

REPORT TO: East Lothian Integration Joint Board
MEETING DATE: 26 March 2026
BY: Chief Officer
SUBJECT: Updated Lothian Psychiatric Emergency Plan

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1 PURPOSE

- 1.1 The purpose of this report is to provide the IJB with the revised and updated multiagency Psychiatric Emergency Plan (PEP) for Lothian. This plan replaces the previous PEP that was developed in 2013. The Plan provides principles, guidance, and advice to all relevant partners about the legal detention of patients in accordance with Mental Health Legislation.
- 1.2 The updated PEP sets out best practice to be followed in the event of someone requiring detention in hospital. It does not attempt to provide solutions to issues of resourcing within existing services that impact on the operational delivery of the plan, however, does highlight the issue of transporting of patients to hospital as an area that requires further consideration by management teams.

2 RECOMMENDATIONS

- 2.1 The updated Lothian Psychiatric Emergency Plan has been approved by the Lothian Mental Health Programme Board. The IJB is recommended to endorse this approval to progress implementation in East Lothian.
- 2.2 It is further recommended that Health & Social Care partnership (HSCP) Management Teams undertake a review of their performance against the PEP and take actions to address any existing gaps in resourcing that potentially impact the safe, effective, and efficient management of psychiatric emergencies.

3 BACKGROUND

- 3.1 Psychiatric Emergency Plans are locally agreed arrangements and procedures outlining the role and responsibilities of health, social work,

police, ambulance, and other partners who are involved in responding to and managing a psychiatric emergency. The aim of a PEP is to agree on procedures to manage the detention and transfer process in a way that minimises distress, trauma, harm, disturbance, and risk for the patient and others, and which ensures as smooth and safe a transition as possible when conveying an individual from the site of the emergency to the legal place of detention (hospital).

- 3.2 Comprehensively developed and locally relevant PEPs are recommended by the Mental Health Act Code of Practice (Vol 2 para 58) [chapter 7 emergency detention certificate \(part 5\) - mental health \(care and treatment\) \(scotland\) act 2003 code of practice volume 2 ?civil compulsory powers \(parts 5, 6, 7 and 20\) - gov.scot \(www.gov.scot\)](#). PEPs aim to assist agencies and service providers to manage local arrangements for the detention and safe transporting/escorting of a patient to hospital and aspects of multi-agency working.
- 3.3 Paragraphs 49-58 of the Mental Health Act Code of Practice set out the expectations and processes of transferring of patients to hospital following detention, and the professional responsibilities of those involved. The PEP is aimed at providing guidance for staff within the local context of service provision and setting in place contingency procedures before they arise.

4 ENGAGEMENT

- 4.1 During the process of the review of the PEP, a wide range of stakeholders have been involved in informing the revised plan. This has included all relevant statutory agencies, representatives from local third sector organisations, and patient representatives. There has also been involvement and representation from all professions who are involved in the process of detaining patients in hospital.

5 POLICY IMPLICATIONS

- 5.1 The Psychiatric Emergency Plan supports compliance with several legislative frameworks including, but not limited to, the Mental Health (Care & Treatment) (Scotland) Act 2003, the Human Rights Act 1998, and the Police and Fire Reform (Scotland) Act 2012.

6 INTEGRATED IMPACT ASSESSMENT

- 6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy. This is an update to an existing Plan to reflect service delivery arrangements.

7 DIRECTIONS

7.1 The PEP relates to the following IJB Directions:

DC 1 – NHS Lothian delivery of core primary and community health services – providing community mental health services, community learning disability services, general medical services

DC 2 – NHS Lothian delivery of hosted services – providing mental health inpatient services

DC 4 – East Lothian Council delivery of social work and social care services – providing Mental Health Officers (MHOs) who must be qualified social workers appointed under law is a statutory duty of local authorities. This duty sits primarily within the Mental Health (Care and Treatment) (Scotland) Act 2003, which requires councils to ensure an adequate supply of trained MHOs to carry out specific legal functions.

The PEP is aligned with East Lothian Strategic Objectives outlined in the **IJB Strategic Plan – Objective 6: Keep people safe from harm.**

8 RESOURCE IMPLICATIONS

8.1 The PEP does not include within its scope solutions to gaps or shortages in operational resourcing. The review process has included lengthy discussions by all partner bodies and agencies about existing gaps and how these impact the efficient use of available resources, the safety and wellbeing of patients, staff, and the public. It is not, however, for the PEP document review group to direct how resources should be organised or deployed within local service areas. However, the review group does recommend that each partner organisation/operating division reviews their performance against the PEP.

8.2 **Financial** – the review of the PEP does not have any financial implications per se, as it is setting out the principles and processes to be followed in administering the existing mental health legislation that has been in statute since 2003 (updated in 2015). Operational services should, however, consider how current services perform against the principles and practice contained within the PEP and identify any gaps in existing resources (see 8.4 and 8.4).

8.3 **Personnel** – the review of the PEP does not introduce additional workload for any of the professions or agencies already involved in the detention of patients to hospital. The process of the review however, involving all agencies and professions, has brought to the fore concerns and lengthy discussions about long term existing shortfalls and insufficient resources which often lead to interruptions to planned day-to-day clinical service delivery, delays in patients being safely transferred to hospital, which increases risks and causes stress to all concerned, and practice that could be improved to ensure patient rights are optimised.

There are implications of increased workload for health and MHO personnel however due to a wider policy position of Police Scotland included in 8.5 below.

- 8.4 **Other** – The current arrangement is for patients being detained to be transported to hospital by Scottish Ambulance Service. There are often significant delays in response times due to the prioritisation algorithms and the availability of staffed ambulances. This has a domino effect on the availability and release of detaining clinicians and practitioners as the patient cannot be left unattended whilst transport is awaited. It is not unusual for this to take several hours. This has a significant impact on the planned duties of the personnel involved, and other patients being negatively impacted consequently.
- 8.5 This issue is being exacerbated further by the recent reaffirming of the policy position of Police Scotland in relation to responding to mental health events. Historically across Lothian, Police Scotland colleagues have supported partners in facilitating the transporting of patients to hospital in complex situations that were not always crime related matters. Legal guidance has been circulated across Police Scotland which reinforces that Police will only respond to requests for assistance where there is a risk of crime (e.g. violence, disturbance). This will place an increased demand on health staffing to facilitate the safe escorting of patients to hospital and will require investment.
- 8.6 Enquiries have been made with a Private Ambulance provision via the NHS Lothian Flow Centre to explore whether this is a service that could be commissioned, which has been confirmed could be done. This is a matter that the PEP Review Group recommend is explored further by operational management teams across Lothian with a degree of urgency, given that Police Scotland colleagues have already issued the policy position.

9 BACKGROUND PAPERS

- 9.1 None.

Appendix: Lothian Psychiatric Emergency Plan

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DATE	16 March 2026

Lothian Psychiatric Emergency Plan

A Guidance Document for personnel of:

NHS Lothian including Primary Care
East Lothian Health & Social Care Partnership
Edinburgh Health & Social Care Partnership
Midlothian Health & Social Care Partnership
West Lothian Health & Social Care Partnership
Scottish Ambulance Service
Police Scotland E and J Divisions

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Approved by:			
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Executive Lead:	Tracey Gillies, Medical Director. NHS Lothian		
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1. Purpose of Plan

- 1.1 The Scottish Government has required all relevant local agencies and service providers who may potentially be involved in psychiatric emergencies to work together to develop and agree on a Psychiatric Emergency Plan (PEP). This allows for local difficulties to be addressed and contingency procedures to be put in place before they arise for real. The aim of the PEP is to agree on procedures which will manage transfer and compulsion processes in a manner that minimises distress, disturbance and risk for the individual and others while ensuring a person-centred and human rights approach to ensure as smooth and safe a transition as possible from the site of the emergency to the appropriate treatment setting.
- 1.2 The professionals involved in developing the PEP include: General Practitioners, Approved Medical Practitioners, Mental Health Officers, Social Workers, Social Care Workers, Community and Ward-based Nursing Staff, Hospital Managers, Independent Service Providers, Police Officers and Ambulance Personnel. It is also important that service users and carers are consulted in relation to the preparation of PEPs.
- 1.3 When people are being assessed for possible admission under the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Mental Health (Scotland) Act 2015, their qualities, abilities and diverse backgrounds, as individuals, will be respected. Their age, gender, sexual orientation, social, ethnic, cultural and religious background will be considered but general assumptions based on any one of these characteristics, will not be made.
- 1.4 This document is designed to describe best practice in admitting patients to hospital for reasons of mental disorder and to explain the roles and responsibilities of each of the services involved in assessment and admission under the Emergency and Breach provisions of the Act. It should contribute to good joint working and, by so doing, will help to minimise the distress that patients, their friends and their family and carers can experience when compulsory admission to hospital is being contemplated.
- 1.5 A Code of Practice offering guidance on the provisions of the Mental Health (Care & Treatment) (Scotland) Act 2003 has been produced by the Scottish Government. The Code supports implementation and ongoing operation by the various agencies that have statutory duties and responsibilities under the Act. It is recommended that this guidance note is read and used in conjunction with the Code of Practice. <https://www.gov.scot/policies/mental-health/legislation-and-guidance/>
- 1.6 The provisions of the Act have been developed following extensive consultation with the range of stakeholders in the field of mental disorder. It is underpinned by a set of Principles and it is the expectation of all the agencies that have developed and endorsed this guidance note, that these principles will be adhered to by all staff in relation to its use.

- 1.7 It is recognised that arranging mental health admissions is unpredictable and circumstances vary from one situation to another. Each of the services involved operates under significant resource constraints, which can affect its ability to deliver an optimal service. It is understood however, that this document, which has been endorsed at senior management and executive levels of the partner organisations involved, in describing best practice, sets out the performance targets that each service will aim to meet. The document, however, does not attempt to solve any day-to-day operational deficiencies or constraints on resourcing which may affect delivery of the plan.
- 1.8 This document is intended to encourage collaboration between the agencies involved that are required to act in partnership with a view to achieving the best possible outcome for the patient.
- 1.9 Compulsory admission to hospital should only be considered when **ALL** alternatives have been examined and excluded.
- 1.10 **Appendix 1** gives the Definitions and Abbreviations contained in the Plan. The 'Out of Hours' period is generally regarded as being before 9am and after 5pm but operating hours do vary across different services.

2. Scope of Plan

- 2.1 This document covers a complex range of operational management arrangements and governance structures relevant to the personnel of NHS Lothian, the City of Edinburgh Health & Social Care Partnership (HSCP), Midlothian HSCP, East Lothian HSCP, West Lothian HSCP, the Scottish Ambulance Service and Police Scotland. Matters relating to the resourcing of the operationalisation of the plan remain the responsibility of each of the respective partner agencies.
- 2.2 It covers admissions under the provisions of the Mental Health (Care & Treatment) (Scotland) Act 2003. Usually this is to a psychiatric hospital, although there are some circumstances when admission to a general hospital is required, particularly if a drug overdose has occurred or is suspected or if other physical injury requires immediate medical treatment. There are also specific provisions related to 'designated places' that are explained in Section 4 of this guidance note.

3. Responsibility for Monitoring and Quality Control of this Agreement

- 3.1 Those responsible for checking that this procedure is maintained and implemented are:
- Chief Social Work Officers or equivalents
 - Medical Director and Associate Medical Directors, NHS Lothian
 - Executive Director of Nursing and Nurse Directors, NHS Lothian

- Regional Director, East Region of the Scottish Ambulance Service
- Chief Officers HSCPs
- Partnerships Superintendents from E and J Division Police Scotland.

3.2 Following every admission, it would be unrealistic to attempt to undertake a complete debrief of the assessment or triage process. However, to enhance the development of good practice, regular review meetings will be held of the various stakeholders involved in drawing up and implementing this psychiatric emergency plan. These meetings will be used to discuss recent cases, any problems encountered and potential solutions to any identified areas of difficulty. All partner representatives can call a review meeting to look at the 'assessment and/or triage process' and/or a debrief over a particular case.

The Associate Medical Director for Mental Health & Learning Disability will chair these review meetings when appropriate and the point of contact for these will be the PA Hub of the Royal Edinburgh Hospital, who will invite as appropriate the Inspector from the Preventions, Interventions and Partnerships team Police Scotland, Edinburgh, the MHO Team Manager Edinburgh, GP Lead, and / or any other professional that may be involved for Edinburgh / East / Mid / West Lothian:

Core Group:

- Associate Medical Director Mental Health & Intellectual Disability NHS Lothian
- REAS Chief Nurse or Nurse Director for Mental Health & Intellectual Disability NHS Lothian
- Clinical Directors for General Adult Psychiatry / Older Peoples' Mental Health / Learning Disability NHS Lothian
- Police Inspector from the Preventions, Interventions and Partnerships Team, Edinburgh E Division
- MHO Team Manager, Edinburgh HSCP
- GP Lead
- Clinical Director for Lothian Unscheduled Care Service (LUCS)

Depending on cases being considered for review, invitation to the following as appropriate:

- Team Leader of Rapid Response Team
- Team Leader of Mental Health Assessment Service for Edinburgh City
- Team Leaders of Intensive Home Treatment Teams in East / Mid Lothians
- Team Leader ACAST West Lothian
- Team Leader Learning Disability MHIST Team
- Team Leader CAMHS Unscheduled Care Team
- Local GP
- Local CMHT Team Leader
- Detaining AMP
- Detaining MHO
- Scottish Ambulance Service Manager

4. A Summary of the Legislation

4.1 The Mental Health (Care & Treatment) (Scotland) Act 2003 contains several provisions that may entail the conveyance of patients from a community setting to hospital, to a designated place or between hospitals, on a compulsory basis. Useful and more comprehensive information and best practice guidance relating to these provisions is contained in the Code of Practice and staff from all agencies are urged to consult the Code in conjunction with this guidance note <https://www.gov.scot/policies/mental-health/legislation-and-guidance/>. The agencies that have developed this guidance note may have an active role in relation to the following Parts of the Act:

4.1.1 Part 4, Chapter 2

Section 33: Local Authority Duty to Inquire

Section 34: requirements for various agencies, including Health Boards, to cooperate with Local Authority inquiries

Section 35: should it be necessary, under Section 33 Local authority Duty to Inquire, to enter premises, carry out medical examination or gain access to medical records and it is established or reasonably considered that this will not be possible, a Mental Health Officer (MHO) should make application to the Sheriff Court using Section 35 of the MH Act. If granted, the warrants allow:

- 35(1): MHO, any other persons so specified and any police constable, may enter premises for eight days following the granting of the warrant. Makes provision also, for the police constable to open the lockfast premises so specified.
- 35(4): detention of an individual for a period of three hours in order that a medical practitioner specified in the warrant may carry out a medical examination.
- 35(7): access to an individual's medical records by a medical practitioner specified in this warrant.

All of the above warrants should be applied for and are granted, separately. These provisions **do not** authorise the removal of a person who is subject to these inquiries which take place via other parts of the Mental Health Act (See 4.1.6 below).

Comprehensive explanatory and practice guidance regarding authorised personnel and application processes are available in the Mental Health Act Code of Practice, Volume 1, Chapter 15 <https://www.gov.scot/publications/mental-health-care-treatment-Scotland-act-2003-code-practice-volume-1/pages/16/>.

4.1.2 Part 5

Section 36: **Emergency Detention:** any medical practitioner may grant an Emergency Detention Certificate, subject to the assessment and consent of a MHO, unless it is a matter of urgency to detain due to 'significant risk'. The certificate confers the power to remove the person to hospital and detain them for up to 72 hours from the time of admission. As soon as practicable it should be reviewed by an Approved Medical Practitioner (AMP), to consider conversion to a short-term detention (STD). In Lothian it is standard that this will be within 24 hours.

Following a review of the Emergency Detention by the AMP, there are only four possible outcomes:

- Continual admission on a voluntary basis
- Continuation of the admission on the EDC
- Continual compulsory admission on a Short Term Detention basis
- The patient is discharged from hospital

4.1.3 Part 6

Section 44 - **Short Term Detention:** only an AMP may grant a Short Term Detention Certificate and only with the assessment and consent of a MHO. The certificate confers the power to remove the person within three days, to detain and to give them medical treatment in hospital for up to 28 days.

4.1.4 Part 7, Chapter 1

Sections 57 to 71 - **Compulsory Treatment Order:** these Sections cover the process of application for a CTO by the MHO following medical examinations of the person carried out by either two AMPs, or one AMP and another medical practitioner such as a General Practitioner. No power is conferred until the Mental Health Tribunal Scotland (MHTS) grants the order. CTOs can be applied for to confer community-based compulsory powers as well as powers to detain and treat the person in hospital. Tribunals can also grant Interim CTOs for a period of up to 28 days.

4.1.5 Part 7, Chapter 5

Sections 112 to 115 - **Breach of Orders:** these Sections cover powers and procedures related to non-compliance with medical treatment and / or community-based compulsory measures conferred in CTOs.

Section 112: applies to the CTO 'attendance requirement' only and confers powers upon the Responsible Medical Officer (RMO) to convey the person to either the designated place or to a hospital. MHO consent is required.

Section 113: confers powers upon the RMO to have the person 'taken into custody' and conveyed to hospital and to detain the patient in hospital for a period of 72 hours from arrival. The RMO can then grant a certificate under

Section 114 to further detain the patient for 28 days. **Section 115** confers a similar power in relation to a person subject to an Interim CTO. MHO consent is required for both detentions.

4.1.6 Part 19

Sections 292 – 294, 297 –298 and 300 - **Entry, Removal and Detention Powers and Place of Safety**: these Sections confer powers to apply for Warrants to gain forced access if there is a requirement to remove a person at risk to a hospital and detail police emergency powers.

Section 292: authorises a person who has already been given authority by the Act to take a patient to any place or into custody, to enter that patient's premises. This would apply, for example, when an already detained patient has absconded or where a CTO has been made but access cannot be gained. The 'authorised person' (usually an MHO) must make the application to Sheriff or Justice of the Peace.

An application made by an MHO to a Sheriff for a warrant under **Section 293** would follow the application of the Local Authority's Duty to Inquire under Section 33, where access to examine the patient is likely to be, or has been, denied. Section 293 enables the removal of the patient to a place of safety. Section 294 permits the application to be made to a Justice of the Peace rather than a Sheriff, if the situation is urgent.

Sections 297: 298: allows for the removal of a person by the police from a public place to a place of safety for a period of up to 24 hours and states who needs to be informed.

Section 299: of the Act empowers certain nurses (RMNs or RNLD) to detain an informal patient who is in hospital receiving treatment for a mental disorder, but that treatment is not being given by virtue of the Act or the 1995 Act. 'In hospital' means within hospital premises, including general hospital wards, accident and emergency departments and clinics held on hospital premises. The patient can be detained by the nurse for a period of up to three hours, (**'the holding period'**) for the purpose of enabling arrangements to be made for a medical examination of the patient to be carried out. Best practice is that the medical practitioner should arrive as soon as practicable, and that the detention period is as short as possible. As short a detention period as possible will best reflect the principles in Section 1 of the Act, in particular the principle of minimum restriction on the freedom of the patient that is necessary in the circumstances.

Section 300: provides the meaning of '**place of safety**' which is a hospital, or premises which are used for the purposes of providing a care home service, or any other suitable place (other than a police station), the occupier of which being willing temporarily to receive persons with mental disorder. (Lothian have agreed that a GP Surgery **is not** to be regarded as a 'place of safety').

4.1.7 Cross-border absconding - absent from other jurisdictions.

Regulations made under **section 309** of the 2003 Act allow patients subject to corresponding compulsory measures in England, Wales, Northern Ireland, the Isle of Man or the Channel Islands to be dealt with while in Scotland under **Sections 301-303** (as modified by the Regulations). The applicable regulations are The Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008 SSI2008 No.333 <http://www.legislation.gov.uk/ssi/2008/333/made> These regulations cover patients subject to detention in hospital corresponding to detention under the 2003 Act and the 1995 Act, including those who are on suspension of detention or conditional discharge.

A patient who is on unauthorised absence from a hospital can be taken into custody and taken to any place that is appropriate by the person acting in the equivalent role to RMO in the relevant territory, or any medical practitioner.

A patient on suspension of detention who has failed to reside in a specified place can be taken into custody. As can a patient who has failed to comply with a suspension of detention condition to return to the hospital they were detained in, or go to another place, on or after the occurrence of a specified event.

These patients can be returned to the specified place they failed to reside at (if applicable)* or taken to any place considered appropriate by the RMO-equivalent person, or any medical practitioner. *NB this is unlikely to be an address in Scotland, and the powers within these regulations are only applicable within Scotland.

The regulations also cover patients who have breached requirements corresponding to CCTO, interim CCO or CCO requirements to reside at a specified place or gain the approval of a MHO to change address. They cover patients who have breached an interim CCTO requirement to reside at a specified place.

Such patients can be returned to the specified place they failed to reside at (if applicable)* or taken to any place considered appropriate by the RMO-equivalent person, or any medical practitioner. *NB this is unlikely to be an address in Scotland, and the powers within these regulations are only applicable within Scotland.

The persons who can take the patient into custody are:

- a police constable
- MHO.
- A member of staff of any hospital.
- If the patient is subject to (a corresponding measure to a) CCTO or CCO with a condition that they reside in an establishment with the address specified in the order, a member of staff of that establishment.
- Any other person authorised for the purposes by the RMO.

Should a patient require compulsory medical treatment before their return to their country of origin, this will require consideration of a STDC. A patient cannot be removed from Scotland under cross-border absconding provisions if they have been detained under Scottish legislation. In that case, a cross-border transfer application to the Scottish Ministers should be made if it is proposed to transfer them out of Scotland.

- 4.2 There is comprehensive explanatory and practice guidance in the **Code of Practice** that will assist staff in developing an understanding of their duties and responsibilities. Regardless of the particular Part or Section of the Act that underpins the intervention proposed, the fundamental practice issues in relation to emergency scene management and the conveyance of patients from the community to hospital, or to places of safety, remain the same.

5. **Summary of Principles within the Mental Health (Care & Treatment) (Scotland) Act 2003**

- 5.1 The Principles of the legislation are laid out in Sections 1 to 3 of the Act and place a requirement on people who have a formal role in discharging any function under the Act. The requirement is that, in discharging his or her function, such a person has regard for:

- The present and past wishes and feelings of the patient
- In so far as is practicable and where they exist, the views of the patient's named person, carer and any guardian or welfare attorney
- The importance of the patient participating as fully as possible in the discharge of the function
- The importance of providing information and support for the patient, in the form that is most likely to be understood, to enable the patient to participate
- The importance of the range of options available in the patient's case
- The importance of providing the maximum benefit to the patient
- The importance of the patient's background and characteristics, including age, sex, sexual orientation, gender, religious persuasion, racial origin, cultural, ethnic and linguistic background
- The importance of providing appropriate services to a patient who is detained and to the provision of continuing care thereafter.
- The needs and circumstances of the patient's carer, providing such information as might be needed to assist in the care of the patient

- 5.2 The functions must be discharged in a manner that:

- Involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances
- Encourages equal opportunities
- If the patient is a child (under 18 years old) best secures his or her welfare

6. Emergency Contact Telephone Numbers

6.1 **Appendix 2** lists the main telephone contact numbers for the key services involved with psychiatric emergencies.

6.2 Requests for Assistance of Police Scotland

6.2.1 Any request for police assistance regarding persons in mental health crisis, should initially be made by contacting the Police Scotland Area Control Room on 101 or 999 in an emergency. The detaining doctor / mental health professional should explain the circumstances of the incident, why police are requested and a 'triage' discussion with a supervisory officer should take place to agree the most appropriate course of action going forward. Where possible this should happen in a planned way in advance of health professionals attending the patient in the community

6.2.2 This initial triage discussion should cover threat, risk and harm, the proposed course of action in respect of the person in crisis and whether police attendance at a location is required. Discussions around transport plans should be agreed at this time and it is important to remember that responsibility for organising transport of a person to hospital, remains that of the detaining doctor / mental health professional and does NOT default to police. There may well however be occasions when police transport is required due to safety concerns, but this can be covered in the triage discussions.

