individuals with a mental disorder can write down in an Advance Statement how they would like to be treated if, in the future, they became too unwell to make decisions themselves. This refers specifically to the treatment they would prefer to receive, or not receive, for their mental disorder. A personal statement can also be made highlighting personal and welfare wishes.

To be valid, an Advance Statement must be in writing, signed, and witnessed according to the following criteria:

1. At the time of making (or withdrawing) an advance statement, the person must have the capacity of properly intending the wishes specified in it.

2. The advance statement must be in writing.
3. It must be subscribed (signed) by the person making it.
4. The person's subscription of it is witnessed by a person who signs the statement as a witness to that subscription.
5. The witness certifies in writing on the document that, in their opinion, the person making the statement has the capacity referred to in 1 above.

An advance statement may be withdrawn by the person who made it if

- at the time of making it the person has the capacity properly to intend to withdraw the statement; and
- it is made by means of a written document which is signed and witnessed in the same way as the original.

## **11. Absconding**

There are specific compulsory powers under the 2003 Act which support the return of patients who have absconded whilst mentally unwell in specific circumstances as defined in S.301 – 308 of the 2003 Act\*, either before mental health assessment and use of the 2003 Act, or after. When a patient absconds, it is vital that all relevant parties have regards for the principle set out at section 1(4) of the Act: that is, the principle that the patient should be treated in a manner which invokes the minimum restriction on his/her freedom that is necessary in the circumstances.

Section 303 of the 2003 Act sets out the procedures to be followed once a patient has absconded. These are detailed in Appendix G.

\*Circumstances are: Patients subject to Hospital Compulsory Treatment Order, Suspended hospital CTO, Interim CTO, EDC, STDC, Extension Certificate, S113 (detained in hospital following non-compliance with CTO or ICTO), a certificate under S.114(2) or S115(2) authorising continued detention (following non-compliance with a community based CTO or ICTO).

## **12. Management of violence or aggression**

Any intervention to manage violence or aggression should be focused on therapeutic rather than punitive support, and should be in the individual's best interests taking into consideration their human rights (MWC 2021).

NHS Shetland Health Board will ensure that restraint will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, voluntary 'time out', or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances.

NHS Shetland's Physical Intervention Policy (document has completed governance process and is awaiting publication) and Management of Violence and Aggression policy should be followed.

## **13. Transport**

### **13.1. Where a patient has not been detained**

Where a patient in a psychiatric emergency requires transport to a Place of Safety, but has not been detained, the Approved Medical Practitioner should make the decision on whether an ambulance transfer is needed and make arrangements for this if required. In some circumstances, use of a taxi or other form of transport may be considered appropriate. The decision on what transport to use should be made by the Approved Medical Practitioner, and based on the least restrictive option, maintaining safety and minimising distress.

### **13.2. Where a patient has been detained**

After a person has been detained in the community, the Approved Medical Practitioner or doctor will be responsible for contacting the admitting Consultant at Gilbert Bain Hospital to arrange admission and transport, which will usually be by ambulance. The nurse manager and senior nurse / charge nurse in the Emergency Department should be made aware of pending admission and contact SAS to let them know if transport will be required. On receipt of the request for admission, the senior nurse will obtain full details of the person, including:

- Name;
- Date of birth;
- Home address;
- Whether they have an Advance Statement;
- Named Person
- Next of Kin
- Address where the person will be located if different from above;
- Mobile telephone number of the referring medical practitioner; and
- Confirmation of whether the police will be required to attend and whether they have been contacted.

In making escort arrangements the senior nurse should observe the following details:

- Confirm that all required documentation has been completed and will be available to hand over to the nurse escorts;
- Confirm that a person able to identify the person will be in attendance;
- Obtain from the medical practitioner all information required to identify risks associated with escort of detained persons; the MHO may be able to contribute additional information.
- Confirm whether the person is to be admitted directly to a ward or whether other arrangements apply; and
- Ensure that the admitting ward has been notified of all relevant details of the expected admission.

A patient who has been sedated should always be accompanied by a nurse, a doctor or a suitably trained ambulance person experienced in the management of such patients. Only in

exceptional circumstances and when it is evident that the sedated patient is reconciled to the situation, should the ambulance crew be asked to act as the sole escort.

Where a patient or their carer has incurred travel costs, these may be reimbursed where eligible, in line with the Highlands and Islands Travel Scheme.

### **13.3. Air transfer**

Where air transfer is required, NHS Shetland's Mental Health Air Transfer guidance (in development, available via CMHT) should be followed. A summary of actions is provided in Appendix H.

## **14. Considerations for specific groups**

### **14.1. Intoxicated individuals**

Where a person is intoxicated through any substances, they must be able to engage in assessment before they can be assessed. This is in line with guidance in the Mental Health Index for Police Scotland. Careful consideration must firstly be made in relation to the appropriate placement for the individual in the immediate term. And secondly, as to whether follow up assessment or support is required.

### **14.2. Young People**

In the event that a psychiatric emergency should occur in a young person, the PEP should be adapted to meet the needs of the young person in accordance with his or her developmental age as appropriately as possible, as long as safety can be maintained. Maintaining the safety of the young person and those who are subject to his or her behaviours should be the first priority. The principles of the PEP as it pertains to adults remain the same for children and young people. There are some additional arrangements that will be put in place for children and young people. Specific arrangements that differ from those for adults are:

#### **14.2.1. Responsibilities**

The tenth principle underpinning the 2003 Act is that the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act. Section 23 imposes a duty on the Health Board to make provision for any child or young person (up to the age of 18) where that person is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. The welfare of a child or young person with a mental disorder should be paramount in any interventions imposed on the child under the act and we endeavour to maintain the following priorities:

- Safety of patient
- Safety of staff
- Safety of public and family
- Working collaboratively with family / carers
- Working within a multi-agency
- To use least restrictive approach
- Use age / developmental appropriate care

- To act in the best interest of the patient to deliver high quality compassionate and non-judgemental care to treat them with respect and dignity at all times
- Adherence to the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003
- Adherence to the human rights act and UNCRC (United Nations Convention on the Rights of the Child)
- Adherence to Getting It Right For Every Child

In the event of a psychiatric emergency of a young person under the age of 18 the general principle is for them to be admitted to a specialist CAMHS bed. Shetland CAMHS falls within the catchment area of the Young Person's Unit (YPU), Dudhope, Dundee 01382 649031 [tay.taynospgcamhs@nhs.scot](mailto:tay.taynospgcamhs@nhs.scot)

The YPU is a regional in-patient unit covering 6 health boards in the North of Scotland. The unit is one of 3 In-patient units in Scotland (along with Melville Unit and Skye House) and has 12 of the 48 national CAMHS beds. To ensure equity of service the YPU only accepts admissions between the hours of 9am and 5pm Monday to Friday. Referrals are accepted by YPU Consultant Psychiatrists from locality Consultant Psychiatrists.

Assessment during core working hours is outlined in Appendix I.

#### **14.2.2. Out of Hours**

CAMHS operate between 9-5 Monday – Friday. If a child or young person presents with a psychiatric emergency out of core hours, the wider PEP applies. Where possible the child/young person will be supported in a place of safety (GBH or social care) until a specialist CAMHS bed can be accessed. In the event that the child / young person requires urgent admission to adult in-patient facility, liaison with relevant CAMHS consultant to arrange transfer to CAMHS in-patient facility the next working day depending on bed availability.

