Greater Glasgow & Clyde Psychiatric Emergency Plan

(PEP)

2023-2024

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Approved By	Mental Health Quality & Clinical Governance Group
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1. Introduction

The **Mental Health (Care & Treatment) (Scotland) Act 2003**[1][2] came into force on 5th October 2005. In the supporting **Code of Practice**, there is guidance that local agencies and service providers, who might potentially be involved in psychiatric emergencies, should produce a joint **Psychiatric Emergency Plan (PEP)** as a means to help manage the detention of a patient and to support multi-agency working.

The purpose of a **Psychiatric Emergency Plan (PEP)** is to agree on procedures which would manage the transfer and detention process in a manner which:

- Minimises distress and disturbance for the patient,
- Ensures as smooth and safe a transition as possible from the site of the emergency to the appropriate treatment setting,
- Allows potential local difficulties to be addressed, and contingency procedures put in place, before they arise for real.

The PEP is drawn up and agreed following consultation with general practitioners, approved medical practitioners, MHOs, other social workers, social care workers, CPNs, ward nursing staff, independent service providers, police officers, and ambulance personnel. Input should also be provided by mental health service users and carers, to draw on their experience of accessing services.

The PEP can be used as a basis for joint training of all those professionals named in the plan as having specific responsibilities in the transfer and detention process.

The PEP should be updated regularly, particularly in light of any significant incidents or specific difficulties, which may have arisen since the PEP was last updated. NHS GG&C aim to update the PEP annually.

The Mental Welfare Commission (MWC) have produced guidance on what would be helpful to have included in a PEP at: http://www.mwcscot.org.uk/node/1475.

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[1] Herein referred to as the Act
[2] Amended by the Mental Health (Scotland) Act 2015

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1.1 Key Principles

- The PEP sets out clear guidance for staff who may be involved in the detention of patients or discharge of any other functions under the Act.
- All statutory services must act in the best interest of the patient to deliver high quality care and to treat patients with compassion, respect and dignity at all times.
- The PEP is underwritten by the principles of the Act and any action undertaken while discharging a function under the Act must take account of the principles.
- Clinicians should also be mindful of the application of **Adult Support and Protection** legislation and **Child Protection** procedures.
- Certain areas or specialties may wish to develop local PEPs. These must comply with this over-arching PEP and be submitted for inclusion in the appendix.
- This document sets out specific arrangements for the assessment, transfer and care of patients detained under the Mental Health Act. However the principles of the act also apply to mentally ill patients not detained under the Act (informal patients). Therefore to avoid prejudice in the care of informal patients, where there is uncertainty, the PEP should be used in the absence of any other policy or guidance on how to proceed.

1.2 Who does PEP apply to?

The PEP applies across all ages and care groups in NHS Greater Glasgow & Clyde, and also to the ‘Northern’ and ‘Cambuslang/Rutherglen’ corridors. Appendix X outlines areas covered by services in NHS GG&C.
This guidance is applicable to all NHS health care staff, local authority staff and police officers and Scottish Ambulance Service.

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<u>Guidance for services Users and Carers:</u>

For services users in crisis, or where first responders are carers or members of the public, they should seek assistance from emergency or primary care services, whereupon the **PEP** guidance will be followed by professionals. Points of contact in an emergency are:

- GP
- NHS 24 on ‘111’
- Local Emergency Department
- Mental Health Assessment Units (MHAU) at either Stobhill or Leverndale Hospitals
- CMHT for those already known to mental health services

People who are struggling with their mental health or wellbeing, but not needing immediate input from health services, can also access support from the following resources / agencies:

Resource / Agency	Information
Samaritans	A crisis services which provides emotional support to those in distress, those struggling to cope, or those with suicidal thoughts throughout the UK and Republic of Ireland. **They can be called 24hrs a day on 116 123, or their website accessed at www.samaritans.org/?nation=scotland**
Breathing Space	Provides a free, confidential phone line for anyone aged 16 or over in Scotland who is feeling low, anxious or depressed. They provide a safe and supportive space and listen, offer advice, and provide information to those in need. **They can be called between 6pm and 2am Monday – Thursday, and from 6pm Friday through to 6am Monday on 0800 83 85 87. Their website can be accessed at www.breathingspace.scot/**
Scottish Government Campaign	Campaign on cost of living crisis. **The website can be accessed at www.costofliving.campaign.gov.scot/**
National Wellbeing Hub	Lots of information and resources that anyone could use. **The website can be accessed at www.wellbeinghub.scot/**
Togetherall	An online peer-to-peer platform providing support to anyone aged 16-24 with a Glasgow postcode, experiencing mental health and wellbeing issues, such as stress, anxiety, depression, low mood, grief and loss. Trained mental health professionals are also available, as well as a wealth of resources and materials, and various self-help courses. This service can be used anonymously and is accessible 24hrs a day. **This service can be accessed via their website at** www.togetherall.com
Lifelink	Provides a range of services to adults and young people, including various wellbeing classes and counselling services. Counselling can be conducted face-to-face, or by telephone or video call to suit the user. **They can be called on 0141 552 4434, or their website can be accessed at www.lifelink.powerappsportals.com/self-referral/**

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Glasgow Helps	A service which provides a directory of over 600 organisations which can be accessed by members of the public and professionals to locate appropriate support services covering a wide range of areas. **They can be contacted on 0141 276 1185, or the directory of services can be accessed at www.glasgowhelps.org/**
Resources and Planning Tools - NHSGGC	Specific to NHS Greater Glasgow & Clyde. **These can be accessed at www.nhsggc.scot/hospitals-services/services-a-to-z/mental-health-improvement/resources-and-planning-tools/**
Adult MH Helplines &Websites (nhsggc.scot)	Specific to NHS Greater Glasgow & Clyde

1.3 Carers & Carer Rights

One of the core principle of the Mental Health (Scotland) Act 2003 is the need for services to take the views of carers, named person, guardian or welfare attorney into account when making decisions about a patient's care. As such, carers, and carer rights are a fundamental aspect of patient care for services and managers.

***What is a Carer*?**

An adult carer is someone **over the age of 18** who **provides or intends to provide unpaid care to a relative, partner or friend**. This could be caring for someone who is ill, frail, disabled or has poor mental health or substance misuse problems.

A young carer is a person **under the age of 18** who **provides or who intends to provide care for an adult or child** needing care, except where the child needs care solely due to their age.

Carer Rights

Given the important role carers play in the care and treatment of patients; they are to be recognised and valued as **equal partners in care**, the **Carers (Scotland) Act 2016** sets out numerous **rights** to be afforded to carers, including:

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- With the patient's consent, carers have the right to be involved, and have their views considered, when determining the need for support and services for the patient;
- Carers have the right to an Adult Carer Support Plan or Young Carer Statement and to support if their needs meet local eligibility criteria;
- Carers have the right to be informed about and involved in discharge planning.

Other rights include the right to be **informed** if the person they care for has been **removed to a place of safety** due to mental disorder, and the right to be **notified** when the person they care for is going to be **moved to another hospital**.

The informal carer does not have to look after the patient and services should be designed in a way that does not pressurise carers into caring for patients.

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2. Principles of the Act

Non-Discrimination	People with mental disorder should wherever possible retain the same rights and entitlements 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, ethnic, and 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 background, and which properly takes into account their age, gender, sexual orientation, ethnic group, social, cultural and religious background.
Reciprocity	Where society imposes and obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
Informal Care	Where ever possible care, treatment, and support should be provided to people with mental disorder without the use of compulsory powers.
Participation	Services users should be fully involved, in so far as they are able, 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. Information should be provided in a way which makes it most likely to be understood.

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Respect for Carers	Those who provide care to service users on an informal basis should be respected for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
Least Restrictive Alternative	Any necessary care, treatment or support for service users should be provided in the least invasive and restrictive manner, and in an environment compatible with the delivery of safe and effective care, taking account, where appropriate, of the safety of others.
Benefit	Any intervention under the act should be likely to benefit the service user in a way that could not reasonably be achieved without it.
Child Welfare	The welfare of a child with mental disorder should be paramount with regard to any interventions imposed on the child under the act.

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3. Advance Statements and Named Persons in an Emergency

When a patient is being detained under the Act, those involved with the detention must:

- attempt to ascertain if the person has an **Advance Statement**
- identify any existing **Named Person**
- offer information on how to access **Independent Advocacy**.

The duty to identify a **Named Person** and offer information on how to access **Independent Advocacy** falls within the remit of the **Mental Health Officer.**
The identification of the presence of an **Advance Statement** is the responsibility of medical staff.

It is good practice and expected that other members of the care team will assist and support the **Mental Health Officer** and **medical practitioner** with these functions to ensure that the service user is aware of their rights by:

- explaining about the different types of **Independent Advocacy**
- discussing **Advance Statements** when the patient is in hospital and has capacity to make one.
- promoting the role of Named person and providing information and assistance on the nomination process

Staff can ascertain this information from the patient, relative, carers, and/or any electronic patient/service user information management system. Within NHS Greater Glasgow and Clyde, Medical Records will upload nominations of Named Persons information and copies of Advanced Statements to EMIS. **Keyworkers / medical professionals** should update EMIS MDT Template to confirm information about an advance statement has been provided and explained. On EMIS there will be an alert to mental health professionals to the existence of any **Advance Statement** or the nomination of any **Named Person**. It should also be added to local social work systems via the **Mental Health Officer**.

The Mental Welfare Commission have information for patients about advance statements:

- http://www.mwcscot.org.uk/get-help/getting-treatment/advance-statements/

It can be difficult to obtain all the relevant records about a patient outside normal working hours. A degree of pragmatism is needed. In a state of emergency the process of

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detention and admission should not be delayed unduly by the attempt to identify an Advance Statement. However, if one exists and can be readily consulted, this may guide the clinical team in its decision making about the management of a patient e.g. in offering one medication in preference to another.

An **Advance Statement** describes how a patient would prefer to be cared for but this acts as a guide rather than a command to clinical team decision making. If, however, a clinical action is chosen in contradiction to the **Advance Statement,** the reasons for this contradiction need to be clearly described in the patient's case file, and a written record of the reasoning sent to the detained person, their named person, any guardian or welfare attorney, and to the Mental Welfare Commission. This action should be carried out as soon as is practicable.

Follow the link below to a 7 Minute brief Advanced Statements:

http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Learning/Advance%20Statements.pdf

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4. Duty to Inquire, Warrants, Places of Safety and Adult Support & Protection

4:1 Duty to Inquire

Section 33 of the Act places a duty on the Local Authority (devolved to Health and Social Care Partnerships) to inquire into the situation of a person with a mental disorder 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,
- when their property is 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 it has reason to believe that it might be appropriate to proceed with a social work assessment or possibly a medical assessment. The duty to inquire may be carried out by any officer of the local authority.

4:2 Warrants - Section 35 versus Section 293/294

Section 35 warrants are appropriate if it is thought that entry to premises, access to medical records, and/or a medical examination is necessary, but where access has been or is likely to be denied. A warrant granted under section 35 does not authorise the removal of the person at risk to a place of safety, but could facilitate an authorised medical examination. The outcome of such an assessment at the premises might lead to an **Emergency Detention Certificate** or **Short Term Detention Certificate** with **Mental Health Officer** consent.

Section 293 (or section 294, if urgent) is required in order to remove a person at risk to a place of safety, in addition to any warrant sought under **section 35**.

Warrants will be granted by a Sheriff or a Justice of the Peace to a **Mental Health Officer.** Prior to an application, the **Mental Health Officer** should discuss the potential need and process with the appropriate medical services and the police in order to ensure that any necessary support by medical staff and / or police is immediately available.

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When the Local Authority is deciding whether to seek a **section 35** warrant or a warrant under **sections 293 or 294**, the key considerations leading to an application for a warrant will include previous knowledge of the person's circumstances, and the level of perceived risk. If the level of risk is thought to be high, and if it is thought that the person may need to be removed to a place of safety, then **section 293** / **294** warrants should be sought.

Although the code of practice suggests that **section 293** may be appropriate in situations of high risk, account needs to be taken of the fact that in general the 'tests' for a **section 293** are more stringent (i.e. sheriff **must be satisfied there is** mental disorder and **there is** neglect / ill treatment etc, while **section 35** simply requires that **'it appears the person has a mental disorder'** and **may be** subject neglect, or ill treatment etc).

An application for **Section 293** will generally require the sheriff to hear the party mentioned in the warrant before it is granted. In other words, a **section 293** requires more substantial and 'certain' information and may well involve some sort of hearing before being granted, therefore requiring a longer process. In contrast, it may be suggested that a **section 35** warrant requires less 'certain' information, can be sought more quickly and will support further investigation and assessment in the first place.

4:3 Removal to a Place of Safety under Sections 293 - 294

A removal order under s293 allows for entry to specified premises, detention of the patient in a place of safety for up to 7 days and must be executed within 72 hours of being granted.

When removing a patient under a section 293 - 294 the place of safety under the Act means:

- A hospital (both acute and psychiatric)
- Premises which are used for the purpose of providing a care home service
- Other suitable place (other than a police station), the occupier of which is willing temporarily to receive mentally disordered persons

A list of suitable places within Greater Glasgow & Clyde is available in Appendix E

Professionals should remember that behavioural disturbance and mental disorder may have a physical cause: therefore an **Emergency Department** could be the best place

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for the initial medical assessment of some apparent psychiatric emergencies. This would allow physical factors e.g. use of alcohol / psychoactive substances, a fractured skull or an infection to be excluded before the psychiatric assessment of a patient.

If there are no physical health issues causing the presentation thenit may be better to transport the patient directly to a place of safety more appropriate for psychiatric care, such as a Mental Health Assessment Unit, psychiatric unit or care home. Even then it would be expected that a routine physical examination would be involved in initial assessment. Professionals must contact the receiving place of safety, in advance, to inform them that they are bringing a patient.

A prisoner holding area is not an environment suitable for the detention of a person with a mental disorder. However, the ability for Police Scotland to use a police cell in an emergency and when other options are not feasible must remain. This fail safe position must be seen as only suitable in the most exceptional of circumstances. The emphasis must be placed on partnership working and consultation between agencies when approaching these issues.

4:4 Warrant of Entry under S292

The entry warrant under s292 is only used to gain entry to a specified premises and once exercised may not be used again. The purpose of this warrant is to remove the patient under the authority of another existing order (e.g. Section 303).

A sheriff or justice of the peace must be satisfied on evidence from an 'authorised person'. An authorised person is not clearly defined but in practice it is likely that an MHO will make the application but be supported by the **medical practitioner / RMO** who will have the relevant medical information to support the application.

There should be evidence of having attempted to gain access (e.g. 3 attempts) or clear rationale for the urgency. Situations where this may apply are to find absconded patients or to get entry to patients who are already subject to mental health legislation.

4:5 Co-operation of other parties where the duty to inquire arises

The Act requires a range of parties and institutions to co-operate in order to ensure that that the local authority is able to comply with its duty to inquire. All parties signing up to the Psychiatric Emergency Plan must agree to co-operate with the Local Authority and its representatives to discharge this function. These parties will co-operate with such a

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request where that request is compatible with the functions those parties must discharge, and where that request does not unduly prejudice the discharge of those functions.

The Local Authority will initiate their procedures around the duty to inquire when concern over the welfare of a person is brought to their attention, either directly or through one of their officers. The Local Authority will follow the guidance laid out within the Code of Practice Volume 1 chapter 15. The officer of the Local Authority carrying out the duty to inquire will inform the person raising the concern as to the progress of the inquiry while taking care to respect confidentiality.

Section 10 provides more information on supporting role of Police.

4.6 Security of Property

It is the duty of the **Mental Health Officer** to ensure that where an entry warrant has been enforced the premises are then secured (made lockfast). The **Mental Health Officer** also has a duty to ensure the protection of any removable property in the premises including pets.