6.2.3 A supervisor within the police control room is likely to be the first point of contact for the GP / mental health professional, however it is recommended that they ask to speak directly to the Duty Inspector (PIO) for the respective area, as they are best placed to be involved in any subsequent action.

6.2.4 Cross-border absconding - absent from other jurisdictions ([see 4.1.7](#)). Patients subject to corresponding compulsory measures in England, Wales, Northern Ireland, the Isle of Man or the Channel Islands can be taken into custody in Scotland. Police Constables have the authority to take these patients into custody.

7. Detention of Patients in the Community and Transfer to Hospital

7.1 Good Practice at the Scene

7.1.1 All personnel involved should ensure the patient's welfare and the welfare of all present. Problems often arise when the parties involved fail to communicate at the scene. Every attempt should be made to keep all of those involved (including the patient), fully informed. As communication is a two-way process, this requires the participation of all parties. Every attempt should be made to ensure that everyone involved in the assessment process be properly briefed. Where possible this should be done prior to attending the location so that ALL are content with the plan and contingencies are covered.

- 7.1.2 It is the responsibility of the detaining doctor, aided where possible by the MHO and with the active participation of all those involved, to try and ensure that involvement, communication and briefing between everyone concerned takes place. Where possible, all participants should be briefed at the same time and place although it is likely that they will take place sequentially and on rare occasions may not be possible.
- 7.1.3 Every attempt should be made to negotiate with the patient and persuade them to cooperate with transfer.
- 7.1.4 The detaining doctor should have with them the necessary Mental Health (Care & Treatment) (Scotland) Act 2003 forms, in case compulsory admission proves necessary.
- 7.1.5 Involving Named Persons, relatives and carers may help defuse a difficult situation and should always be considered. If time allows, involvement of a patient's advocate may also be helpful.
- 7.1.6 Reference to existing care plans, Anticipatory Care Plans, Emergency Care Summaries and in particular Advance Statements, crisis management and risk assessment information may also be helpful, however it is accepted that these may be difficult to access in an emergency. Every effort to access an Advance Statement should be made. There are a variety of ways to access such documentation e.g., patient held forms, TRAK, SCI Store and Clinical Viewer. MHAS can support searching TRAK for patients in the community and where TRAK is not available.
- 7.1.7 If present at the scene of an assessment / admission, ambulance and police personnel need to be aware of the further distress and disturbance which might be caused by their appearance (uniforms, radios, lights etc.). If a silent approach is requested, this must be communicated to Ambulance Control at the time of ordering ambulance support. Police should consider turning off vehicle emergency lights and sirens and lowering the volume of personal radios as they approach the patient's residence. Similarly, if an emergency ambulance has had to be summoned, ambulance personnel should switch off vehicle emergency lights and sirens as they approach (silent approach).
- 7.1.8 Further, whenever the police are present at an assessment / admission, the reason for their presence should be explained to the patient by the mental health professionals in charge. This explanation should be given by the person who has developed the best rapport with the patient. It should be emphasised to the patient that they have done nothing wrong and that the police are only present because of the need to ensure everyone's safety.
- 7.1.9 To ensure compliance with health & safety, all personnel involved should adhere to their organisation's Lone Working Policy. The policy is required to acknowledge working procedures in collaboration with external agencies. These agencies may have differing working procedures and policies but where

possible local operational procedures should be agreed through the examination of commonalities within each organisation's lone working policy.

7.2 *Emergency Detention Certificate versus Short Term Detention Certificate*

7.2.1 A Short-Term Detention Certificate (STDC) rather than Emergency Detention Certificate (EDC), is the **most appropriate** gateway order to better ensure the rights of the patient.

The Code of Practice, however, recognises that in an emergency it is not always possible or best practice for patient care, to delay the process of detention and admission. Therefore, this PEP allows 4 options to support patients:

- **EDC:** EDC used to urgently protect patient safety or safety of others (Note: Within Lothian all EDCs are reviewed within 24 hours by an AMP, where a STDC will be considered. This means the period a patient would be detained under an EDC will be very limited).
- **EDC in lieu of STDC:** EDC used where arranging the STDC would cause undesirable delay to the patient's care or pose a greater risk to the patient or others.
- **STDC:** STDC used if there is time to arrange AMP and MHO within the current service configuration.
- A less restrictive option is identified.

7.2.2 The Short Term Detention Certificate allows up to 28 days detention and treatment for mental disorder in a hospital, has a right of appeal, requires MHO consent and is completed by an AMP.

7.2.3 An EDC authorises the transport of the patient to hospital but admission to hospital can only occur after the certificate has been given to hospital managers or someone acting on their delegated authority, usually a senior nurse. The certificate only authorises detention in hospital and does not give authority to give additional medical treatment e.g. medication.

[Appendix 5](#) describes the doctors' Crib Sheets and [Appendix 10](#) flow diagrams for granting an EDC or a Short Term Detention Certificate.

7.3 *Responsibilities of Primary and Secondary Care Doctors in respect of in and out of hours AMP availability*

7.3.1 GPs and AMPs should focus on the balance of risks when selecting the Detention Order being applied, putting the needs of the patient and their carers first to ensure as rapid as possible admission and minimum upset to the patient and carers.

7.3.2 If it has been possible to consult an MHO, the compulsory admission can only proceed with their consent. If the GP and MHO disagree on the need for Emergency Detention, then detention cannot take place. In the event of complexity in respect of the assessment and detention, GPs can contact secondary care MH or LD services for advice.

7.4 *Obtaining Entry*

7.4.1 Where there are reasonable grounds for concern for safety of an individual and where consensual access cannot be obtained **or** it is reasonably anticipated that access will be refused, there are a range of measures to assist with access under the Mental Health Act:

Section 35 (1): should it be necessary, under s.33 Local authority Duty to Inquire, to enter premises and it is established or reasonably anticipated that this will not be possible, a Mental Health Officer (MHO) should make an application to the Sheriff Court using Section 35 (1) of the MH Act. If granted, the MHO, any other persons so specified, and any police constable may enter premises for eight days following the granting of the warrant. It makes provision for the constable to open the lockfast premises so specified. It does not authorise the removal of a person.

Section 292: allows for entry to premises by an authorised person, an MHO, a police constable and a medical practitioner. The authorised person should make application to the Sheriff Court in order to obtain this warrant. The authorised person is defined by having the authority to take the patient to any place or into custody by virtue of other provisions in the MH Act, for example a patient subject to a Compulsory Treatment Order.

Sections 293 / 294 Removal Orders: where, upon application by a Mental Health Officer, a Sheriff or Justice of The Peace is satisfied that an individual of 16 years or over, who has a mental disorder is likely to experience significant harm if not removed to safety, may authorise a removal order. This allows 72 hours after granting, for the MHO, any other person specified in the order and any constable, to enter premises, remove and then detain the individual to a place of safety for a period not exceeding seven days.

Comprehensive explanatory and practice guidance regarding authorised personnel and application processes is available in the Mental Health Act Code of Practice, volume 1, chapter 15. [Mental Health \(care and treatment\) \(Scotland\) Act 2003: Code of Practice Volume 1 - gov.scot \(www.gov.scot\)](http://www.gov.scot/Resource/0/4/04009/nid24535/p1226222.html)

7.4.2 Where a warrant has not been obtained and entry has been refused, but it appears that it is urgently necessary to gain access for the purpose of protecting life and property, the police or fire and rescue services are empowered in common law and statute to forcibly enter for this purpose. Police Scotland SOP and guidance on forced entry will be followed.

7.4.3 The MHO has a responsibility to determine whether the Subject of assessment has any dependents, either children or adult, who will be left without care because of the subject's compulsory admission to hospital.

- 7.4.4 The MHO will have responsibility for ensuring that alternative care arrangements are put in place for any such dependents and shall seek the support and guidance of the relevant Children & Families or Adult Social Work duty teams.
- 7.4.5 Under S48 of the National Assistance Act where a person is to be admitted to hospital and it appears to the Council that there is a danger of loss of or damage to property by reason of the patient's temporary or permanent inability to protect or deal with the property and that no other suitable arrangements have been or are being made for this purpose, it shall be the duty of the council to take reasonable steps to mitigate or prevent this loss or damage. In order to fulfil this duty, the MHO shall take steps to ensure the welfare of any pets within the house and that the house is appropriately secured. The MHO will liaise with the Council or Housing Association who will ensure new keys are conveyed to the patient in hospital or keys are retained at an appropriate place. Contact details for pet places is included in the contact information in Section 6.
- 7.4.6 Should the MHO determine that the subject of assessment is a person who may need community care services the local authority must carry out an assessment of needs under S12A of the Social Work (Scotland) Act 1968 upon the written request of the MHO.
- 7.4.7 Where the subject of assessment is a child and the MHO determines that there is a necessity for assessment of their needs under S23 of the Children (Scotland) Act 1995, the local authority shall carry out an assessment of the needs of the child, or any other person in the child's family, as far as is attributable to the mental disorder.
- 7.4.8 Where the patient is already subject to a detention order in England, Wales or Northern Ireland, Police Scotland, an MHO, or a member of staff of any hospital have the authority to take those patients into custody
https://www.mwscot.org.uk/sites/default/files/2021-07/Cross-border-guidance_AdviceNote_2021.pdf.

7.5 *Clinical Assessment of the Patient*

- 7.5.1 Irrespective of whether it is an AMP or a registered medical practitioner involved, the following process for assessment and involvement of relevant others should be followed.
- 7.5.2 Should it appear likely that a patient is requiring admission under the Mental Health (Care & Treatment) (Scotland) Act 2003, it is the responsibility of the doctor to consult an MHO and coordinate the initial assessment and for determining, by means of a joint risk assessment, which other agencies need to be present.

- 7.5.3 The AMP/Registered Medical Practitioner and MHO should also ensure that, if available, any Advance Statement prepared by the patient is given due regard and efforts are made to locate it. Copies of Advance Statements must be held in the patient's clinical record on TRAK Care (health records system). During the initial contact between the GP and Secondary Care Services, it is mental health staff's responsibility to share the information held on the Advance Statement. It would be best practice to have a note added to the Key Information Summary (KIS) system to alert that the patient has an advance statement. Copies of Advance Statements should also be held in the relevant social work electronic system (AIS) in Edinburgh and West Lothian, MOSAIC in Midlothian and East Lothian. As per the local SOP on Advance Statements, any Advance Statements should be noted on SCI store and an alert on TRAK to direct the reader to SCI Store.
- 7.5.4 As outlined in Section 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003, anyone who makes decisions about treatment for a patient, subject to the Act, must have regard for the wishes in an Advance Statement. They are not legally binding, however, should there be an override of these wishes, the doctor must record this, by writing the circumstances and adding a copy of this to the patient's clinical notes. It is advisable to provide a copy of the record or write directly to the patient about the override. A copy should also be given to the patient's named person, the patient's welfare attorney, guardian (if applicable) and the Mental Welfare Commission (see [Appendix 1: Definitions & Abbreviations & Responsibility for Monitoring and Quality Control of this Agreement of Roles and Responsibilities](#)) and sections 3.1 and 3.2 of this guidance.
- 7.5.5 If any aspects of the management plan are in conflict with the patient's Advance Statement, the reasons for this should be clearly documented and reviewed by the doctor treating the patient. It is the doctor's responsibility to make a record where there has been conflict, as outlined in Section 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and Section 2 of this guidance. Notifications of any conflict and/or override should be clearly documented and reviewed by the RMO on the next working day.
- 7.5.6 The MHO should assess the patient with the medical practitioner for possible admission unless the urgency of the case prevents this. Where it has not been practicable to consult an MHO, or the MHO is unavailable, this is documented on the EDC form.
- 7.5.7 An AMP must consult an MHO and obtain their consent to the granting of a Short-Term Detention Certificate in all instances and where practicable must consult the patient's named person (where there is a nominated Named Person) prior to granting the short-term certificate.
- 7.5.8 Where an MHO refuses to consent to either an Emergency Detention Certificate or a Short Term Certificate, the AMP or the medical practitioner **may not grant the certificate and the patient may not be detained. In this circumstance, there must be a joint care plan developed for the patient**

and consideration should be given to other legislative frameworks and their applicability.

7.5.9 Those others that may also be involved in the assessment process include:

- Patient's advocate
- Named Person (must be consulted, where practicable, prior to granting a short term detention certificate)
- Relative or carer
- Patient's General Practitioner (when not the detaining doctor)
- Psychiatrist (when not the detaining doctor)
- Other member(s) of the Mental Health Team e.g. Community Psychiatric Nurse (CPN), Community Learning Disability Nurse
- IHTT/ RRT/ MHIST / ACAST / CAMHS Unscheduled Care staff
- Social Worker
- Service Provider
- An Interpreter for patients who have little or no English, are deaf, or who otherwise may not be able to understand and or take part in the assessment procedure, the involvement of an interpreter will be vital at as early a stage as possible. (N.B. there may be conflict of interests if family members are used as interpreters)

7.5.10 Communication of Assessment Information: information about the assessment of every patient in the community should be documented and available to have as part of their communication of assessment information, to accompany the patient at point of admission. The person doing the assessment completes the relevant form which could be a referral letter from the GP or an assessment template completed by the local Thrive Teams (Edinburgh), CMHTs, MHAS, IHTT, RRT, MHIST or CAMHS Unscheduled Care staff.

7.5.11 **Where the patient's mental state presentation is thought to be as a consequence to a physical health condition**, it may be appropriate to detain the patient for further assessment of mental disorder or for treatment. The Mental Welfare Commission provide guidance on this in their publication [Right to treat](#) (2025)

Where someone has capacity to consent to treatment for a physical disorder (whether or not a consequence of the mental disorder) that route should be followed.

Where a person *cannot consent due to lack of capacity* to make that decision, for medical treatment of a physical disorder that is a manifestation of the mental disorder, or a consequence of mental disorder- there are two routes available: treatment under the Adults with

Incapacity (Scotland) Act 2000 (AWI) or treatment under the Mental Health (Care & Treatment) (Scotland) Act 2003.

Where there is no objection/resistance, then treatment may proceed under the AWI 2000 subject to the safeguards present within this Act.

Where treatment is provided for mental disorder or in consequence of the patient having a mental disorder, this treatment falls within the meaning of treatment that can be provided under the 2003 Act.

'Medical Treatment' under the Mental Health Act (s329) is defined as 'treatment for mental disorder'; and for this purpose, 'treatment' includes nursing care, psychological intervention, habilitation (including education, and training in work, social and independent living skills), and rehabilitation'. The code of practice (1.21) states medical treatment includes pharmacological and physical interventions.

See also Section 10 of the PEP.

- 7.5.12 **Where a patient presents as intoxicated** (drugs or alcohol), the attending Doctor will assess for accessibility of mental state and risks. If the matter is not thought to be related to mental disorder, detention in hospital should not be considered. Intoxication does not exclude someone from assessment and detention, this is a decision for the assessing clinician. Consideration should be given as to whether an EDC is appropriate - the EDC allows detention for assessment if it *is likely* the patient has a mental disorder. If the criteria for detention are met, then they should be detained. If the patient is considered too intoxicated to participate in assessment, they should be conveyed to the nearest Emergency Department to ensure safe management of airways until less intoxicated. If this is deemed unnecessary by the Doctor, they should be admitted to Psychiatric hospital but clear advice communicated regarding the need for monitoring of vital signs.

7.6 *Confirming Hospital for Admission & Clerking Process*

- 7.6.1 The detaining doctor needs to contact the duty co-ordinator at the normal receiving hospital to ask them to identify if a bed is available. This can be done via the main hospital switchboards. It is the site coordinator's responsibility to try to locate an available bed (the detaining Dr is not required to call round looking for alternatives if there is no bed available at the normal receiving hospital).
- 7.6.2 *When a bed is available:* the flow charts at [Appendix 6](#) show process by location, age and speciality.

There is the system for in-hours detention in the community. After 5pm and at weekends the Co-ordinating Charge Nurse (CCN) for REH is responsible for bed coordination of adult beds. Note CAMHS units out of area do not admit out of hours. CAMHS, LD and Forensics medium secure all have specific consultants on call who are to be involved in any admission decisions and can be contacted via NHS Lothian Switchboard. See [Appendix 5](#)

- 7.6.3 While it is preferable that a bed is found as close to the patient's locality as is possible, it should be noted that once the patient has been detained it is a legal requirement that a bed must be made available as soon as possible. If a locality bed is not available, it is the expectation of the agencies endorsing this guidance note that the next and nearest available alternative bed will be allocated to the detained patient. This will be co-ordinated by the CCN at REH in the out of hours period. Within normal working hours, all specialist services are responsible for having procedures in place for locating an available bed (CAMHS, Learning Disability, Perinatal Mental Health, Regional Eating Disorders, Forensic Mental Health).

There will be occasions when a CAMHS inpatient bed is not available either locally or in other CAMHS facilities, or it may be unsafe to transfer due to distance / complexity of need. In this situation, consideration should be given to whether it would be appropriate to source a paediatric bed. Alternatively an adult acute Mental Health bed should be sought in the patient's local area. The CAMHS service must facilitate a nurse to provide 1:1 care and arrange transfer to the first available bed in a CAMHS service.

Where possible, all CAMHS assessments should be planned and completed by the local CAMHS service. There may be occasions when an emergency assessment is required and this should be accommodated by the service in hours, if this occurs after office hours (after 4pm), CAMHS patients should be directed to contact the CAMHS Unscheduled Care Team (USC). This team operates from 0730-2030 Monday to Sunday and additionally overnight Saturday -Tuesday inclusive. Out with these hours calls should be made to the Doctor on call for CAMHS via switchboard, to arrange an appointment for assessment.

- 7.6.4 *When a patient has been detained:* the detaining doctor must contact the hospital to ask them to identify a bed and on arrival at the site, the patient should be 'clerked in'.

Where a patient has been allocated a bed elsewhere in Lothian the patient should be clerked in at the hospital they are being admitted to.

- 7.6.5 *Patients being transferred from Emergency Departments:* where a patient is being admitted directly from The Royal Infirmary of Edinburgh Emergency Department the patient will undergo 'clerking' before they leave the Emergency Department. The patient needs to be medically fit before being transported.

- 7.6.6 *For patients transferring to a hospital site outside Lothian:* the patient will be clerked at the Lothian hospital site they should have been admitted to before being transferred with the appropriate patient documentation to the hospital site outside Lothian. Specific attention must be paid on the medical fitness of a person to be transferred to another health board. This may involve a long journey with limited medical support so a full physical examination must take place prior to transfer. Transfer may need to be delayed whilst blood test results are obtained.

The service specialty that the patient belongs to, will secure the available bed. Each service will have their own SOP on how this is done.

7.7 *Arranging Transport to Hospital*

- 7.7.1 The detaining doctor has the responsibility for the risk assessment, triggering triage and arranging transportation of patients to hospital. The detaining doctor has a professional obligation to ensure that the most humane and least threatening method of conveying the patient is used, consistent with ensuring that no harm should come to the patient or to others.

- 7.7.2 If other agencies are present, a joint risk assessment should take place between the detaining doctor / community team / police and the following should also be taken into account:

- The patient's Advance Statement
- The patient's preferences, supported by an independent advocate if available
- The views of Named Persons, relatives, carers involved with the patient
- The views of other professionals involved in the application, or who know the patient
- Their judgement of the patient's state of mind and the likelihood of the patient behaving in a violent or dangerous manner
- The impact that any particular mode of conveying the patient will have on the patient's relationship with the community to which he or she will return
- The safety of all involved

- 7.7.3 In cases where police are present, a joint risk assessment process should be carried out by NHS staff and the police to ascertain whether or not the relevant individual is a degree of risk to themselves or any other person that would indicate they could not be left in the care of NHS staff without police remaining.

- 7.7.4 It is important for both parties to participate in the joint risk assessment by providing information regarding circumstances which brought the person to the attention of the NHS staff or police, along with any known relevant previous medical history or background (e.g. known to be violent, relevant risk markers, offending history, previously suicidal and absconder).

- 7.7.5 Information can be shared verbally, under the terms of the Data Protection Act 2018, with the proviso that the content of the information shared, who it was shared with and the justification for doing so, is fully recorded by the party disseminating the information.
- 7.7.6 To further assist staff in identifying risk, the risk assessment matrix can be used see [Appendix 9](#)
- 7.7.7 Once all risks have been identified, a joint decision can be made about the best mode of transport, see [Appendix 12](#)
- 7.7.8 It is the responsibility of the detaining doctor to ensure the safe hand over of the patient to whosoever is transporting. While this may be delegated, depending on circumstances, to the police, a carer, relative, mental health or learning disability nurse or MHO, the ultimate responsibility remains with the detaining doctor. However, the detaining doctor may hand over responsibility to another doctor if there are delays in transport for the patient. **NB** if a GP is the detaining doctor, and their normal work session is coming to an end, it has been agreed locally that they should see through the detention to completion. On a case-by-case basis, handover may be negotiated between in-hours GPs and LUCS and vice versa.
- 7.7.9 Holding a person in a police car, police van or another location such as a police cell for lengthy periods should be avoided other than in the most exceptional circumstances of physical risk.

As a last resort, a police vehicle may be used to convey a patient to hospital where a joint risk assessment and decision has been agreed and:

- The police have been informed in advance of the destination of the patient
- The SAS ambulance crew assess it is unsafe to use an ambulance
- The patient is violent or up to date intelligence indicates they are potentially violent
- There is no immediate risk to life and the patient is **not** sedated
- It is the responsibility of the attending doctor to assess if the patient is medically fit for transfer
- Where a patient has been detained, the police have attended and a threat of violence or disorder still exists, a police officer(s) should always travel in the ambulance and a police vehicle should always follow behind.

Sections 297 – 298, para 4.11, allows for the removal of a person by the police from a public place (but not the patient's home) to a place of safety and states who needs to be informed.

- 7.7.10 For reasons of safety, the police will use a police van to transport the patient. There will be circumstances when it is reasonable and sensible to use another type of police vehicle to transport a patient. In any circumstance, the duty

senior officer must be kept informed and may advise against the use of a police vehicle.

7.7.11 If a patient has been told to attend and is doing so on a voluntary basis, the police will not provide transport.

7.7.12 If ambulance transport is required, the detaining doctor will be required to provide as much of the following information as possible to the Ambulance Control Room to allow them to prioritise and triage the request:

- The patient's name or other identifying information
- Address from which the patient will be conveyed
- If the ambulance is being pre-booked, the rendezvous point and time for the ambulance to meet for the briefing
- The patient's condition but not necessarily a diagnosis, e.g. whether they are sedated or under the influence of other substances, or if there is another medical condition of which the ambulance crew should be aware. This will determine what crew will be required, for example paramedics, two technicians or technician with driver.
- Specifically, inclusion of information as to whether physical restraint or medical sedation has been used, or may be required to ensure patient safety during conveyance. If this is the case an escort team would be required to support SAS.
- An indication of the patient's likely attitude to admission, e.g. whether they are likely to be violent or distressed
- Who will be accompanying the patient
- Whether or not the police will be in attendance
- Where the patient will be going
- A contact telephone number and name.

Information on the use of Taxis is at [Appendix 13](#)

7.7.13 If there are overwhelming grounds for predicting admission and for predicting a straightforward admission process without delays, an ambulance, or other mode of transport as per the *transportation plan* ([Appendix 12](#)) should be requested before the assessment is undertaken or alternative transport could be considered.

7.7.14 If the transportation is to be pre-booked, the detaining doctor should use the procedure described in Section 7 along with the risk assessment and transportation plan and give the time at which the most suitable transportation should be at the agreed rendezvous point for the pre-assessment briefing. If at any time it becomes clear that the transport will no longer be needed, it should be cancelled.

7.7.15 Police involvement should only be requested if the risk assessment indicates that there is a perceived risk of violence. This is because such police involvement may:

- Unnecessarily add to the tension of the situation
- Add to the stress experienced by the patient and may lead to feelings of stigmatisation

7.7.16 In circumstances where there is violence or risk of violence then the authorised escort may be a police officer. Where circumstances dictate a police escort then it is the duty of the detaining doctor to make sure relevant paperwork is in place for admittance to hospital and handed over to a police officer. This will be by exception and should not be seen as routine practice. In such circumstances the escorting officers would be given the detention papers and any other reports with them and hand them over with the patient at the hospital. The documents should arrive at the hospital at the same time as the patient. During such circumstances and where possible a health professional should accompany the police officers in their vehicle for reasons of patient care.