#### **14.2.3. Transfer to hospital**

If admission is necessary and the patient is detained under the Mental Health (Care & Treatment) (Scotland) Act 2003, the same arrangements applies as per wider PEP and SAS risk assessment with regards to hospital transfer.

The CAMHS team will provide escort of patients where possible. The family should be included in planning and to be considered as part of escort unless assessed not appropriate (e.g. for child protection reasons).

Pharmacological management of acute behavioural disturbance should only be considered after consultation with the CAMHS Consultant Psychiatrist, or through discussion with an on call CAMHS consultant. Medication choice and dose would be directed from the specialist Consultants and be in line with guidance specifically for child/young person.

#### **14.2.4. Care of Child / Young Person during detention**

The welfare of the child/ young person is paramount therefore the least restrictive options of care need to be considered whilst a trauma informed approach is maintained throughout. Careful consideration also needs to be given to the age and developmental stage throughout the process.

The CAMHS nursing team are most appropriate to support the child / young person during the transfer process and where possible should provide constant observations within the place of safety until onward transfer to the inpatient mental health facility.

Parents and carer's must also be fully involved in the detention process as per the Age of Legal Capacity (Scotland) Act 1991. Some children / young people may request that their parents / carers are not involved or kept informed during the process. This choice must be taken into account if the young person is assessed to be fully competent in decision making. However, if they are assessed to not have competence in decision making then it is the responsibility of the Approved Medical Practitioner to decide what information is shared with parents and carers.

A child under 16 years old cannot nominate a Named Person under S250 of the 2003 Act. Anyone who is over 16 years and has parental rights and responsibilities under the Children (Scotland) Act 1995 would assume the role of Named Person. Where uncertainty exists about who should assume the Named Person role then reference should be made to S252 of the 2003 Act.

### **14.3. Learning Disability and Autism**

People with learning disability presenting with known or suspected mental ill health should be able to access the emergency services available to the wider population.

It is recognised that people with learning disability and other developmental disorders continue to face significant diagnostic overshadowing and that without specialist treatment their mental ill health may not be recognised or treated.

It is recommended that each person is assessed individually rather than a decision being made due to their diagnosis alone. Many people with mild and moderate learning disability will be able to participate in an assessment provided by generic services and an initial management plan made. Where there is concern regarding a person's presentation out-of-hours, discussion can be had via on call Consultant Psychiatrist or on call CPN. An urgent specialist assessment can be made thereafter for the next working day. As can routine referrals to Community Learning Disability Nursing Team.

NHS Shetland Community Learning Disability Nurse can be contacted in working hours on 07385 425036.

Any escalated health matter out of hours should be referred to NHS24 / 111 or by attendance at A&E. In an emergency, the contact would remain 999

Adult Concern forms should be completed for any person with a known or suspected learning disability thought to be at risk and unable to safeguard their own wellbeing.

<https://www.safershetland.com/for-professionals/adult-protection>

Duty Social Work team may have a role for those known to local authority and / or with an established care package.

Duty social work can be contacted on 01595 74 4420 / 744422 during office hours or out of hours (emergencies only) on 01595 696511.

### **14.4. Carers and Patients with Caring Responsibility**

The Mental Welfare Commission guidance on Human Rights in Mental Health Services clearly states that all patients have a right to agree how much they want family and friends to be

involved in their care and support (unless there is a legitimate reason to restrict this, in which case any restriction should be the least possible). The principles of the 2003 Act make it very clear that the wishes of patients and their carers should be taken into consideration during treatment, so mental health staff should include questions about family, friends and key personal contacts in any initial assessment.

In addition, wherever possible and reasonable to do so, a full discussion should take place with the patient around the nature and level of contact, and the patient's consent should be gained regarding the amount of information to be shared with family members. The role that family and friends play in a patient's life, and how much support they can offer, is also worthy of discussion and can set a benchmark for the nature and frequency of contact. This should be set out in a patient's Advance Statement about the care and treatment they wish/do not wish to receive if they are unwell, but should be clarified again in detail in case of situations where no Advance Statement has been made.

In an emergency situation which this plan focuses on, it should be recognised that there may be a need to restrict relationships – for example, due to safety issues for patients or family members, particularly if children are involved. The relationship between parents and children is also clearly highlighted in Section 278 of the 2003 Act, which states that any adverse effects, when patients are subject to compulsory measures, should be mitigated.

It is the responsibility of the Mental Health Officer (MHO) to ensure that any dependants, including children and other vulnerable persons, for any detained patient, are appropriately cared for. It is good practice for the MHO to also make arrangements to secure property, belongings and check that suitable arrangements are made for pet care. To fulfil these duties there may be a requirement for collaboration between partner agencies to maintain the safety, security and well-being of all involved. It is the responsibility of MHOs both in hours and out of hours to co-ordinate these actions as necessary.

The Code of Practice states, in relation to the police taking a person to a place of safety under S297 of the 2003 Act that, "the nearest relative must also be informed as soon as practicable after the removal has taken place. If it is impracticable for the constable to inform the nearest relative or if the nearest relative is informed but does not live with the person removed, then the constable should ensure that one of the following is informed instead: a person who lives with or provides a care service to the person; or who is a carer of that person.

Section 1(5) stipulates that the needs and circumstances of the carer should be taken into account and the importance of providing such information to any carer as might assist the carer to care for the patient. Carers may be informally caring for people, and as such may require support in their own right. A link for signposting to local services can be found here: Support information and signposting for carers can be found here: <https://www.shetland.gov.uk/social-care-health/caring-someone>

The Mental Welfare Commission Good Practice Guidance 'Carers and Confidentiality' can assist with any concerns about confidentiality and sharing information. The document can be found here: [https://www.mwscot.org.uk/sites/default/files/2024-10/CarersConsentAndConfidentiality\\_2024.pdf](https://www.mwscot.org.uk/sites/default/files/2024-10/CarersConsentAndConfidentiality_2024.pdf)

Section 6 of the Carers (Scotland) Act 2016 places a duty on Local Authorities to offer an adult carer support plan to individuals who are undertaking a Carer role.

## 15. Advocacy

The 2003 Act provides every individual with a mental disorder the right of access to independent advocacy and puts duties on Health Boards and Local Authorities to ensure that independent advocacy services are available. The right to access advocacy applies to all mental health service users, not just to people who are subject to powers under the Act. All parties to make individuals aware of their right to advocacy.

Advocacy contact for Shetland:

Tel 0300 303 1660

Email [helpline.scotland@voiceability.org](mailto:helpline.scotland@voiceability.org)

Website [www.voiceability.org/shetland](http://www.voiceability.org/shetland)

Advocacy Aberdeen — RCH 01224 557 912

## 16. Information Sharing

Effective sharing of information and communication are vital during all processes contained in this PEP. However, information-sharing between agencies raises problems in terms of an individual's confidentiality. Whilst it is vital for the proper care of individuals that appropriate agencies have ready access to vital information, it is equally important that service users and their carers can be confident that personal information will be kept confidential and that their privacy will be respected.

Personal details listed below should be shared with other agencies in order for them to discharge their functions according to their duties of care (this list is not definitive and should be seen as a minimum requirement):

- Name of person;
- Address and contact telephone numbers;
- Date of Birth;
- Named Person;
- Risk Assessment Summary; and
- A brief history of events leading up to the need for detention.