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4.7 Adult Support and Protection

The Adult Support and Protection (Scotland) Act 2007 came into force in October 2008 to ensure that adults are kept safe from harm or abuse. The legislation places a duty upon Local Authorities (Councils), NHS Boards, the Police and others to work together to protect adults at risk of harm. This includes the powers to make inquiries and take action when it is suspected that an adult may be at risk of physical or psychological harm, neglect or sexual abuse, or being taken advantage of financially. It is important to emphasise that any intervention under the Act must benefit the adult at risk and be the least restrictive option.

If you are worried that an adult who meets these criteria is being harmed, is suffering from neglect, or is being abused, it is important to consider making an adult support and protection referral.

The 3 point test for ‘Adults at Risk’ as defined by the Act is a person who is over 16 years and:

1. Are unable to safe-guard their own well-being, property, rights or other interests
2. Are at risk of harm

3. And because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

Click on the following for further information and guidance.
Adult Protection Referral Form - AP1

Adult Support & Protection Guidance for Health Staff - Guidance Chart

Adult Support & Protection Act - Guidance for NHS Staff

West of Scotland Inter Agency - Adult Support & Protection Practice Guidance

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5. Detention of Patients

5:1 Emergency Detention Certificate versus Short Term Detention Certificate

The Act recommends the use of **Short Term Detention Certificate** rather than **Emergency Detention Certificate** as the preferred psychiatric emergency gateway order. The Act seeks to better protect patients' rights and to involve specialists at an earlier stage in their journey of care. The hope is that fewer detentions will be needed in accordance with the principle of the Least Restrictive Alternative and of Informal Care.

Short Term Detention Certificate allows for up to 28 days detention and for the assessment and treatment of mental disorder in a hospital. The application is by an **Approved Medical Practitioner,** and the granting of the order **requires the consent of a Mental Health Officer**. The detained person has a right of appeal.

Emergency Detention Certificate allows up to 72 hours detention for the assessment of mental disorder in a hospital. **Mental Health Officer** consent should be sought in all cases. However, if it is impracticable to obtain a **Mental Health Officer** the detention may proceed with clear details recorded of efforts made to obtain consent. A clear reason should be recorded as to why an EDC is needed, providing as much detail as possible as to why there is an emergency situation, especially if the EDC is being granted without MHO consent, or if an MHO is unavailable. If an EDC is granted without MHO consent, it is good practice to notify the MHO of the EDC as soon as possible. The application is by **any fully registered medical practitioner**. The detained person has no right of appeal.

The Code of Practice recognises that it is not always in the patient's best interests to delay the process of detention and admission when in an emergency situation: an **Emergency Detention Certificate** may therefore be granted instead of a **Short Term Detention Certificate** if arranging the **Short Term Detention Certificate** were to cause an undesirable delay in the patient's care. The Code of Practice describes a pragmatic approach by services to proceed with any necessary detention as smoothly and quickly as possible so as to facilitate the rapid transport and admission of a patient.

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The application criteria for a **Short Term Detention Certificate** must include:

- A statement that the patient is likely to have a mental disorder, and that because of this the patient's ability to make decisions about the provision of medical treatment is significantly impaired
- A statement that it is a matter of urgency to detain the patient in hospital to determine what treatment is required, **or to give medical treatment**
- A statement that if the patient were not detained there would be significant risk to the patient or others.
- **Mental Health Officer consent is required** at all times
- The application is made by an **Approved Medical Practitioner**

The application criteria for **Emergency Detention Certificate** must include:

- A statement that the patient is likely to have a mental disorder, and that because of this the patient's ability to make decisions about the provision of medical treatment is significantly impaired
- A statement that it is a matter of urgency to detain the patient in hospital to determine what treatment is required.
- A statement that if the patient were not detained there would be significant risk to the patient or others.
- Granting a **Short Term Detention Certificate** would involve undesirable delay.
- **Mental Health Officer** consent or state why it was impracticable to get this.

The certificate must also clearly identify the patient and medical practitioner, include date and time of examination, date and time for the completion of the certificate, and be signed by the certifying medical practitioner.

The **Emergency Detention Certificate** recommendation does not have to be given on a prescribed form; however, it is strongly recommended that the appropriate form (DET 1) is used as this draws attention to the requirements of the Act: all parts of DET 1 should be completed.

The certificate authorises the transport of a patient either to a psychiatric or to a general hospital, whether or not a bed is available at that hospital.

Escort staff must ensure the certificate is lawful before taking the patient into their custody and hospital managers must also ensure the certificate is lawful to authorise detention in hospital. Although escorting staff may have been sent an electronic copy of

the certificate initially, it is of paramount importance that the original documentation is forwarded to medical records.

Admission to hospital can only occur after the certificate has been given to hospital managers.

The detaining medical practitioner must ensure that any certificate is handed to hospital managers (Medical Records or Page Holder) to ensure that the requirements of the Act are met and the detention is lawful. See chapter 11

If detention occurs out with working hours, the detaining medical practitioner must ensure a copy of the certificate/paperwork is scanned and emailed to the relevant Medical Records mailbox (see below) for processing next working day, with the original document to follow as soon as possible. The email must detail where the paperwork has been left, and with whom.

Medical Records Generic Mailboxes

- ***GRH*** **- gartnavelroyal.medicalrecords@ggc.scot.nhs.uk**
- ***Stobhill*** **- stobhill.medicalrecords@ggc.scot.nhs.uk**
- ***Leverndale*** **- leverndale.healthrecords@ggc.scot.nhs.uk**
- ***Dykebar*** **- healthrecords.dykebarhospital@ggc.scot.nhs.uk**
- ***Inverclyde*** **- ggc.crownhousehealthrecords@nhs.scot**

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5.2 Detentions in the Community

5:2.1 Responsibilities of Primary and Secondary Care

When a psychiatric emergency occurs in the community, the primary care service should, if possible, contact the appropriate secondary care psychiatric services prior to making a decision on detention. There is a single point of contact through Consultant Connect to speak with the Mental Health Assessment Unit (MHAU). GPs have access in their practice via the Consultant Connect app, alternatively the MHAU's can be contacted via local hospital switchboard. This contact should happen when a General Practitioner has completed an assessment of the patient's physical and mental state, their social circumstances and level of risk. The **General Practitioner** and or **Mental Health Officer** should consider the need for Police involvement to manage any risk. (See section 10)

The Act indicates that a patient should be seen by specialist mental health services as quickly as possible. In an emergency, the Mental Health Assessment Unit will offer an assessment. A taxi can be provided if the patient agrees to attend the hospital voluntarily. If not staff from the mental health assessment unit will offer a joint assessment with the General Practitioner, if it is likely detention will be required. Experienced nursing staff will do this with the **General Practitioner** and it would be good practice to also contact the **Mental Health Officer.**

If, following assessment, detention is considered necessary, there should be a discussion between the **General Practitioner** and an **Approved Medical Practitioner** as soon as is practicable. Psychiatric staff should remember that a **General Practitioner** may find himself in a difficult or risky situation and that he will need direct and immediate access by phone to an **Approved Medical Practitioner** and **Mental Health Officer**. Access to an **Approved Medical Practitioner** will be through the process described in section 5:2.2.

The discussion between the **General Practitioner** and an **Approved Medical Practitioner** should firstly focus on what other options to detention may be possible. This may include discussions about alternatives such as crisis team support or informal admission. If it is mutually agreed that there is no viable option, the process of detention should be discussed.

Arrangements for a **Short Term Detention Certificate** assessment and detention should then ideally occur if the attendance of the **Approved Medical Practitioner** and **Mental Health Officer** can be arranged safely and does not pose a delay of greater than **1 hour** (as a guide). However, an AMP may advise to proceed with an **EDC** if there is likely to be a delay or it is felt there is a clinical risk in delaying a secondary assessment by the **Approved Medical Practitioner**. It must be remembered that the use of the **Short Term Detention Certificate** is the preferred form of detention in an emergency.

Most out of hours psychiatric emergencies that require detention will be served by an **Emergency Detention Certificate.** A **General Practitioner** will have already assessed the patient and the delay posed by the travelling of a duty **Approved Medical Practitioner** from his home at night may be considered 'undesirable' or would potentially increase the clinical risk / distress to patient.

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If clinical urgency dictates that the **General Practitioner** has no time to contact the **Approved Medical Practitioner** or **Mental Health Officer** before issuing an **Emergency Detention Certificate,** then he should inform the appropriate **Approved Medical Practitioner** so as to ensure that the **Approved Medical Practitioner** can make arrangements to review the patient, along with a **Mental Health Officer**, as soon as is practicable.

General Practitioners and **Approved Medical Practitioners** should focus on pragmatism, putting the needs of the patient and their carers first, whilst taking into account the preference for a **Short Term Detention Certificate.**

5:2.2 Accessing Mental Health Services

In an emergency, patients must be put in touch with specialist mental health services as soon as possible. If a patient is assessed by a **General Practitioner** as requiring detention, the **General Practitioner** should contact the Mental Health Assessment Unit through a single point of contact, the Consultant Connect app or via the local hospital switchboard.

The Mental Health Assessment Unit will have processes in place to contact an **Approved Medical Practitioner**. This will ensure the General Practitioner can consultant with an **Approved Medical Practitioner** about an Emergency Detention Certificate required as a matter of urgency, when it would be impracticable to delay to allow an assessment by an **Approved Medical Practitioner**. It will also allow coordination when both they and the **Mental Health Officer** are required to attend a psychiatric emergency.
Patients who are known to the local CMHT or open to another mental health service, will be redirected by the MHAU to their usual service, unless it is out of hours. It is expected that the local team would have arrangements to respond to any patient on the case-load who is in crisis, as they would know the patient best.

5:2.3 Patient Transport and Support

The responsibility for organising the transfer of the detained patient to hospital is assumed by the **Certifying Medical Practitioner**. However, in practice the receiving mental health service will take on this responsibility once contacted by the **Certifying Medical Practitioner** after detention. If mental health staff e.g. from MHAU or Crisis

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Team, have been present when a decision to detain has been made, they will remain with the patient until transfer can be arranged.

This **Certifying Medical Practitioner** should inform the **Duty Doctor** at the appropriate receiving psychiatric hospital, giving patient details, confirmation of detention, and their own contact phone number as well as requesting an escort and transport for the patient. The **Duty Doctor** in turn should contact the **Hospital Manager / Bed Manager,** passing on the contact phone details. (See section 11 for a definition of a hospital manager)

The **Hospital Manager** must organise a nursing escort and transport, thereafter contacting the **Certifying Medical Practitioner** in order to confirm arrangements and timescales. All detained patients must be provided with an escort via the locality psychiatric services to which the patient would normally be admitted. For under 18s see section 7.3. If patients are being transported from another Health Board, responsibility for transfer would be with the transferring Health Board.

Escort staff should be a **1st level registered nurse** and additional escorts as considered appropriate by the **Hospital Manager** according to the clinical situation and discussion with the Certifying Practitioner about any risks. Preferred transport, where this is available, should be **the contracted taxi provider** which should arrive with the patient as soon as possible and within **two hours** at the latest of its being ordered. Depending on the risk assessment of the situation an ambulance may be required as an alternative mode of transport. In this circumstance escort staff should still attend the patient using the contracted taxi provider and await the ambulance with the patient. Considering the risks posed to patients and staff, the use of personal transport such as lease cars by community staff to transport patients is **not** an option unless absolutely unavoidable.

Following Detention, if access is lost to remove the detained individual to hospital, or if there are threats or potential threats of violence, or the person is believed to be in possession of a weapon, (Police may gain access first in these situations) the appropriate **Mental Health Officer** should be contacted by the **Hospital Manager** to support medical staff to apply for a **section 292 warrant** to enable entry. It would be the duty of the **Mental Health Officer** to ensure the **police** are present to enforce the warrant. If weapons or threats are involved, then the **police** will intervene to prevent harm to any person present.

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5:2.4 Effect of a Detention Certificate

The issuing of both the **STDC** and **EDC** give lawful authority for a patient to be removed to hospital and for keeping that person in hospital for the specified period.
To enforce the certificate circumstances may arise where restraint will be appropriate. Restraint has to be a proportionate response to the needs of the patient and the assessed level of risk. Circumstances where restraint may be appropriate are, for example, to prevent the patient from leaving the custody of staff, to facilitate the transport of the patient to hospital or a place of safety, prevention of violence and self harm. (See section 10)

It is important that all staff both in hospital and community settings consider the need to do what is reasonable in the circumstances to prevent any reasonably foreseeable harm to the patient and staff (Duty of Care) and follow relevant policies to manage these situations.

If an EDC or STDC is authorized by a medical practitioner, but the patient absconds before they can be transferred to hospital, then they should be considered a missing person. The certifying doctor should then inform the appropriate duty **Approved Medical Practitioner**, **Mental Health Officer** and the **Police** of the detention and ask the latter to consider the patient a missing person and to affect their transfer to the relevant Psychiatric hospital under the powers of the said **Emergency Detention Certificate**.

5:2.5 Transporting a Detained Patient to a General Medical Hospital

In the event that a patient is detained under the Mental Health Act but requires to attend a General Medical Hospital for assessment and or treatment for serious / life threatening issues, the **Certifying Medical Practitioner** should communicate with the **Hospital Manager** for the psychiatric hospital where the patient would normally be admitted. The responsibility to decide whether or not the patient being detained requires acute medical assessment or services prior to admission into a Psychiatric facility is the responsibility of the **Certifying Medical Practitioner.**

The **Hospital Manager** for the psychiatric hospital will have responsibility to identify and provide escort and transport for the patient. The need for escort should not delay transport in the case of a "blue light emergency". The **Certifying Medical Practitioner** must contact the **Hospital Manager** for the General Medical Hospital to inform them of

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the detention and ensure that the certificate is delivered to **Hospital Managers** of the General Medical Hospital.

Responsibility for the patient will hand over to the General Medical Hospital, within an Emergency Department or ward, depending on what facility the patient arrives at first, upon the handing over of the detention certificate (DET1 or DET2 Certificates) to the **Hospital Manager** for the General Medical Hospital. This form must be sent to Health Records for processing or the detention is not valid. The **Hospital Manager** must ensure that Liaison Psychiatry and / or Out of Hours psychiatric services are informed of the detention to ensure timely review.(See section 11 for details on the hospital manager)

5:2.6 Patient Handover

When the patient arrives at hospital, the **Hospital Manager** or their representative must authenticate the certificate and then carry out their notification duties as laid out in the Act. The detention period commences at this point. (See section 11:2)

Hospital managers at the receiving hospital and the escort staff must in all circumstances, whether the patient is detained or not, participate in a formal handover of the patient. This will entail the passing over of any relevant paperwork and information, and the clear acceptance of the patient's care by the receiving team. Until the receiving team has formally accepted the patient, the escort staff must remain with the patient.

Care of the Patient in an Emergency Department

Handover of patients who are detained and escorted by staff from a psychiatric hospital must happen as swiftly as possible to allow escort staff to resume other duties. The handover should occur no more than **2 hours** after arrival at the department.

Once handover has occurred patients awaiting assessment within the Emergency Department are the responsibility of that department: any requirement to administer emergency medication or to set a higher degree of nursing observations remains with the Emergency Department.

Where a patient is to be seen for a short period of time prior to being admitted to a psychiatric facility (e.g. stitches, wound dressing) the escort staff should remain with the patient to provide ongoing escort for return to the psychiatric facility. This period of time would be part of the 72 hour for EDC or 3 days for STDC allowed for the removal of the

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patient to hospital. The patient during this time will remain in the custody of escort staff and must be accompanied at all times by the escort staff when in the Emergency Department. Staff in the Emergency Department should notify escort staff of the expected length of time for the patient's treatment.