7.8 *Uncooperative Patients*

7.8.1 Passive Resistance

Where a patient passively resists any attempt to remove them to hospital, the detaining doctor and / or MHO should make every effort to persuade the person to comply. Relatives, carers and the patient's advocate may also be helpful, but consideration should be given to the risk of their alienation, particularly with regard to the patient's advocate, whose role is to support the patient.

In addition, if the patient is known to local Mental Health Service or Learning Disability personnel, particularly a CPN or Community Learning Disability Nurse, those members of staff have a role in persuading the patient to co-operate. An assessment of the relative value of such an approach in terms of the likely availability of local personnel and the time taken to get them on site should be undertaken.

7.8.2 Where such attempts have failed, and violence is not exhibited or anticipated (particularly where the patient is elderly or infirm) the detaining doctor and / or MHO should explain to the patient that he or she will be encouraged by whoever is present to the ambulance. If after approximately 20 mins the patient hasn't been persuaded, the situation should be escalated to hospital staff to request assistance from nurse escorts.

7.8.3 Active Resistance

In the event of active resistance, nurses of the specified class, who have undertaken the appropriate violence and aggression training do have the *authority* to physically restrain detained patients to assist them into the vehicle being used for transport however they can only do this if there are adequate numbers of appropriately trained staff to do so. The welfare of the patient should always come first. However, if there are concerns that the situation

could escalate during transportation, this should be taken into consideration in the risk assessment of the situation.

In the event of escalation of active resistance and the patient is being violent, police officers can prevent crime and protect life and property under Section 20 of the Police and Fire Reform Act 2012. Any force used requires to be proportionate and to the minimum level necessary to ensure the safety of all involved.

- 7.8.4 A patient so restrained will be subjected to a search for objects that may be used to cause injury to themselves or any person present.
- 7.8.5 Compulsory treatment is only authorised under a Short Term Detention Certificate or a Compulsory Treatment Order in hospital.
- 7.8.6 Special Note on use of PAVA spray (see [Appendix 14](#))

Police Officers should only use PAVA spray in line with their operational safety training. Officers must mention this at handover to medical staff, along with explaining possible adverse side effects and handing the patient (and medical staff) an aftercare leaflet, which includes signs and symptoms to be aware of and any action that is required should those signs and symptoms persist.

7.9 Patient Escorts

It is best practice to have patient escorts and each locality will have arrangements in place for providing nurse escorts where the risk assessment indicates this is required (contact REH CCN for Edinburgh patients; ACAST for West Lothian patients; IHTTs for East and Mid Lothian patients). On some occasions however, there may be no nurse escorts available.

- 7.9.1 If an ambulance crew is present, in the majority of cases, no additional escort will be required. If there is no resistance from the patient, ambulance staff will assume the responsibility of escort, as per the joint risk assessment.
- 7.9.2 *The authorised escort should carry with them completed detention papers and any other reports:* the documents should arrive at the hospital at the same time as the patient. The detaining doctor may authorise an escort who is travelling with the patient to carry the papers and consequently, will hand over all paperwork to them.

The authorised escort can be Police, Ambulance Service, Mental Health or Learning Disability Nurse, other Mental Health Professional or at least one suitably trained health care professional.

The detention papers / reports should be transferred in line with current General Data Protection Regulations (GDPR) and NHS Lothian's safe transfer and transmission of records policy and procedure. Papers / records should be stored and carried in a secure bag / case or held securely by the person

responsible for delivering the papers. Records should not be carried loosely as this increases the risk of dropping them and losing something. Any loose identifiable information should not be handed to another person for delivery simply because they are going to the designated department.

- 7.9.3 If the patient agrees, a relative, a carer or the patient's advocate may accompany the patient.
- 7.9.4 If the authorised escort is a member of the ambulance crew, the notes should be kept with the driver and not the crewmember attending the patient. Relatives cannot be an 'authorised escort', a separate arrangement by the MHO would need to be made to ensure that the detention papers go to hospital with the patient.
- 7.9.5 A patient who appears sedated or under the influence of substances must be accompanied by a nurse or a doctor. Ambulance control needs to be informed if the patient is sedated or under the influence of substances, to help decide the need for a paramedic.
- 7.9.6 If police officers convey a patient to hospital for an assessment under Section 297, then they must remain with the patient until a joint risk assessment has been carried out to determine whether or not the police need to remain.

If police officers convey a patient to hospital that has already been assessed, they require to stay with that patient until staff have accepted hand over of the patient. Ideally this should be within 1 hour. This links to Section 7.6.4.

7.10 Medical Emergencies en route

- 7.10.1 In the event that the patient has a medical emergency whilst en route to the booked hospital, the conveying vehicle should divert to the nearest Accident and Emergency department. The ambulance crew will not be able to remain with the patient until they are assessed and deemed fit to carry on the journey. The patient would be handed over to the receiving hospital staff and once fit to carry on the journey then the hospital will need to contact Ambulance Control to book another vehicle at the correct level of response.

In the event the patient is assessed as not being fit to continue their journey and is instead admitted to the acute general hospital, responsibility for the care of the patient will then transfer to the hospital ward they are admitted to. The admitting doctor should inform the duty psychiatrist of the patient's medical status. It is the responsibility of the patient escort to communicate to the relevant detaining doctor or MHO that the patient has been admitted to an acute general ward hospital.

- 7.10.2 The detention remains in force and the duty consultant psychiatrist at the hospital where the patient should have been admitted, will be responsible for ensuring a reassessment of the patient when the patient is judged well enough. The acute general hospital staff will be responsible for liaising with

the hospital the patient was originally meant to be admitted to and agreeing arrangements for transfer and onward transport, if this is still necessary.

7.11 Patient Absconds

7.11.1 In the event a patient absconds after detention in the community, the certifying medical practitioner should take the following steps:

- Notify Police Scotland, stating explicitly that the patient is detained and that they should be conveyed to the Mental Health Unit (or other ward if admission to a non-psychiatric ward is required) when located. The Police will work in partnership with all parties although primary responsibility for tracing the reported missing patient will lie with the Police
- Notify the receiving ward that the patient is missing and has been reported missing to the police
- Notify the duty doctor for psychiatry (or relevant specialty if the patient is being admitted to a non-psychiatric ward) that the patient is missing and provide a clinical handover of the patient
- Convey the detention papers to the receiving ward
- It is expected that, to minimise the risk to the patient or to others, all parties will give all assistance and information about the possible whereabouts of the patient.

7.11.2 All partner agencies should refer to the Joint Missing Persons Protocol and their own organisations SOP for missing persons^{1, 2, 3}

On being reported to the police, the duty senior operational police officer (who will normally be of Inspector rank but in some out-of-hours circumstances will be a Sergeant), will be immediately made aware of the incident by Area Control Room. The absconded patient will initially be graded in line with the Missing Persons SOP status and the duty senior police officer will ensure that the appropriate initial action is taken. Police will obtain the relevant information from the person reporting that the patient has absconded.

7.11.3 A patient may abscond at the hospital between the ambulance (or other escorting vehicle) and the ward. To minimise this risk, the ambulance crew, or other escort, will contact the admission ward to arrange to be met by a member of hospital staff at the agreed reception area. Normal communications would be via switchboard asking for the sites co-ordinating charge nurse (CCN) or the nurse in charge of the ward the patient is to be admitted to. There may be alternative entrances on some sites rather than

¹ Standard Operating Procedure for Reporting Persons Missing from Mental health In-patient Services within REAS and from St John's Hospital site V4.

http://intranet.lothian.scot.nhs.uk/Directory/pireas/policiesandprocedures/Documents/missing_person.docx

² [Acute Partnership Agreement](#) Adult Missing Patients, Adult Acute Hospitals.

³ [SOP Interventions in General Inpatient Settings.pdf](#)

using the main public reception area e.g. Melville Unit at RHCYP has alternative entrance rather than through main hospital foyer.

7.12 Handover at Hospital

- 7.12.1 The escort will liaise with the ward regarding the expected time of arrival and nurses from the ward will greet the patient from the vehicle. If the ambulance is delayed en route the escort will update ETA to the CCN / Ward nurse.
- 7.12.2 If the GP has no time to contact the AMP or MHO due to clinical urgency, the admitting hospital should inform the relevant AMP (e.g. sector or speciality AMP), to ensure that he / she is then aware of the detention and can make arrangements to review the patient 'as soon as is practicable'.
- 7.12.3 On arrival at hospital, the escort will be responsible for ensuring that the patient and the relevant detention and admission papers are handed to the ward staff/relevant manager in charge, who are acting on behalf of the Hospital Manager. Where the police or ambulance staff are in attendance, they will remain with the patient until the handover is confirmed with clinical staff, or until a joint risk assessment is made to leave the patient in the care of staff.
- 7.12.4 The handover process should take place as efficiently and swiftly as possible, and **in all cases be complete within 1 hour of initial arrival**, allowing the escorting clinicians and SAS to resume their duties, and police officers to resume patrol duties.
- 7.12.5 The health, safety and welfare of the patient and staff are paramount.

7.13 Resolving Disputes

- 7.13.1 Proper risk assessment, triage planning discussions and briefings for those involved should where possible take place prior to any action in order to minimise and reduce the likelihood of disputes. However, disagreements may arise in the course of mental health admissions. This is perhaps inevitable when a number of different agencies are attempting to co-operate in tense and difficult circumstances. Such disputes may need to be resolved immediately.
- 7.13.2 If the ambulance crew need advice, they should contact their Control Centre in the presence of the detaining doctor or MHO who may ask to speak to the Clinical Adviser.
- 7.13.3 If the police need advice on scene, they should contact the Duty Inspector (PIO) for the respective area.
- 7.13.4 If the MHO needs advice, they should contact their MHO Service Manager or Line Manager.
- 7.13.5 If the doctor needs advice he / she should contact the Duty Consultant.

7.13.6 If a dispute arises that cannot be resolved at the time, or which suggests that joint learning and review would be useful, the issue should be referred to the review meetings mentioned in paragraph 3.2.

8. Inter-hospital Transfer of Psychiatric Patients

8.1 Transfers of patients between hospitals for admission happen regularly. They are known to be times of risk. The following are guidelines to cover the arrangements for these transfers, in an effort to reduce risk (though it is not possible to mitigate risk entirely). The issues to be considered include:

- The use of the Mental Health (Care and Treatment) (Scotland) Act 2003
- The use of sedation before transfer
- The type of vehicle (relative's car/taxi/ambulance/police van)
- The number and training of any nursing escorts
- Involvement of the police

8.2 With this number of variables it is impossible to lay down hard and fast guidelines for every clinical situation: clinical judgement and consultation with the patient, carers and professionals involved is required. Nonetheless, the following general principles can be established:

8.3 Most patients, including the majority of those who are being treated on an informal basis, should be transferred using contract taxis and a nurse escort. These arrangements should be confirmed by discussion between the referring doctor and the nurses on the unit from which the patient is to be transferred. If there is evidence of a risk of absconding and consequent heightening of risks to the patient or others, then it is preferable to use a two person ambulance with nurse escort, although the presence of nursing escorts is probably more important than the type of vehicle chosen.

8.4 *Nursing escorts:* it is not specified in the Mental Health (Care and Treatment) (Scotland) Act 2003 that an RMN/RNLD qualification is required when acting as a nurse escort for a detained or detainable patient, although it is clearly advisable if it can be arranged. In the absence of an RMN/RNLD what matters most is the skill and confidence of the nursing escorts in being able to engage with the patient before and during transfer. Where possible, consideration should be given to particular sensitivities which might reduce distress in patients e.g. gender of escorts.

8.5 *Use of relatives as escorts and use of relative's vehicles for transfers:* this should only be considered when the doctor arranging the admission and the nurses responsible for the patient before admission, are in agreement that the risk of absconding and subsequent risks to the patient, or to others, are minimal and the patient and relatives are agreeable to it. Patients may find the company of a relative reassuring but this should normally supplement, rather than replace, nursing escorts.

- 8.6 *Police vehicles:* should only be used for ward to ward inter-hospital transfers in exceptional circumstances.
- 8.7 *Sedation:* if the patient needs to be medically fit to undertake an inter hospital transfer then this is a clinical decision of the assessing doctor. In addition there **must** be a discussion between the referring doctor and the receiving doctor.
- 8.8 *Detention Certificates:* where detained patients are transferred from one hospital to another, the appropriate Mental Health (Care and Treatment) (Scotland) Act 2003 papers and transfer forms must be transferred with them. It is the responsibility of the nurse in charge of the referring unit to ensure this happens along with the single assessment SBAR / Admission Summary.
- 8.9 *Responsibility and Documentation:* whatever arrangements are made for the transfer, the primary responsibility lies with the senior nurse on the referring unit and the doctor covering the referring unit, in consultation with each other. The nature of the arrangements chosen should be documented in the clinical record, with the reasons for choosing them specified. It should be recognised that transfer arrangements may need to be modified in the light of changing circumstances.
- 8.10 *Transfer of physically ill psychiatric inpatients:* where a psychiatric inpatient is transferred for medical assessment and treatment, these general principles also apply, although the responsibilities for making the arrangements lie with the referring psychiatric unit. In addition, the referring unit remains responsible for arranging and providing continued psychiatric nursing observation on the medical ward. Where medical facilities have access to liaison psychiatry services, there should be consultation between them, the referring psychiatrists and the medical team with regard to further psychiatric assessment and treatment and the timing of the patient's return.

9 Detention of Patients in a Psychiatric Hospital

- 9.1 *Emergency Detention Certificate versus Short Term Detention Certificate (see [Appendix 10 Flow Diagrams](#))*

If an informal inpatient is requesting discharge against medical advice and they are not persuadable to stay, nursing staff should contact the appropriate duty doctor who should, as soon as possible, interview the patient and discuss with the nursing team and any other relevant individuals such as the patient's carers. If the duty doctor is unable to persuade the patient to stay, they should decide if they think detention is likely to be needed. If the situation is one of acute risk e.g. the patient is violent or is being forcibly restrained, the duty doctor should directly grant an Emergency Detention Certificate without Mental Health Officer consent. If there is less risk and distress, the duty doctor should contact the appropriate AMP by telephone and discuss the situation. If the AMP agrees that detention is needed, they will instruct the duty doctor to arrange MHO

assessment. Consent should not be assumed at this point. The Code of Practice states, 'Where the medical practitioner has been able to consult an MHO, it is imperative that the two parties engage in as much joint assessment and consultation as possible with respect to the patient before the certificate is granted'.

- 9.2 If the duty doctor has no time to contact the AMP or MHO due to clinical urgency, they should still inform the appropriate AMP and MHO after issuing the Emergency Detention Certificate – this is to ensure that the AMP is aware then of the detention and can 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. 'As soon as is practicable' will depend on service arrangements, it must happen within 72 hours of admission and generally should happen on the next working day. Patients should not be prematurely reviewed e.g. disturbing their sleep. This is covered in earlier parts of the PEP.
- 9.3 A Short Term Detention Certificate would be the expected detention mechanism unless the Approved Medical Practitioner assessment would pose a delay of over an hour. The AMP, when contacted will need to decide if and when they are able to attend, if they know the patient already and feel it important that they are involved in any Short Term Detention Certificate but if they themselves are held up e.g. in a ward round or outpatient clinic, they might choose to instruct a hospital based doctor to proceed to Emergency Detention Certificate. Alternatively for a new patient they do not know they may feel it preferable to ask a different AMP e.g. consultant colleague, to assess for Short Term Detention Certificate in their 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.
- 9.4 Out of hours, the Emergency Detention Certificate would be the expected detention mechanism.
- 9.5 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.
- 9.6 Nurses' Holding Power ([Appendix 11](#)), Regulations under The Mental Health (Class of Nurse) (Scotland) Regulations 2005, can be used for informal patients within hospital premises, including general hospital wards, accident and emergency departments and clinics held on hospital premises. The power cannot be used for detaining patients in other settings such as in the home setting.
 - 9.6.1 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 pending medical examination to determine whether an

Emergency Detention Certificate or Short Term Detention Certificate should be granted.

- 9.6.2 The patient can be detained by the nurse for a period of up to **3 hours** (**‘the holding period’**) for the purpose of enabling arrangements to be made for a medical examination of the patient to be carried out.
- 9.6.3 A written record must be made in the clinical notes stating why the patient was detained, the time the holding period began and the reasons for detention.
- 9.6.4 Notification of detention must be made to the Mental Health Officer Service 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.

10. Patients being Detained in Acute General Hospital Settings

- 10.1 Most of the provisions detailed elsewhere in this Plan will also apply in the acute hospital setting and Section 7 guides the management of transfers between acute general hospital and psychiatric settings.
- 10.2 Any registered doctor can undertake an assessment for detention and can apply an emergency detention certificate, but advice should be sought from a Psychiatrist.
- 10.3 It is expected however, that detentions initiated in the acute general hospital setting would normally be short term detentions following assessment by an AMP under Section 22 of the Mental Health Act and an MHO. The Certifying Medical Practitioner must contact the Hospital Manager for the Acute General Hospital to inform them of the detention and ensure that the certificate is delivered to Hospital Managers of the Acute General Hospital.
- 10.4 *Legal Requirements:* Responsibility for the patient will hand over to the Acute General Hospital, within an Emergency Department or ward, depending on what facility the patient arrives at first, upon the handing over of the detention certificate (Emergency Detention Certificate - DET1, or Short Term Detention Certificate - DET2) to the Hospital Manager for the Acute General 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 are informed of the detention to ensure timely review. Arrangements must also be in place to ensure the correct processing of detention papers, through the medical records department and patients must be provided with written information and verbal explanation of their rights as detained patients. The Mental Welfare Commission website provides information for patients detained in hospital. - [Preparation-CarePlans-PeopleSubjectToCompulsoryCareTreatment_October2021.pdf](#) (mwscot.org.uk)

10.5 *Community follow-up after discharge from Acute General Hospital:* if a patient has been assessed for detention whilst in the acute general hospital, whether they have been detained or not, the doctor responsible for the assessments must ensure communication, as soon as practicable, with the patient's GP and appropriate community services, including those for mental health or learning disability, to enable suitable follow-up arrangements. If the assessing doctor is not able to undertake this communication directly, he or she must ensure it happens through appropriate handover.

10.6 *Parallel use of incapacity legislation and common law:* in the Acute General Hospital setting the MHA is often applied in circumstances where concurrent investigation and treatment of acute medical problems is also required; consideration should in such circumstances be given to the use of the Adults with Incapacity Legislation. Guidance can be found within the Mental Welfare Commission website - guidance re 'Consent to Treatment' - [consent to treatment 2018.pdf \(mwccscot.org.uk\)](https://www.mwccscot.org.uk/consent-to-treatment-2018.pdf). and the 2025 guidance [Right to treat](#) It is not possible to include in this guidance all eventualities and discussions on such cases should involve discussion with an AMP.

11. Emergency Admission of Patients Subject to a Community Compulsory Treatment Order (cCTO)

11.1 *Powers to convey and detain the person:* where a patient fails to comply with any community-based compulsory measure specified in a Compulsory Treatment Order or an Interim Compulsory Treatment Order, the Responsible Medical Officer (RMO) can exercise two powers under Section 113(4) and (5) of the Act:

- The power to take the patient or to have the person taken into custody and conveyed to a hospital
- The power to detain the patient in hospital for a period of 72 hours beginning with the patient's arrival in hospital.

Section 112 can be exercised with respect to a lack of compliance with the "attendance requirement" alone. (The attendance requirement is the compulsory measure which can be specified in a CTO or interim CTO by way of section 66(1) (c) of the Act.) This section confers the power to recall a person to a healthcare facility to give medical treatment. This is usually for the administration of a long-acting depot anti-psychotic and will be covered by a T3 consent to treatment certificate. It is not an emergency power to facilitate admission to hospital.

11.2 Before this stage is reached however the RMO must be satisfied that:

- All reasonable steps have been taken to contact the patient following the patient's lack of compliance with the compulsory measures
- The patient has been afforded a reasonable opportunity to comply with the compulsory measure in a case where contact has been made with the patient

- It is reasonably likely that there would be a significant deterioration in the patient's mental health if the patient were to continue to fail to comply with the compulsory measure and
- It is necessary as a matter of urgency to exercise the power to take the patient, or have the patient taken into custody in terms of Section 113(4) of the Act.

11.3 It would be expected that the RMO will come to a decision to use these recall powers after minuted multidisciplinary team discussion with as many people as possible involved in the patient's care plan e.g. MHO, Key worker, CPN, GP, named person. This will be dependent on the degree of urgency and any potential risk to patient or others. In non-urgent situation where possible, after Multi-Disciplinary Team discussion, the RMO should write to the patient urging compliance and contact within a reasonable timescale prior to using these powers.

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Once a person is subject to Sections 113, they are in effect detained in hospital. This means that the powers and arrangements described in this psychiatric emergency plan to return a detained person to hospital, are valid.

11.4 A patient on a Compulsory Treatment Order in the community may become acutely unwell requiring emergency admission. If possible, this should happen with the patient's agreement, although the patient would remain subject to the Compulsory Treatment Order. If the patient refused admission the psychiatric team involved, or out of hours the AMP would need to identify whether the Compulsory Treatment Order authorises in its existing powers, admission under compulsion or not i.e. whether the order is hospital or community based. If this was authorised the patient should be compelled to be transported and admitted as above. However, if there were no powers to admit or if the situation was unclear, e.g. out of hours when records are not readily available, the clinical team involved should consider whether double detention using Emergency Detention Certificate or Short Term Detention Certificate in addition to the Compulsory Treatment Order is needed. Once the patient is admitted to hospital their RMO would need to consider, with the team and MHO, the continued need for detention and an application for variation in the powers of the Compulsory Treatment Order (Section 114).

12. Revocation of Suspension of Detention

12.1 A patient subject to detention who has improved to the stage of being out of hospital on a suspension order may become acutely unwell requiring readmission to hospital. If possible, this should be done with the patient's agreement. In the situation where the patient refuses readmission, the Responsible Medical Officer or their Approved Medical Practitioner representative (e.g., out of hours, the on-call Specialist Registrar or Consultant), should revoke the suspension, thereby compelling transport and readmission to hospital.

- 12.2 Within hours a non-statutory form should be filled in and notice given to the patient, out of hours the on call Approved Medical Practitioner should verbally instruct revocation to the clinical team managing the emergency and should inform the appropriate day time Responsible Medical Officer as soon as is practicable – ideally at the start of the next day to allow the necessary paperwork to be completed.
- 12.3 If the situation is unclear and readmission is required against the patient's wishes, double detention using Emergency Detention Certificate or Short Term Detention Certificate may be the safest legal option to buy time allowing the next working day for a decision to be made by the Responsible Medical Officer and clinical team about suspension/revocation. Detention should be carried out by an AMP in these circumstances, where possible.