### 16.1. Data Protection

The Data Protection Act 2018 controls how your personal information is used by organisations, business or government. Everyone responsible for using personal data has to follow strict rules called data protection principles. They must make sure information is:

- used fairly, lawfully and transparently
- used for specified, explicit purposes
- used in a way that is adequate, relevant and limited to only what is necessary
- accurate and, where necessary, kept up to date
- kept for no longer than is necessary

- handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage

These points must be followed in conjunction with the Human Rights Act 1998, which applies to all public authorities. It makes it unlawful for a public authority to act in a manner inconsistent with the rights set out in the European Convention on Human Rights and Fundamental Freedoms. Article 8 covers the right to respect for private and family life, and while this right is not absolute, any breach must:

- Be in accordance with law, particularly in regard to confidentiality;
- Pursue a legitimate aim;
- Be supported by sufficient and relevant reasons; and
- Be proportionate to the risk observed

Confidentiality and data protection are linked in that the unlawful disclosure of personal information would potentially be a breach of the Data Protection Act 2018, which is a criminal offence. A victim of a breach of human rights may pursue legal action up to one year after the alleged breach, accurate recording of procedures taken and information shared and with whom, is therefore crucial.

The NHS Shetland Community Mental Health Team is part of the Shetland Community Health and Social Care Partnership. The Partnership is made up of health and social care services from the NHS and from Shetland Islands Council working together to deliver integrated person centred care.

The Community Mental Health Team routinely shares information about assessments with the Mental Welfare Commission. Depending on the case they may request and receive information from Police Scotland, other public, third or private sector organisations, or from family members. This will only be limited information which is relevant to inquiries and assessments. Reports and applications written by Mental Health Officers may be lodged with the Mental Health Tribunal Service and Scottish Ministers.

While each partner retains separate records, they work together to deliver care, and this will involve sharing limited, relevant information when required.

As part of integrated working arrangements the CMHT also shares limited relevant information with the Scottish Government and NHS for the purposes of planning, delivering and monitoring services, and to inform the strategic design of integrated services.

Information about any assessments carried out under the Act 2003 is kept for ten years from the date that the case file is closed if statutory measures are undertaken

Any person subject to the Act (2003) or someone legally appointed on their behalf, has rights to request data, including the right to ask for a copy of any data held. NHS Shetland has details of how patients can access information as well as the contact details for the NHS Shetland Data Protection Officer.

<https://www.nhsshotland.scot/rights>

People also have the right to make a complaint to the Information Commissioner's Office (<https://ico.org.uk/>). They are the body responsible for making sure organisations handle data lawfully.

Informed consent to information sharing should ideally be sought from the person, in writing, as part of the assessment process. In emergency situations this may not be possible and the above guidelines should be followed as far as is practicably possible in the circumstances.

## **16.2. How should information be shared?**

All information should be shared on a strictly “need to know” basis and the minimum amount of information needed to complete the task should be shared. All involved personnel should ensure that the following guidelines are observed:

- Ensure all sensitive information is kept secure and confidential whilst in your care;
- All personal details should be not be left unattended;
- When using the telephone ensure that the minimum information required is divulged

## **17. Debrief and aftercare**

All psychiatric emergency events, where legal measures have been taken, should be subject to the consideration of a formal debrief. This will support continual reflection on practice, and assessment of what went well and any learning.

Following a crisis presentation out of hours, outcomes should be recorded in the on-call log and discussed, with follow up as appropriate by the Community Mental Health Team. Where someone is seen out of hours and may be at deliberate self-harm or risk of suicide, this should be discussed in the 0910 risk and safety meeting in Mental Health with a plan for contact made and documented in notes.

## **18. Monitoring and Review arrangements**

This PEP and attached appendices are intended to be practical working documents and in accordance with the 2003 Act, monitored and reviewed on a regular basis.

This PEP document will be subject to review by all stakeholders at 24 months, as the scope of the document and care provided does not sit solely with one service area or service group.

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Section 328

<https://www.legislation.gov.uk/asp/2003/13/section/328>

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## Appendix A – Arranging assessment in a psychiatric emergency

Initial contact		
Hours	09:00 – 17:00	17:00 – 09:00
Contact	Duty Community Psychiatric Nurse (CPN) via CMHT. For patients not know to Mental Health Services, GP would be first point of routine contact for onward referral	NHS24 111 – Mental Health Hub will triage calls OoH CPN / on-call MH clinician via Hospital Switchboard
Contact details	01595 743006	01595 743000
Specific considerations / exclusion criteria		
Under 14s	Refer to CAMHS who can be contacted 01595 743000, who are located at Breiwick House in Shetland.	Refer to ED. CAMHS will review in service hours as no out of hours service available locally.
14-18 years old	Refer to CAMHS who can be contacted 01595 743000, who are located at Berwick House in Shetland.	Refer to CPN. CAMHS will review in service hours as no out of hours service available locally.
All ages	<ul style="list-style-type: none"> <li>Intoxicated individuals must be able to engage in assessment.</li> <li>Individuals with physical health concerns (e.g. self-harm injuries or overdose) will need to have physical concerns addressed before undertaking an assessment.</li> <li>CAMHS and patients with acute/physical needs must be medically triaged prior to MH Assessment.</li> </ul>	

### The duty MHO can be contacted on:

Office hours (Monday to Friday 9 am to 5 pm): 01595 744 400 / 744 460

Out of hours and public holidays: 01595 695 611

## Appendix B – Vignettes – Possible Scenarios

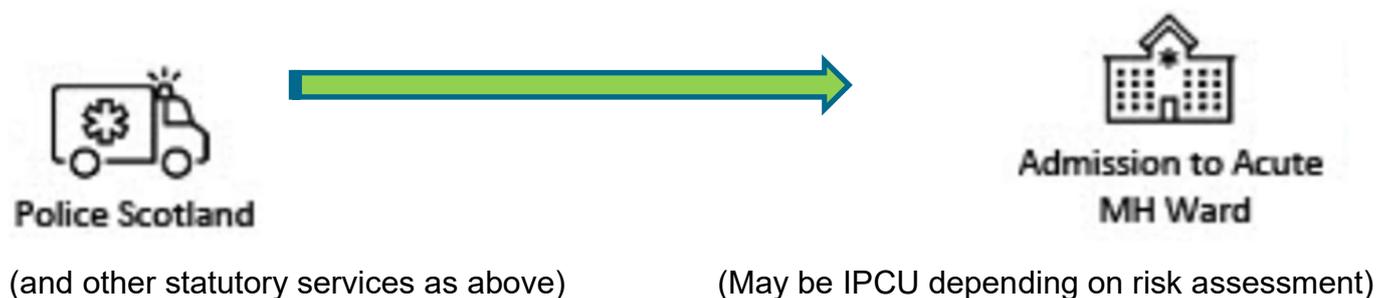
### Scenario 1:

A 33 year old man has a history of psychosis complicated by poor insight, distrust of services and known misuse of a variety of illicit substances including cannabis and stimulants. He has been convicted of several violent offences including the use of weapons. He has had previous admissions to the Royal Cornhill Hospital when he has been acutely unwell. His family have contacted the local CMHT to raise concerns that he is in distress and may have become unwell again. He has voiced fixed persecutory beliefs about his neighbour and has indicated he may cause him harm. He has also expressed hopelessness about his situation and thoughts of suicide. It seems he has barricaded himself in his home (a local authority tenancy) and is refusing access even to those he knows well.