5:2.7 Identification of Psychiatric Beds for Admission

It is always preferable for the patient to be cared for in a hospital within their catchment area. If this is not possible the nearest available hospital should be the next preferred choice. If there is a delay in accessing the nearest available psychiatric hospital bed, the patient should be moved to the catchment area hospital **(using a pass bed, or any other available bed in the hospital - this would include IPCU and elderly beds but exclude Forensic, addictions and CAMH beds)** until an appropriate bed is found. The crisis services, the appropriate bed manager and the Duty Psychiatrist should at all times be informed of the detention and the need for admission.

- The **Hospital Manager** / **Bed Manager** for the hospital will liaise with the wards to identify where there are vacant beds.
- If there are no available beds then the **Hospital Manager** / **Bed Manager** will liaise with his/her colleagues across the board area initially or elsewhere in Scotland in a bid to resolve the situation.
- For all under 18 admissions see appendix S.
- For all women in late pregnancy or within 12 months of childbirth, contact the West of Scotland Mother and Baby Unit based at Leverndale Hospital.
- For patients who are being sent out with their catchment area, the **Bed Manager** will advise as to which consultant is receiving out of area admissions.

5:2.8 Boarding Out

If there are no beds at the appropriate hospital the **Hospital Manager/Bed Manager** must take responsibility for finding a suitable bed in liaison with the Duty Doctor, negotiating admission with the relevant site and arranging an escort and transport. Even if there are no beds, then the patient's usual catchment hospital will take responsibility for the escort and transport to the boarding hospital.

Within Greater Glasgow & Clyde there is no need for Consultant to Consultant (**Approved Medical Practitioner**) discussion to authorise boarding and admission. However, if a patient is required to be boarded into another Health Board area, or into

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Greater Glasgow & Clyde from other Board areas, then the appropriate Greater Glasgow & Clyde **Approved Medical Practitioner** must be involved by telephone.

The primary clerk in and physical examination of the patient will be carried out by the receiving hospital when admitted under detention from the community.

The ward at the originating hospital (where the patient is being moved from) will keep in contact with the patient's family to ensure they are kept informed if the patient is moved.

5:2.9 Actions Following the Making of an Emergency Detention Certificate

The **Approved Medical Practitioner** who has been made aware of the detention must make arrangements to review the patient 'as soon as is practicable'. The purpose of this review is to make a decision about the **Emergency Detention Certificate** – either to lift it or to grant a **Short Term Detention Certificate** with **Mental Health Officer** consent.

The term 'as soon as is practicable' is interpreted to mean that following admission of the patient they should be examined/interviewed by the **Approved Medical Practitioner** and **Mental Health Officer** within 24 hours of the time of admission. At weekends and on Public Holidays, all mental health and acute hospital in-patient services have access to an on call **Duty Approved Medical Practitioner** who should review the necessity of continued detention and the patient's need for compulsory treatment. In some cases for clinical reasons the patient may require a delay before the review e.g. patient is catching up on sleep. In these cases it is recommended that the reasons for the delay in reviewing the **Emergency Detention Certificate** be noted in the medical records.

5:2.10 Dispute Resolution

When a delay is possible as a result of a dispute between the **Certifying Practitioner** and **Approved Medical Practitioner** as to whether **Emergency Detention Certificate** or **Short Term Detention Certificate** is the more appropriate, then the **Certifying Practitioner** should proceed to an **Emergency Detention Certificate** so that admission is arranged without delay.

If the **Certifying Practitioner** feels there is no option but detention and the **Approved Medical Practitioner** disagrees, the **Approved Medical Practitioner** should either

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assess the patient directly himself or the **Certifying Practitioner** should proceed to **Emergency Detention Certificate**, if possible with **Mental Health Officer** consent.

If the **on call Approved Medical Practitioner** is not available to attend for the review of the **Emergency Detention Certificate**, the responsibility for organising a response from another **Approved Medical Practitioner** remains with the **on call Approved Medical Practitioner** and should not be passed to anyone else.

5:2.11 Patients Subject To Suspension of Detention (CTO or CO)

The patient's **Responsible Medical Officer** may revoke a suspension certificate where they are satisfied that it would be in the best interests of the patient, or in order to protect another person. A revocation requires the **Responsible Medical Officer** to notify various parties within a reasonable time after the revocation: this is a planned event and not within the scope of the PEP.

When an emergency situation arises, and a patient requires to be brought back into hospital, the **Responsible Medical Officer** may revoke the certificate so that the patient can be taken into custody for return to the hospital. The following considerations should be made out of hours:

- The **on call Approved Medical Practitioner** may authorise the revocation of the suspension. This can be communicated verbally to the on call medical staff on site. The **Approved Medical Practitioner** has to be satisfied that the evidence available indicates that the recall is necessary in the interests of the patient or to protect others. This may require an on-site medical examination of the patient.
- As a last resort an **Emergency Detention Certificate** or **Short Term Detention Certificate** can be made if detention is appropriate. The patient's **Responsible Medical Officer** must subsequently review the situation and revoke both the suspension and detention certificate allowing the patient to be detained in hospital under the original order.

Patient and public safety are paramount and therefore a pragmatic approach should be adopted to ensure the patient is returned to hospital as quickly as possible with a minimum of distress to him/her and their family / carers.

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5:2.12 Referrals from Police Custody Healthcare Service

Referrals for urgent mental health issues may arise regarding individuals in police custody. An initial assessment will be undertaken by the Police Custody Healthcare Service, ideally by an RMN, and background information re contact with psychiatric services obtained. If no RMN is available and assessment is required urgently, Police Custody healthcare staff will refer to the service in which patient is known, or whichever service is closest to the police station the patient is being held. Police will arrange to transfer the patient to the service for assessment and wait with the patient until there is a decision on whether admission is required.

The Police Custody Healthcare (RMN) will carry out an assessment and if emergency admission is deemed appropriate, they will arrange for admission by contacting the bed manager and duty doctor in the catchment hospital advising of the reasons for seeking admission. (If the patient is being referred to Renfrewshire services during working hours, then in the first instance contact the Dykebar Duty Consultant via RAH/ Dykebar Switchboard to discuss potential admission, prior to contacting the Duty Doctor or Page Holder.). The Police Custody RMN must seek agreement from Police Scotland that patient can be released from custody for an informal admission assessment. It may be appropriate for a person to be assessed at the service nearest to the Police Custody Suite if:

1. The person is homeless
2. The person lives out with NHS Greater Glasgow and Clyde area

Emergency Departments: Individuals in Police Custody should only be attending Emergency Departments (ED) if they require medical attention for a physical health care problem and will be escorted there by the police. If ED staff considers that a psychiatric assessment / emergency detention is required, then the ED staff should return them to Police Custody if they are physically fit and they will receive a mental health assessment by police custody healthcare staff.

The police will have responsibility for deciding if they can release the individual from custody to allow them to receive psychiatric input in hospital (either as informal patient or using civil mental health legislation) or the community. If admission is arranged it is the responsibility of the Police to liaise with inpatient areas re information about charges/ offences the person has committed and how this will be taken forward by the Procurator Fiscal's Office. If admission is not necessary then the person should be returned to Police

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Custody and healthcare staff there made aware that the person has been returned, and relevant information shared.

The police or procurator fiscal may decide it is not appropriate for the individual to be released from a custodial setting. The police custody service will put in place care plans and risk management plans until the first court appearance and pass information to the court diversion scheme (see next section).

Serious offences that have involved serious aggression (assault to severe injury, attempted murder, murder) or serious contact sexual offences (rape / attempted rape) are not appropriate for Diversion to a local hospital or IPCU and further expert assessment will be required by medium or high secure service. In such cases, a recommendation should be made for the Procurator Fiscal to seek psychiatric reports and refer to the appropriate medium secure or high secure hospital from a custodial setting.

There are provisions within the Criminal Procedures (Scotland) Act 1995 that allows the courts to deal with cases where there are concerns about fitness to stand trial. Further advice can be provided by the On-call Consultant Forensic Psychiatrist.

5:2.13 Detentions in a Court Setting

Greater Glasgow and Clyde has a Sheriff Court liaison/diversion service which operates in the 4 Sheriff Courts within the Board area (Glasgow, Paisley, Greenock, and Dumbarton). The service involves triage and initial assessment by Forensic CPNs with medical staff being called to attend as necessary. The role of the Diversion scheme is to divert those who are acutely mentally ill and who need in-patient care to hospital. The service is not to provide expert opinion on e.g. fitness for trial.

Referrals to the court liaison service are made by the Procurator Fiscal to the Forensic CPN Team. If the FCPN considers that diversion to hospital may be required, the on call medical staff (Psychiatric Higher Trainee) will be asked to assess to consider if a detention under an Assessment Order is appropriate. The recommendation is made using an assessment order form.

Individuals who are facing charges and would otherwise be remanded may only be detained to hospital if the court makes an **Assessment Order** or **Treatment Order** (Section 52 of the Criminal Procedure (Scotland) Act 1995).

For an Assessment Order to be made there must be reasonable grounds to believe that:

- The person has a mental disorder (the category of mental disorder need not be specified);

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- Detention in hospital is necessary to determine if the person meets the criteria for a Treatment Order;
- If not assessed in hospital there would be a significant risk to the health, safety, or welfare of the person or a significant risk to the safety of any other person.
- A **suitable** hospital bed **will be available within 7 days.** This should be an IPCU or other secure bed, given that the person would otherwise be on remand.

Patients detained on an Assessment Order (or Treatment Order) are transported to hospital by court services (currently GeoAmey).

If the Procurator Fiscal decides not to pursue the case, so that the charges are dropped, or if the person is bailed at court, the patient may be detained using the 2003 Act, on an EDC or STDC. Admission in such cases would be to a bed in the locality hospital and transport arranged as outlined in Section 5.2.3.

NB – a hospital should not be used as an appropriate bail address.

Patients on Assessment or Treatment Orders should not be transferred to open ward settings. This is because these are remand orders, and thus patients technically have 'restricted patient' status (which involves liaison between the RMO and the Scottish Government- refer to the Memorandum of Procedure on Restricted Patients). Therefore, best practice is always to transfer to an IPCU bed in the first instance unless the nature of the alleged offence, or other aspects of the individual, indicate that medium or high secure care needs to be considered.

More serious offences that have involved serious aggression / violence or serious contact sexual offences are unlikely to be appropriate for Diversion to a local hospital. In such cases, a recommendation should be made for the Procurator Fiscal to seek psychiatric reports and refer to the appropriate medium secure or high secure hospital from a custodial setting. Further advice can be provide by the **On-call Consultant Forensic Psychiatrist**.

Patients who need diversion from court should initially be discussed with the senior on-call for Forensic Psychiatry before the appropriate bed manager and clinical team are contacted and any written recommendation is made. This will ensure the most appropriate setting for the patient's ongoing care is considered fully.

Urgent Detention of Acquitted persons: If a person is acquitted of a charge the Sheriff may detain the person under s60C of the Criminal Procedures (Scotland) Act 1995 for a period of up to 6 hours for the purpose of medical examination. Section 60C can be

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recommended when: there is evidence from two medical practitioners that the person has a mental disorder; there is medical treatment available to prevent or alleviate symptoms; and that there is a significant risk to the health safety or welfare of the person or to the safety of others.

The detention of the person is to a place of safety. In the first instance this will be the Sheriff court, although the court may organise for the person to be taken to a Mental Health Assessment Unit for a medical examination. It would then be for the hospital where the person would normally be admitted to organise for medical examination to take place; this would include the provision of transportation and escort.

5:2.14 Detentions in a Prison Setting

Where a prisoner requires transfer to psychiatric hospital for assessment and/or treatment civil legislation cannot be used. Instead an **Assessment Order** or **Treatment Order** is used for remand / unsentenced prisoners.

A Transfer for **Treatment Direction (TTD)** is used for sentenced prisoners and a local MHO should be consulted to approve detention, giving them as much notice as possible. The relevant forms are on the Scottish Government website and need to be completed by medical staff (2 recommendations required for treatment order or TTD) following an examination of the patient.

It is essential that any doctor who has examined the patient in prison and is proposing transfer liaises closely with the proposed hospital, and in particular secures agreement with the receiving clinician *prior* to any recommendation for transfer being made. They must also seek MHO consent for a TTD and document outcome of discussions.

In terms of a suitable hospital bed being available, the 7 day rule also applies. As such, if a bed fails to be found within 7 days, and a transfer to hospital is still necessary, the medical recommendations will need to be renewed.

Transport is arranged by the prison using GeoAmey.

5.2.15 Prisoners Requiring Emergency or Urgent Treatment in Acute Hospital

Prisoners who are on remand or sentenced, may require transfer to acute hospital for treatment of physical illness or physical sequelae related to mental disorder e.g. acts of deliberate self-harm or delirium relating to organic / physical issue; delirium secondary to drug induced psychosis.

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Prison rules allow a prison governor to authorise a prisoner to be escorted to an acute hospital site by SPS staff / GeoAmey for treatment. If a prisoner is refusing to attend for treatment; is in hospital and trying to leave; or is resisting treatment being given in hospital, then it may be necessary to consider an assessment of capacity, under Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003 to facilitate further assessment / treatment.

Prison rules can allow a prisoner to be brought from prison to hospital, but cannot enforce treatment.

If a prisoner is receiving treatment in an acute hospital and is considered to have capacity and is refusing some aspect of their treatment then treatment cannot be given. If a prisoner is acutely agitated e.g. due to delirium and in need of treatment, then it would be appropriate to consider if they have capacity to consent to treatment. If they lack capacity but can be persuaded or are not resisting treatment then treatment under AWI legislation using a Section 47 certificate may be sufficient.
If a prisoner is acutely agitated, or is refusing treatment and wishing to leave hospital then detention under mental health legislation may be required. An assessment should be undertaken to review for the presence of mental disorder which may be impacting on capacity and decision making abilities. If necessary, it may be appropriate to move to detention under the Mental Health (Care and treatment) (Scotland) Act 2003 if the criteria for detention on either an EDC or STDC are met. An MHO should be consulted before a decision is taken. If the medical practitioner is not an AMP, then efforts should be made to seek advice from an AMP too. In circumstances such as these, a Transfer for Treatment Direction or an order under the Criminal procedures (Scotland) Act 1995 would not be the most appropriate, as they do not fit the urgency of the situation and nature of the treatment setting.

Section 5.4 of the PEP provides guidance on urgent / emergency medical treatment. If a prisoner is physically well and medically fit for discharge, but continues to require inpatient care for mental disorder, then further psychiatric review will be required to consider the most appropriate order and secure placement for psychiatric treatment to continue. See 'Section 5.2.14 Detentions in a Prison Setting'.

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5:2.16 Assessment and admission Forensic Community Patients

Please refer to appendix X for procedures on the assessment and arrangements for admission of patients managed by the Forensic CMHTs

5:3 Detention in Hospital

5:3.1 Detention in a Psychiatric Facility

Where an informal inpatient is requesting discharge against medical advice and cannot reasonably be persuaded to stay, nursing staff must ask the patient if they will wait to see the Duty Doctor.

If the patient refuses to wait until the Duty Doctor attends, the nurse must consider whether they need to use the **Nurses Power to Detain** Pending Medical Examination. **Detaining a patient without lawful authority, even for a short period of time is unacceptable.**

Nurse's Power to Detain Pending Medical Examination

(Nurse's Holding Power)

The nurse's power to detain can be used in any hospital setting, including clinics in hospital, general wards and emergency departments, where a person is receiving treatment or assessment of mental disorder. The use of the holding power can only be authorised by a **first level Registered Mental Nurse** or **Registered Learning Disabilities Nurse**. It is used to detain a patient for the purpose of obtaining medical examination to determine whether a **Short Term Detention Certificate** or **an Emergency Detention Certificate** should be granted.