13. Care of the Patient during Detention

- 13.1 At an appropriate time, hospital staff will debrief the patient about his or her experiences during admission. There will be occasions when this debrief will have to be deferred until such times as the patient has recovered the capacity to understand the process of admission.
- 13.2 It is incumbent upon all statutory services to act in the best interests of patients to deliver high quality care and to treat patients with respect and dignity at all times. All procedures should be directed towards the best overall interests of the patient, being based on the principle of minimum necessary force or action to achieve a desired outcome and be carried out in a safe, professional and competent manner. A pragmatic approach should also be taken to ensure the smooth running of any function discharged under the Act, with good communication being essential.
- 13.3 The underlying principles of the Act relating to the care of the patient should be adhered to at all times. The following points of best practice relating to the care of the patient reflecting the principles should be adhered to:
- Patients have a right to be informed about detention decisions using language and in a way that is easily understood
 - Patients have a right to be informed about all aspects of the detention procedure and to be updated throughout this. Staff should not assume that this will be easily understood by the patient and allow for this
 - Staff should respect any race, cultural, gender or ethnicity issues.
 - Any delay in the detention of the patient or transfer to hospital should be minimised
 - Allowances should be made for any complaints raised and procedures should be in place to allow for this by patients and/or relatives
 - Relatives/carers should be informed about all aspects of the detention procedure and allowed to accompany the patient to hospital wherever reasonably possible
 - There may be situations where a patient does not wish carers to be informed or involved. The team must consider the situation in relation to

the patient's capacity, reasons and potential outcomes. The level of information can be decided by the team with regard to the patient's wishes at present and as laid out in any advanced/personal statement

- Confidentiality must be maintained at all times, whilst being aware of the situational context of the detention and the potential presence of relatives
- Physical restraint of the patient is undesirable and should only be used as a last resort. It should only be used by those who are competent to do so; in a community setting this is likely to be police officers as it is highly unlikely there will be sufficient numbers of nursing staff trained in level 4 restraint in a community setting. The decision to restrain a patient within a community setting will be based on clinical judgement and assessment of the risk posed by the patient to either self or others. The full document on the Rights, Risks and Limits to Freedom can be found at: [..\RightsRisksAndLimitsToFreedom_March2021.pdf](#)
- 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. All staff involved in the use of restraint must be appropriately trained in doing this. Circumstances where restraint may be appropriate include:
 - Preventing the patient from leaving the custody of staff
 - Where there is a risk of harm to the patient or others
 - Facilitating the transport of the patient to hospital or a place of safety
 - Prevention of violence and self-harm.
- 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.

Any observation of patients should be conducted in the least oppressive way possible

13.4 Patients detained under an English, Welsh or Northern Irish hospital based order are liable to be detained in hospital in Scotland until transfer back to their local unit can be arranged. Any police officer can detain the patient in a public place and convey them to the local psychiatric hospital e.g., REH or SJH. The patient is only liable to be detained if additional medical treatment is required e.g., medication, then either the criteria for urgent medical treatment must be met or an assessment for a STD should take place

Reciprocal powers exist for Scottish patients who are in other parts of the UK.

It is expected that the transfer of the patient back to the local unit would take place as soon as possible.

Specific arrangements have been negotiated regarding psychiatric emergencies at Edinburgh Airport. MHAS can provide advice and the appendices include guidance at Edinburgh Airport ([Appendix 6.10](#)).

14. Designated Places of Safety

14.1 The place of safety within the Mental Health (Care and Treatment) (Scotland) Act 2003 means a hospital, premises which are used for the purposes of providing a care home or another suitable place (other than a police station and not a GP Practice) the occupier of which is willing to temporarily receive the mentally disordered person.

- *In Edinburgh, Midlothian and East Lothian the designated places of safety are:* The Royal Edinburgh Building on the Royal Edinburgh Hospital site and The Accident and Emergency Departments of the Royal Infirmary.
- *In West Lothian the designated place of safety is:* The Accident & Emergency Dept at St John's Hospital, Livingston

Section 297 of the Act provides that if no place of safety is immediately available, a police constable may remove a person to a police station but the patient should be removed from the police station as soon as possible to a suitable place of safety.

15. References

- Mental Health (Care & Treatment) (Scotland) Act 2003
- Mental Health (Care & Treatment) (Scotland) Act 2003 Code of Practice
- Potentially Violent Mentally Disordered Persons in The Community - Community Care Circular 3/1999
- Rights, Risks and Limits To Freedom – A Mental Welfare Commission Good Practice Guide March 2021 [RightsRisksAndLimitsToFreedom_March2021.pdf](#) (mwscot.org.uk)
- *Standard Operating Procedures for Reporting Persons Missing from Mental Health In-patient Services within REAS and from St John's Hospital Site (Version 4)*
http://intranet.lothian.scot.nhs.uk/Directory/pireas/policiesandprocedures/Documents/missing_person.docx

16. APPENDICES

Appendix 1: Definitions & Abbreviations

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.
Ambulance Categories		EMERGENCY – require an immediate response. The vast majority of these calls result from 999 calls. Calls received from the control rooms of other emergency services are also included in this category. URGENT – require a response within a specific time. These normally come from the detaining doctor or other professionals who have arranged admission for their patient and the time arranged is normally the time of admission into hospital.
Ambulance Control Centre	ACC	The Scottish Ambulance Service control room at which all emergency and urgent calls are received
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 hospital requires entry to the premises where the patient has been found.

Carer		A person, perhaps a partner, relative, friend or neighbour who is looking after another individual who has care needs because of illness or frailty.
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 CPNE	A registered mental health nurse who contributes to the care and treatment of individuals with mental health difficulties in a community setting. Their primary role is the assessment, planning and implementation of individualised support programmes addressed to meet the mental healthcare needs for those individuals within their allocated caseload. Central to their work is liaison with other health and social care professionals and other relevant agencies involved with the individuals within their caseload. CPNE is a CPN who works in the Older Adult service areas
Community Learning Disability Nurse	CLDN	A registered learning disability nurse who contributes to the care and treatment of individuals with a learning disability in a community setting.
Co-ordinating Charge Nurse	CCN	Charge Nurse who manages hospital resources and responses on a shift by shift basis
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.
Detaining Doctor		Doctor taking responsibility for determining that a patient requires detention under the MH (C&T) (S) Act 2003. This can be any registered medical practitioner but must be an Approved Medical Practitioner (AMP) when a short-term detention certificate is utilised.
Emergency Detention Certificate	EDC	Section 36(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 patient's 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.

General Practitioner	GP	A fully registered medical practitioner providing primary care services within a community based practice.
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.
Management Plan		the foundation of a patient's treatment after an initial admission and treatment, based on the patient's medical condition and treatment preferences, as well as recommendations by doctors, nurses, or other healthcare professionals
Mental Disorder		Means any mental illness, personality disorder or learning disability however caused or manifested; and cognate expressions shall be construed accordingly. A person is not mentally disordered by reason only of any of the following sexual orientation, sexual deviancy, transsexualism, transvestism, dependence on, or use of alcohol or drugs, behaviour that causes or is likely to cause harassment, alarm or distress to another person or acting as no prudent person would act.
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 respect to persons with mental disorder.
Mental Welfare Commission	MWC	The Mental Welfare Commission for Scotland is a non – departmental public body, responsible for safeguarding the rights and welfare of people in Scotland with a learning disability, mental illness or other mental disorder. The Commission was original established by the Mental Health (Scotland) Act 1960.
Named Person	NP	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 provision 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.
Nurses' Holding Power		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 two hours, while awaiting a medical examination. Where necessary the detention may be extended by up to one hour while the medical examination is carried out. This only applies to Registered Mental Nurses or Registered Learning Disability Nurses
Patient		In this document the term 'patient' is used as equivalent to client, service user or other terms which may be used to describe the person who is being assessed as possibly requiring detention.
Patients Welfare Attorney		The person appointed, who has the legal power, to make decisions about the health and welfare of someone if they lose the capacity to do so for themselves.
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.
Qualified Ambulance Technician	QAT	A Qualified Ambulance Technician is a member of staff who works on the Accident and Emergency Service of the Scottish Ambulance Service. He or she may also be a qualified paramedic.
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	RO	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.
Royal Edinburgh & Associated Services	REAS	This is the collective name for services and sites managed by the Royal Edinburgh Hospital.

Scottish Ambulance Service	SAS	The Scottish Ambulance Service
Short -Term Detention Certificate	STDC or STD	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.
Specialty Doctor	SD	A fully registered medical practitioner who has achieved further qualifications within their chosen field of medical practice.
Trainee (medical)		A fully registered medical practitioner working within a medical speciality as part of their ongoing training

Appendix 2: List of emergency contact telephone numbers

Police - Area Control Room (ACR)	0131 440 6801
Edinburgh	
<u>Older Adults Rapid Response Team</u> Mon – Sun 8am – 6pm	0131 537 6882 (or via switchboard 0131 537 6000)
East Lothian	
East Lothian MHOs: Monday - Thursday 9am – 5pm Friday 9am – 4pm	01875 824 309
General enquiries Out of Hours Edin SW Services	0800 7316969 0131 200 2324
East Lothian Mental Health Services: IHTT East Lothian Community Hospital	01620 642910 Mob 07483 991057
Midlothian	
Duty MHO Monday – Thursday 9am – 5pm Friday 9am – 4pm	07771 845 748
General MHO enquiries Out of Hours:)	0800 7316969 (<i>this goes to Edinburgh</i>)

<p>Midlothian Mental Health Services Adult 18-65 8am – midnight Tel:</p> <p>For referrers (Out of Hours including Functional over 65) 8am – midnight - IHTT After midnight to 8am -MHAS</p> <p>Mental Health and Resilience service 18-65 Crisis and or distress with mental health and mental well being 8am - 10pm</p> <p>Over 65 Mon- Fri 9-5 Older Adult- 0131 5379878</p>	<p>0131 536 8300 ask for Home Treatment Team (<i>redirected to MHAS at midnight</i>)</p> <p>07924 823 888 0131 536 8300</p> <p>08001182962</p>

<u>West Lothian</u>	
<p>MHO Service Monday –Thursday 8.30am – 5pm Friday 8.30am – 4pm Mental Health Officer Office</p>	01506 282252
<p>Social Care Emergency Service Out of Hours Social Work inc MHO</p>	01506 281028 01506 281033
<p>Psychiatric Service St. John's Hospital main switchboard</p>	01506 523000

<u>Other Services</u>	
<p><u>Edinburgh Crisis Centre</u> Smith's Place, Edinburgh EH6 8NR Open 24/7 hours</p>	0808 801 0414

<u>Advocacy Services</u> -Please note no out-of-hours provision – day time numbers only	
<p>Edinburgh Advocard - Mental Health (functional) all ages REH, Morningside Place, Edinburgh. Advocard, 332, Leith Walk, Edinburgh Partners in Advocacy – Learning Disability, Dementia (and other organic mental health problems) – all ages</p>	<p>0131 537 6004</p> <p>0131 554 5307 0131 478 7723 / 7724</p>
East Lothian	

<p>CAPS Mental Health, ages 18-65 – general queries CAPS Mental Health, ages 18-65 – individual advocacy Tel: EARS Advocacy – Mental Health – ages 65+ Partners in Advocacy – Learning Disability – ages 16+</p>	<p>0131 273 5118 0131 273 5118 0131 478 8866 0131 478 7723 / 7724</p>
<p>West Lothian Mental Health Advocacy Project – Mental Health – all ages EARS Advocacy – Mental Health – ages 65+ & Advocacy for Learning Disability</p>	<p>01506 857230 01506 205840</p>
<p>Midlothian CAPS Mental Health, ages 18-65 – general queries CAPS Mental Health, ages 18-65 – individual advocacy EARS Advocacy – Mental Health – ages 65+ Partners in Advocacy – Learning Disability – ages 16+</p>	<p>0131 273 5118 0131 273 5118 0131 478 8866 0131 478 7723 / 7724</p>
<p><u>Animals</u> Pet Care Network (Fostering of pets & Transportation to Vets) Edinburgh Dog & Cat Home (Rehoming, pet care and boarding)</p>	<p>0131 476 0022 0131 669 5331</p>
<p><u>West Lothian Justice of the Peace</u> in Livingston can be contacted on the Justice of the Peace Court numbers Monday – Friday 9am – 4pm. <i>There is an out of hours Justice of the Peace rota which is accessible to all MHOs working with West Lothian Council.</i></p>	<p>01506 402414 or 01506 402400.</p>

Appendix 3: Summary of roles and responsibilities

All of those involved in the detention of a patient should work in concert, in a co-operative way, to engender mutual support and to minimise the distress to the patient.

The escort is responsible for:

- Accompanying the patient to hospital
- Ensuring that detention papers are given to hospital staff
- Assisting the patient and explaining events to him or her

The detaining doctor in attendance is responsible for:

- The detaining doctor can be any registered medical practitioner but must be an Approved Medical Practitioner when a short-term detention assessment is undertaken and a certificate is granted.
- Where possible co-ordinating the time and place of the assessment with the necessary parties
- Requesting police presence if that is necessary and supplying the police with details that enable them to assess the level of response that will be necessary to ensure the safety of all concerned
- Examining the patient, to assess the nature and seriousness of any mental disorder and to ascertain the need for further assessment or treatment in hospital
- Determining the use of an Emergency Detention Certificate or a Short Term Detention Certificate in consultation with others as appropriate
- Ordering the ambulance
- Ensuring that all parties are briefed before and after the assessment
- Liaising with others involved in the assessment and making a medical recommendation where appropriate
- Completing the necessary MH(C&T)(S)A'03 form
- Making arrangements for the patient to be escorted if required
- Handing over forms to the escort
- Arranging a hospital bed where needed

Mental Health Officers are responsible for:

- Considering whether to consent to the detention of the patient, interviewing the patient, ascertaining where possible the name of the patient's named person, advising the patient about independent advocacy services and supporting the person to make use of this service
- Assessment of any possible alternatives to the proposed period of formal detention. The MHO should therefore make sure that as many forms of informal and less restrictive treatment as practicable have been explored before consenting to the last resort of compulsory detention (Code of Practice volume 2 Chapter 7)
- Ensuring the welfare of the patient, whether detained or not

- In discussion with and with consent of, the patient, ensuring that their carer and/or nearest relative has/have been informed
- Security of property and premises
- Arranging short term care of any children or pets.

Ambulance Control Centre (ACC) is responsible for:

- Taking details of the detaining doctor's call requesting an ambulance
- Referring the call request to the Duty Manager for prioritisation decision
- Ensuring that an ambulance is allocated to arrive at the requested address, if at all possible, at the requested time
- Giving the ambulance crew full details to enable them to carry out the request
- Informing the detaining doctor or other designated contact of any delay or difficulty in providing the requested ambulance
- The ACC will provide the doctor with an incident number on request

Scottish Ambulance Service Qualified Ambulance Technicians and Paramedics in Attendance are responsible for:

- Receiving the journey details from CAC
- Co-operating with the request of the detaining doctor or MHO over the method and timing of assistance
- Co-operating with others present at the assessment, including the MHO, doctors and the police
- Contributing to the care and physical well-being of the patient (and others present) by conducting an assessment of any other relevant or significant illness or injury
- Making a record of the call to the patient, including information given by the medical practitioner or AMP regarding any medication the patient is using
- Passing information to the hospital on their arrival.

Police Scotland are responsible for:

- Taking details of the call from the detaining doctor or MHO
- Ensuring that a supervising officer is made aware of the incident
- If the patient is deemed to be violent / potentially violent ensuring that where at all possible, an appropriate officer attends at, or participates in, any joint risk assessment and/or briefing
- Ensuring that an appropriate police presence is allocated to arrive at the requested address, or briefing location, if at all possible, at the requested time
- Taking necessary action, including the use of physical restraint when necessary to prevent the patient harming themselves or others, with a view to effecting the admission in as peaceful a way as possible whilst striving to ensure the safety of all concerned - in doing so, they will liaise with the ambulance crew, the detaining doctor or MHO over the method and timing of assistance, particularly where violence or aggression is expected. **Police are not permitted to restrain patients for the purpose of sedation.**

- In certain circumstances, travelling as an escort to the patient in the ambulance and where it is considered necessary, transporting the patient in a police vehicle
- At the conclusion of any such incident, at a supervisory level, discussing with other professionals involved in the incident, any concerns of the police and raising these with the E&D Sergeant from the Preventions, Interventions and Partnerships Department.

The Local Base Hospital is responsible for:

- Having in place a system for identifying and contacting the relevant AMP when contacted by a primary care registered medical practitioner in psychiatric emergencies
- Having in place agreed protocols for Bed Management and for taking the responsibility of finding a bed once a person has been detained
- Having in place a process for ensuring patients are cared for safely whilst they await the allocation of an available bed for admission
- Where a GP has had no time to contact the AMP or MHO due to clinical urgency, the admitting hospital will inform the relevant AMP in order to ensure that the necessary arrangements are made to review the detention as soon as is practicable

Appendix 4: Action Cards for Key Professions (MHO / Detaining Dr / Hospital Manager)

MHO ACTION CARD

INCIDENT: Psychiatric Emergency

SERVICE/ORGANISATION: Mental Health Officer

LOCATION: Lothian Wide

CONTACT INFORMATION: Edinburgh – SCD – 0131 200 2325 / 2324
Out of Hours: 0800 731 6969

West Lothian – MHO Office 01506 282252
Out of Hours – MHO & SW 01506 281033

East Lothian – 01875 824 309
Out of Hours – 0800 731 6969

Midlothian - 07771 845 748
Out of Hours – 0800 731 6969

Responsibilities of service / organisation during a psychiatric emergency (What should be expected/provided)

1. Ensure prompt response
2. Assess risk
3. Obtain warrants (where necessary)
4. Assess Patient

IMMEDIATE ACTIONS TO BE TAKEN

		DONE
1	Mental Health Officer to contact referrer by telephone within 30 minutes of referral and attend in person within 60 minutes (where geographically possible)	
2	Assess and share information on risk with partner agencies. Undertake a joint risk assessment or 'triage discussion' when support from Police Scotland is required. See triage procedure. Support partners appropriately and work together to minimize risk and distress to person in crisis.	
3	Apply for warrants under s35, 292, 293, 294 of the MH Act. Police assistance will be required to execute the warrant and Triage Procedure should be followed by MHO and partner agencies. MHO must inform Police which warrants have been granted and ensure officers in attendance have sight of them.	
4	Assess requirement for detention under the Mental Health Act with appropriately qualified medical practitioner	

PRIORITIES

		DONE
1.	Prompt response	
2.	Assess risk and share information with partner agencies	
3.	Ensure criteria and principles of the MH Act are followed	
4.	If detained ensure the patient is made aware of their rights and that property is secure and pets taken care of.	

GP ACTION CARD

INCIDENT: Psychiatric Emergency in Community

DEPARTMENT: Primary Care

LOCATION: Community

Emergency Detention Certificate

The criteria which must be met are laid out in section 36 of the MHA(1). The medical practitioner must consider it likely that:

- the patient has a mental disorder; and
- because of that mental disorder, the patient's decision-making ability with regard to medical treatment for that mental disorder is significantly impaired.
- it is necessary as a matter of urgency to detain the patient in hospital in order to determine what medical treatment should be provided to the patient for the suspected mental disorder
- there would be a significant risk to the health, safety or welfare of the patient or to the safety of another person if the patient were not detained in hospital; and
- Making arrangements with a view to granting a short-term detention certificate would involve undesirable delay. It should be noted that the above conditions are cumulative: that is, that all five conditions must be met before the emergency detention certificate can be granted. (1)

Short Term Detention Certificate

A short-term detention certificate should be granted, wherever possible, in preference to an emergency detention certificate, where this is practicable and where the relevant detention criteria have been met.

A short-term detention certificate is the preferred 'gateway order' because, as compared with an emergency detention certificate, it can only be granted by an approved medical practitioner; the consent of an MHO to the granting of a short-term detention certificate is mandatory; and it confers on the patient and the patient's named person a more extensive set of rights, including the right to make an application to the Tribunal to revoke the certificate'. Mental Health (Care and Treatment) (Scotland) Act code of practice 2003

Responsibilities of GP

1. Ensure safety of staff and patients

2. To ensure appropriate patient care and deployment of appropriate form of section under the mental health act
3. All of those involved in the detention of a patient should work in concert, in a co-operative way, to engender mutual support and to minimize the distress to the patient.

	DONE
<p>Danger during Assessment</p> <p>If during any assessment danger / violence is perceived by GP they should phone 999 ask for police assistance</p> <p>1a) Initially GP leaves and only remains if safe to do so</p> <p>1b) Following discussion with police if custody is deemed inappropriate, GP completes emergency detention and person is conveyed to identified ward at Mental health hospital.</p> <p>Given immediate danger it would be appropriate for police =/-ambulance to be involved in transferring patient to hospital.</p> <p>Given emergency nature and that ongoing assessment is required in hospital, it may be impossible to inform the MHO for in person review, but if time permits GP should discuss the case with MHO.</p>	
<p>Facilitating Appropriate Care; Patient potentially detainable but willing to receive treatment /Assessment</p> <p>If patient is willing to receive psychiatric help, it maybe that an emergency detention is not the best solution.</p> <p>In Hours Options for those under 65</p> <p>Lothian</p> <ol style="list-style-type: none"> 1. For emergency referrals requiring same day input, call MHAS (Mental Health Assessment Service) on 0131 537 6000 to discuss 2. Urgent mental health referrals are seen within 5 days and can be made via sci gateway and discussion with relevant CMHT <ul style="list-style-type: none"> • North East: 0131 537 4530 • North West: 0131 315 2026 • South East: 0131 536 9460 • South West: 0131 537 8650 3. In circumstances where patient is already known to the locality CMHT, they should be alerted to arrange urgent review <p>Out of hours</p> <ol style="list-style-type: none"> 1. For emergency referrals requiring same day input, call MHAS (Mental Health Assessment Service) on 0131 537 6000 to discuss <p>East Lothian</p>	

Urgent referrals made via IHTT Phone Number 01620 642910

- The person is experiencing severe level of mental distress
- The person and/or others are at risk due to this mental distress
- Admission is being considered

The shift coordinator will call you back immediately to discuss your referral.

IHTT in East Lothian works from 8am to 12 midnight. From 12 midnight to 8am all urgent/emergency cases will be seen in the MHAS suite at the Royal Edinburgh Hospital.

Mid Lothian

In hours

- The person is experiencing severe level of mental distress
- The person and/or others are at risk due to this mental distress
- Admission is being considered

IHTT same day assessment, when making a referral we ask initially for a telephone discussion of the referral on 07976842093 once accepted a letter referral sent either via sci gate way or to the team inbox for TRAK IHT.Team@nhsllothian.scot.nhs.uk

West Lothian

In hours, please contact St John's Hospital, Livingston, on 01506 523000 and ask for the ACAST duty bleep.

Over 65

Rapid Response Team (Edinburgh patients only)

Referrals to the RRT are for people who require a rapid response to a mental health crisis.

Patients must be seen by referrer within 24-48 hours prior to referral and a delirium screen should be completed.

All referrals to RRT require a telephone call to the service prior to sending electronic referral forms.

How to refer:

The RRT referral line is: 0131 537 6882

Referrals will only be accepted via the number above. SCI Gateway forms should be submitted to Older People Mental Health Services (North or South).

Midlothian

In hours

- The person is experiencing severe level of mental distress
- The person and/or others are at risk due to this mental distress
- Admission is being considered

Older Adult Referrals : 0131 5379878

Deployment of Emergency Detention

Situation A: Patient detainable but no immediate danger identified

If patient is detainable but not willing to receive assessment or treatment but no immediate pressing danger identified, (for example those who are neglecting own welfare due to mental health condition) the GP should contact the MHO to discuss and arrange an MHO assessment and contact sector psychiatrist, to consider feasibility of arranging a short-term treatment order.

During this discussion it should be considered whether a triage meeting is necessary. Police Scotland should only be involved where individuals have a history of aggression, have made threats recently or where current presentation includes threatening /aggressive behaviours.

A triage meeting between Police Scotland / assessing doctor / MHO and any other relevant person such as the CPN should take place the day before any planned section, where possible. In an emergency it may take place in 'real time'. If there is time to plan such a meeting, contacting the sector psychiatrist would be advisable to again consider whether a STD certificate.

MHO/assessing doctor should initially call 101 to arrange police assistance, or 999 in an ongoing emergency. A brief summary of the circumstances will be provided to control room staff, to allow for the initial assessment of threat, risk and harm. This should be followed by a request to speak to the relevant duty Inspector/Sergeant for the local area, to discuss police assistance with a psychiatric emergency. The Call Handler should be advised that this is agreed protocol within the Lothian PEP. Duty Inspector/Sergeant will aim to call back within 20 minutes. Initial information regarding potential/identified risks, needs and reasons for police assistance being required will be shared.

If a more in-depth triage meeting is felt necessary the MHO / assessing doctor making initial contact with police, will co-ordinate the meeting, inviting relevant partners including sector psychiatrist, ideally this would be at least a day prior to an emergency detention.