### **Actions for consideration:**

- In this instance it would be appropriate to convene an urgent multi-agency planning meeting to gather and share all relevant information and to agree an approach to ensure this man has access to essential healthcare in a way which maintains safety and dignity.
- This will require close co-operation between police/ SAS/ local authority/ MHO/ AMP/ CMHT colleagues.
- The pathway for admission to Royal Cornhill hospital would be through an admission to a place of safety, and a planned air transfer. Admission to RCH would require a Consultant referral, and RCH agreeing admission. Bed flow in RCH would source a bed and then transfer can be planned via air desk, and following air transfer pathway

### **PATHWAY ELEMENTS:**



**Scenario 2:** An 80 year old woman lives with her husband who is fit and well and has herself functioned independently until very recently. Over the course of a couple of weeks she has become withdrawn and uncommunicative. When she does interact she is often tearful and seems to be blaming herself for things in the world which cannot possibly be her fault. Her appetite has progressively reduced. In the last few days she has had no food at all and only sips of water. She is starting to become confused about the time and the identity of people she knows well.

**Actions for consideration:** This is potentially both a mental and physical health emergency. The risks are to the person themselves and not to others. It would be appropriate to seek help through GP/ NHS 24 in the first instance. It is likely that ambulance transfer to ED for physical health assessment (stabilisation/ rule out underlying cause) is required before determining whether fit for transfer to older adult ward in psychiatric hospital for further assessment and treatment of e.g. depressive episode as indicated. MHA assessment in the community may be required if unable to consent and co-operate with interventions.

**PATHWAY ELEMENTS:**



**Scenario 3:** An 18-year-old woman has been supported to attend ED by her friends after making several deep lacerations to her forearms. This has not happened before. She has had a number of recent stresses including the breakdown of a relationship and the death of a close family member. Once her wounds have been treated, she still seems low in mood and when asked directly confirms that she has persistent thoughts of harming herself or perhaps even suicide as a means of escape. She is, however, open to the idea of seeking help and support.

**Actions for consideration:** The clinical picture here meets the criteria for referral to MH. Options available are a face to face assessment with the on call CPN or a NearMe assessment in the ED department if felt not safe for her to leave. Alternatively, if risk assessment satisfactory she could be safely discharged from the department with a commitment to connect to a NearMe assessment by the on call CPN in her home. All options would happen on day of referral to MH. If assessment clarifies underlying symptoms of treatable mental disorder then routine follow up may be indicated after initial crisis intervention.

**PATHWAY ELEMENTS:**



(Secondary Care CMHT)

These vignettes were developed in line with national guidance on unscheduled care pathways and clinical scenarios. Further general and tailored sources of support for specific groups or presentations can be found at: <https://www.gov.scot/publications/resources-mental-health-unscheduled-care-services/>

## **Appendix C - Principles of the Mental Health (Care and Treatment) (Scotland) Act 2003**

S328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 defines a mental disorder as a mental illness, personality disorder or learning disability, however caused or manifested.

The conditions that do not constitute a mental disorder are detailed in S328 (2) (a)-(g)

The 2003 Act is based on a set of principles that must be applied when discharging any functions under the Act. More detail is provided in Section 1 of the 2003 Act and Volume 1 of the Code of Practice:

<https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/documents/>

### **The 10 Principles are:**

**Non-discrimination** – People with mental disorder should, wherever possible, have the same rights and entitlement as those with other health needs.

**Equality** – All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

**Respect for diversity** – Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds.

**Reciprocity** – Where an obligation is imposed on an individual to comply with a programme of treatment of care, an obligation is also imposed on the health and social care authorities to provide safe and appropriate services including ongoing care following discharge from compulsion.

**Informal care** – Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

**Participation** – Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully.

**Respect for carers** – Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

**Least restrictive alternative** – Service users should be provided with any necessary care, treatment and support both in the least invasive and least restrictive way, and in a place that allows the delivery of safe and effective care, taking into account the safety of others, where appropriate.

**Benefit** – Any intervention under the 2003 Act should be likely to produce a benefit for the service user.

**Child welfare** – The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the act.

## **Appendix D - Compulsory Measures:**

The compulsory measures that may be enacted in an emergency include:

### **Compulsory Treatment Order**

Where a person's mental health is deteriorating, they are at risk as a result and are refusing treatment on an informal basis then consideration should be given as to whether an application should be made for a Community Compulsory Treatment Order. An application for a CCTO would normally be progressed following the agreement of the multi-disciplinary team. An MHO would make the application to the Mental Health Tribunal for Scotland along with two medical reports (one of which must be provided by an AMP i.e. doctor approved under Section 22 of the 2003 Act).

This would not be a solution in an emergency (as it could take around 2 weeks for the application to be completed and a tribunal to be held), but it is a less restrictive option that could be considered if a person's mental health begins to deteriorate in order to prevent it becoming an emergency and the need for a hospital admission.

### **Non-Compliance with a Compulsory Treatment Order**

When a patient is already on an Interim CTO, Community CTO or Compulsion Order and not complying with an attendance requirement under S66 (1)(c) then S112 allows the Responsible Medical Officer to compel the patient to attend a specified place at a specified time to be given medical treatment for a mental disorder. If the patient does not comply the RMO can arrange for the patient to be taken into custody and conveyed to a specified place or hospital. Reference should be made to the MWC Advice note: 'Non-compliance with community compulsory treatment orders'.

Under S113 a patient subject to a Community CTO, Interim CTO (that does not authorise detention in hospital), or a Compulsion Order can be taken into custody and conveyed to a hospital if they fail to comply with any authorised measure in the order and their health is likely to deteriorate as a result. S113 lasts for up to 72 hours beginning with the patients' arrival in hospital.

If a patient is on a Suspended Hospital CTO the RMO can revoke the suspension certificate if he/she is satisfied that it is necessary in the interests of the patient or for the protection of other persons. The SUS1C form should be used.

### **Short Term Detention Certificate (STDC)**

<https://www.gov.scot/publications/mental-health-law-forms/>

The above link provides access to the forms described in the PEP.

A Short Term Detention Certificate (S44 of the 2003 Act) is the preferred order to use in an emergency if the criteria is met, as it provides the person with more safeguards and rights than an Emergency Detention Certificate. It can only be granted by an Approved Medical Practitioner (AMP) with the consent of an MHO. An AMP is a medical practitioner approved under S22 of the 2003 Act. This would normally be a Consultant Psychiatrist, or a doctor approved by the Health Board as having specialist experience in the diagnosis and treatment of mental disorder. An STDC cannot proceed without MHO consent.

The DET2 form should be used and can be found at <https://www.gov.scot/publications/mental-health-law-forms/>

The criteria for an STDC is:

- The patient has a mental disorder and that;
- Because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired;
- It is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient; or giving medical treatment to the patient;
- That if the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient; or to the safety of any other person; and
- That the granting of a short-term detention certificate is necessary.

If the person has an Advance Statement it must be taken into account and prior to granting an STDC the AMP must consult the person's Named Person, and take their views into account, unless it is impracticable to do so.