The "holding period" lasts for up to **3 hours**.

The nurse must contact the appropriate **Duty Doctor** who should interview the patient as soon as possible and discuss their presentation with the nursing team and any other relevant individuals, such as the patient's carers / named person. If practicable the **Mental Health Officer** service should be contacted at this time by the **Nurse**, to inform them that the power has been used and that a possible further detention is being considered to improve the opportunity for a **Mental Health Officer** to attend.

A written record must be made using the NUR1 form which must be forwarded to health records. A copy of the form can be found by following the link below:

NUR+1+v7.1.pdf (SECURED) (www.gov.scot)

Notification of detention must be made to the on call **Mental Health Officer** and the **Hospital Manager** by the nurse applying the holding power. Notification to the **Mental Welfare Commission** by the **Hospital Managers** must be made within **14 days.**

Detention by a Medical Practitioner

To authorize detention, the **medical practitioner** must be fully registered (i.e. FY2 or above).

During routine working hours, there is an expectation that appropriate supervision and review arrangements are in place for all patients seen.For emergency assessments:

- All FY/core trainees should do an assessment with a duty nurse whenever possible, AND
- All FY/core trainees should discuss emergency patients with an appropriate senior medical colleague.

For patients who are trying to leave, the **Duty Doctor** should make an assessment of the patient to ascertain whether it is safe to discharge the patient and if they have capacity to make that decision. If the duty doctor believes the patient meets the criteria for detention he should contact the **Approved Medical Practitioner** and **Mental Health Officer.**

Within working hours, **Short Term Detention Certificate** would be the expected detention mechanism unless the **Approved Medical Practitioner** assessment or **Mental Health Officer** attendance would pose a delay of over **an hour** or the risk to the patient or others was too great to delay.

The **Approved Medical Practitioner,** when contacted, should make a firm decision as to whether he can attend within the hour, and if he cannot, then, having fully discussed the case with the **Duty Doctor**, he might advise the **Duty Doctor** to detain the patient by means of an **Emergency Detention Certificate.** Alternatively he might feel it preferable to ask a different **Approved Medical Practitioner** e.g. consultant colleague to assess for **Short Term Detention Certificate** in his place. A pragmatic and flexible response is intended, deciding on a course of action based on the patient’s individual situation and the availability or otherwise of the **Approved Medical Practitioner**.

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5:3.2 Detention in a General Medical Hospital

If an informal patient, who may fulfill the detention criteria, is requesting discharge against medical advice from a General Medical Hospital and cannot reasonably be persuaded to stay, nursing staff should contact the appropriate **Duty Medical Doctor** (a fully registered and licensed **Medical Specialist Trainee / FY2** or above) who should, as soon as possible, interview the patient, review his medical status, mental state, decision making capacity and risk assessment. If the duty doctor believes the patient meets the criteria for detention he should contact the **Approved Medical Practitioner** and **Mental Health Officer.**

The **Medical Specialist Trainee / FY2** should contact the appropriate local **Psychiatric Duty services** for advice if there is a concern about a mental health issue**.**

- **Within working hours** this will be the local **liaison psychiatric service**.
- **Out of hours** this can be arranged by contacting the local MHAU at either Leverndale Hospital or Stobhill Hospital**.**

Queen Elizabeth University Hospital	Leverndale	**0141 211 6400**
New Victoria	Leverndale	**0141 211 6400**
Royal Alexandria Hospital	Dykebar	**0141 201 1099**
Inverclyde Royal Hospital	Langhill Clinic	**0141 314 9504**
Glasgow Royal Infirmary	Stobhill	**0141 531 3100**
Gartnavel General	Gartnavel Royal	**0141 211 3600**
Vale of Leven	Gartnavel Royal	**0141 211 3600**
Stobhill ACAD	Stobhill	**0141 531 3100**

The psychiatric services should pass on the **Medical Specialist Trainee / FY2's** contact details and the appropriate **Approved Medical Practitioner** should phone the medical **Specialist Trainee / FY2** immediately and discuss the situation.

If the **Approved Medical Practitioner** agrees that detention is needed he will either attend and assess the patient himself, along with a **Mental Health Officer,** with a view to making a **Short Term Detention Certificate** or instruct the **Medical Specialist Trainee / FY2** to proceed to an **Emergency Detention Certificate** with, if practicable, **Mental Health Officer** consent. Only fully registered and licensed medical practitioners can grant **Emergency Detention Certificates**.

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If the situation is one of acute risk e.g. the patient is violent or is being forcibly restrained, the **Specialist Trainee / FY2** should directly grant an **Emergency Detention Certificate** without **Mental Health Officer** consent or **Approved Medical Practitioner** contact. Where a patient is detained in an acute setting, it is acute services responsibility to obtain RMNs for observation/supervision of the patient if this is deemed necessary.

Where a detained patient from a mental health in-patient unit, **who is also under an observation level**, needs transferred to an acute hospital for **physical** treatment, the mental health **in-patient** service retain the responsibility of providing RMN supervision for the patient if this is necessary. It should be clearly noted in the risk assessment when a decision is made that this is not necessary.

Approved Medical Practitioner Involvement

Telephone contact with an **Approved Medical Practitioner** must happen for all acute hospital detentions even if the **Medical Specialist Trainee / FY2** has had to proceed to **Emergency Detention Certificate** where there has been insufficient time to contact an **Approved Medical Practitioner** or a **Mental Health Officer**. An **Approved Medical Practitioner** must be made aware of the detention **no later than 8 hours** from the point of detention commencing to make arrangements for the review of the patient 'as soon as is practicable'.

The purpose of the AMP review is to make a decision about the **Emergency Detention Certificate** – either to revoke it, or to grant a **Short Term Detention Certificate** with **Mental Health Officer** consent. 'As soon as is practicable' will depend on service arrangements – it must happen within **72 hours** of detention / admission and generally should happen within **24 Hours** including weekends and public holidays. Patients should not be prematurely reviewed e.g. disturbing their sleep. It would be expected that this decision would be discussed with the team, with the decisions and reasons recorded in the notes.

(See 5: 5.3 Emergency Detention Certificate in an Acute Setting Flowchart)

5.3.3 Patients Who Wish to Leave or Abscond from an Acute Hospital Prior to Medical Examination

Where it would not be possible to use the Nurses Power to Detain under s299, a patient may be prevented from leaving, and be restrained and / or sedated by staff under a duty of care and the common law doctrine of necessity. The use of common law powers should only be considered as last option, and where there is **no alternative course of action** available, such as detention under the Mental Health Act, to prevent immediate

danger of death or great bodily harm. Medical / surgical staff should clearly record their action in the casefile and complete a Datix report. After the immediate use of common law the staff should consider use of the **Mental Health (Care and Treatment) (Scotland) Act 2003** and /or the **Adults with Incapacity (Scotland) Act 2000**. Discussion with appropriate covering psychiatrists may be helpful – either through dedicated psychiatric liaison services or psychiatric hospital duty doctors.

If a patient absconds and members of staff are concerned about the patient's wellbeing on the basis of a possible mental disorder – nursing staff should attempt to contact the patient's carers e.g. nearest relative, named person, service provider, or friend. The patient may or may not be known to psychiatric and social care services: however, responsibility for his/her care remains with the General Medical Hospital. Staff should inform the police depending on the degree of risk and concern.

If the patient has been seen that day by any fully registered and licensed medical practitioner e.g. the ward **Specialist Trainee / FY2** then the option exists for that doctor to issue an **Emergency Detention Certificate** without **Mental Health Officer** consent (if the examination took place before 8pm, the certificate must be signed before midnight; if the examination took place after 8pm, the certificate must be signed within 4 hours). The certifying doctor should then inform the appropriate duty **Approved Medical Practitioner**, **Mental Health Officer** and the **Police** of the detention and ask the latter to consider the patient a missing person and to effect his/her return to the **Acute Hospital** under the powers of the said **Emergency Detention Certificate**.

5.3.4 Intoxicated Persons

The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated. When a request for assessment is received, it is not appropriate to insist that the person be free from the effects of alcohol and/or drugs. This includes requests by police for assessment of persons held in police cells when there is a concern that mental illness or risk of suicide is present in a person who is also intoxicated. The coexistence of intoxication does not prevent assessment by MHAU.

Collateral history and risk assessment should be completed with all patients who present in mental health crisis, regardless of whether alcohol and/or drug intoxication is

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present. Where a patient is unable to engage due to levels of intoxication, but concerns remain in relation to mental health presentation/suicidality, a safety plan should be formulated with treatment options as noted below. There should never be an assumption that mental illness/risk of suicide will decrease as levels of intoxication reduce.

Treatment options

Treatment options available to clinical staff where a person is assessed as drug and/or alcohol intoxicated include:

- Admission to a mental health inpatient service if there is concern regarding mental state or suicidality.
- Referral to an emergency department where there is concern regarding physical condition.
- Referral to police in the setting of offending or aggressive behaviour.
- Return home with provision of carer support and/or Crisis Services/IHTT/CMHACS for ongoing assessment and management of risk.
- Onward referral to Community Mental Health Team where there are significant concerns in relation to severe or enduring mental health. It is expected the CMHT will follow the Mental Health ADRS Interface guidance and referrals should not be rejected on the basis of alcohol and/or drug use.
- Onward referral to Alcohol and Drug Recovery Service where concerns exist in relation to dependant/harmful alcohol and/or drug use.

Staff should familiarise themselves with ADRS in their local area to facilitate appropriate referral and collaborative interventions. Where a patient is open to an ADRS team, the Mental Health team should ensure that the presentation is communicated within 24 hours by whatever means is agreed with the locality ADRS team. This will be either telephone call, email and/or EMIS tasking where in use. Telephone contact with ADRS should be made where there are significant concerns that require urgent follow up in the community. Emails should be sent to a swinbox and not an individual worker.

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5:4 Urgent/ Emergency Medical Treatment

Patients who are subject to an **Emergency Detention Certificate** cannot be given medical treatment under that certificate. However, in a medical emergency a detained patient may be administered medical treatment for the causes or symptoms of mental disorder without consent under **section 243 of the Act** in order to:

- Save the patient's life
- Prevent serious deterioration in the patient's condition
- Alleviate serious suffering on the part of the patient
- Prevent the patient behaving violently and/or being a danger to themselves or others.

Following such treatment the administering doctor has a responsibility to inform the **Mental Welfare Commission** using a **T4 form** (T4 form) of their action within **7 days** and to inform the patients **Responsible Medical Officer**.

In medical and psychiatric emergencies for any non detained patient, common law allows treatment to preserve life or function. No certification is needed beyond description of the action in the casefile.

Administration of Medication in the Community

Generally patients being admitted from the community should not receive medication prior to admission to hospital. There may be situations where a patient can give informed consent for oral medication which may be offered by the assessing medical practitioner. In situations of high risk where the patient's behaviour is such that there is a risk to the health and safety of the patient and/or others it may be necessary to give emergency medication without consent under the **common law.**

Administration of treatment under **common law** (duty of care and doctrine of necessity provides a lawful basis for treatment) would require that the practitioner is sure that the treatment is given in the face of immediate death, bodily harm or significant risk to the patient and there is no statutory alternative. The decision for this action would be the responsibility of the attending medical practitioner in consultation with other involved individuals and may involve the use of safe holding techniques. If sedative medication has been given in this way an **ambulance** should then be used for transporting the patient to hospital to ensure their physical wellbeing is supported, with a police escort if necessary.

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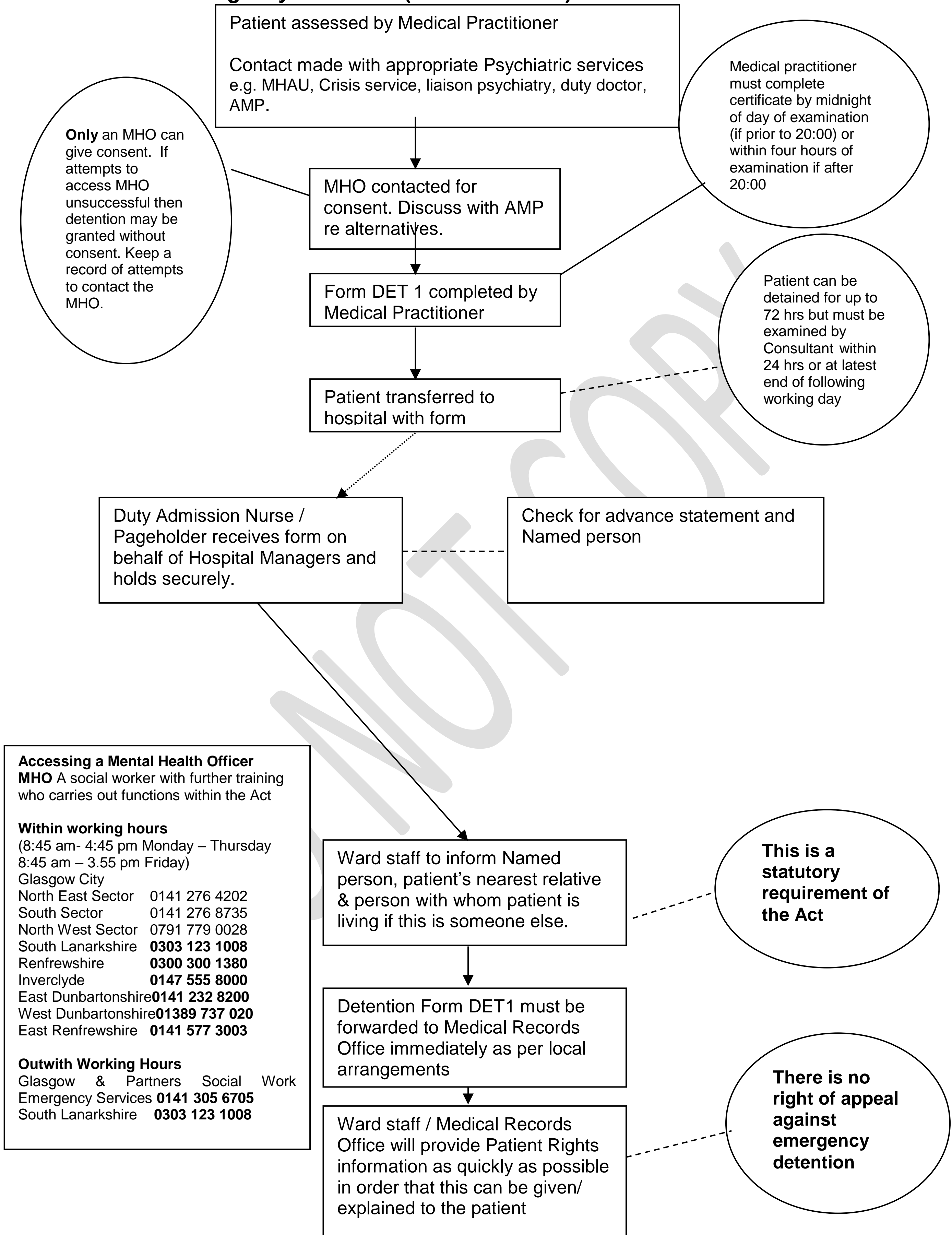
5:5.1 Emergency Detention (Sections 36-43) Flowchart