Focus of the discussion will be on how to effect entry to the individual's home address, relevant prior offending history and potential risks, the role of each organisation and transport to hospital as safely as possible. Police will only transport an individual in exceptional circumstances and other means should routinely be organised by the detaining doctor/MHO.

Detention paperwork may be conveyed to the Duty Coordinating Charge Nurse at Royal Edinburgh Hospital: by the MHO or via SAS or Police who are attending the patient.

Situation B Patient detainable and danger to self and are actively refusing assessment or transport

Those who have assessed the patient as needing an emergency detention have a duty of care to the patient in this situation and should it be safe to do so must

<p>stay with patient. This could be either the MHO or GP, in some circumstances both practitioners may be required to stay to ensure safety of all.</p> <p>If there is any risk of violence to the practitioners or relatives, the GP should get to a place of safety and call 999.</p> <p>If the MHO / GP and ambulance are unable to persuade the patient to get into the ambulance, police can be contacted on 101 if there are concerns about violence or absconding, to discuss involvement and facilitation of escorting the patient to hospital. If police do not believe their involvement is appropriate or advise the necessity of a warrant, the involvement of sector psychiatrist and mental health officer in the procurement of warrants may be the most appropriate route.</p>	
<p>Informing Royal Edinburgh Hospital Patient Coordinator</p> <p>GP to inform SCN Patient Coordination / Coordinating Charge Nurse of detention on 07973660068 or 0131 537 6000 page 7005 and be advised by them of the admitting ward. Ambulance staff can convey detention forms and referral letter to hospital with the patient.</p>	
<p>Transport</p> <p>GP should arrange. Mode of transport should be informed by triage discussion and or risk assessment.</p> <p>Patient transport can be requested through the Flow Centre: 0300 0134 000. If time frame is greater than one hour, then a one hour ambulance is requested but whether this happens will be dependent on ambulance availability.</p> <p>Contract taxis could be used to facilitate admission but a Clinician or MHO would need to travel with the patient to the Royal Edinburgh Hospital</p>	

PRIORITIES

		DONE
1.	Where possible, coordinating the time and place of the assessment with the necessary parties	
2.	Examining the patient, to assess the nature and seriousness of any mental disorder and to ascertain the need for further assessment or treatment in hospital	
3.	Ensuring the most appropriate detention order is applied to the patient and referring to sector psychiatry accordingly.	
4	Liaising with Hospital Patient Coordinator / Coordinating Charge Nurse and requesting appropriate transport ambulance via Flow Centre	
4.	Liaising with others involved in the assessment and making a medical recommendation where appropriate	

5.	Completing and signing the necessary MH(S)A form	
6.	Liaising with police in a triage meeting and requesting police presence if that is necessary and supplying the police with details that enable them to assess the level of response that will be necessary to ensure the safety of all concerned.	
7.	Providing referral information and appropriate mental health act forms.	

Useful Documents

- [Mental Health Care and Treatment Act 2003 Pertaining to Emergency Detention](#)
- [Emergency detention Certificate](#)
- [Short Term detention Certificate](#)

HOSPITAL MANAGER ACTION CARD

INCIDENT: Psychiatric Emergency

SERVICE/ORGANISATION: NHS Lothian

LOCATION: Lothian Wide

CONTACT INFORMATION: Royal Edinburgh Hospital 0131 537 6000
(Request duty manager for Midlothian Community Hospital 01314541001
department through relevant East Lothian Community Hospital 01620642700
Hospital Switchboard) SJH MH & Acute General Hospital 01506523000
Royal Infirmary Edinburgh 01315361000
Western General Hospital 01315371000
Royal Hospital for Children and Young People
01315361000

Responsibilities of service / organisation during a psychiatric emergency (What should be expected/provided)

The Act places responsibility to discharge certain functions on Hospital Managers. In effect this is the NHS Board who delegates the functions listed below to a variety of managers / 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 be delegated to one or a combination of the following:

- Medical Records Officer
- Coordinating Charge Nurses
- Duty page holders
- SCN Patient Coordination / Bed managers
- Senior Charge Nurses
- Nurse in Charge of specific shift
- For Acute General 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. There are many duties placed upon hospital managers throughout the act. Listed below are those duties relevant to admission under detention in an emergency.

1. Ensure prompt response to detaining Doctor
2. Ensure process in place for providing nurse escort support to community staff
3. Allocation of suitable bed
4. If no bed can be allocated, initiate process for ensuring safe waiting arrangements for patient
5. Ensure criteria and principles of the MH Act are followed
6. Identification of Responsible Medical Officer at receiving Hospital

IMMEDIATE ACTIONS TO BE TAKEN

		DONE
1	Take receipt of Detention paperwork, ensure certificate of detention is compliant with the requirements within the Act	
2	Take all reasonable immediate steps to ensure the patient understands the effects of the detention certificate, providing verbal and written information on patient Rights.	
3	Identification and allocation of a Responsible Medical Officer for the patient	
4	Ensure medical examination by an Approved Medical Practitioner for those patients subject to an EDC.	
5	Ensure certificate is delivered to the Medical Records Department to ensure that any certificates and timelines are managed properly.	

	PRIORITIES	DONE
1	Ensure patient is provided with information in an appropriate format for their individual needs, on the terms of their detention and their Rights	
2	Emergency Detention Certificate: Within 12 hours of receiving the certificate inform the nearest relative or person who resides with the patient, named person of the granting of a certificate.	
3	Notify within 7 days of section 37 information ⁴ , 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.	
4	Short Term Detention Certificate Notify as soon as practicable the patient, named person, any welfare Guardian or attorney of the granting of a certificate	
5	Within 7 days of the granting of a certificate send a copy of the certificate to the Mental Welfare commission and Mental Health Tribunal.	

⁴ (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.

Appendix 5 : Doctor's Crib Sheet (LUCS Primary Care)

For advice about psychiatric patients OUT OF HOURS:

West Lothian: duty psychiatrist via SJH switchboard **01506 523 000**

Midlothian: IHTT **07976842093, 0131 285 9624/25/29**

East Lothian: IHTT **07483 991057, 01620 642910**

Edinburgh patients (and Mid and East after midnight): MHAS **0131 286 8137/07966278778**

CAMHS: duty psychiatrist for CAMHS via Switchboard 0131 537 1000 (0131 537 3961)

Old Age Psychiatry: Edinburgh Rapid Response 0131 537 6882/6868 (0131 537 5938)

NHS24 Mental Health ADVICE CALLS

In the OOH period, Advice calls from NHS24 for adult (18y and over) patients with mental health issues and NO PHYSICAL INJURIES OR OVERDOSE will be phoned through to mental health services directly and then the NHS24 call sheet emailed by the LUCS Hub to the relevant MH team.

Following MH assessment, MH senior clinical decision maker can action and close the case on TRAK; they can also phone LUCS Hub prof to prof line to arrange a LUCS GP Home Visit to consider detention under the Mental Health Act.

The LUCS Prof to Prof line can also be used by MH teams to obtain advice for patients that they cannot contact after 3 attempts.

NB: MHAS and the other MH services across Lothian no longer offer a walk-in service so please do not ask patients to self-present to services. Worsening advice should include self-care management plan if one is in place, call back to NHS111 mental health hub, wait for own GP or CPN, or attend nearest ED in extremis. Maintaining patient and relatives' safety is paramount.

Mental Health HOME VISIT requests

Before visiting, LUCS GP contacts relevant MH team for background information and reviews Adastra Special Notes, KIS and previous encounters. If relevant, check TRAK or speak to ED Reg. Carry out a risk assessment with LUCS Driver (who can enter the property with GP if requested).

LUCS GP contacts MHO OOH (Edinburgh/East/Mid: 0800 731 6969, West: 01506 281 028/029) to discuss situation and where possible arrange to meet ahead of visiting the

patient and undertake a risk assessment (take name of MHO for EDC form if unable to attend and reason why not) – arrange Police presence through 101 if required.

EDC paperwork kept in LUCS Cars – contact LUCS Clinical on Call to discuss concerns.

LUCS GP undertakes visit after risk assessment, with staff and patient safety as a priority. If threat of violence, leave and call 999.

LUCS GP completes paperwork as appropriate with MHO support.

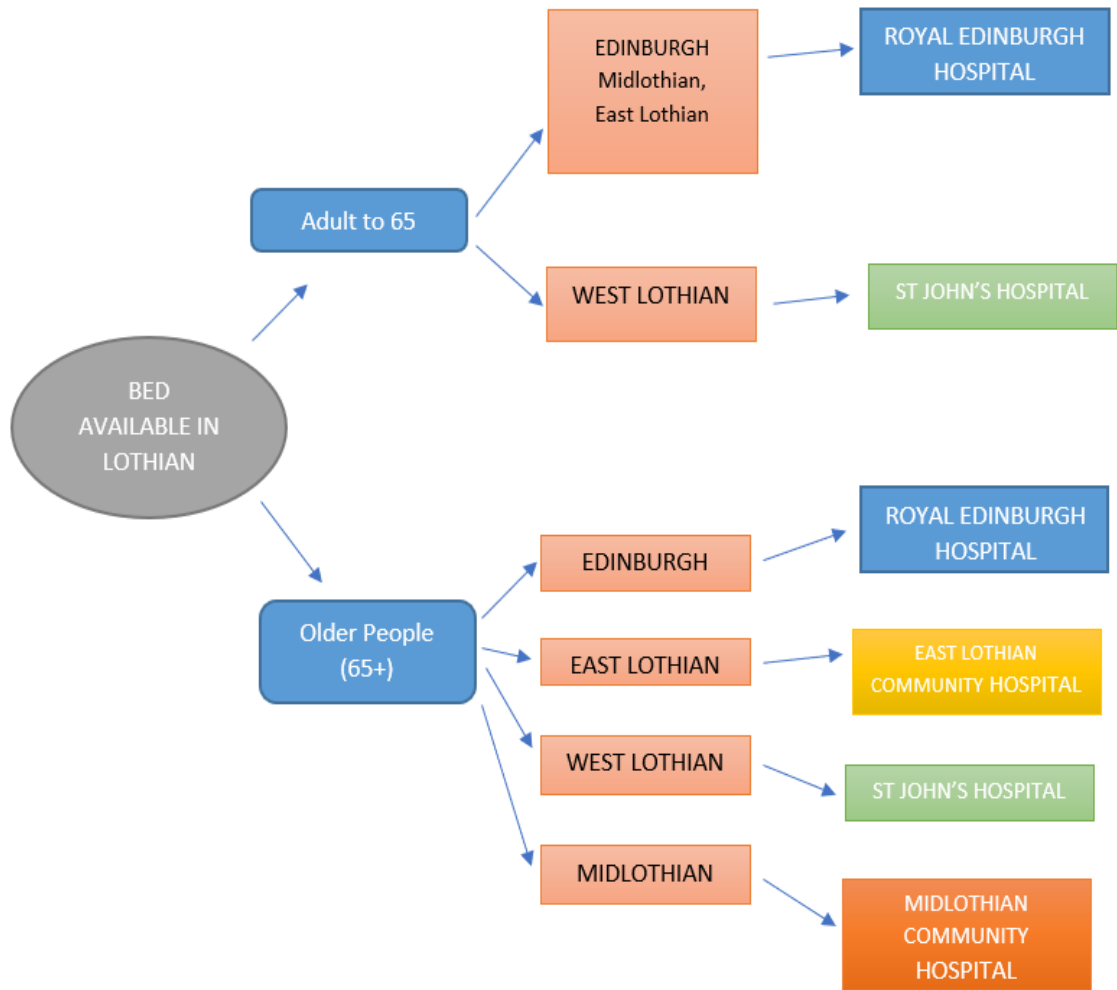
LUCS GP contacts hospital to arrange a bed (via Switchboard – ask for Coordinating Charge Nurse (CCN) or Cons on call for Psychiatry/Specialty eg Learning Disability Cons on call). The Coordinating Charge Nurse will organise a suitable destination for the patient including out of sector beds, and in some cases may be able to help with a nurse escort.

LUCS GP arranges transport as appropriate and hands completed EDC to escort to take with patient to hospital (escort can be MHO, SAS or Police, not a family member).

ED referrals (for those experiencing a mental health crisis with injuries or overdose) can be made through the Flow Centre, who may be able to help with transport options. Flow centre does not take referrals for Psychiatry OOH.

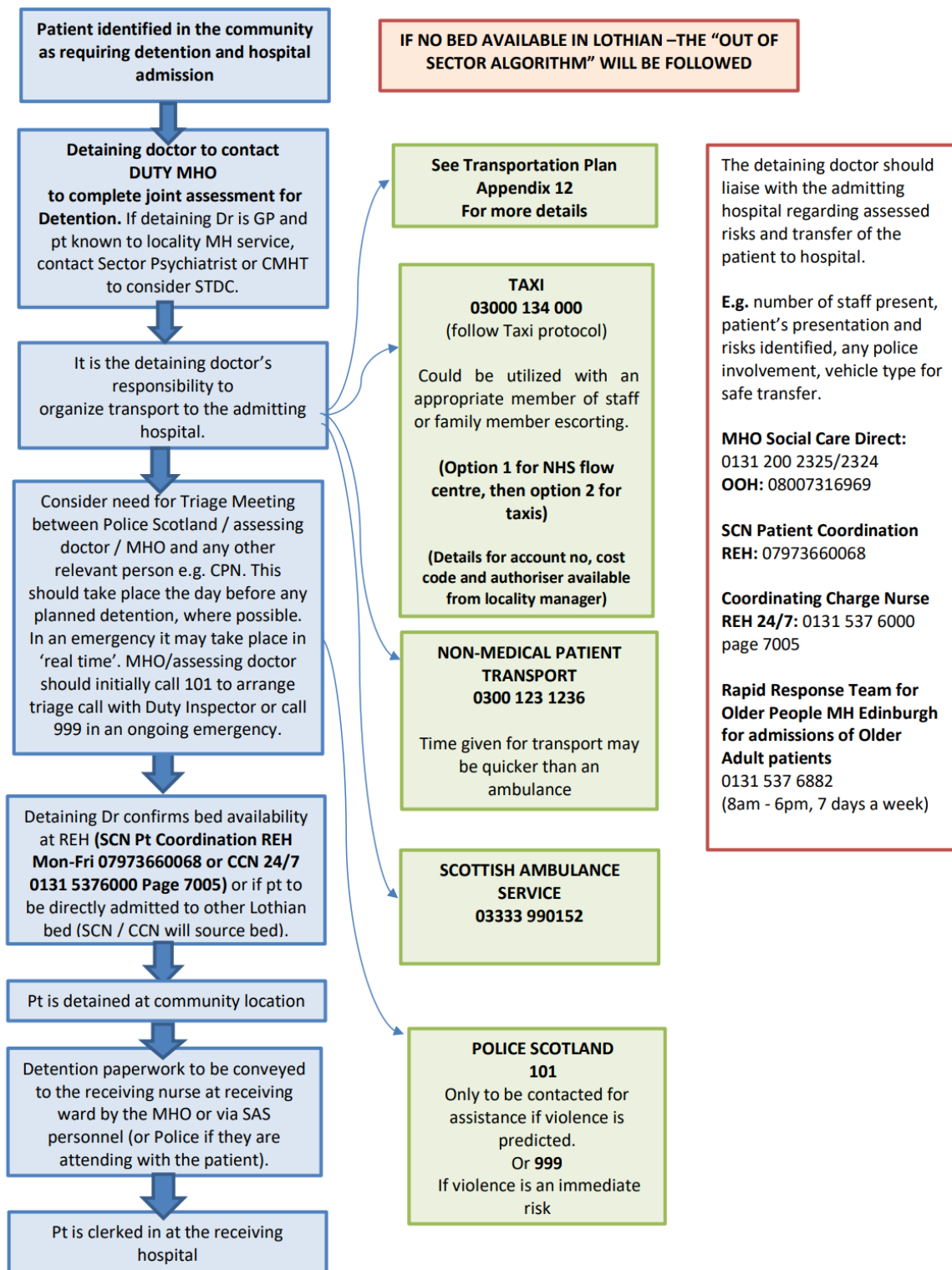
Appendix 6: Assessment and Bed availability

Appendix 6.1 Geographic Sectorisation of Hospital Admissions



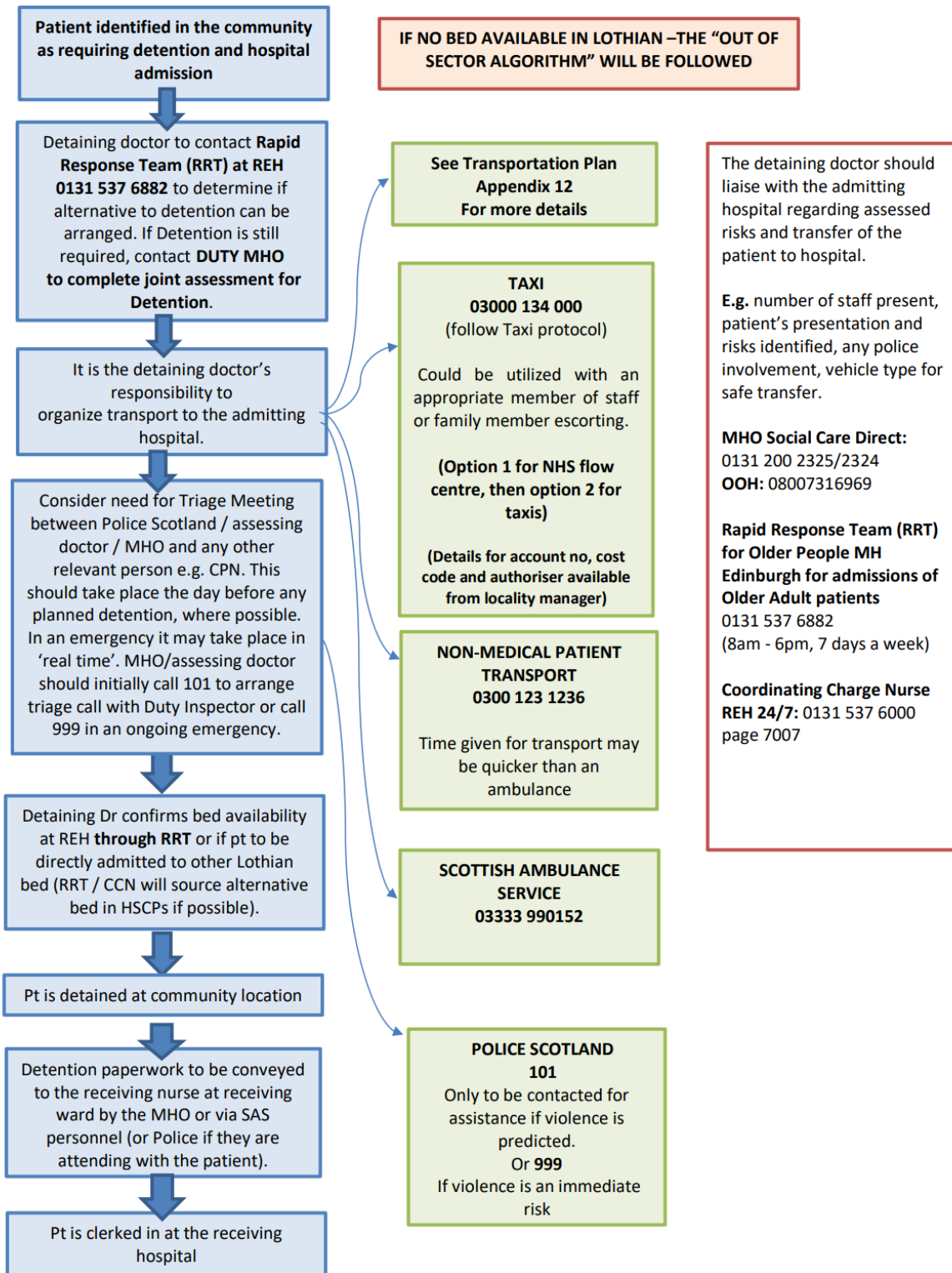
Appendix 6.2.1: Edinburgh Adult Community Detention: In Hours

Edinburgh Adult Community Detention IN HOURS



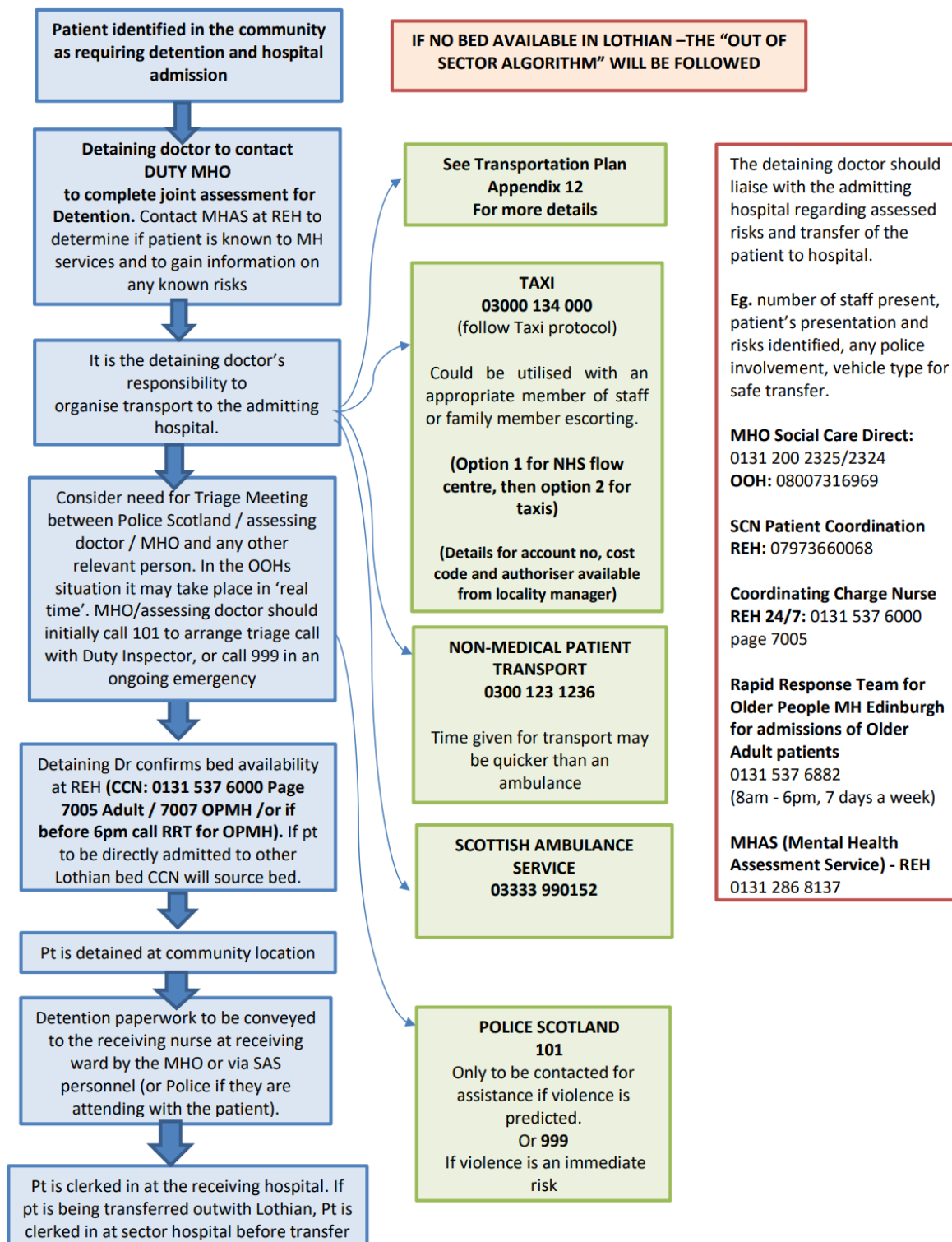
Appendix 6.2.2: Edinburgh Older Adult Community Detentions: In Hours