### **Length and Effect of STDC:**

Once granted an STDC authorises a person to be removed to hospital within 3 days, but admission to hospital is authorised only after the certificate has been given to the hospital manager or his/her representative. If the person is already in hospital the STDC provides authority for the person to be detained in that hospital, or transferred to another hospital within 3 days and for the patient to be detained in hospital for up to 28 days from the day the STDC was granted if in hospital, or from the day the patient is admitted to hospital.

### **Emergency Detention Certificate (EDC)**

An Emergency Detention Certificate (S36 of the 2003 Act) may be granted where the person meets the criteria and waiting for an AMP to assess for a Short Term Detention Certificate would be impracticable. Any fully registered medical practitioner can grant an EDC with the consent of an MHO.

An EDC can only proceed without MHO consent where it is too urgent to wait for an MHO, or if an MHO is not available. The reasons for not gaining the consent of an MHO must be clearly explained on the EDC form. The Emergency Detention Certificate does not have to be given on a prescribed form, however, it is advisable to use a DET1-form to avoid invalid detentions. The form is available at <https://www.gov.scot/publications/mental-health-law-forms/>

An EDC cannot be granted if an MHO refuses consent.

It should be noted that a nearest relative or named person cannot provide consent to a patient being detained.

The Medical Practitioner must complete the relevant pages, as highlighted at the top of each page on the form. Gilbert Bain Hospital managers, or their representative, must complete the last pages, as highlighted at the top of each page on the form.

It does not have to be specified on the DET1 form as to which hospital the person will be admitted to, or the nature of the person's mental disorder.

The criteria for an Emergency Detention Certificate is:

- That the patient has a mental disorder; and

- As a result of the mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired;
- That it is necessary as a matter of urgency to detain the patient in hospital to determine what medical treatment is required for the suspected mental disorder;
- That if the patient were not detained there would be significant risk to the patient and/or others; and
- Making arrangements with a view to granting a short-term detention certificate would involve an undesirable delay.

It is good practice to take the views of the patient's named person, carer and nearest relative into account. Where a person has a Power of Attorney (where the welfare part has been activated), or a Welfare Guardian then their views must be taken into account.

### **Length and Effect of EDC:**

The EDC authorises the transportation of a person to hospital, but admission to hospital is authorised only after the certificate has been given to the hospital manager or his/her representative. If an Emergency Detention Certificate is granted whilst the person is in the community then admission to a hospital must take place within 72 hours of the certificate being completed.

The certificate then authorises detention in hospital for up to 72 hours from the time the patient is admitted to the hospital ward (arrival at A&E is not classed as admission). The EDC must be given to the hospital managers, or their representative for it to become effective. If an Emergency Detention Certificate is granted where a person has already been admitted to hospital on an informal basis, the 72 hours commences immediately.

Where a patient is detained in hospital under an EDC Hospital Managers must arrange for an AMP to review the patient at the earliest possible opportunity (S38).

Only an AMP can revoke an EDC.

### **Offenders with a Mental Disorder**

The 2003 Act has a number of provisions that can be applied when a person with a mental disorder becomes involved in the Justice system. Some of those measures that may apply in an emergency include:

**Custody** – When a person is arrested for an offence the police, prosecutor or court can request that a mental health assessment is undertaken where a person has or appears to have a mental disorder. The first point of assessment should be a GP / custody health team for physical health assessment then onward referral can be made if required.

A psychiatric assessment can be carried out when a person is in police custody having been detained (i.e. removed from a public place and taken to a place of safety under S297 of the 2003 Act).

The medical practitioner may make recommendations relevant to the person's first court appearance.

### **Assessment Order**

The court can detain a person in hospital for 28 days for assessment of their mental health, if it is recommended by a doctor who examined the person.

## **Treatment Order**

If a person has been given bail or remanded in custody before trial the court may detain the person in hospital for treatment of their mental disorder. A Treatment Order can only be made if it is recommended by two doctors, one of whom must be a psychiatrist approved under S22 of the 2003 Act.

## **Temporary Compulsion Order**

If the court decides a person's trial cannot start or continue because a person is considered unfit to stand trial due to their mental health the person can be detained in hospital for treatment. This order can only be made if it is recommended by the two doctors who examined the patient, one of whom must be a psychiatrist approved under S22 of the 2003 Act.

## **Acquitted but detained**

If at the end of Examination of Facts the court is not satisfied beyond reasonable doubt that the person did commit the offence which they are charged with then the person must be acquitted. However, if the court has received recommendations from two doctors that the person needs treatment for a mental disorder the court can detain the person for 6 hours so a doctor can carry out an examination.

If at the end of Examination of Facts the court is satisfied beyond reasonable doubt that the person did commit the offence with which they are charged but acquits them on the grounds of 'insanity', the court may detain the person in hospital for further assessment under an Interim Compulsion Order.

If the court considers that the person may require treatment in hospital it can detain the person in hospital under a Compulsion Order which may have a Restriction Order attached. A Restriction Order means a person cannot be transferred to another hospital or granted leave from hospital without the consent of the Scottish Ministers.

## **Use of Nurse's Power to Detain a Patient Pending Medical Examination (s299)**

The registered mental health nurses' holding power can only be used for informal persons (i.e. those not already detained) in a hospital in-patient setting who are receiving treatment for a mental disorder. The only exception to informal persons is where a person is subject to a Community Payback Order with a requirement for treatment for a mental health condition via S227A(1) of the Criminal Procedures (Scotland) Act 1995. It cannot be used for detaining persons in the community or in a person's home and it can only be authorised by a Registered Mental Health Nurse.

It is used to detain a person pending medical examination to determine whether an EDC or SDTC should be granted and the following points should be noted:

- The "holding period" lasts for up to 3 hours to allow a medical practitioner to attend as soon as possible;
- A written record must be made stating why the person was detained, the time the holding period began and the reasons for detention using NUR1 form
- Notification must be made to the on-call MHO and the Nurse in Charge of the hospital along with Silver command for acute services.

## Appendix E – Use of Warrants

### Warrant for Entry

An MHO may apply to the Sheriff for a Section 35 warrant (MHO1 form) if it is thought that entry to premises, access to medical records, and/or a medical examination is necessary but access has been, or is likely to be, denied. The Sheriff will normally require evidence that informal attempts have been made but denied. A warrant granted under section 35 does not itself authorise the removal of the person at risk to a place of safety.

If a warrant is granted under Section 35(1) it authorises the MHO, any police constable or other person specified in the warrant to enter the premises within 8 days.

### Warrant to Detain for Medical Examination

An MHO should make an application to the Sheriff (MHO2 form) if the criteria in Section 35(2) is met, in that the person appears unwell, is at risk and is refusing consent to medical examination. If granted the warrant authorises the detention of the person for the purpose of medical examination, by the medical practitioner specified in the warrant, for a period of up to 3 hours.

### Warrant for Removal to a Place of Safety

An MHO may apply to the Sheriff to remove a person to a place of safety under S293 of the 2003 Act (MHO5 form) for up to 7 days, where a person has a mental disorder and is at risk. This is a last resort that may only be used where informal options have been fully explored and exhausted; the person must be at risk of significant harm and the other criteria in S.293 be met, for example, they are exposed to ill-treatment, neglect, are unable to look after their self, property or financial affairs.