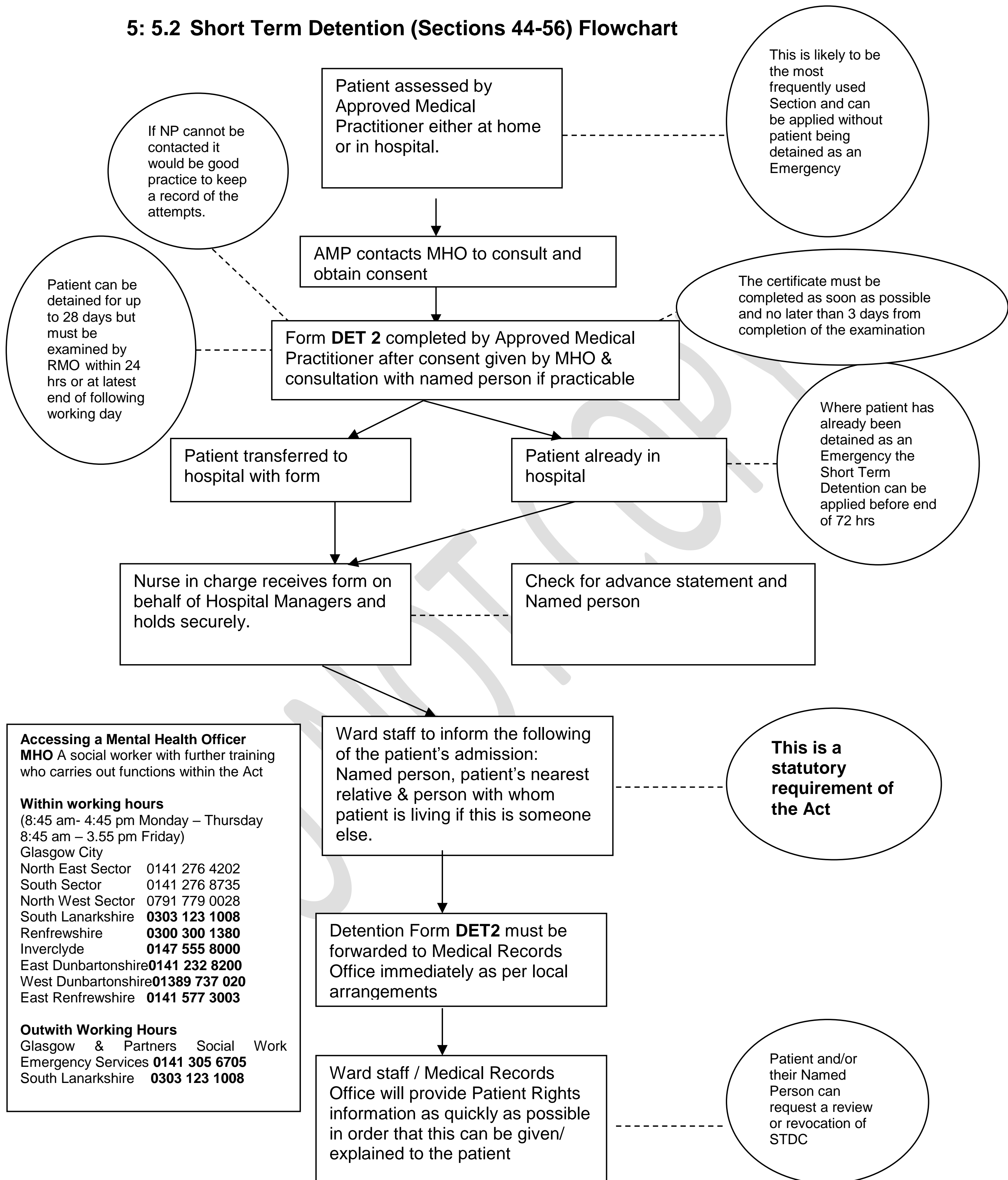
Accessing a Mental Health Officer
MHO A social worker with further training who carries out functions within the Act

Within working hours
(8:45 am- 4:45 pm Monday – Thursday
8:45 am – 3.55 pm Friday)
Glasgow City

North East Sector	0141 276 4202
South Sector	0141 276 8735
North West Sector	0791 779 0028
South Lanarkshire	**0303 123 1008**
Renfrewshire	**0300 300 1380**
Inverclyde	**0147 555 8000**
East Dunbartonshire	**0141 232 8200**
West Dunbartonshire	**01389 737 020**
East Renfrewshire	**0141 577 3003**

Outwith Working Hours
Glasgow & Partners Social Work Emergency Services **0141 305 6705**
South Lanarkshire **0303 123 1008**

5: 5.2 Short Term Detention (Sections 44-56) Flowchart



Accessing a Mental Health Officer
MHO A social worker with further training who carries out functions within the Act

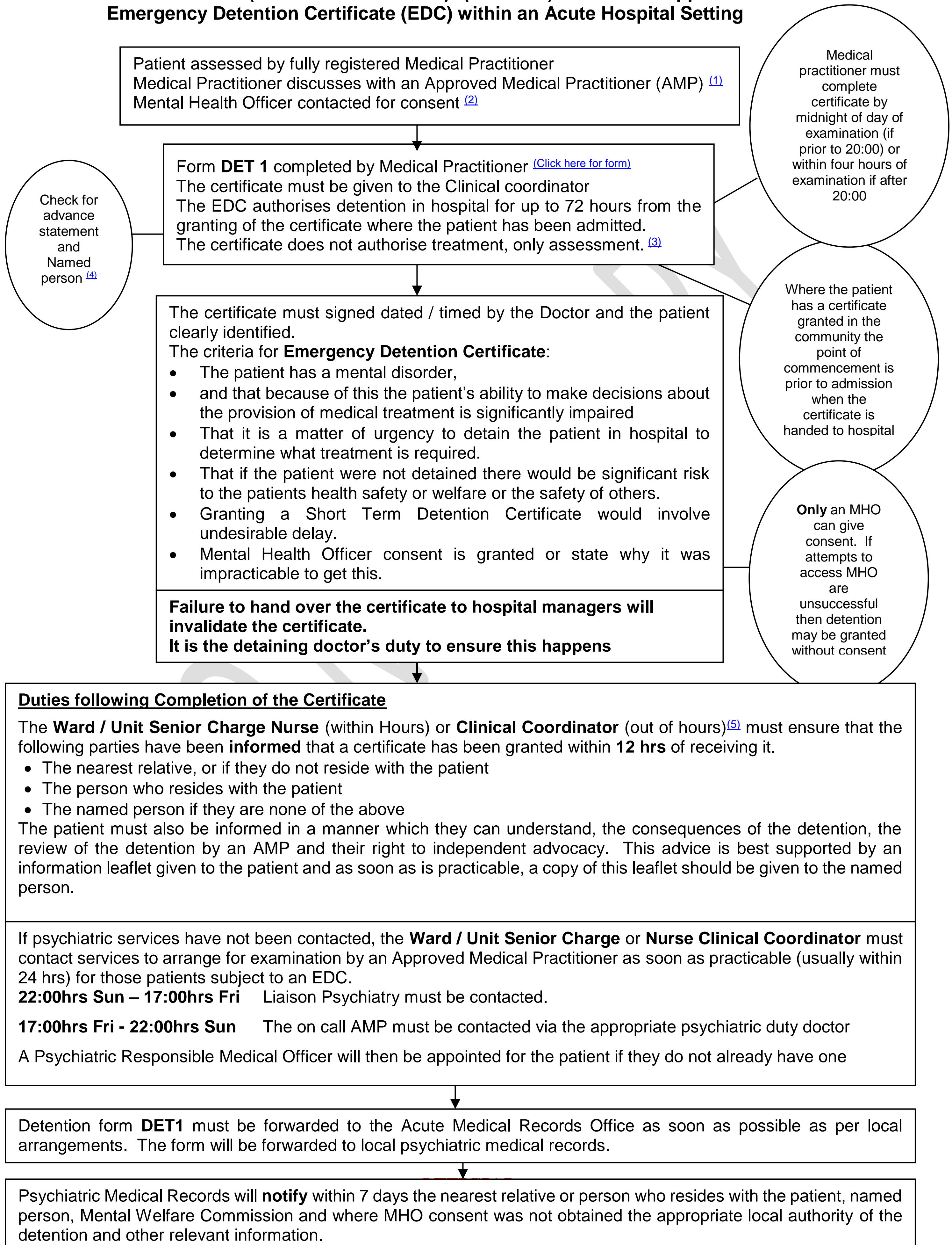
Within working hours
(8:45 am- 4:45 pm Monday – Thursday 8:45 am – 3.55 pm Friday)
Glasgow City

North East Sector	0141 276 4202
South Sector	0141 276 8735
North West Sector	0791 779 0028
South Lanarkshire	**0303 123 1008**
Renfrewshire	**0300 300 1380**
Inverclyde	**0147 555 8000**
East Dunbartonshire	**0141 232 8200**
West Dunbartonshire	**01389 737 020**
East Renfrewshire	**0141 577 3003**

Outwith Working Hours
Glasgow & Partners Social Work Emergency Services **0141 305 6705**
South Lanarkshire **0303 123 1008**

5: 5.3 Emergency Detention Certificate in an Acute Setting Flowchart

Mental Health (Care and Treatment) (Scotland) Act 2003 Application of an Emergency Detention Certificate (EDC) within an Acute Hospital Setting



1 Approved Medical Practitioner Contact Details

AMP A psychiatrist with further training who is approved by the board to carry out certain functions within the Act

Within working hours contact should be with liaison psychiatry. Out of hours, contact the 2nd on-call psychiatrist / AMP through switchboard for the locality hospital:

Queen Elizabeth University Hospital	Leverndale	**0141 211 6400**
New Victoria	Leverndale	**0141 211 6400**
Royal Alexandria Hospital	Dykebar	**0141 201 1099**
Inverclyde Royal Hospital	Langhill Clinic	**0141 314 9504**
Glasgow Royal Infirmary	Stobhill	**0141 201 3000**
Gartnavel General	Gartnavel Royal	**0141 211 3000**
Vale of Leven	Gartnavel Royal	**0141 211 3000**
Stobhill ACAD	Stobhill	**0141 201 3000**

2 Accessing a Mental Health Officer

MHO A social worker with further training who carries out functions within the Act

Within working hours

(8:45 am- 4:45 pm Monday – Thursday 8:45 am – 3.55 pm Friday)

Glasgow City	North East Sector	**0141 276 4202**
	South Sector	**0141 276 8735**
	North West Sector	**0791 779 0028**
South Lanarkshire		**0303 123 1008**
Renfrewshire		**0300 300 1380**
Inverclyde		**0147 555 8000**
East Dunbartonshire		**0141 232 8200**
West Dunbartonshire		**0138 973 7020**
East Renfrewshire		**0141 577 3003**

Out of hours

(5pm – 9am Monday – Friday / all day Saturday & Sunday and public holidays)

Glasgow & Partners Social Work Emergency Services	**0141 305 6705**
South Lanarkshire	**0303 123 1008**

3 Urgent/ Emergency Medical Treatment

Patients who are subject to an **Emergency Detention Certificate** cannot be given medical treatment under that certificate. However, in a medical emergency a detained patient may be administered medical treatment without consent for the mental disorder under **section 243** of the Act in order to:

- Save the patient's life
- Prevent serious deterioration in the patient's condition
- Alleviate serious suffering on the part of the patient
- Prevent the patient behaving violently and/or being a danger to themselves or others.

Following such treatment the administering doctor must inform the Mental Welfare Commission (T4 form) of their action within 7 days and inform the patients Responsible Medical Officer.

In medical and psychiatric emergencies for any non-detained patient, common law allows treatment to preserve life or function. No certification is needed beyond description of the action in the casefile.

4 **Named Person** someone nominated by a person or appointed under the provisions of the Act to support and protect the patient interests. (Named Person Guidance)

Advance Statement A written, document stating how the person would prefer to be treated (or not treated) if they were to become ill in the future, any doctor treating the patient must have regard to the advance statement. (Advance statement Guidance)

5 The **Ward / Unit Senior Charge Nurse** or **Clinical Coordinators** are acting as hospital managers and must ensure the prescribed functions are carried out. Failure to carry out these functions could lead to a successful appeal against detention and a civil liability for unlawful detention.

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5.5:5 Seven Point Checklist

Emergency Detention: 7 point Checklist

1. Nurses Power to Detain (Section 299 of the Act) can be used by any registered Mental Health or Learning Disabilities nurse to detain a patient who is either an informal patient or is in the hospital for assessment for up to 3 hours. It is used where the nurse believes it likely that the patient has a mental disorder and it is necessary to prevent them leaving hospital because there is some risk to the patient or others and that a medical examination is necessary.

   Note: It is best practice for an Approved Medical Practitioner (AMP) and Mental Health Officer (MHO) to attend at the same time with a view to making a Short-Term Detention Certificate (STDC).

2. Where an AMP is available they should consider proceeding to an STDC. However where the MHO cannot attend within a **1 hour** period the use of an EDC may be warranted until MHO and AMP assessment for an STDC can be made.

3. The direct telephone number for an MHO out of hours is **0141 305 6705** (South Lanarkshire **0303 123 1008**).

4. **MHO Contact In Hours:**
   (8:45 am- 4:45 pm Monday – Thursday 8:45 am – 3.55 pm Friday)
   Glasgow City North East Sector **0141 276 4202**
   South Sector **0141 276 8735**
   North West Sector **0791 779 0028**
   South Lanarkshire **0303 123 1008**
   Renfrewshire **0300 300 1380**
   Inverclyde **0147 555 8000**
   East Dunbartonshire **0141 232 8200**
   West Dunbartonshire **0138 973 7020**
   East Renfrewshire **0141 577 3003**

   Please note: a telephone discussion with the MHO **DOES NOT** constitute consent.

5. Please ensure you complete part 5 of the DET 1 form carefully, since this will be used for audit purposes. Please record one of the following categories, as well as any other information you think relevant:

   A. The AMP was unable to attend within [specify time period]

   B. The AMP was not contactable [specify time, duration and number of attempts made]

   C. The patient required immediate detention because of the following immediate risk [specify clinical situation]

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(This could include patient attempting to leave the hospital, patient restrained to prevent violence to self \ others.)

I am satisfied, for the reas
certificate would involve u
detention certificate

5

"The AMP was unable to attend within one hour"
OR
"The AMP was not contactable on 0141 211 6000: I phoned three times from 18:20h and the call was not answered for more than four minutes on each occasion."
OR
"The patient was actively trying to leave the ward and required restraint."

6. If an MHO is not available, when completing Section B of the DET 1 form about MHO consent (below), please record one of the following categories, as well as any other information you think relevant:

   a. The MHO was unable to attend within [specify time period]

   b. The MHO was not contactable on (**Insert Number)** [specify time, duration and number of attempts made]

   c. The patient required immediate detention because of the following immediate risk [specify clinical situation]

   (This could include patient attempting to leave the hospital, patient restrained to prevent violence to self \ others.)

Example:

PART 1 : CERTIFICATE (cont) To be completed by the Medical Practitioner

MHO Consent

Complete A or B as appropriate

A I have consulted with the MHO named below, and he / she consents to the granting of this emergency detention certificate.

Surname

First name(s)

Title

Appointed to act as a MHO by:

Local Authority

eg Greater Glasgow, City of Edinburgh, Highland, Scottish Borders, etc (the word "Council" can be omitted)

Building name / town

OR

B It was not practicable, for the reasons stated below, to gain the consent of a mental health officer to the granting of this certificate.

7

"The MHO was unable to attend within one hour"
OR
"The MHO was not contactable on 0141 305 6705: I phoned three times from 18:20h and the call was not answered for more than four minutes on each occasion."
OR
"The patient was actively trying to leave the ward and required restraint."

7. Check that the time/date of the medical examination on page 5 is before the time/date of the certificate being granted (getting these times wrong is a common error and potentially invalidates the detention).

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8. It is the responsibility of the detaining medical practitioner to ensure that the certificate is given to Hospital Managers. DO NOT file in the case notes; if the administrative process is not followed it may invalidate the detention.