Edinburgh Older Adult Community Detention IN HOURS



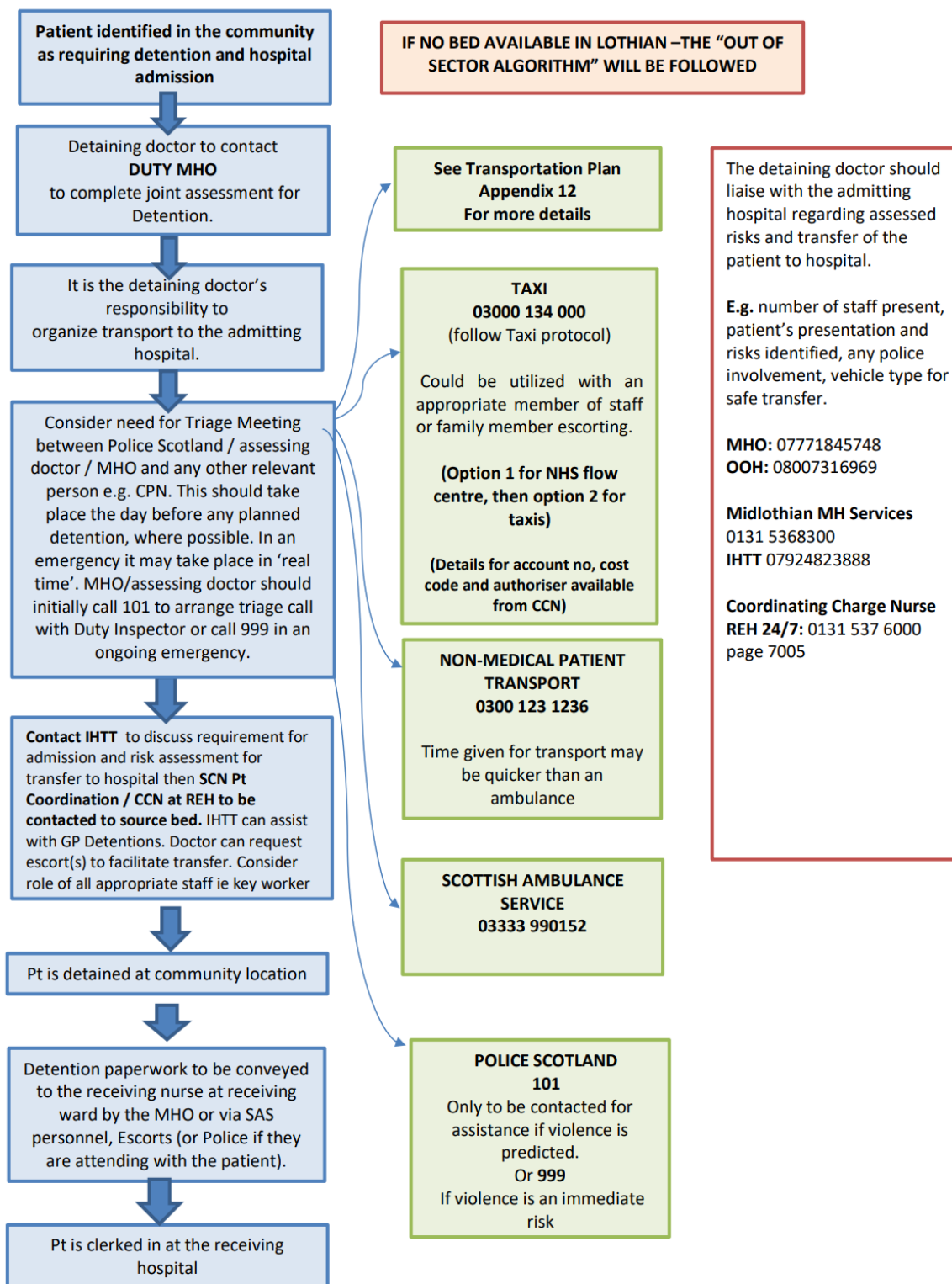
Appendix 6.2.3 Edinburgh Adult and Older Adult Community Detentions: OOHs

Edinburgh Community Detentions OUT OF HOURS

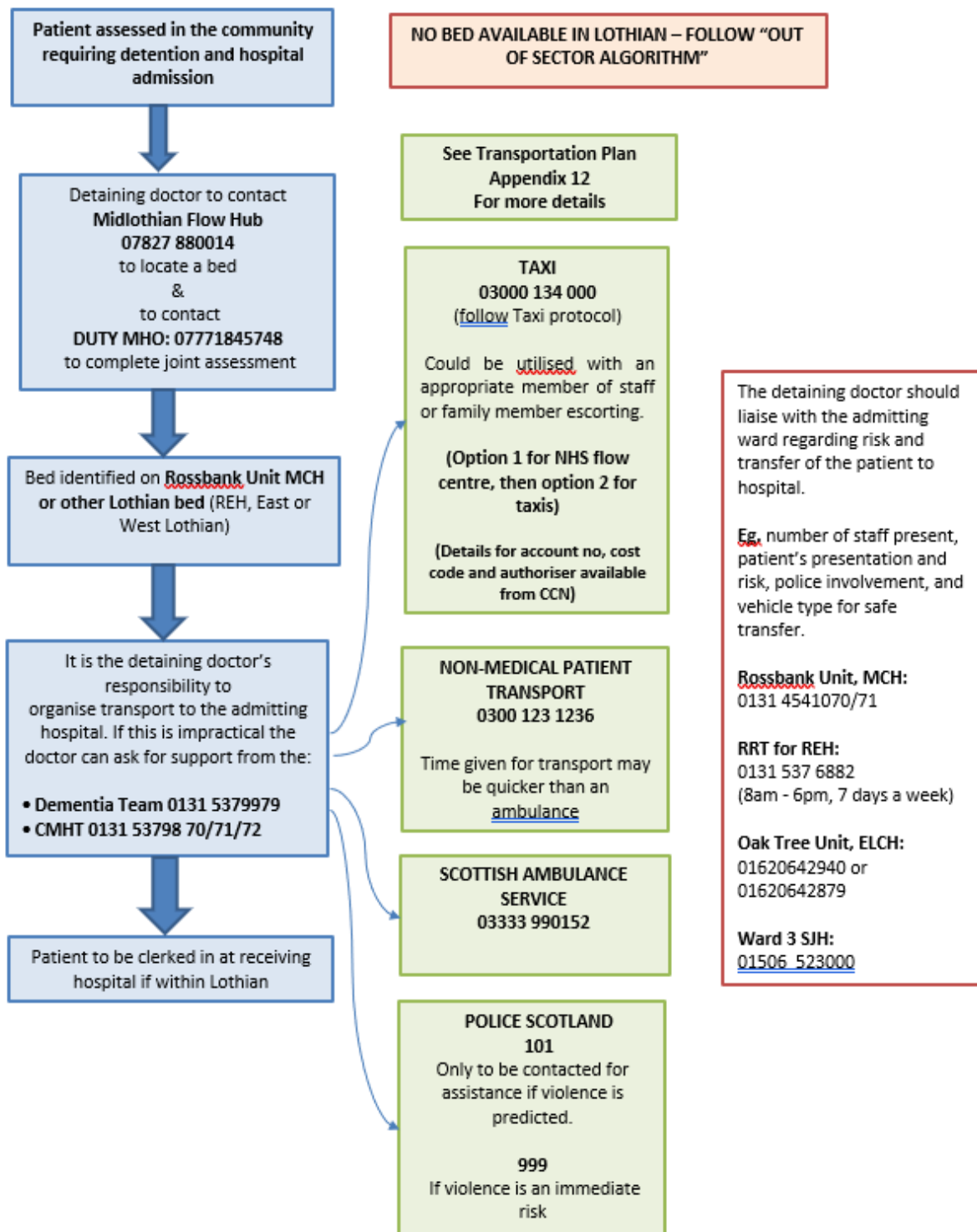


Appendix 6.3.1: Midlothian Adult Community Detention Until 12MN

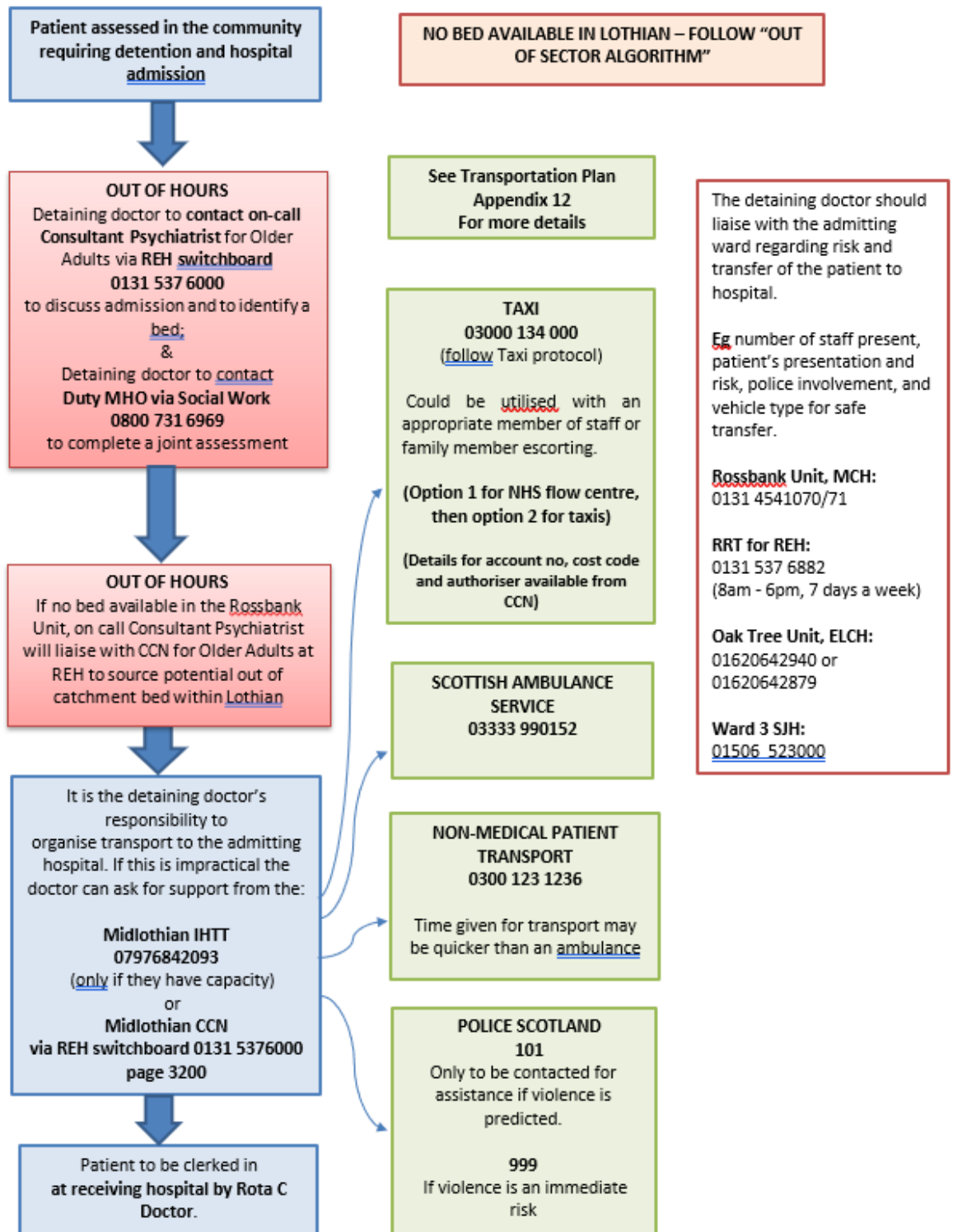
Midlothian Adult Community Detention Until 12MN



Appendix 6.3.2: Midlothian Older Adult Community Detention, IN HOURS

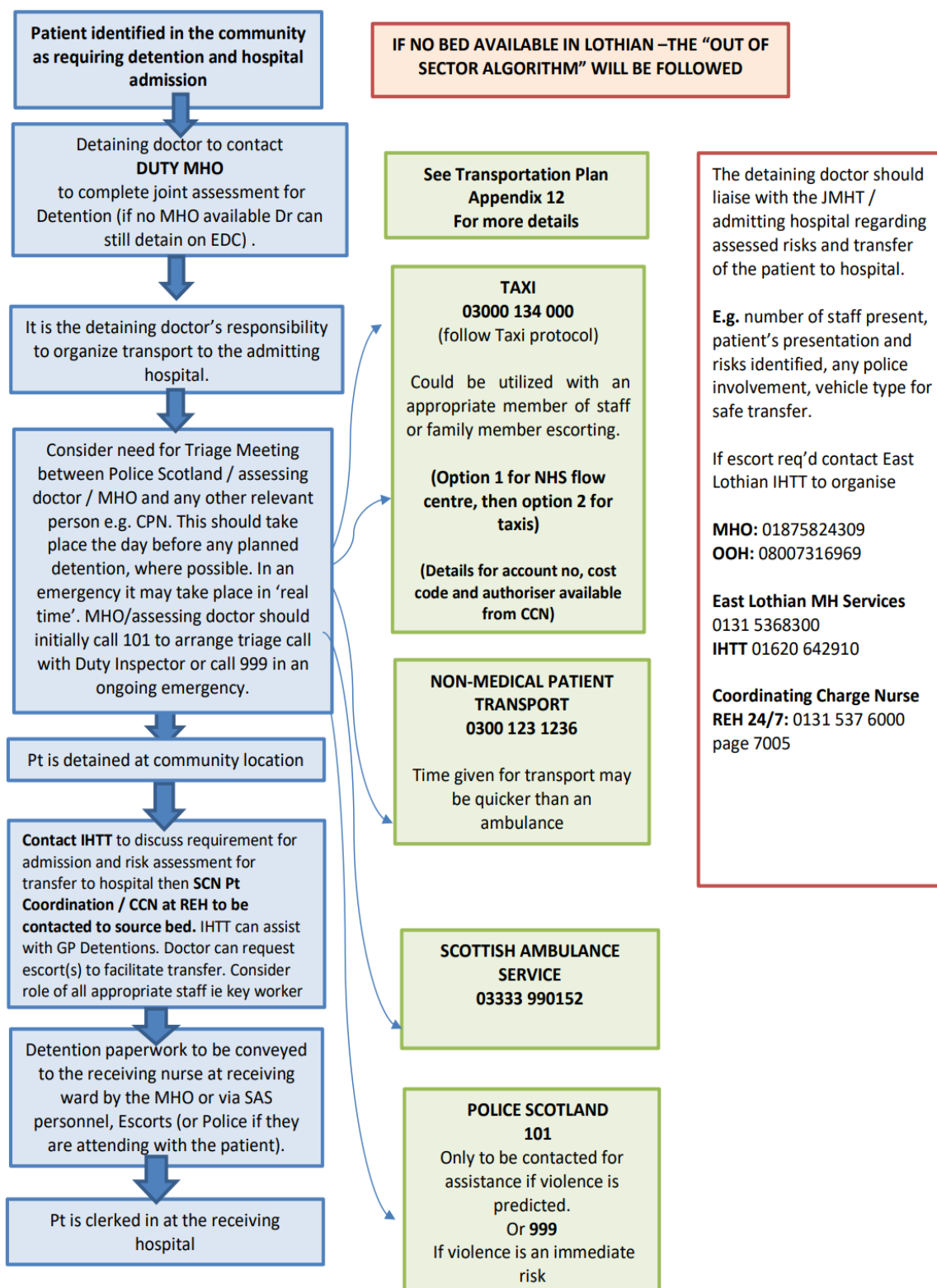


Appendix 6.3.3: Midlothian Older Adult Community Detention, OUT OF HOURS



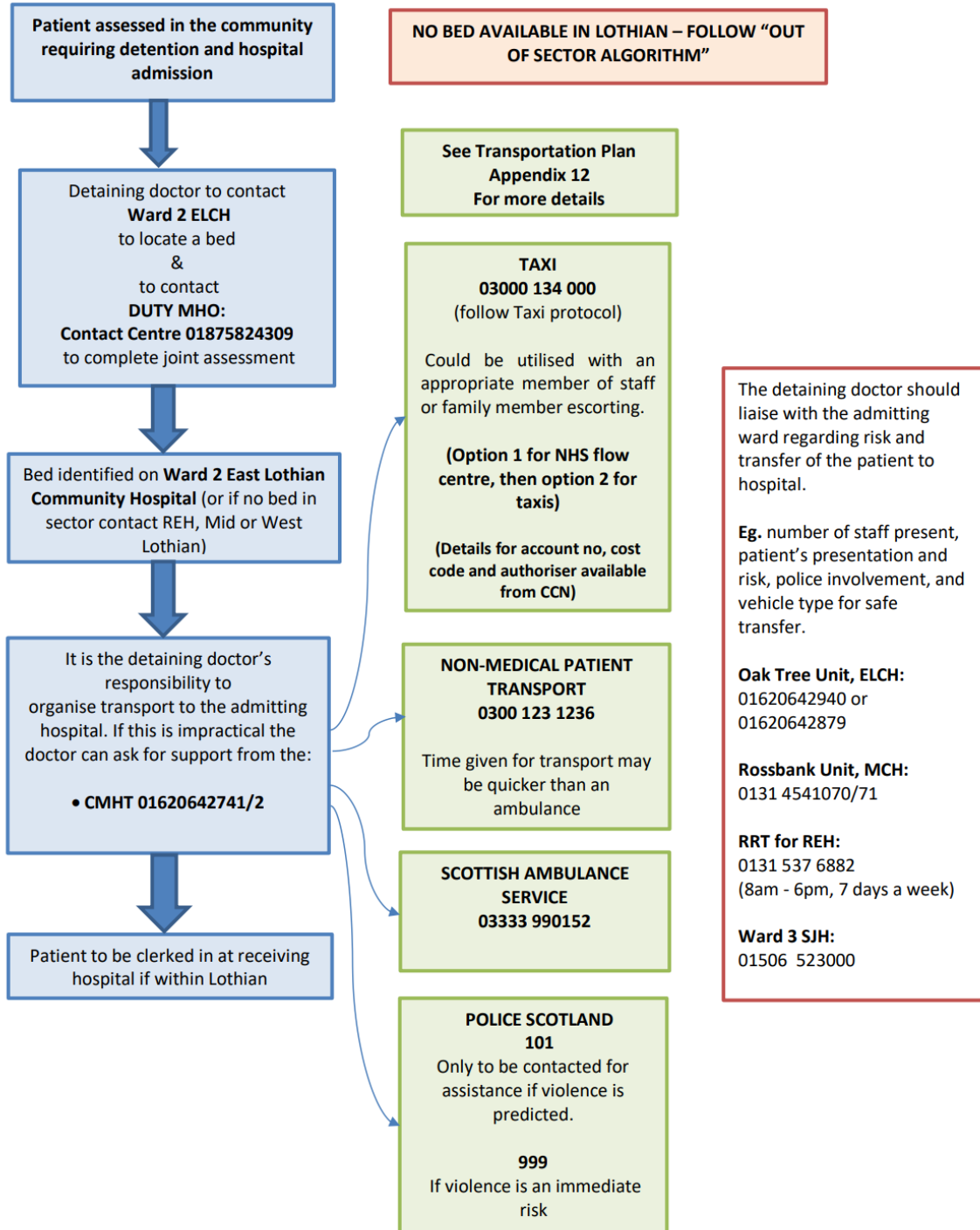
Appendix 6.4.1: East Lothian Adult Community Detention 8am - 12MN

East Lothian Adult Community Detention 8am - 12MN



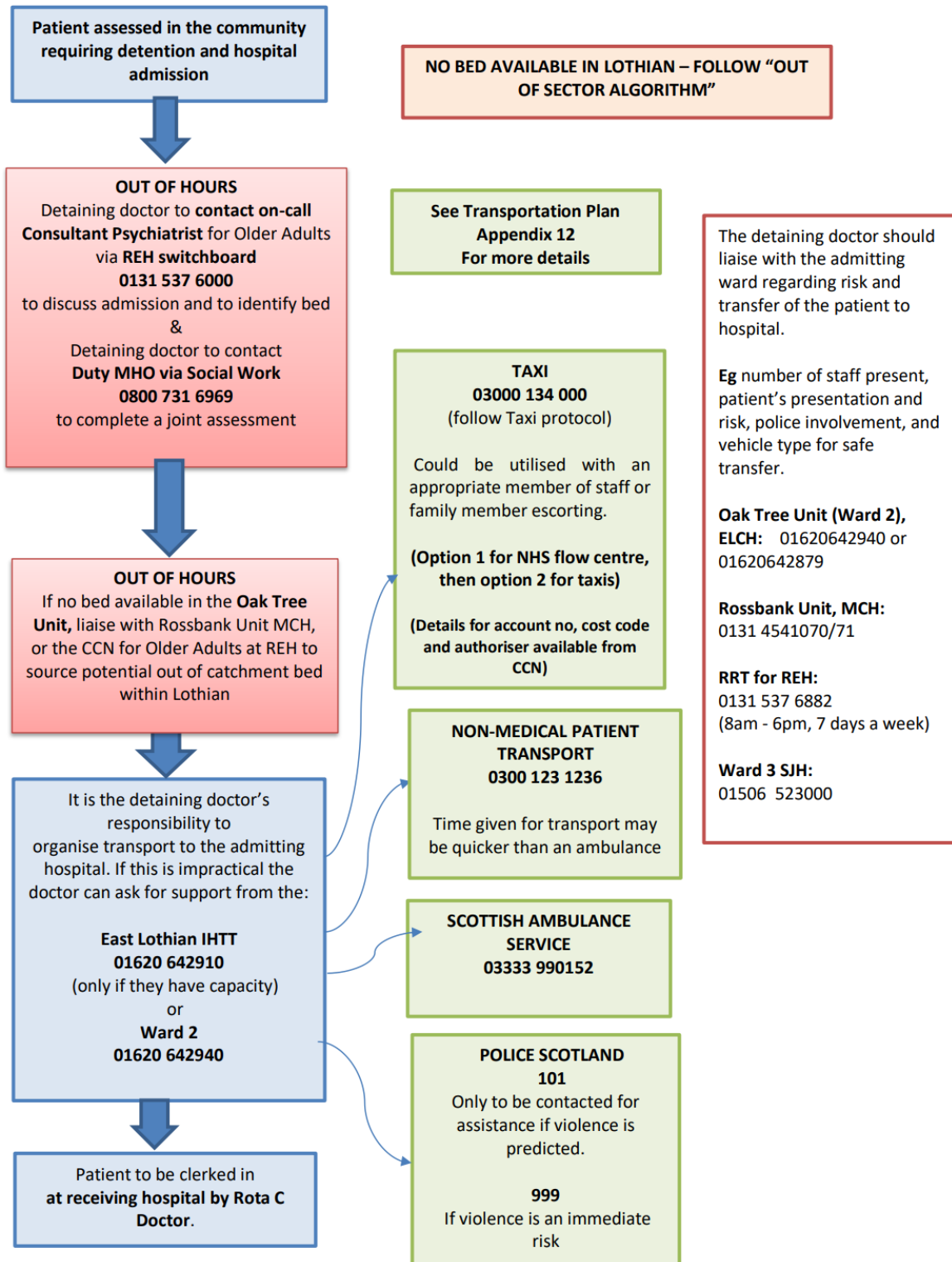
Appendix 6.4.2: East Lothian: Older Adult Detention In Hours