If a removal order is granted it authorises the person to be removed to a place of safety e.g. a care home for up to 7 days. A removal order **does not authorise the provision of medical treatment on a compulsory basis** and therefore would be inappropriate where a person requires medical treatment in hospital.

### Warrant for Access to Medical Records

An MHO can apply to the Sheriff (MHO3 form) to request access to medical records for a medical practitioner where that is being denied.

### Warrant to Enter Premises for the Purpose of taking or Re-taking a Patient

Section 292 of the 2003 Act details the criteria where an MHO should apply to the Sheriff (MHO4 and MHO4a form) for a warrant to take or re-take a patient into custody. For example, where a person subject to a Compulsory Treatment Order has absconded from hospital and all other reasonable steps to access the patient has been exhausted.

If granted the warrant authorises the persons specified in the warrant to enter premises and take or re-take the person into custody, hospital or where they are required to reside.

In theory, the authority to remove a person at risk to a place of safety for up to 7 days can be granted by the issuing of a warrant under section 293/ 294.

Where an initial duty to inquire provides sufficient evidence that a person may be at risk as a result of a mental disorder, plans should be made for assessment and to agree who needs to be involved. Geographical distances may mean that a Consultant Psychiatrist is unable to attend in an emergency and initial assessments have to be carried out by GPs. If it is considered that

compulsory measures may have to be invoked under the 2003 Act then the **GP must attempt to contact an MHO prior to the assessment, unless it is too urgent to do so.**

## Appendix F – Recommended sequence of events when compulsory measures may be needed

The recommended sequence of events should be:

### - Doctor or Consultant Psychiatrist contacts an MHO (see [7.2](#))

- Multi-agency preparation meeting if required, agreeing grounds for intervention and timing of actions based on available resources (practitioners to conduct assessment, ambulance/ escort, in-patient bed confirmation etc.)

- MHO applies to sheriff for warrants, if required, under the relevant section (see Appendix E above - Warrants)

- Police Scotland are required to attend all warrants on the request of MHO as the warrant provides the legal authority only to a police constable to open lock fast premises. The MHO will arrange a joiner if required to ensure that the property is accessed and then secured, but this is solely to make the process smoother and less distressing for the patient.

MHO and medical practitioner, and any persons specified in the warrant, enter premises under authority of these warrants (supported by police and/ or escort team as appropriate) to conduct assessment. This may include assessing whether the criteria for detention is met under the 2003 Act (EDC if GP, STDC) if Approved Medical Practitioner (AMP) – approved under 2003 Act), depending on the type of warrant being executed.

Where possible the [Short Term Detention Certificate \(s44\)](#) is the preferred gateway order as it affords the person more rights. It requires the consent of a Mental Health Officer (MHO) and it can only be issued by an Approved Medical Practitioner (AMP). In situations of extreme urgency an [Emergency Detention Certificate \(s36\)](#) may be the most appropriate order to apply. It can be granted by any fully registered medical practitioner where an Approved Medical Practitioner (AMP) is not immediately available and the Short Term Detention Certificate would be impracticable. If a GP is considering applying an EDC they must attempt to contact an MHO, unless it is too urgent to do so.

The certificate authorises the transportation of a person to the Gilbert Bain Hospital but admission to hospital is authorised only after the certificate has been given to the Nurse in Charge of the hospital / Silver Command or his/her representative.

The Emergency Detention recommendation does not have to be given on a prescribed form, however, it is strongly advised that a DET1 form is used to avoid the possibility of invalid recommendations. The application for emergency detention must include the following statements:-

- That it is likely the person has a mental disorder;
- As a result of the mental disorder the person's ability to make decisions regarding his/her medical treatment is significantly impaired;
- That it is a matter of urgency to detain the person in hospital to determine what treatment is required;
- That if the person were not detained there would be significant risk to the person and/or others; and
- Granting a short-term detention certificate would involve an undesirable delay.

The following points should be noted:-

- It is not necessary to specify which hospital the person will be admitted to or the nature of the person's mental disorder;
- Mental Health Officer (MHO) approval should be sought or a reason why this was not possible must be clearly detailed on the form
- The nearest relative plays no formal role in detention and therefore cannot give consent, but should be informed of the detention, as should the named person(s)

Where an EDC has been granted without MHO consent then the hospital managers must notify the local authority that the person resides in within 7 days (S38).

## Appendix G - Absconding

There are specific compulsory powers under the 2003 Act which support the return of patients who have absconded whilst mentally unwell and are subject to specific orders. When a patient absconds, it is vital that all relevant parties have regards for the principle set out at section 1(4) of the Act: that is, the principle that the patient should be treated in a manner which invokes the minimum restriction on his/her freedom that is necessary in the circumstances. Moreover, it should be noted that all of the principles apply to any action taken under the 2003 Act.

Section 303 of the 2003 Act sets out the procedures to be followed once a patient has absconded who is subject to any of the conditions detailed in S301 + S302 of the Act. The conditions include a person subject to an STDC or hospital based CTO.

- the absconding patient can be taken into custody;
- the absconding patient can be returned or taken to the hospital in which he/she was detained or was to be detained. If this is not appropriate or practicable, the patient may alternatively be taken to any other place which is considered appropriate by the patient's RMO;
- the absconding patient may be returned to or taken to any other place which he/she absconded from or where he/she failed to reside. If this is not appropriate or practicable, the patient may alternatively be taken to any other place which is considered appropriate by the patient's RMO.

The persons who are allowed to carry out the actions described in section 303(1) of the 2003 Act are set out in section 303(3). They are:

- a mental health officer;
- a police constable;
- a member of staff of any hospital;
- a member of staff of the establishment where the patient is required to reside as a result of a residence requirement being specified in a CTO; and
- any other person who has been authorised to carry out any of the above actions by the patient's RMO

In a Shetland context, the Police should be contacted as an emergency via 999 and the individual reported as missing. It is vital that the police are given as much information as possible around location where last seen, direction heading, clothing, etc. along with any significant risks.

A DATIX (adverse event report) should be submitted for any instance when a patient absconds.

## Appendix H – Transport

The following procedure should be followed for all Air transfer requests; it is the responsibility of SAS to ensure that the details of the assessment are documented accurately and all checks are satisfactory prior agreement to transfer. Where a patient is subject the Mental Health act, a minimum of one RMN is required for air transfer.

The following should be read in combination with NHS Shetland Mental Health Air transfer guidance (in development, available through CMHT).

Procedure:

It is the responsibility of SAS to confirm with the referring Doctor that

- the patient's mental health status has been assessed prior to the air transfer request being processed
- Patients who have not been appropriately assessed by the referring Consultant Psychiatrist within the preceding 4 hours may not be accepted for transfer by air.

The Air Ambulance Paramedic will make contact with transferring Mental Health Nurse for the patient and request information to complete the Mental Health Risk Assessment tool.

Once tasking details are received, the Paramedic should make contact with the referring Doctor to gain further information on the patient's condition and devise a risk score in accordance with the risk assessment tool (this allows for a clinician to clinician discussion).

SAS will contact the ward or area where the patient is as a place of safety to advice of estimated time of arrival for land transfer to air strip to meet with air ambulance.

The Commander (Captain) of the aircraft is responsible for the safe conduct of the flight and will always retain the right to refuse any passenger if they are concerned for flight safety or the safety of their crew.

Air transfer documentation should be completed by the transferring Mental Health Nurse and checklist for transfer completed prior to leaving Gilbert Bain Hospital.