   All hospitals both mental Health and Acute must ensure they specify who the hospital manger is for all units at all times so they may receive a copy of the certificate and ensure the required statutory functions are carry out. E.g. nursing page holder, service manager, ward charge nurse.

See the Psychiatric Emergency Plan for further details.

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6 Accessing a Mental Health Officer

This chapter relates to the accessing of a **Mental Health Officer** for the requirements of a **Short Term Detention Certificate** or **Emergency Detention Certificate**. However the Duty **Mental Health Officer** will also have to respond to other demands such as applications for warrants.

The consent of a **Mental Health Officer** must be sought whenever reasonably possible in the granting of an **Emergency Detention Certificate** and must be sought for a **Short Term Detention Certificate**.

The Mental Health Officer will coordinate appropriate referrals to Social Work Services to ensure appropriate assessment of any dependents and securing any protection of property.

6.1 Within working hours

Glasgow City

The rota will operate during working hours: 8:45 am - 4:45 pm Monday – Thursday & 8:45 am - 3:55 pm Friday

Requests for emergency consents to detention and other urgent MHO tasks can be made through Mental Health Officer rotas covering the North East, North West and South Sectors of the city. These should mainly be used where there is a potential need for Short Term Detention Certificates and Emergency Detention Certificate. Generally, contact should be made with the area number, which covers patient's home address.

When a non-urgent referral is being made for planned work, which may require Mental Health Officer such as Compulsory Treatment Orders, the relevant team in the client's locality should be contacted.

To request a duty **Mental Health Officer** during daytime working hours the referrer will contact the relevant telephone number. Client details and brief details of the referral will be taken and the duty **Mental Health Officer will be contacted to respond:**

North East Sector	**0141 276 4202**
South Sector	**0141 276 8735**
North West Sector	**0791 779 0028**

Outwith working hours contact Glasgow and Partners Emergency Social Work Service **(See section 6:2 for out of hours details)**

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South Lanarkshire

(8:45am – 4:45pm Monday - Thursday and Friday 8:45am to 4.15pm)

A centralised duty Rota is devised by the **Team Leaders** in the **Community Mental Health Teams** incorporating the mainline & mobile number of the **Mental Health Officer** on duty and backup **Mental Health Officer**. This Rota is circulated to a wide range of locations including hospital & community based services.

In the event of the Rota not being readily available contact should be made with the **Reception or Team Leader** at the **Rutherglen / Cambuslang Community Mental Health Team** in the first instance on: **0303 123 1008**

(See section 6:2 for out of hours details)

Renfrewshire

Within working hours (08.45- 16.45 Monday – Thursday or 08.45 – 15.55 Friday):

Tel: 0141 207 7878

Team Manager – Mental Health Officer Service

Tel: **0303 123 1008**

Outwith working hours contact Glasgow and Partners Emergency Social Work Service
(See section 6:2 for out of hours details)

Inverclyde

Within working hours (08.45- 17:00 Monday – Thursday or 08.45 – 16:00 Friday):

MHO Services
Crown House
30 King Street
Greenock, PA15 1NL

The duty mental health officer can be accessed by calling: **Tel. 0147 555 8000**

Outwith working hours contact Glasgow and Partners Emergency Social Work Service
(See section 6:2 for out of hours details)

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East Dunbartonshire

Working Hours Monday – Friday 09.00 – 17:00

Duty Mental Health Officer or back-up worker available any requests for a Duty MHO should be through our shared services team at social work.

Contact for a **Mental Health Officer** is: **0141 232 8200**

East Dunbartonshire Council

Kirkintilloch Health and Care Centre

10 Saramango Street

Kirkintilloch, G66 3BF

Outwith working hours contact Glasgow and Partners Emergency Social Work Service **(See section 6:2 for out of hours details)**

East Renfrewshire

Working Hours Monday – Thursday 08.45 – 16.45, Friday 08.45 – 15.55

Contact for a **Mental Health Officer** is; - **0141 577 3003**

East Renfrewshire Adult Community Mental Health Team

Barrhead Health and Care Centre

213 Main Street

Barrhead

G78 1SW

There is a Mental Health Officer Duty Rota with a main duty worker and back-up duty worker available each day. Any requests for duty MHO should be made to Business Support officer within the Social Work Mental Health Team. This will be passed immediately to the duty MHO if available, or details of the referrer taken and passed to duty MHO to respond as soon as possible. If it is an emergency or urgent and duty MHO cannot be contacted for whatever reason then back up MHO will respond.

Outwith working hours contact Glasgow and Partners Emergency Social Work Service **(See section 6:2 for out of hours details)**

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West Dunbartonshire

Working Hours Monday – Thursday 08.45 – 16.45, Friday 08.45 – 15.55

Social Work Area Office

Riverview Resource Centre

Cardross Road

Dumbarton

G82 5JA

Contact for a **Mental Health Officer** is: **01389 737 020**

Outwith working hours contact Glasgow and Partners Emergency Social Work Service **(See section 6:2 for out of hours details)**

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6:2 Outwith Working Hours

(5pm – 9am Monday – Friday / all day Saturday & Sunday and public holidays)

Glasgow and Partners Emergency Social Work Service 0141 305 6705

This number is **only for use in an emergency** where any of the following events are about to or have taken place and a **Mental Health Officer** is required.

- Emergency Detention Certificate
- Short Term Detention Certificate
- The nurses holding power has been applied

For non-urgent calls Glasgow and Partners Emergency Social Work Service can be contacted on **0800 811505**

This service provides an emergency social care service for the seven Local Authorities in the West of Scotland and provides such a service for all care groups, predominantly child care/child protection, mental health and frail adults, along with a number of other duties.

When the assistance of a **Mental Health Officer** is requested from the service, the senior manager on shift will make the decision to release a **Mental Health Officer** whilst considering other statutory competing priorities and the expectation would be that an estimate of response time would be given.

It will be the duty of the **Mental Health Officer** from Glasgow and Partners Emergency Social Work Service, in the case of a detention having been made, or otherwise, to advise the relevant Social Work Area Office when office hours are resumed, of the intervention in each case and resulting outcome and requirement for further action. This information will be sent to the relevant Operations Manager for Mental Health in the relevant Area Team for Glasgow, and to the local office in the case of the other Local Authorities.

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South Lanarkshire

Emergency Social Work Service

(4:45pm – 8:45am Monday - Thursday and Friday 4.15pm - 8:45am)

The on call **Mental Health Officer** can be contacted via the Emergency Social Work Service based in Hamilton on: **0303 123 1008**

North Lanarkshire (Stepps and Chryston)

Tel: **0800 121 4114**

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7 Child and Adolescent Admission

The principles of the Psychiatric Emergency Plan as it pertains to adults remain the same for children and adolescents. There are some additional arrangements that will be put in place for children and adolescents. Specific arrangements that differ from those for adults are contained in this chapter.

7.1 Principles and Responsibilities

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 general principle should always exist that admission of all under 18s should be to specialist CAMHS beds. The only exceptions at present are:

- The routine admission of 16-18 early intervention (ESTEEM) patients into individually agreed (through appropriate CD and ward staff) admission general adult beds
- Perinatal admissions

It is always preferable for the patient to be cared for in an age appropriate setting. In all cases before admission is planned, intensive community interventions should be considered. A nurse-led intensive CAMHS community nursing service (i-CAMHS), provides a 7 day a week crisis and intensive response to children and young people experiencing moderate to severe mental health difficulties. This service is available to under 18 year olds who are already known to NHS GGC CAMHS or have been assessed the service.
The initial point of contact for all referrals of children and young people aged 0-17 is via the nurse led UCAMHS pathway, and should be directed to the team via the Mental Health Assessment Unit (MHAU). The team will co-ordinate requests for involvement, provide assessments and signpost and provide advice as necessary.
Contact Number – 0141 201 3136 (Stobhill Hospital).

See *CAMHS Out of Hours On Call Pathway (Appendix Q) and Standard Operating Procedure for Tier 4 CAMHS Scheduled/Unscheduled Services* (Appendix R) for details of Unscheduled CAMHS (UCAMHS) and Intensive CAMHS (iCAMHS) pathways.

Following referral from a CAMHS Consultant the CAMHS bed manager will have

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authority to admit a patient directly to the Adolescent Psychiatric Unit (Skye House) including the use of identified pass beds. If this is not possible then admission to the catchment area adult bed should be the next preferred choice. If there is a delay in accessing the nearest available psychiatric hospital bed, the patient should be moved to the age appropriate unit **(using a pass bed if one is available)** until a permanent bed is found.. The CAMHS bed manager and the Duty CAMHS Psychiatrist should at all times be informed of the detention and the need for admission.

The **CAMHS Bed Manager** (in hours) and the Duty Charge Nurse at Skye House (out of hours) will liaise with the adult bed managers / adult wards to identify where there are vacant beds.

If there are no available beds in the patient's catchment area then the **CAMHS Bed Manager / Skye House Nurse in Charge (out of hours)** will liaise with his/her colleagues across the board area in a bid to resolve the situation. NOTE - if an adult bed is identified for admission the CAMHS Consultant requesting admission will require to agree this with the consultant of the adult ward.

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If there are no beds found in the NHSGG&C area then the **CAMHS Bed Manager / Skye House Nurse in Charge (out of hours)** will contact the other 2 age appropriate in-patient units in Scotland (Dundee and Edinburgh). If no beds are identified in either of these 2 areas the **CAMHS Bed Manager / Skye House Nurse in Charge (out of hours)** will contact other areas in Scotland to try to identify an available bed for admission.

All proposed admissions out with NHSGGC catchment area will require authorisation from the Head of Service or the Clinical Director (in hours) or the on call CAMHS manager (out of hours).

RMO responsibility for a patient admitted within GG&C will remain with the referring / admitting Consultant until that is formally passed to another CAMHS Consultant e.g. an in-patient Consultant Child and Adolescent Psychiatrist, or the locality Consultant Child and Adolescent Psychiatrist.

Further details can be found in the document 'Admission of Adolescents to Adult Wards' paper.

Out of hours if there is an admission to an adult psychiatry bed, the CAMHS and adult Consultants will maintain shared responsibility for the patient until this can be agreed by the adult psychiatrist and the relevant CAMHS Consultant, the next working day.

7.2 Responsibility of Medical Staff

In a psychiatric emergency involving a young person under the age of 18 years the same principles apply. It is desirable in the case of a child or adolescent requiring detention for the **Approved Medical Practitioner** to be a Child and Adolescent psychiatrist. The duty **Approved Medical Practitioner** for children and adolescents should be contacted via the switchboard of the Royal Hospital for Sick Children at Yorkhill.

If the emergency does not allow time for the **Approved Medical Practitioner** and **Mental Health Officer** to attend and there is need to detain quickly the referring medical practitioner should use the **Emergency Detention Certificate**. The **Approved Medical Practitioner** should be informed of this and make plans to review the patient "as soon as is practicable" (this must be within 72 hours and should be on the next day) remembering not to disturb the patient unnecessarily e.g. if sleeping.

For detention during working hours the **Approved Medical Practitioner** will be a member of the area sector Child and Adolescent Mental Health team or if not available the duty consultant (Rota in team site or PA to Clinical Director) Out of hours the **Approved Medical Practitioner** will be the second or third on-call psychiatrist for Child and Adolescent Psychiatry.

7:3 Transporting a Patient to Hospital

Transport and support is essentially similar to that for an adult however remembering the young age of the patient it may be appropriate for a parent to accompany the young person.

The Bed Manager/Nurse in charge of Skye House would be responsible for organizing the transfer of detained young people to hospital, although it may be necessary to ask for the assistance of general staff from adult in patient's services or the CMHT / crisis Out of Hours service through their senior shift page holder. Best practice would be the safe transport of the patient as fast as possible to the admission site. Escorting staff should stay at the general hospital site until a handover of care to inpatient staff occurred. Any necessary detention required to admit the under 18 would be the responsibility of CAMHS staff.

Once handover has occurred patients awaiting assessment within the Emergency department are the responsibility of that department: any requirement to administer

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emergency medication or to set a higher degree of nursing observations remains with the Emergency department.

Where a patient is detained directly to a general hospital /ward or Paediatric Hospital / ward all relevant detention paperwork requires to be submitted to the hospital manager and then lodged with the medical records department of the 'detention' hospital. If the patient is moved from the emergency department to a ward in the General Hospital / Paediatric Hospital they are the responsibility of that ward. Any requirement to administer emergency medication / treatment such as Naso Gastric feeding, or to set and staff a higher degree of nursing observations or 'RMN cover' lies with that ward.

Where a patient is admitted directly to an adult mental health ward it is the responsibility of that ward / service to determine the nursing observation levels required and to organise / provide the nursing staff to carry out such observations.

7:4 Care of a Child or Adolescent during detention

Particular consideration needs to be given to the developmental stage of the young person remembering that their welfare is paramount. It would therefore be imperative that every effort is made to ensure that the parent or carer is fully involved in the process taking into account the **Age of Legal Capacity (Scotland) Act 1991** with consideration being given to confidentiality. The child or adolescent may be fully competent in decision making and can therefore choose that the parents or carers may not be party to information and decisions and this must be respected. If it is considered that the child or adolescent is not yet mature enough to be fully competent in decision making then the **Approved Medical Practitioner** must decide what information needs to be disclosed to parents and carers.

7.5 Removal by police to a Place of Safety (see appendix H - Police Scotland 'Mental Health and Place of Safety SOP)

When a child or young person aged under 18y is brought by police to an acute hospital site, advice should first be sought from Unscheduled CAMHS via the Mental Health Assessment Unit (MHAU) number on **0141 201 3136**

Police may also contact Unscheduled CAMHS directly for advice (0141 201 3136) prior to bringing the child to hospital.

Under 16y would be taken to the Royal Hospital for Children for assessment.

16y/17y may be seen at the MHAU where appropriate.

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The Police Custody Pathway for under 18y is detailed in section 8 of the SOP for Tier 4 CAMHS Scheduled/Unscheduled services (Appendix R)

7:6 Child and Adolescent Mental Health Teams - Contact Details

Glasgow – East	Templeton Business Centre 62 Templeton Street Glasgow G40 1DA	Tel: 0141 277 7515
East Renfrewshire	Barrhead Health Centre 201 Main Street Barrhead G78 1SW	Tel: 0141 800 7886
Inverclyde	Inverclyde CAMHS Greenock Health and Care Centre Wellington Street Greenock PA15 4NH	Tel: 01475 495500
Glasgow – North	New Woodlands Health & Care Centre 891 Garscube Road Glasgow G3 8SL	Tel: 0141 201 5640
Renfrewshire	Aranthrue Centre 103 Paisley Road Renfrew PA4 8LH	Tel: 0141 886 5921
Glasgow – South	New Gorbals Health & Care Centre 2 Sandiefield Road Glasgow G5 9AB	Tel: 0141 201 5031
Glasgow – West	The West Centre 60 Kinfauns Drive Glasgow G15 7TS	Tel: 0141 207 7100
West Dunbartonshire	Acorn Centre Vale of Leven District General Hospital Main Street Alexandria G83 0UA	Tel: 01389 817324
Regional Adolescent Inpatient Psychiatric Unit	Adolescent Psychiatric Inpatient Unit Skye House Stobhill Hospital 133 Balornock Road Glasgow G21 3UW	Tel: 0141 232 6425

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National Child Psychiatry Inpatient Unit	National Child Psychiatry Inpatient Unit Ward 4 Royal Hospital for Children 1345 Govan Road Glasgow G51 4TF	Tel: 0141 452 4540 (Ward 84540) 0141 452 4535 (Secretary 84535)
GGC Unscheduled CAMHS	MHAU	Tel: 0141 201 3136
GGC Intensive CAMHS	ICAMHs Level 4 West Glasgow Ambulatory Care Hospital Dalnair Street Glasgow G3 8SJ	Tel: 0141 201 0213 (Duty - 201 0210)
GGC Paediatric Liaison	Paediatric Liaison Psychiatry Team Office Block Zone 2.01 Royal Hospital for Children Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	Tel : 0141 451 6529 (86529)
GGC Tier 4 Hub: Learning Disability, Forensic CAMHS, Complex Trauma, Infant Mental Health	Floor 4 West Glasgow Ambulatory Care Hospital Dalnair Street G3 8SJ	Tel: 0141 201 0808

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8 Mother and Baby Unit (MBU) Admissions

West of Scotland Mother and Baby Unit
Leverndale Hospital (Site A)
510 Crookston Road
Glasgow G53 7TU
Tel. 0141 211 6539 (internal x46539)

8:1 Inpatient Admission Criteria

The **Mental Health (Care & Treatment) (Scotland) Act (2003)** requires that all women admitted to inpatient psychiatric care have the opportunity to have their babies admitted with them, where the baby is under one year. **Facilities must meet the needs of both mother and baby**. For Glasgow, this legal requirement has been met through the establishment of the **Mother & Baby Unit (MBU)** at Leverndale Hospital.