East Lothian Older Adult Community Detention IN HOURS

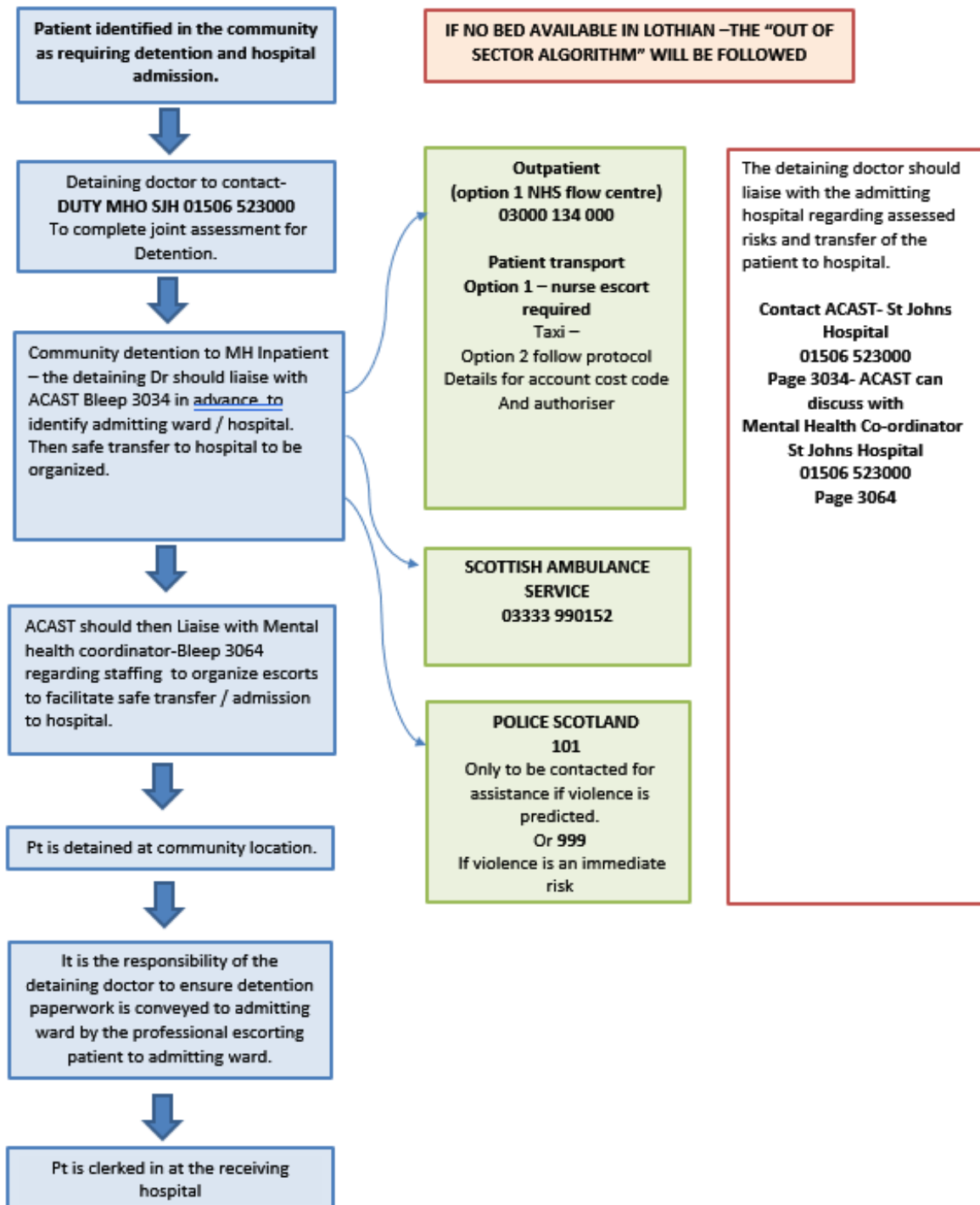


Appendix 6.4.3: East Lothian: Older Adult Detention Out of Hours

East Lothian Older Adult Community Detention OUT OF HOURS



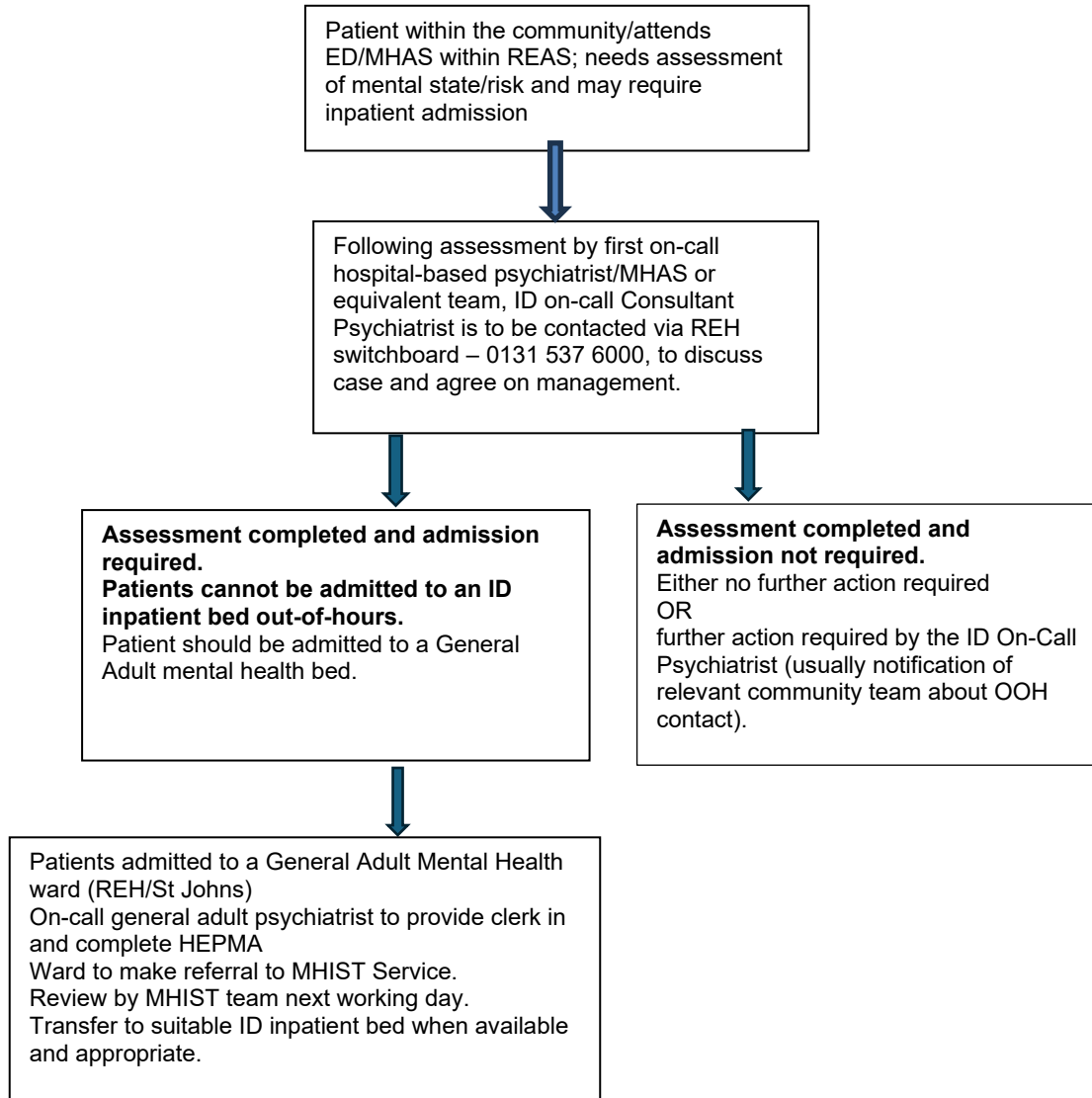
Appendix 6.5.1: West Lothian - Adults and Older People Detention in Community Setting IN HOURS and OOHs



Appendix 6.6: Lothian Mental Health Detention of Patients with Intellectual Disability

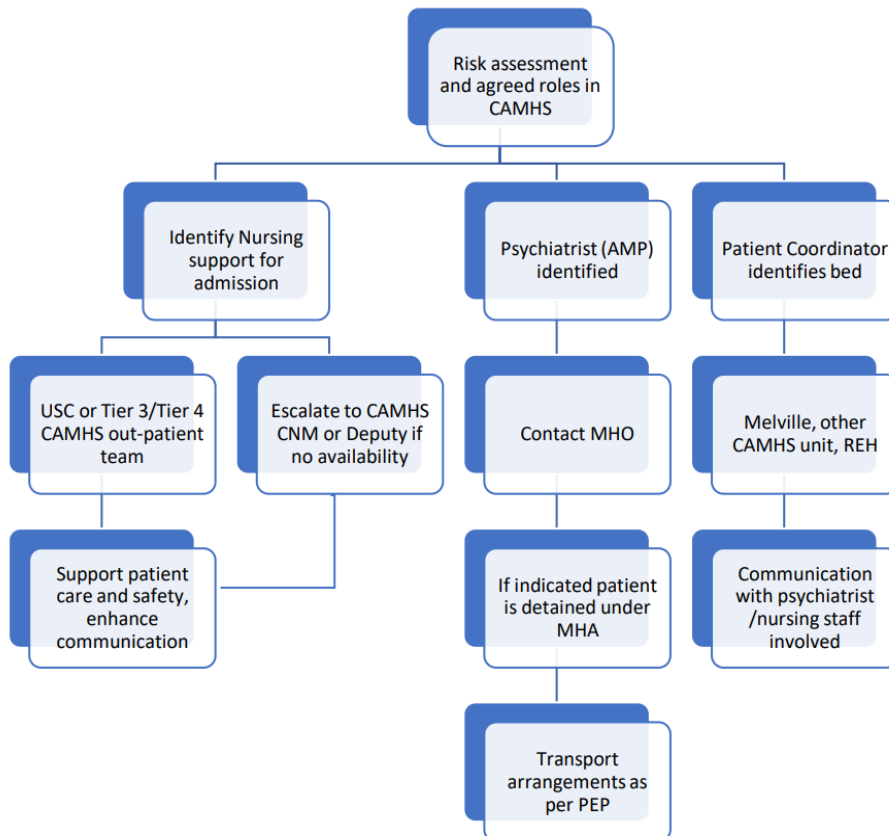
17:00 – 09:00 – Out of hours

All adults diagnosed with an Intellectual Disability over the age of 18



Appendix 6.7: Lothian Young People Under 18 – CAMHS Community detention IN HOURS

In hours – Monday – Friday 9am-5pm



Bed Coordinator (or deputy) Mon-Fri Melville Unit Reception 0131 3120050

Rotawatch <http://rotawatch.luht.scot.nhs.uk/>

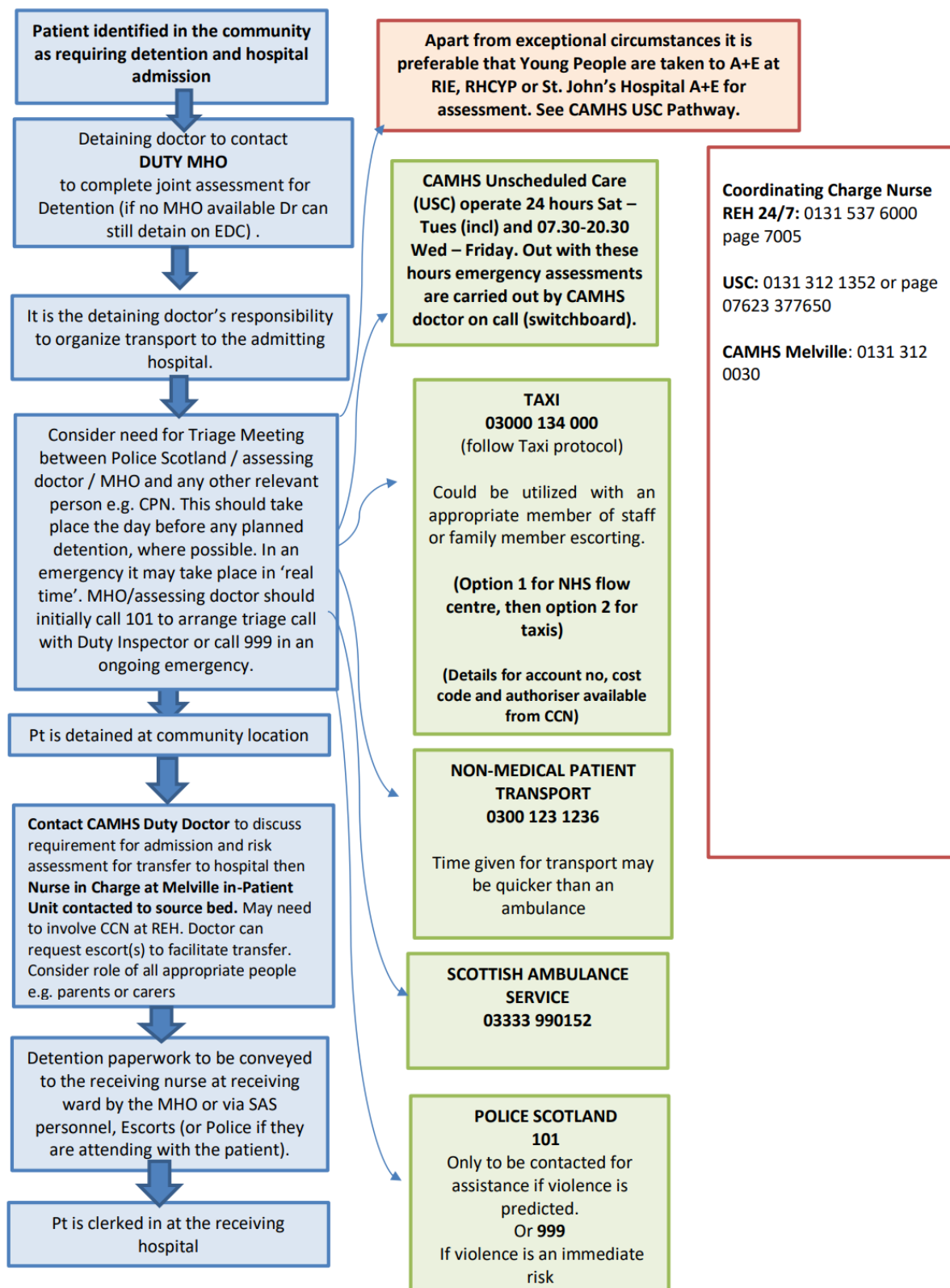
Immediate risk assessment should include decisions on timing and which staff need to be involved.

This is the system for in-hours detention in the community.

After 5pm and at weekends the CCN for REH is responsible for the coordination of access to adult mental health beds. Note CAMHS units out of area do not admit OOH.

Appendix 6.7.1: Lothian Young People Under 18 – CAMHS Community Detention OUT OF HOURS

Community Detention Out of Hours Young people up to Age 18



Appendix 6.7.2: Lothian Young People Under 18 – CAMHS Unscheduled Care Referral Process from Emergency Departments

CAMHS UNSCHEDULED CARE REFERRAL PROCESS A&E

OPERATING HOURS:

- 7 days per week 0730-2030 (face to face Wed-Frid until 18.00hrs)
- Overnight UNTIL 0100 Saturday to Tuesday night

IN-HOUR REFERRAL PROCESS:

If the young person meets referral criteria, contact:

CAMHS USC on x51352, 0131 312 1352, or pager 07623 377649

OOH REFERRAL PROCESS:

OUTWITH SERVICE OPERATING HOURS, I.E. OVERNIGHT 0100-0730, CONTACT: **ON CALL PSYCHIATRY FOR SJH via ACAS Bleep 3334 or trainee Bleep 3040**

Or if elsewhere in Lothian CONTACT ON CALL PSYCHIATRY ROTA C via switchboard.

If a young person presents in the early hours, where appropriate, USC can come out from 0730 onwards

SERVICE REMIT: CAMHS Unscheduled Care is an emergency assessment service for children and young people (0-18) who are experiencing a mental health crisis and require same day assessment.

REFERRAL CRITERIA: OVERDOSE; SEVERE MENTAL DISTRESS; SERIOUS SELF HARM; SUICIDE RISK; OTHER UNUSUAL/CONCERNING BEHAVIOURS RELATING TO MENTAL HEALTH

POTENTIAL REFERRAL OUTCOMES: Not all young people referred to CAMHS USC will require a face to face assessment. It is CAMHS USC's responsibility to decide on the most appropriate course of action, and to explain the rationale to the referrer. This will involve one of the following:

CAMHS USC nurse will attend in person to carry out assessment. They will then feedback the outcome and plan to a clinician in the ward/department

In some situations, the CAMHS USC nurse may suggest that it is more appropriate for the on call doctor to carry out the assessment. A joint assessment may also be agreed

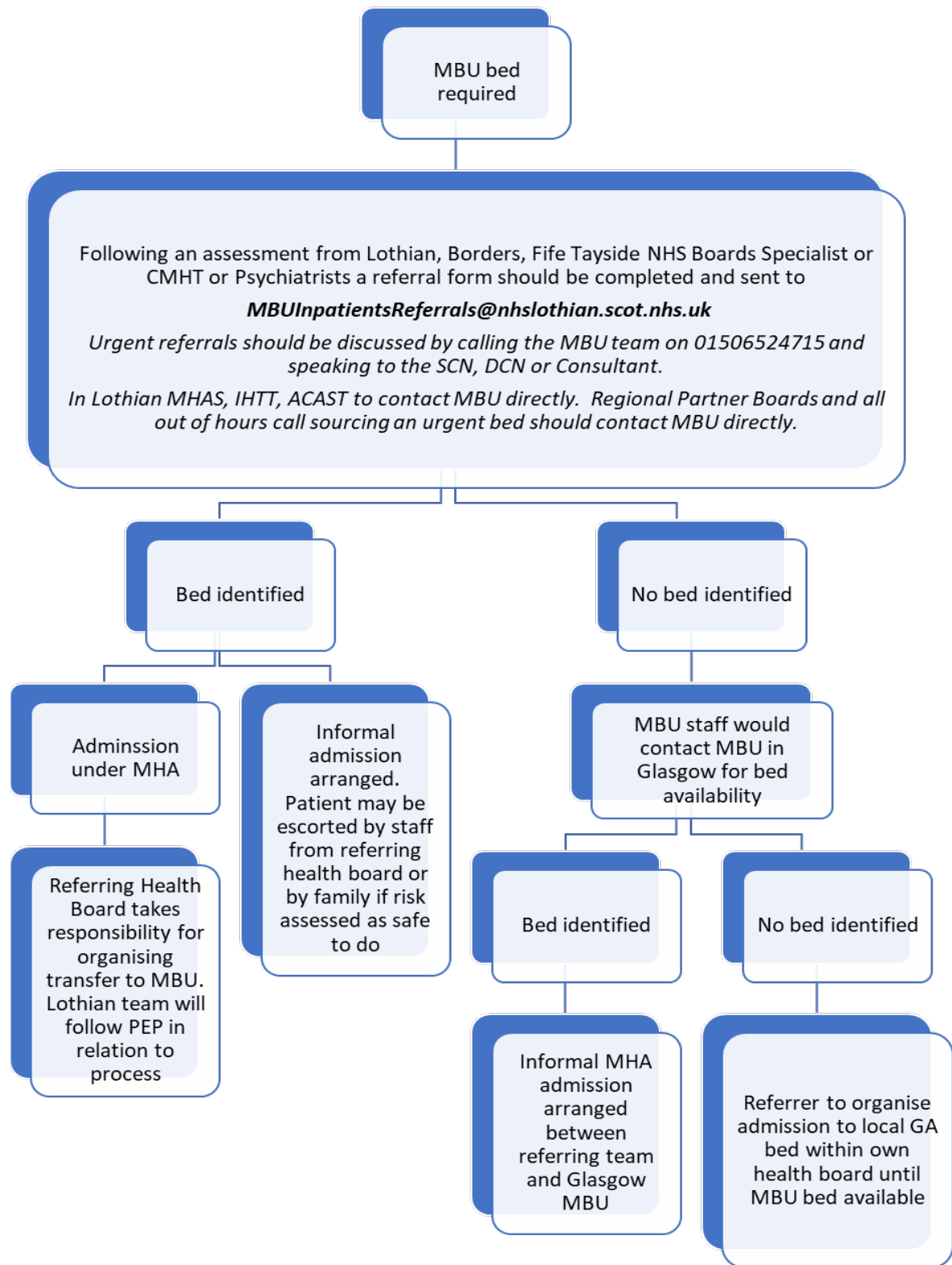
It may be appropriate for the young person to return home and then receive a telephone appointment with CAMHS USC

In some circumstances, it may be more appropriate for USC to make a plan with a parent/carer, than meeting with the young person directly

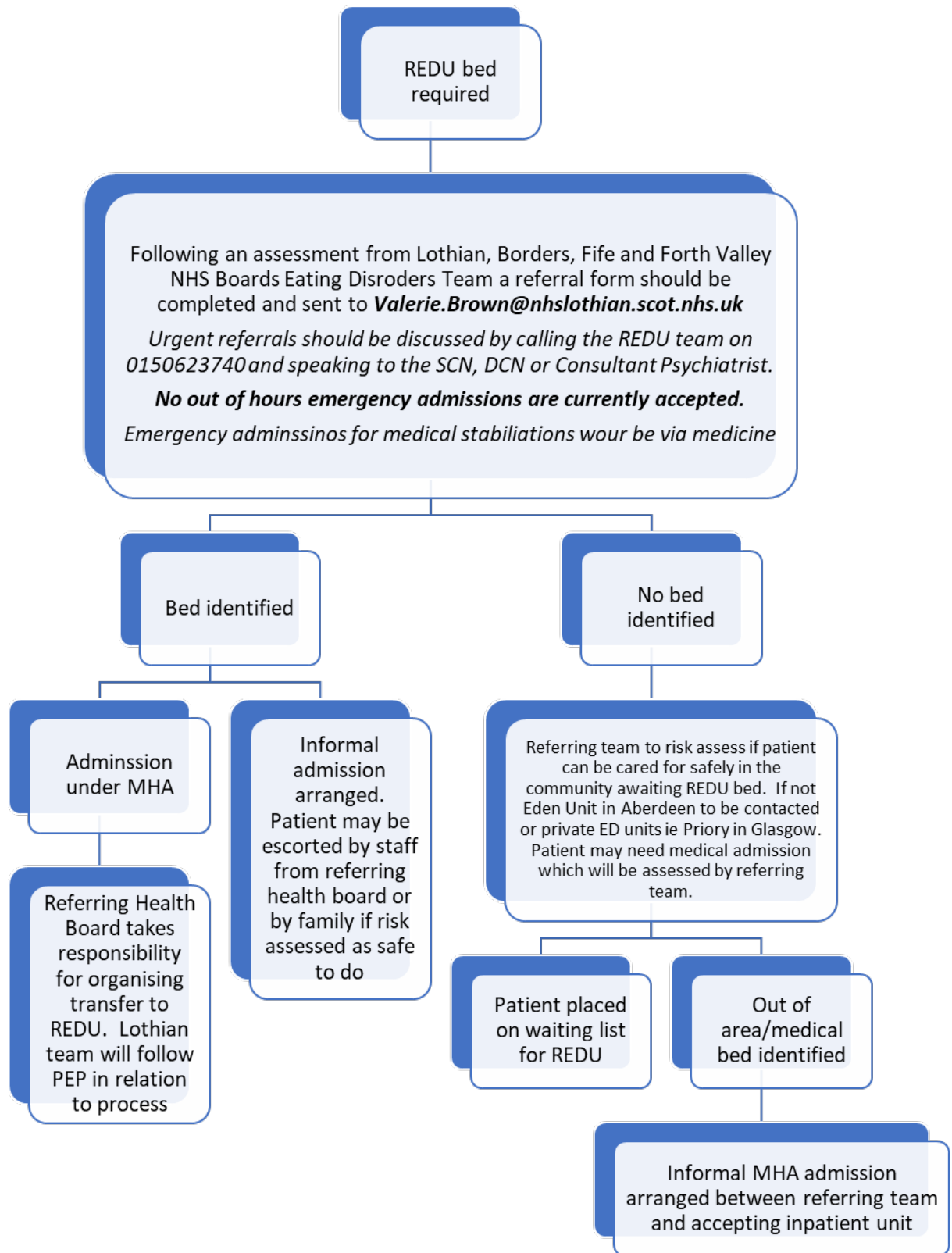
The young person may not meet criteria for assessment. In this case CAMHS USC will advise /sign post as to what may be appropriate in terms of supports in the community. This can be passed on to the young person/family by the clinician involved.