The transferring Mental Health Nurse should advise the receiving ward at RCH of estimated time of arrival.

## Appendix I - Assessment of a child/young person during core working hours (Mon-Fri 9-5):

- Child/Young Person to be assessed by CAMHS duty nurse and or case holder at CAMHS department, community setting or A+E for mental state / risk assessment.
- If a completed assessment is deemed a psychiatric emergency, the key worker will liaise with the Community Mental Health Consultant Psychiatrist, who is an AMP, for further assessment. (This is most likely to be CMHT Consultant Psychiatrist unless visiting CAMHS Consultant is on-island).
- Liaison with Young Person's Unit (YPU), Dundee (01382 649031 [tay.taynospgcamhs@nhs.scot](mailto:tay.taynospgcamhs@nhs.scot)) to discuss admission and or support with care planning, treatment and decision making.
- Before admission is considered, the option of home treatment provided by the Shetland CAMHS team in collaboration with the Tier 4 network needs to be explored but bearing in mind the limited resources within the locality home team.
- Multi-agency and family liaison
- If detention deemed appropriate – wider PEP applies
- Referral to YPU to be arranged by locality Consultant Psychiatrist with assistance from CAMHS key worker – referral form must be completed (see CAMHS Team Lead)
- Referral must be accepted by North of Scotland Network
- If no beds available in regional unit, responsibility of local team along with NoS tier 4 specialist nurse to allocate a bed in another CAMHS inpatient facility
- Out of hours the wider PEP applies.

## Appendix J – Rapid Impact Checklist

An equality and diversity impact assessment tool:

Which groups of the population do you think will be affected by this proposal?\*

All – population of Shetland, transient visitors and tourists. This plan is for people who present with a Psychiatric Emergency. All groups are included, the only exclusion criteria is a presentation that is not a Psychiatric Emergency

### Other groups:

- Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers)
- Women and men
- People with mental health problems
- People in religious/faith groups
- Older people, children and young people
- People of low income
- Homeless people
- Disabled people
- People involved in criminal justice system
- Staff
- Lesbian, gay, bisexual and transgender

\*the word proposal is used as shorthand for the policy, procedure, strategy or proposal that is being assessed

**In the following sections, please consider what positive and negative impacts you think there may be and which specific groups will be affected by these impacts?**

### What impact will the proposal have on lifestyles?

For example, will the changes affect:

- Diet and nutrition
- Exercise and physical activity
- Substance use: tobacco, alcohol and drugs
- Risk taking behaviour
- Education and learning or skills

The purpose of this plan is improve the health and wellbeing and life experience of anyone who experiences mental health emergencies in Shetland

This plan supports people who are mentally unwell and as such can seek to positively impact risk behaviours

The plan seeks to support staff across Shetland in how to support people in mental health emergencies

<p><b>Will the proposal have any impact on the social environment?</b></p> <p>Things that might be affected include:</p> <ul style="list-style-type: none"> <li>• Social status</li> <li>• Employment (paid or unpaid)</li> <li>• Social/Family support</li> <li>• Stress</li> <li>• Income</li> </ul>	<p>The plan does not seek to change social environments as such</p> <p>Carers and family are included in this plan</p>
<p><b>Will the proposal have any impact on the following?</b></p> <ul style="list-style-type: none"> <li>• Discrimination?</li> <li>• Equality of opportunity?</li> <li>• Relations between groups?</li> <li>• Fairer Scotland Duty</li> </ul>	<p>This plan supports positive care environments and experiences for people who experience mental health emergencies</p>
<p><b>Will the proposal have an impact on the physical environment?</b></p> <p>For example, will there be impacts on:</p> <ul style="list-style-type: none"> <li>• Living conditions?</li> <li>• Working conditions?</li> <li>• Pollution or climate change?</li> <li>• Accidental injuries or public safety?</li> <li>• Transmission of infectious disease?</li> </ul>	<p>This plan supports positive care environments and experiences for people who experience mental health emergencies</p>
<p><b>Will the proposal affect access to and experience of services?</b></p> <p>For example:</p> <ul style="list-style-type: none"> <li>• Health care</li> <li>• Transport</li> <li>• Social services</li> <li>• Housing services</li> <li>• Education</li> </ul>	<p>This plan seeks to support service experiences which are safe and effective</p> <p>It supports equal access to services and service areas</p>

## Summary sheet

<b>Positive Impacts (note the groups affected)</b>	<b>Negative Impacts (Note the groups affected)</b>
<b>Additional Information and Evidence Required</b> Where appropriate to do so, this PEP will be shared with people in Shetland with lived experience of Psychiatric Emergencies in Shetland	
<b>Recommendations</b> As above	
<b>From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?</b>	

Signature(s) of Level One Impact Assessor(s):

Date:

Signature(s) of Level Two Impact Assessor(s):

Date:

Scenarios potentially addressed by PEP	Yes/ No/ Not Applicable/ contained elsewhere <i>(if not in the PEP but refers to details contained elsewhere, e.g. in local operating procedures)</i>
<b>Initial Contact</b>	
Is it clear who a first responder should contact if they discover a patient in a mental health crisis?	Yes
Are there suitable services that a patient can self-refer to in crisis? Are there services where they can access face-to-face support when appropriate?	Yes
Is there appropriate triage and offer of appropriate support to address presenting problems which may not at their source be diagnosable mental health presentations?	Yes
Have statutory services or others ways of responding to crisis that minimise the need for police intervention?	Yes
Is there a description of a clear predictable response to crisis and evidence of crisis care planning?	Yes
Is there a clear explanation of powers to gain entry to a patients home with consideration for minimising risk and distress caused by deteriorating health (with reference to and explanation of: Mental Health Care and Treatment Act 2003 Section 35 Warrant, Section 292 Warrant, Section 293 and 294 Removal Orders, Application of common law in situations of immediate risk).	Yes
Is there clear guidance on the role of police which minimises as far as possible the use of force and restraint and ensures they should keep a low profile and avoid criminalising the patient?	Yes
Does the PEP emphasise sensitive and empathetic response to patients in crisis? Does the PEP emphasise the need for compassionate non-judgemental care by all professionals involved?	Yes
Is there a plan for prompt provision of AMP/Medical practitioner and MHO out of hours and what their responsibility is?	Yes
<b>Place of Safety (POS)</b>	
Is there a clear and appropriate place of safety specified which provides adequate privacy?	Yes