The **Mother & Baby Unit** provides for joint admissions, where the child is under one year, and usual practice is that mother and baby are admitted together unless there are good clinical reasons not to do so. It would not normally be in the best interests of the patient to be admitted to the inpatient unit if her baby cannot be admitted with her. Where this is the case, the patient's inpatient care will be provided by the local psychiatric service and care for the baby should be arranged with the family or with social services where that is appropriate.

If a woman needs inpatient admission and she does not meet the criteria for an MBU (for various reasons) then a bed should be organised through her locality ward as per relevant section of the PEP. However this should be a rare occurrence and such a decision should only take place in consultation with **Mother & Baby Unit** staff. **All women considered for admission to any Glasgow psychiatric hospital who care for a baby under one year should be discussed with the MBU in the first instance.**

The **Mother & Baby Unit** can admit patients both within and out with normal working hours, including those detained under the Mental Health Act, 24 hours a day, 7 days a week.

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1. Patients admitted will be within one year of childbirth and suffering from major mental illness of a severity requiring inpatient care. In most cases such illness would be associated with psychotic symptoms, severe behavioural disturbance or risk to self/others. Planned admissions may also be appropriate where women with major mental illness have failed to respond to standard treatments. In general, admissions of women with substance misuse problems or personality disorder would only be appropriate where additional acute mental illness is present.

2. Admissions may be appropriate in late pregnancy, usually from 32 weeks' gestation, where it is likely that the woman will require continuous inpatient care through to delivery and beyond.

3. It would not usually be in the best interest of the baby to be admitted to the Mother and Baby Unit if the mother is not the primary carer.

4. Parenting assessment is an important component of inpatient evaluation but would not be a sole reason for admission in the absence of acute mental illness of a significance requiring inpatient treatment. If there is significant doubt about the woman's capacity to care for her infant in the longer term, then a pre-admission assessment, involving social work, should take place. The Perinatal service is happy to help organise this.

5. The unit aims to provide a safe environment for infants and mothers. Admission would not be appropriate where the woman poses a direct risk to her child or to others on the unit.

6. Perinatal red flag risk factors for severe maternal illness include:

- Recent significant **change in mental state** or emergence of new symptoms
- New thoughts or acts of **violent self-harm**
- New and persistent expressions of **incompetency as a mother** or **estrangement from the infant**

7. Where MBU admission is not suitable (e.g. mother and/or father does not want baby to be in MBU; mother is not primary carer; level of aggression or risk) the patient should be admitted to a general adult bed in their locality hospital. Suitability for admission should always be discussed with the relevant Bed Manager.

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8:2 Referral Process

1. During normal working hours: all potential referrals for inpatient care should be discussed with a senior member of the Perinatal Mental Health Team. Senior members of the team include the Consultant Psychiatrist, Nurse Consultant, Nurse Team Leader, Senior Charge Nurse or their nominated deputies.

2. Out with working hours: all potential admissions should be discussed with the MBU senior nurse on duty.

3. Where a woman is initially referred to another Glasgow hospital or locality out with the Leverndale Hospital catchment area, but clearly meets criteria for admission, then it may be appropriate for her to be sent directly to Leverndale Hospital for assessment/admission (e.g., directly from primary care/maternity services), following catchment hospital **Specialist Trainee / FY2** discussion with the Leverndale Hospital on-call **Specialist Trainee / FY2.**

4. "Clearly meets criteria for admission" means that the woman has a significant acute mental illness requiring admission **and** it has been established that her baby will be admitted with her. The local sector on-call **Specialist Trainee / FY2** should determine this in discussion with the referrer.

5. Where there is doubt about the need for admission, the woman should be seen at her base hospital (or other local arrangement) for assessment in the first instance.

6. Referrals from out with Greater Glasgow & Clyde NHS Board should always be seen by the local perinatal mental health service or if not available, a psychiatrist in the first instance and then discussed with the senior nurse on duty. Currently contractual arrangements are in place to accept admissions from **NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Lanarkshire, NHS Western Isles and Argyll area of NHS Highland**. Any requests for admission from out with these areas will usually require a decision by senior management during normal working hours.

7. Where a patient is referred for admission, the local service (within or out with Glasgow) will be responsible for arranging transport, including escort where necessary, to the unit. The Perinatal Mental Health Team will endeavour to offer assistance, if possible, within working hours.

8. If there are no beds in West of Scotland MBU, the first option would be for the MBU senior nurse on duty to contact St John's MBU, Livingston (NHS Lothian) to determine if they have a bed available until such times as a bed is available in Glasgow. If no bed in St John's MBU or woman does not wish to travel then she should be admitted to an Acute Adult ward locally until bed is available in MBU, following discussion with the relevant Bed Manager.

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9. It is the expectation that babies admitted to the **Mother & Baby Unit** will be healthy and thriving. Arrangements are in place for all admitted babies to receive a primary care examination within 2 working days. The admitting **Specialist Trainee / FY2** must satisfy themselves however that the baby is well. If there are any concerns for the babies health it is best to delay admission of the baby until a review can take place during normal working hours. In cases where the delay is likely to be brief, it may still be appropriate to admit the mother to the unit.

REMEMBER

- **The aim is always to minimise any delay or red tape in admitting seriously ill women along with their babies.**
- **It is essential good practice to discuss potential admissions (i.e., all women who have babies under one year) with staff on the Mother & Baby Unit, who will offer advice on appropriateness and bed availability.**
- **Perinatal red flag risk factors for severe maternal illness.**

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9. Learning Disability Issues

See appendix M: Protocol for admission of people with Learning Disability to mental health inpatient services

Specialist Learning Disability Inpatient Services have expertise in assessing mental health needs and health-related behavior problems, they provide treatment and rehabilitation for people with moderate, severe and profound learning disability. People with a mild learning disability will ordinarily receive the same services as the general adult population with reasonable adjustments to ensure that their needs are met (learning disability teams will provide this support to mental health colleagues where required), there may however be a small number of people with a mild learning disability who require Specialist Learning Disability inpatient assessment and treatment. This would only occur when admission to generic mental health settings was believed to be inappropriate.

Admission to a specialist learning disability inpatient service can only take place when a psychiatrist specialising in learning disability (consultant or senior trainee) refers the patient through the learning disability bed management group. New referrals for admissions are not accepted out of hours to Learning Disability inpatient services. There may also be situations when admission to the specialist service is not available, and in these situations it may be necessary to request admission or transfer to an adult mental health unit, with appropriate support from the learning disability service.

In these situations, the appropriate hospital (or 'receiving service') described in the Psychiatric Emergency Plan, will be the mental health service that would be accessed by other patients of the same age from the same address

If a detained patient has already been admitted to a specialist learning disability service and is referred for transfer from there, the clinical team from that unit should ensure that appropriate specialist input is available for the patient throughout the period of transfer, and should resume the care of the patient (either by transfer or enabling timely discharge) as soon as possible after the presenting clinical problems are manageable again in the learning disability service.

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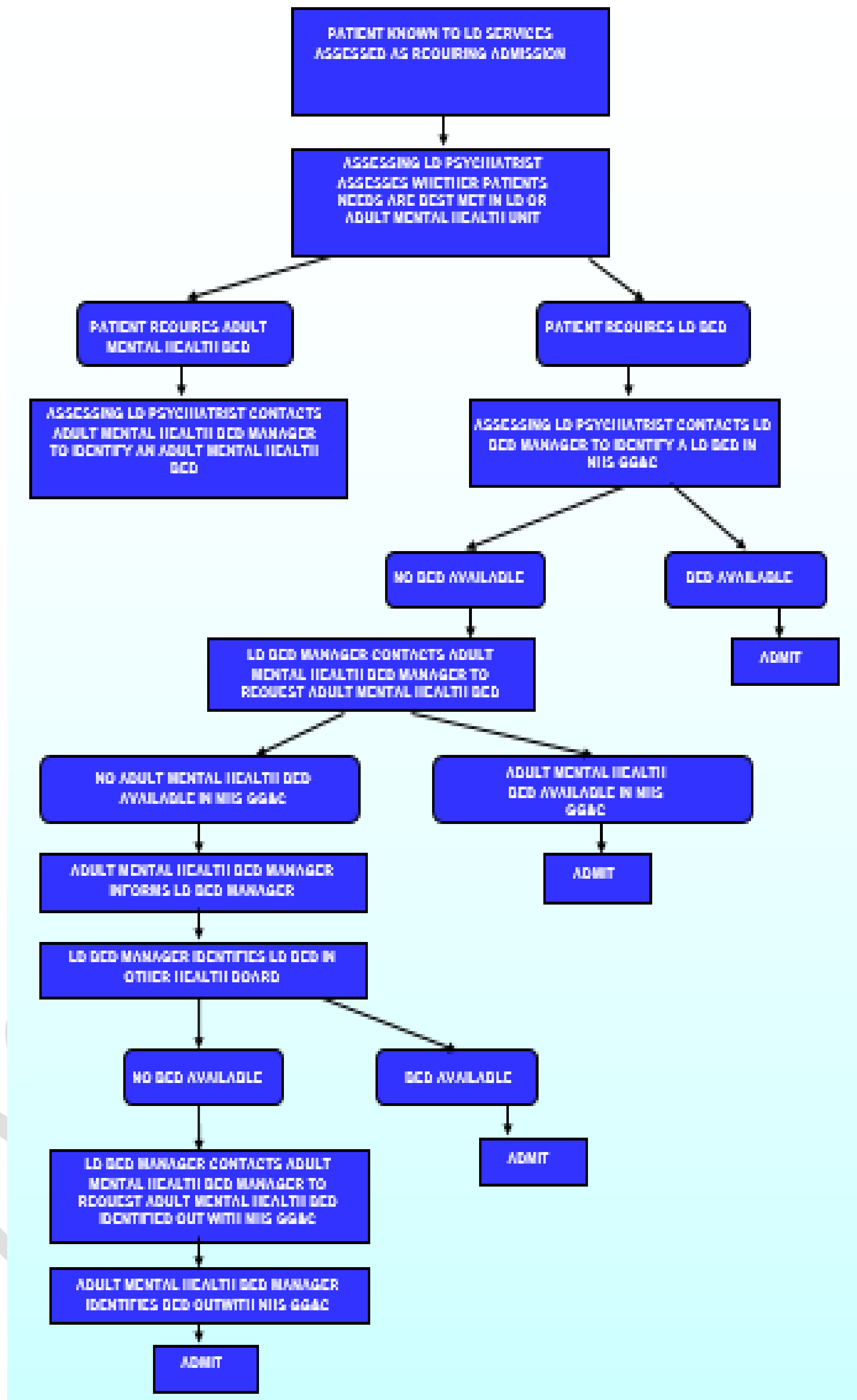
APPENDIX 1: PROCESS FOR IDENTIFYING AN ADMISSION BED FOR PATIENTS WITH LD



Occasionally there are patients whose behavior presents risks that cannot be managed safely in the Specialist Learning Disability Inpatient Service, for example because of intentional and repeated absconding, fire-setting, violence (including sexual violence) towards other patients or staff. The opinion of a forensic psychiatrist specialising in learning disability is usually sought and sometimes admission to a forensic service is appropriate. If the patient is not suitable for a forensic unit, other options to consider may include IPCU. These rare cases are likely to require discussion with the clinical directors of the relevant services.

Where a patient with learning disability is detained directly to an Acute General Hospital it is the responsibility of hospital managers to appoint a Responsible Medical Officer for the patient. (Sec 11:2) Any contact with specialist learning disability services will be a decision made by the Responsible Medical Officer.

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9:2 Contact Details for Community Learning Disability Teams

Area	Consultant	Contact Details	Postcodes covered
North West Glasgow	Dr Mantry Dr Macfie	NORTH WEST AREA LEARNING DISABILITIES TEAM GLEN KIRK CENTRE 129 DRUMCHAPEL ROAD GLASGOW G15 6PX Tel: Dr Mantry 0141 232 1339 Tel: Dr Macfie 0141 232 1333	G1, G2,G3, G4, G11, G12, G13, G14, G15, G20, G21, G22, G23,
North East Glasgow	Dr Soni Dr Ullah	NORTH EAST AREA LEARNING DISABILITIES TEAM PETERSHILL PARK BUSINESS CENTRE 30 ADAMSWELL STREET GLASGOW G21 4DD Tel: Dr Soni 0141 201 5960 Tel: Dr Ullah 0141 201 5960	G1 1, G1 5, G40, G31 2-5, G32 6, G32 6-9, G32 0, G40, G33 6, G69 0, G69 8, G69 9, G68 9
South East Glasgow	Dr Dodds	SOUTH AREA LEARNING DISABILITIES TEAM CASTLEMILK SOCIAL WORK AREA OFFICE 10 ARDENCRAIG PLACE CASTLEMILK G45 9US Tel: 0141 276 4921	G5, G41, G42, G44, G45
South West Glasgow	Dr Badee (Locum)	SOUTH AREA LEARNING DISABILITIES TEAM CASTLEMILK SOCIAL WORK AREA OFFICE 10 ARDENCRAIG PLACE GLASGOW G45 9US Tel: 0141 276 2337	G41, G43 1, G43 2, G44 4, G46 8, G51, G52 1, G52 3, G52 4, G53 5, G53 6, G53 7
East Renfrewshire	Dr Welsh	EAST RENFREWSHIRE LEARNING DISABILITY TEAM BARRHEAD HEALTH & CARE CENTRE 2ND FLOOR	G44 3, G46 6, G46 7, G76 0, G76 7, G76 8, G77 5, G77 6, G78 1, G78 2, G78 3, G78 4

		213 MAIN STREET BARHEAD G78 1SW Tel: 0141 800 7814	

East Dunbartonshire	Dr Mohammed	JOINT LEARNING DISABILITY TEAM KIRKINTILLOCH HEALTH AND CARE CENTRE 10 SARAMANGO STREET KIRKINTILLOCH G66 3BF Tel: 0141 355 2383	G61, G62, G63, G65, G66
West Dunbartonshire	Dr Nicholson	WEST DUNBARTONSHIRE LEARNING DISABILITIES TEAM CLYDE WING 2ND FLOOR CLYDEBANK CENTRE FOR HEALTH & CARE QUEENS QUAY MAIN AVENUE CLYDEBANK G81 1BS TEL: 0141 232 2190	G60, G81, G82, G83
Renfrewshire	Dr Jeffrey Dr Rennie	RENFREWSHIRE LEARNING DISABILITY SERVICES RENFREW HEALTH AND SOCIAL CARE CENTRE 10 FERRY ROAD RENFREW PA4 8RU Tel: 0141 207 7821	PA 1, PA 2, PA 3, PA 4, PA 5, PA 6, PA 7, PA 8, PA 9, PA 10, PA 11, PA 12, PA 13
Inverclyde	Dr Farquharson	INVERCLYDE COMMUNITY LEARNING DISABILITY TEAM PORT GLASGOW HEALTH CENTRE 2 BAY ST PORT GLASGOW PA14 5EW Tel: 01475 715295	PA11, 13, 14,15,16,19

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10 Role of the Police

When there is a clear threat to staff, patient or public; healthcare staff should request the assistance of the Police. When contacting the Police, healthcare staff must provide as much information as possible explaining:

- What risks are we concerned about?
- Who is the risk to, and the basis for this?
- How imminent is the risk?

This will allow Police to fully assess the situation and provide the most appropriate assistance. To prioritise police resource, it is helpful to alert police that a warrant is / has been obtained and when you expect they will be required.

There may be occasions when members of staff are unable to contain a situation within a resource centre/patient's home, and require additional assistance to ensure the safety of the patient, public and staff. It may not always be practicable for the staff directly involved in the detention interview to request police assistance. As such, the decision to involve the police may be taken by any member of the team involved in the detention. It is important that whoever makes the call to Police is fully aware of the situation and can provide a thorough update.

Contact should be made with police on: **101 (or** 999 **in an emergency).** The caller will then be put through to the call-handling centre staff. Police call-handlers will assess each call in accordance with their THRIVE assessment protocol:- Threat, Harm, Risk, Investigation, Vulnerability and Engagement. Police will support requests from heath staff when there is a clear threat to staff, patient or the public. It is important that the threat is made clear to the call taker which will ensure police resources are directed to attend the call. Clear communication from both agencies is paramount to ensuring the dispatch of police.

10:1 Removal by the police to a Place of Safety under Section 297 and 298 (See appendix H)

This provision allows a Constable to remove a person from a public place to a place of safety for up to 24 hours where:

(a) a constable reasonably suspects:

(i) that a person (referred to as a "relevant person"), who is in a public place, has a mental disorder; and

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(ii) that the relevant person is in immediate need of care or treatment; and:

(b) the constable considers that it would be in the interests of the relevant person, or necessary for the protection of any other person, to remove the relevant person to a place of safety, the constable may remove the relevant person to a place of safety.

The period of detention is 24 hours from when the relevant person is removed from the public place. In the first instance a **Constable** will remove the person to an agreed **Emergency Department or MHAU** (appendix E). If possible, the **Constable** should communicate in advance, by telephone, with the place of safety they intend taking the person to. The police officer must provide as clear and concise update of their concerns.

The purpose of Section 297 is for the purposes of enabling:

(a) arrangements to be made for a medical practitioner to carry out a medical examination of the relevant person; and

(b) the making of such arrangements as the medical practitioner considers necessary for the relevant person's care or treatment,

Therefore anyone brought to a place of safety must be seen by a fully registered medical practitioner (FY2 or above) who can decide on appropriate care or treatment. This does not need to be a psychiatric specialist, although the medical practitioner may choose to refer on to crisis or liaison health professionals for further advice.

Where there is a clear and obvious threat to staff, the person or the public, police officers should remain with the person until an assessment has taken place. Any decision about the police leaving the patient in the care of health staff must be done jointly.

On the rare occasion where it is not feasible to take the person to the **Emergency Department** the **Constable** may under **section 297(5)** remove the person to the police station. The Police Custody Healthcare Service must be contacted immediately to provide a medical assessment and /or the person moved on as swiftly as possible to a suitable place of safety.

The **Constable** must notify:

- The **Local Authority** where the place of safety is situated as soon as is practicable.
- The **Nearest Relative** (where this is not practical someone who resides with the person or provides care services) as soon as is practicable.

- The **Mental Welfare Commission** of the removal to a place of safety within **14 days**.

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11 Role of the Hospital Managers

11:1 Identification of a Hospital Manager

The Act places responsibility to discharge certain functions on **Hospital Managers**. In effect this is the **Health Board** who delegates the functions listed below to a variety of individuals. To ensure consistency throughout the document we have used the term **Hospital Manager**. The person or persons who discharge these functions should be clearly identified locally.

The role may also be delegated to one or a combination of the following:

- Medical Records Officer
- Duty page holders
- Bed managers
- Ward Managers
- Senior Charge Nurses
- Lead nurse / Nurse in charge
- For Acute services this includes Ward / Unit Senior Charge Nurse or Clinical Coordinators

It is the responsibility for each locality / hospital to identify who carries out this function at a local level.

11:2 Duties of Hospital Managers

There are many duties placed upon hospital managers throughout the act. Listed below are those duties relevant to admission under detention in an emergency.

- Appointment of a Responsible Medical Officer for the patient and medical examination by an Approved Medical Practitioner for those patients subject to an EDC.
- Take all reasonable steps to ensure the patient understands the effects of the certificate.
- To ensure any certificate of detention is compliant with the requirements within the Act.
- To ensure that any certificates and timelines are managed properly.

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- EDC
    - Inform within 12 hours of receiving the certificate the nearest relative or person who resides with the patient, named person of the granting of a certificate.
    - Notify within 7 days of section 37 information[3], the nearest relative or person who resides with the patient, named person, Mental Welfare Commission and where MHO consent was not obtained the appropriate local authority of additional information in section 37.
- STDC
    - Notify as soon as practicable the patient, named person, any welfare Guardian or attorney of the granting of a certificate
    - Within 7 days of the granting of a certificate send a copy of the certificate to the Mental Welfare commission and Mental Health Tribunal.

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[3] (a) the reason for granting the certificate; (b) whether consent of a mental health officer was obtained to the granting of the certificate; (c) if the certificate was granted without consent to its granting having been obtained from a mental health officer, the reason why it was impracticable to consult a mental health officer; (d) the alternatives to granting the certificate that were considered by the medical practitioner; and (e) the reason for the medical practitioner determining that any such alternative was inappropriate.

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12 Glossary of Terms and Abbreviations

Adult Carer		Someone over the age of 18 who provides or intends to provide unpaid care to a relative, partner or friend. This could be caring for someone who is ill, frail, disabled or has poor mental health or substance misuse problems. Adult carers should be supported as equal and expert partners
Advance Statement	**AS**	**Section 275 MH(C&T) (S) Act 2003** A written, witnessed document made when the patient is well, setting out how he or she would prefer to be treated (or not treated) if they were to become ill in the future. The Tribunal and any doctor treating the patient must have regard to the advance statement, they must send the Commission a written record of the ways they have worked out with these instructions, and the reasons why, if the advance statement is not followed.
Approved Medical Practitioner	**AMP**	**Section 22 MH(C&T) (S) Act 2003** A medical practitioner who has been approved by a NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder. An approved medical practitioner will often be a consultant psychiatrist. Only an approved medical practitioner can grant a short-term detention certificate; and at least one of the two mental health reports forming part of a compulsory treatment order application must be provided by an approved medical practitioner.
Authorised Person's Warrant		**Section 292 MH(C&T) (S) Act 2003** Authorises a person to enter the premises of another person where the person entering the premises has already been given the authority under another provision of this Act to take the person to another place or into custody. This could happen, for example, in a situation where a patient has absconded and a person who has been authorised under Section 303 MH(C&T) (S) Act 2003 to take that patient into custody or to return them to

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		hospital requires entry to the premises where the patient has been found.

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Care Plan		**Section 76 MH(C&T) (S) Act 2003** A document prepared by the patient's responsible medical officer after a compulsory treatment order has been made. It lays out the forms of medical treatment and the other services the patient will be receiving while subject to the compulsory treatment order. This document should not be confused with the 'proposed care plan', which is prepared under Section 62 MH(C&T) (S) Act 2003 as part of the application for a compulsory treatment order.
Community Mental Health Team	**CMHT**	A Multi-disciplinary team providing care, treatment and support to the patient while they are in receipt of mental health services. It would, be expected that the team would be made up of, where appropriate and relevant, medical practitioner(s), a mental health officer and other social workers, Community Psychiatric Nurses, psychologists, Occupational Therapists etc.
Community Psychiatric Nurse	**CPN**	A qualified nurse who delivers the majority of their care to a patient within a community setting.
Compulsion Order	**CO**	**Section 57A of the Criminal Procedure (Scotland) Act 1995** A mental health disposal made by the court authorising compulsory measures (either hospital or community-based) for a period of six months, if not otherwise renewed.
Compulsory Treatment Order	**CTO**	**Section 64(4) MH(C&T) (S) Act 2003** An order granted by the Tribunal. It authorises any of the compulsory measures listed at Section 66(1) MH(C&T) (S) Act 2003 for a period of six months, if not otherwise renewed. The compulsory treatment order can be renewed for six months, then for twelve months thereafter

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Designated Medical Practitioner	**DMP**	**Section 233 MH(C&T) (S) Act 2003** An appropriately qualified and experienced medical practitioner who is appointed by the Mental Welfare Commission to provide a second medical opinion with respect to certain medical treatments being given under Part 16 of the Act.
Emergency Detention Certificate	**EDC**	**Section 36(1) MH(C&T) (S) Act 2003**. A certificate issued subject to strict criteria, it authorises the removal of a person to hospital within 72 hours and the detention of that person in hospital for up to a further 72 hours after admission.
Extension Certificate		**Section 47(1). MH(C&T) (S) Act 2003** A certificate issued that extends a period of short-term detention by three days to allow for the preparation of an application for a Compulsory Treatment Order where a change has occurred to the patients condition. **Section 98 MH(C&T) (S) Act 2003** extends the detention period for a previously detained patient for 5 days after the expiry of the detention certificate where a Compulsory Treatment Order is being applied for.
Forensic Physician		A doctor who provides clinical assessment for and gathers forensic evidence from detainees, including preparation and implementation of care plans, prescribing and administering medicine, health and behavioral monitoring and clinical care to safeguard the health and welfare of detainees.
General Practitioner	**GP**	A fully registered medical practitioner providing primary care services within a community based practice.
Hospital Discharge		**Section 28(1) and (2) Carer (Scotland) Act 2016** requires each health board to involve the carer before a cared-for person is discharged from hospital. It must do so by (a) taking steps as it considers appropriate to: inform the carer as soon as reasonably practicable of the intention to discharge the cared-for person; and invite the views of carers about the discharge; and (b) taking account, 'so far as it is reasonable and

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		practicable to do so', of any views given by the carer in making decisions relating to discharge of the cared-for person. Section 28(3) provides that this duty only applies where: • the carer of the cared-for person can be identified 'without delay'; and • where it appears to the health board that the cared-for person is likely to require care following discharge.

Independent Advocate		**Section 259 MH(C&T) (S) Act 2003** Person who enables the patient to express their views about the decisions being made about their care and treatment by being a voice for the patient and encouraging them to speak out for themselves. An independent advocate is employed by an advocacy organisation which is not directly funded or run by the NHS Board or local authority. All people with mental disorder have a right to independent advocacy, not only those subject to compulsory measures.
Interim Compulsion Order	**ICO**	**Section 53 of the Criminal Procedure (Scotland) Act 1995** A pre-disposal order made by the court under authorising hospital detention for 12 weeks (but can be renewed regularly for up to one year) so that the court can gather further evidence on whether the forensic criteria apply.
Interim Compulsory Treatment Order	**ICTO**	**Section 65(2) MH(C&T) (S) Act 2003** An order granted by the Tribunal It authorises compulsory measures for a period of up to 28 days at a time.
Mental Health Assessment Unit	**MHAU**	**The Mental Health Assessment Units (MHAU)** will offer a face to face assessment to individuals presenting in mental health crisis/distress who would have ordinarily attended GRI, QEUH, RAH and IRH Emergency Departments. The MHAU staff will offer Consultant Connect which is an app based service in which GP's can directly access advice and support from

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		the Senior Nurse in the MHAU. This service will be accessible to all G.P surgeries across GG&C and the service is available to patients 18 years and older presenting with urgent mental health needs requiring an emergency same day response. For patients known to the CMHTs and/or who do not require an emergency same day response should be referred to their local CMHT in the normal way using existing referral routes. The MHAU will have the ability to offer emergency medication and treat minor injuries occurring in the context of the individual's mental health needs. Any significant self-harm or overdose with requirement for medical intervention should continue to be referred to local Emergency Departments for treatment.
Mental Health Officer	**MHO**	**Section 32 MH(C&T) (S) Act 2003** Officers of the local authority (social Workers) who meet certain requirements on qualifications, training, experience and competence with respects to persons with mental disorder.
Named Person		**Section 250 MH(C&T) (S) Act 2003** A 'named person' is someone nominated by a person in accordance with the provisions of the Act to support them and protect their interests. The named person is entitled to receive certain information about the person and to act on behalf of the person in certain circumstances and at certain times set out in the Act
Nearest Relative		There are occasions in the act where the nearest relative is given information about a person coming under the provisions of the Act such as when a person is removed to a place of safety. **Section 254 MH(C&T) (S) Act 2003** sets out a list of the people who will be considered in identifying a person's nearest relative.
Nurse's Power to Detain		**Section 299 MH(C&T) (S) Act 2003** A power that can be exercised by nurses 'of a prescribed class' to detain a patient for up to three hours, while awaiting and conducting a medical examination

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On Call System		Level 1 Junior Doctors at foundation year 2 (FY2) and Specialty Trainees (ST) Level 2 Senior Specialty Trainee (ST) Level 3 Consultant Psychiatrist
Place of Safety		**Section 300 MH(C&T) (S) Act 2003** defines a place of safety as a hospital, premises which are used to provide a care home service or any other suitable place (other than a police station) where the occupier is willing to temporarily receive a person with mental disorder. However, if no place of safety is available, a police officer may remove a person to a police station which should then be treated as a place of safety for the purposes of the person's detention.
Young Carer		A person under the age of 18 who provides or who intends to provide care for an adult or child needing care, except where the child needs care solely due to their age. Young carers are supported by reducing levels of inappropriate and harmful care responsibilities where possible. The overriding intention for young carers is that they should have a childhood similar to their non-carer peers. We want to ensure that young carers are enabled to be children and young people first and foremost and relieved of any inappropriate caring roles to allow them to have a quality of life.

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Proposed Care Plan		**Section 62 MH(C&T) (S) Act 2003** A documents drawn up by the mental health officer who is making the application for a compulsory treatment order. It contains details of the medical treatment for mental disorder, the community care services; and any other forms of care and treatment which it is proposed to provide to the patient if the compulsory treatment order is made. The "proposed care plan" should not be confused with the "care plan" which is prepared under Section 76 MH(C&T) (S) Act 2003 by the patient's responsible medical officer subsequent to the making of a compulsory treatment order.
Registered Mental Nurse	**RMN**	A qualified nurse under part 3 of the register by the Nursing and Midwifery Council who specialises in the provision of care for people with mental health problems.
Removal Order		**Section 293(1) MH(C&T) (S) Act 2003** An order granted by a sheriff or a justice of the peace. It authorises certain persons to enter the premises of an individual at risk in order to remove them to a place of safety.
Responsible Medical Officer	**RMO**	**Section 230 MH(C&T) (S) Act 2003** A fully registered medical practitioner who must be an Approved Medical practitioner who is appointed by hospital managers.
Short-Term Detention Certificate	**STDC**	**Section 44(1) MH(C&T) (S) Act 2003** This is a certificate subject to strict criteria, it authorises the detention of a person in hospital for a period of up to 28 days.
Social Worker	**SW**	An officer of the local authority who has achieved appropriate qualifications and experience in the assessment and delivery of social care needs.

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13. Mental Health Act forms

The Scottish Government website has copies of the most up to date version of Mental Health Legislation forms:

Mental Health law: forms - gov.scot (www.gov.scot)

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