Are there clear guidelines on when each place of safety is appropriate (for example A&E may be a separate place of safety to a Psychiatric Hospital with different criteria for presenting to each)?	Yes
Are there clear guidelines for when police should be dismissed and pass responsibility to staff at the place of safety for the welfare of a person taken there for assessment?	Yes
Is there a clear procedure for transfer to most appropriate care facility of a patient from police cells where this has been used as a place of safety but there are no criminal charges?	Police Stations should not be routinely used as a POS. If, in exceptional circumstances, a police cell has been used, the general guidance for transport to hospital should be followed.
Is there clarity about the difference in powers and roles of the British Transport Police compared with Police Scotland?	Not applicable in Shetland.
<b>Alcohol and Substance Misuse</b>	
Is there clarity of responsibility for intoxicated patients in mental health crisis which includes a plan for what to do when a patient is too intoxicated to be assessed?	Yes
Is there guidance which explains the need to consider that an intoxicated patient may have underlying distress or other feature of mental or physical ill health needing urgent treatment?	Yes
<b>Transport</b>	
Is it made clear what mode of transport should be used under what circumstances? (this could include reference to police van, ambulance, private car or taxi with staff or with family). Does this guidance take into consideration the principles of reducing stigma and taking the least restrictive option?	Yes
Is there provision for transport of an informal patient which is supportive and with financial provision where necessary?	Yes
Is there clarity of each professional's role in transport to hospital of a distressed patient? Is there clear guidance on use of force where appropriate and who is authorised to do this?	Yes
Is there a safe and appropriate plan for transportation of an intoxicated patient to POS?	There is no specific plan for transportation of intoxicated patients; a decision on appropriate transportation can be made by the AMP and would usually be by ambulance.
Are there guidelines for administering medication to a patient prior to arrival at POS (this should detail whose responsibility and under which circumstances)?	If medication requires to be administered prior to arrival at POS, such as sedation, the NHS Grampian Rapid Tranquilisation policy

	should be followed (available via Grampian Guidance).
If journey to a place of safety may be complicated (e.g. boat or air travel) is consideration given to patient's privacy and comfort and is it clear whose responsibility it is to organise and carry out escort?	Yes
Is there a clear plan for onward travel of a patient following initial assessment at POS and which agency is responsible for this?(including transfer A&E to psychiatric unit, transfer between psychiatric units, organising transport home where appropriate)?	Yes
<b>Assessment</b>	
Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order requires that the individual subject to the act be taken to POS for the purpose of assessment by a medical practitioner. Does the PEP make it clear who has responsibility for carrying out this assessment at the place of safety?	It gives options for different scenarios and the who the responsible person would be for assessment
Is there an outreach service for people when there are concerns about their mental state which prevent them accessing regular services but they have not yet presented in acute crisis?	No specific outreach service in Shetland for this purpose but a number of different local services are available and can be referred to / signposted as appropriate.
Is there clear guidance on when the police should stay during the waiting time for and duration of assessment and how this should be agreed?	No specific time limits but detail on scenario and who to notify if Police leave
Are services trauma-informed and sensitive to needs such as to see a specific gender of professional to reduce distress? Are there services appropriate for patients with Emotionally Unstable Personality Disorder?	Link to transforming psychological trauma framework and a section on trauma informed care have been included
If someone is waiting a long time to be assessed are they in a pleasant environment and are they being supported?	General principles of care would apply, to the extent that this is possible in the hospital environment. In Shetland there are no long waits to MHA.
<b>Resolving Disputes</b>	
Is there a clear plan for what to do when there is a disagreement between professionals for example if MHO and AMP have differing opinions about whether detention is appropriate?	Yes
<b>Sharing Information</b>	

Is there a clear pathway for sharing information which incorporates new GDPR guidance and which includes circumstances when information must be reviewed and shared?	Yes
Is there reference to the duty to share information (as per Caldicott Principle 7: 'the duty to share information can be as important as the duty to protect patient confidentiality'. Does guidance include whose responsibility it is to pass information to relevant parties?	Yes
Is there a system in place to ensure advance statements are available at time of mental health assessment?	Yes
Is there a system in place to establish named person and for them to be consulted?	Yes
Is there a system in place to ensure professionals access any anticipatory care plan or key information summary which can inform any assessment and appropriate management?	The mental health team has access to A&E Trak, and A&E staff have access to Care Partner.
<b>Young People</b>	
Is the definition of young people clear including definitions in differentiating circumstances such as school leaving age, young people in care?	Yes
Is there an appropriate place of safety for young people?	Yes
Is it clear who is responsible for assessment and ongoing care of young people presenting in crisis and is the responsible professional adequately trained to deal with young people?	Yes
Are there appropriate local inpatient and community services specifically for young people?	Yes
Is there consideration to young people in care and their and staff's specific needs?	The PEP does not detail specific considerations for young people in care or the specific needs of the staff caring for them during a psychiatric emergency, beyond general principles for all young people
<b>Carers and Patients with caring responsibilities</b>	
Is there a clear plan for who is responsible and what duties there are in relation to dependents of someone being taken into a place of safety?	Yes
Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order stipulates that the nearest relative of the individual subject to the order must be informed of the use of the act. Is there guidance as to what information should be shared with relatives and carers and who holds this responsibility?	Yes

Is there consideration of carer burden and other dependents when carers are relied upon for informal support?	Yes
Is it made clear that the informal carer does not have to look after the patient and that services are designed in a way that does not pressurise carers into caring for patients?	Services in this PEP are not reliant on carers looking after patient.
Is it made clear that the informal carer should be sufficiently supported and are given the option of statutory services taking over care?	Link to signposting for local services and consideration of formal and informal carers
<b>Missing patients</b>	
Is there a clear plan which covers procedures if a patient absconds from hospital prior to assessment or after assessment?	Yes
Is there clear guidance on unwell patients in the community, and reference to appropriate use of Mental Health (Care and Treatment) (Scotland) Act 2003 Section 35 warrant, Section 292 Warrant and Section 293 Removal Order?	Yes
<b>Homelessness</b>	
Is there a direct referral route from homeless services to access mental health or other appropriate support for residents presenting in crisis?	There are no dedicated homeless services in Shetland; anyone who is homeless or at risk of homelessness could be referred via Housing or Duty Social Work.
Following presentation of a patient who is homeless and in crisis, is there appropriate aftercare linking with homeless-specific services?	As above
Is there consideration of medical and psychiatric aftercare for homeless patients and a pathway to enable them to access GP and mental health services?	If a patient required in-patient treatment but was not resident in Shetland or already being supported by local housing services, an out-of-area transfer to their own locality would be made.  There are no specific homeless services in Shetland in terms of GP and health care. There is no roofless population and no rough sleepers.

<b>Learning Disability and Autism</b>	
Is there consideration for other conditions which might require specific approaches and management strategies?	Yes
<b>Aftercare</b>	
If health agencies cannot provide immediate support, is there guidance on follow-up arrangements and alternatives to deal with distress? Does this guidance ensure that when patients present to a service which will not be providing ongoing input that there remains a duty to respond to the distress and re-direct to appropriate service?	Yes
Is there guidance on how to manage patients when they present in crisis despite an assessment stating they do not need immediate treatment?	We include alternative routes for support
Is there guidance on the recording of outcomes following a crisis presentation?	Yes
Is there consideration of carer needs and support?	Link to local services in updated carers section.
Is there help available to people who are at risk of suicide but who do not have impaired judgement?	Details routes for referral for people who are not an Psychiatric Emergency
<b>Use and Relevance of PEP</b>	
Does the PEP have a clear set of values which ensure good quality patient-centred care?	Yes
When will the PEP be reviewed? Are there stipulations that under certain circumstances the PEP would be reviewed sooner than the statutory 5 yearly review?	It will be reviewed after 24 months.
Is there a plan for dispersion & accessibility of the PEP?	Via local governance structures.
Is there a named manager responsible for PEP publication and review?	Yes
Is there a procedure outlined for recording any emergency clinical actions taken outwith the specifics of the PEP?	Debrief – section details that debrief should be considered and actions outwith PEP can be reviewed through this process

Is there a plan for debrief?	Yes
What parties have been involved in writing up the PEP?	As outlined in Section 1.