IN ORDER FOR CAMHS USC TO BE ABLE TO SEE AS MANY YOUNG PEOPLE WE CAN, WE WOULD REQUEST THAT THEY ARE TRIAGED AS SOON AS POSSIBLE ON ARRIVAL AT A&E AND CAMHS USC ARE CONTACTED PROMPTLY, WITH CLEAR INFORMATION AS TO THE PRESENTING ISSUE

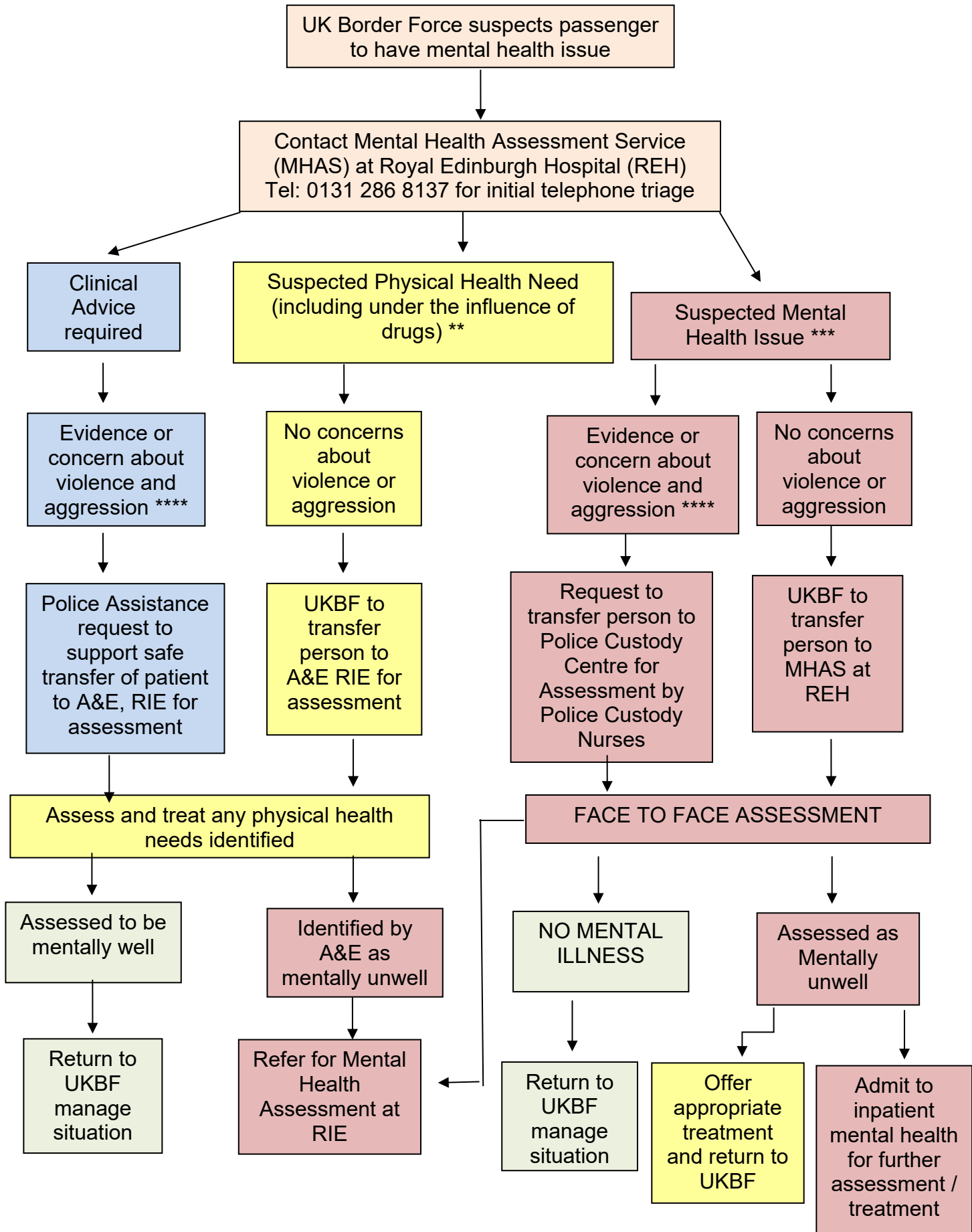
Appendix 6.8: Perinatal Mother and Baby Mental Health Unit
 NB – GPs cannot refer directly to the Mother and Baby Mental Health Unit



Appendix 6.9: Regional Eating Disorders Unit



Appendix 6.10: Psychiatric Emergencies at Edinburgh Airport



* This applies to persons with an address in Edinburgh, East Lothian and Midlothian as well as those with no address in Edinburgh

*If there is a clear reason that the patient cannot be brought to the REH, and if the REH OOH team have capacity the assessment can take place in UKBF Detention Suite at Edinburgh Airport

**For example, restless, sweating, agitated, feverish, person complaining of physical pain or distress

*** For example, visibly anxious, paranoid, expressing suicidal ideas, mood swings

****RIE 5pm - 8am otherwise REH

NOTE THE OVERLAP BETWEEN PHYSICAL AND PSYCHOLOGICAL SYMPTOMS – IF IN DOUBT RULE OUT PHYSICAL ILLNESS.

Appendix 6.11: Protocol for Scottish Ambulance Service direct access to the REH & REH referral pathway

PLEASE NOTE THAT:

- **THIS PROTOCOL APPLIES TO EDINBURGH ONLY.**
- **WEST LOTHIAN PATIENTS ARE TAKEN TO ST JOHN'S HOSPITAL.**
- **FOR EAST & MIDLOTHIAN PATIENTS SAS ARE REQUESTED TO CONTACT THE IHTT and A PLACE OF ASSESSMENT WILL BE IDENTIFIED)**

The Scottish Ambulance Service (SAS) has secured permission from NHS Lothian to take people experiencing mental health difficulties directly to REH for mental health assessment.

However, where SAS receive an emergency call for anyone experiencing mental health difficulties that also has a physical injury, has taken an overdose, is incapable through alcohol/any other substance misuse or is causing any medical concern, the person should be taken to Royal Infirmary Edinburgh (RIE) to receive appropriate medical care and treatment.

Prior to transporting the person to REH site, the SAS will contact the **Mental Health Assessment Service (MHAS) 0131 286 8137** to discuss the referral and to establish the appropriate site for assessment. Since MHAS are able to access clinical information for people known to mental health services, this early dialogue also enables identification of potential risks that may compromise either the person's own safety or safety of others including the ambulance crew involved.

Professional to professional discussion may enable the decision that a person, currently engaged with mental health services and well known to MHAS can remain at home (with MHAS contacting the appropriate team for follow-up). In the event that SAS have unresolved concerns about the person's mental health and well-being, the default is for the person to be taken to REH for a face to face assessment. All 'remain at home' outcomes will be monitored.

The place of assessment within Royal Edinburgh Hospital site is the Main Reception of the Royal Edinburgh Building. On arrival, at the main reception, SAS will provide a verbal handover and written report to the receiving nurse, outlining the reason for referral.

SAS will not remain with the person until the assessment has been carried out, however the person remains SAS responsibility until the hand over to MHAS has taken place. As with police referrals, MHAS may be required to prioritize the assessment depending on the person's individual circumstances.

If for any reason the person's physical condition deteriorates, posing sufficient concern that transfer to RIE is clinically indicated, MHAS staff are able to request an ambulance according to the level of response considered appropriate. This can range from a 999 emergency response to a graded response of within 1 to 4 hours depending on the clinical need of the person.

Appendix 7: Police and Mental Health Triage SOP

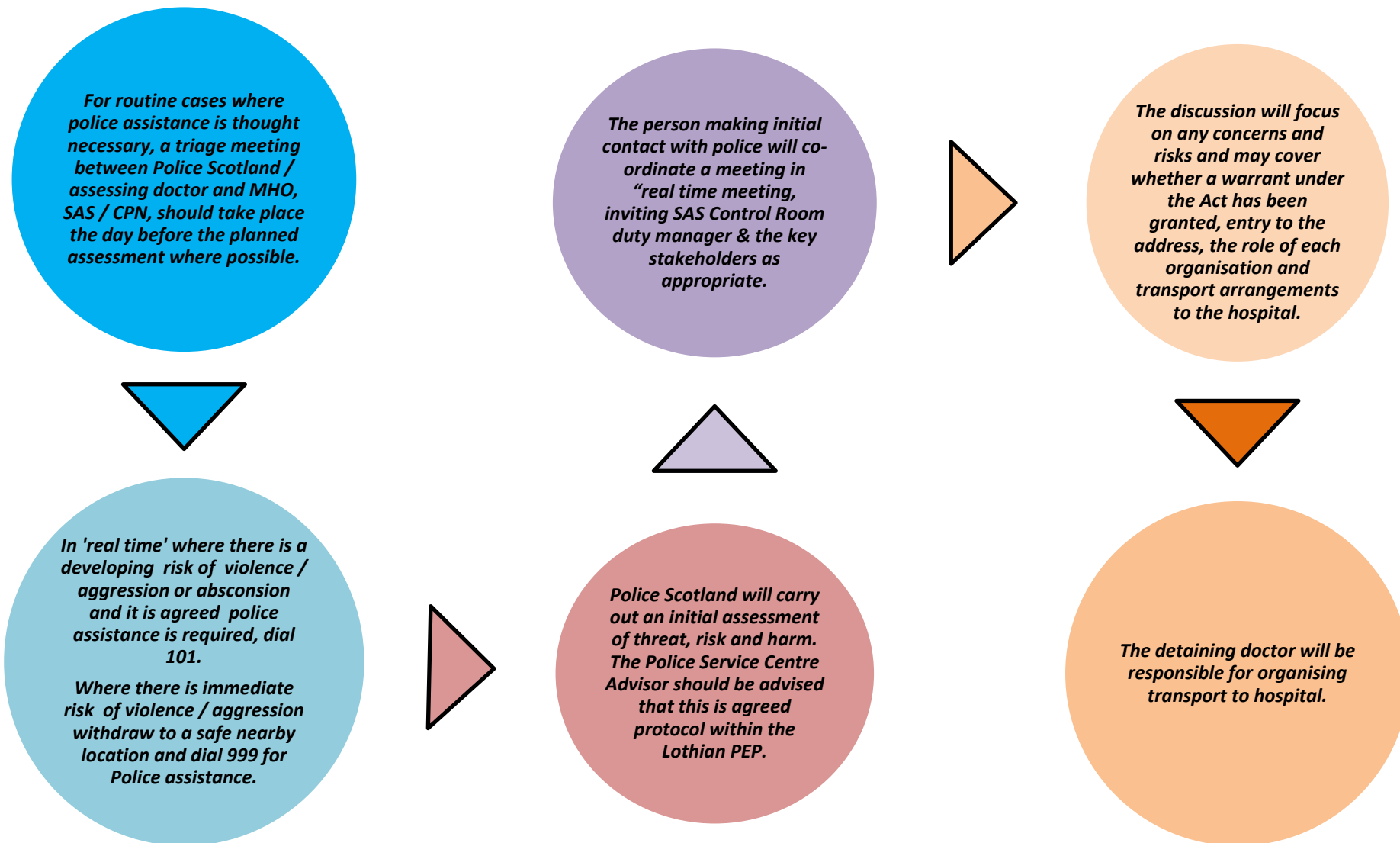
1. Where police assistance is thought necessary to support the detaining of patients in the community, a triage meeting between Police Scotland / assessing doctor and MHO, SAS and any other relevant person such as the CPN, should take place the day before the planned assessment where possible. In an emergency the meeting will take place in “real time” but where possible, the pre-planned discussion is the preferred process.
2. To allow for an initial assessment of threat, risk and harm, **the detaining Dr should place a call to Police Scotland by dialling 101**. A summary of the circumstances will be provided by the detaining Doctor to Police Scotland Service Centre staff, and a request made to speak in person with the duty Sergeant/Inspector for the local area, to discuss police assistance in the psychiatric emergency. Police Scotland Service Centre staff will create a Storm Incident and contact will be made with the local response Sergeant/Inspector for that area. The Service Centre Advisor should be advised that this is agreed protocol within the Lothian PEP (Mental Health services should NOT be told this is not a police matter).
3. Duty Sergeant/Inspector will aim to call back within 20 minutes
4. The MHO / assessing doctor making initial contact with police will co-ordinate the meeting, inviting SAS Control Room duty manager & the key stakeholders as appropriate. The Triage meeting may take place by conference call or on Microsoft TEAMS where it is impractical to meet in person.
5. The discussion will focus on any concerns and risks and may cover whether a warrant under the Act has been granted, entry to the address, the role of each organisation and transport arrangements to the hospital. A priority for all partners will be to protecting the individual’s privacy and dignity during the process and to minimise any distress caused to the person in crisis.
6. Consideration should be given where appropriate. for a family member to be present for the detention if it is felt this would be reassuring for the patient.
7. Police Scotland will record details of the meeting on the Storm Incident. and NHS Lothian staff will do likewise on Trak; MHO will record details of the meeting on the Social Work electronic record - decisions, agreed actions, and contact details for all partners.

8. The detaining doctor will be responsible for organising transport to hospital. Police will only transport an individual to hospital in exceptional circumstances and not if the patient has been sedated. The detaining Dr should contact SAS Control Room and request to speak to duty manager (See transportation plan [Appendix 12](#) of PEP).

DETENTIONS IN 'REAL TIME'

9. Where there is a high risk to the patients, professionals or public safety, the MHO/assessing doctor should dial 999 and ask for urgent police assistance to attend the psychiatric emergency. Stating there is violence/aggression, the patient has made recent threats, or where current presentation includes threatening /aggressive behaviour.
10. Where the patient has been detained under the Mental Health Act and is refusing to be conveyed to hospital, but not exhibiting threatening or aggressive behaviours, ie are passively resistant, all professionals present should draw on their training and skills in communication, engagement and negotiation, to encourage the person to go with them to hospital.
11. * **NB** see footnote below ⁵It would be expected that such negotiation take place with any passively resistant individual for around 1 hour before consideration is given to calling police for assistance. Police should only be requested when all professionals present agree that they have tried all they can, to encourage the person to attend hospital. MHO and assessing doctor, including GP, should agree who is best to contact the police for assistance.
12. In such cases the Assessing Doctor or MHO should dial 101 to ask for police assistance.
13. All incidents should focus on effective partnership working, clear communication, joint decision making and they will conclude with a review and debrief as required.

⁵ * **NB** The passive resistance '1 hour' principle section is no longer applicable and has been superseded by legislative guidance confirming policing powers. As such assistance would be on the basis of the risk assessment indicating a Police response is required or when relevant legislation is in place to afford required policing powers of entry and/or removal. **Updated 11/03/2026**



Appendix 8: Police Scotland Decision Making Model



National Operational Safety Training Unit National Decision Model

Introduction

Police decision making is often complex; decisions are required in difficult circumstances, often in quick time and they are open to challenge. Using the National Decision Model (NDM) will ensure a greater focus on delivering the mission of policing and acting in accordance with our ethical principles.

Understanding and practising the NDM will help officers/staff to develop the professional judgement necessary to make effective policing decisions.

The NDM is suitable for all decisions. It can be applied to spontaneous incidents or planned operations, by an individual or a team of people, and to both operational and non-operational situations. Decision makers can use it to structure a rationale of what they did during an incident and why. Supervisors/managers and others can use it to review decisions and any actions taken. Adherence to the model will assist officers/staff when writing reports after an incident and if they are subsequently called upon to justify their actions.

The NDM has been adopted to support and assist decision making as to the most appropriate response when dealing with a situation.

Applying the National Decision Model

The NDM has six key elements. Each component provides the user with an area for focus and consideration. The corners of the values pentagon connect to and support the five stages of the decision-making process. One step logically follows another, but the model allows for continual re-assessment of a situation and the return to former steps when necessary. This allows the officer/staff to use the model with a degree of flexibility assisting with their dynamic risk assessment and decision making. An officer/staff may apply the NDM in any given situation both consciously and subconsciously. This may be before, during or after an incident.



Stage 1: Gather Information and intelligence

A correct and defensible decision is more likely to result from consideration of all relevant information and intelligence such as:

When gathering information and intelligence officers/staff should also attempt to establish as much information about the following in relation to the subject:

- Identity
- Capability
- Intent

This may come from what the individual officer/staff sees, hears or even feels for themselves or from what they are told by another person. Information from local circulations, experience from previous encounters or data gleaned from a use of force reporting system may also be relevant.

Gathering information and intelligence is an ongoing process.

Officers/staff will continually ask themselves:

- What has happened?
- What do I know so far?
- What further information do I want or need?
- How do I obtain this information?

Stage 2: Assess Threat and Risk and Develop a Working Strategy

Threat assessment means accurately assessing any person, object or place which could put an officer/staff at risk. In addition, the identity of the threat such as the subject should be assessed; the capability of the subject (for example armed) and the subject's intent to cause harm should also be assessed. Officers/staff should establish an appropriate and prioritised working strategy. It should be a proportionate and focused policing response. The working strategy should:

- Minimise the risk to the victim
- Minimise risk to public and immediate area
- Maximise the safety of officer/staff
- Maximise safety of any specialist officers
- Minimise the risk to the subject
- Allow for detention/arrest of the subject
- Allow for recovery/preservation of evidence

Threat Assessment

Officers/staff are routinely required to respond to conflict situations. A conflict can be described as “a trial of strength between opposed parties or principles or be at odds with”.

General

Officers/staff should remain alert to the possible risks at all times. Awareness is a method of increasing the chances of recognising a threat at an early stage allowing officers to respond effectively. Part of that awareness involves assessing the threat that confronts officers/staff. On the basis of the available information/intelligence, an officer/staff will be able to make an assessment of the threat faced. Threat assessment links into the common understanding of dynamic assessment of risk. Officers/staff carry out subjective assessments of hazards during high-risk real-time incidents and take appropriate and immediate actions to manage the hazards and control the risks.

Definition

Threat assessment means accurately assessing any:

Person

This may be obvious from a subject's actions, demeanour or their ability.

Objects

For example, a syringe in a subject's pocket, a razor blade taped to the door handle of a stolen car.

Place

Environmental factors such as a confined dwelling when confronting an aggressive volatile subject(s).

Risk Categories

Every person, object or place falls into one of two categories:

- High Risk – Presents an obvious threat
- Unknown Risk – Presents an undiscovered threat

There is no such thing as a 'LOW RISK'

This system has only two categories: high risk and unknown risk. There is no 'low risk' or 'no risk' categories due to the unpredictable nature of subject interaction.

Linking this into previous understanding of a threat, does a subject have the **Means, Ability, Opportunity** and **Intent** to do harm to an officer/staff, others or themselves?

When all four elements are present with an immediate danger and no other means of escape this is known as **Jeopardy**.

Preparation for Policing

An officer's/staff's most common threat is through their own complacency. Officers/staff are required to continually conduct dynamic risk assessments, re-assess the situations and ensure the correct response is put in place.

The following colour coding system highlights the phases an officer/staff routinely experiences on duty:

White: Relaxed / unaware of surroundings, low survival prospects, relies on luck.

Yellow: Still relaxed, but aware and confident of dealing with any situation.

Red: Ready and alert to any person, object or place.

Black: Survival Mode.

In an effort to enhance operational safety, officers/staff should be in the yellow stage as a minimum response when on duty.

Confrontational Considerations

There are three factors which will have a direct effect on an officers/staff's chances of falling victim to a violent assault. They are as follows:

- *Mental conditioning (mind set)*
- *Tactics*
- *Skills*

Individual officers/staff must account for any deficiencies identified in these areas and take the appropriate action to rectify them. Mental conditioning begins with the

realisation that any officer/staff can become a victim of violence. Mental conditioning enables an officer to:

- Operate at the proper and appropriate level of awareness
- Detect or anticipate warning signs (assessment)
- Deal with the threat appropriately
- Reduce and deal with any trauma suffered during and after an incident

The subject's behaviour is a factor in identifying options.

Warning Signs, Danger Signs and Impact Factors

Generally subjects who are aroused to fight do not launch into an assault for fear of injury. They initially begin by using attack gestures known as '**ritualised combat**'.

By learning to identify these signals officers/staff give themselves a significant advantage.

Warning Signs include:

- Direct eye contact
- Facial colour darkens
- Head back
- Subject stands tall to maximize height
- Kicking the ground
- Large movements
- Breathing rate accelerates
- Stop/start behaviour

Danger Signs

Danger signs are more than warning signs. Subjects begin to lose control physically. When this occurs, their physical signals are significant and spontaneous.

It is critical that officer's/staff understand and recognise these signals as they are indicative of an imminent attack.

Neglecting or ignoring these signals will put the officer/staff at a serious disadvantage.

Danger Signs include:

- Fists clenching and unclenching
- Facial colour pales
- Lips tighten over teeth
- Head drops forward to protect throat
- Eyebrows drop to protect eyes
- Hands raised above waist

- Shoulders tense
- Stance changes from square to sideways
- Subject breaks their stare and looks for intended body targets
- If the subject is out of breath, the final signal will be a lowering of their entire body before moving forward to attack

Impact factors

Impact factors are those human and environmental differences which make each incident unique and every officer's/staff perception different. These factors have a crucial bearing on making decisions and choice of tactics and may provide justification to use a specific level of force:

- How should an officer/staff approach the situation?
- What should an officer/staff say?
- Does an officer/staff need assistance?
- What personal protective equipment is the best option? Being aware that impact factors will not provide officer's/staff with answers but will encourage them to ask the right questions.

Impact factors include:

- Size, age, strength, gender
- Drugs/alcohol
- Ability
- Numbers
- Opportunity and intent to do you harm
- Weapons
- Skill levels
- Injury/fitness
- Exhaustion
- Willingness to listen
- Special knowledge
- State of subject's mental health
- Subject's physiology
- Nature of crime
- Clothing
- Proximity of others
- Danger to others
- Police powers, skill and perception
- Perception of the non verbal behaviour of a subject
- Perception of imminent danger
- Perception of being in a position of disadvantage
- Perception of the subject's level of resistance

Please note that these lists are not exhaustive

Environmental Impact factors include:

Space
Proximity to furniture
Domestic situation (kitchen = access to weapons)
Escape routes
Weather conditions
Conditions underfoot

Profiled Offender Behaviour

The term Profiled Offender Behaviour encompasses the actions and behaviour of the subject and comprises the warning and danger signs they exhibit, coupled with the impact factors present. This profiled behaviour will determine the response. Officers/staff must react proportionately to the actions of the subject. Profiled Offender Behaviour is split into six categories which are as follows:

Compliance

Large percentages of subjects dealt with are reasonable and will comply with any lawful instruction given by the officer/staff. This compliance may be verbal or it may be active compliance, such as stopping when told or showing the contents of their hands.

Verbal Resistance and/or Gestures

Where a subject verbally refuses to comply with an officers/staffs request and/or also exhibits body language which indicates non-compliance.

Passive Resistance

This is non-active conduct with non-compliance e.g. subject simulates a dead weight / sits or stands and will not move.

Active Resistance

A form of conduct where the subject actively resists the officer/staff but does not become assaultive: e.g. swallows drugs / runs away or struggles against officers/staff.

Assaultive Resistance

Physical conduct that results in a direct attack on an officer/staff or person.

Serious/Aggravated Resistance

The highest category of resistance displayed by a subject where there is a possibility of serious injury and or death. This could include the production of a weapon of any kind.

Dynamic Risk Assessment

In addition to any role specific risk assessment, officers/staff should conduct an assessment of any actions they are undertaking or being tasked to undertake. This is sometimes referred to as dynamic risk assessment.

The eight guidelines for conducting dynamic risk assessments are:

- Officers/staffs duty to protect/preserve human life; that includes their own
- Officers/staff should be aware of their physical limits – never take unnecessary risks
- Officers/staff should advise someone what they are doing (or going to do) and try to get support before they do it
- Officers/staff should seek information and advise – it will help them make a judgement
- Officers/staff should apply correct procedures in every situation
- Officers/staff will record their decision making process either at the scene or soon afterwards in official notebook or other recognised journal
- Officers/staffs supervisors and managers are there to assist and offer guidance

Stage 3: Consider Powers and Policy

Officers/staff must only act within the law. A sound knowledge and understanding of available legal powers is therefore essential. In addition, local policies may determine what or how action should be taken. Other areas such as common law, powers of search etc, should also be considered. European Convention of Human Rights (ECHR) provide an essential point of reference and will impact on any assessment or decision implemented. The ECHR articles are:

- **Article 2** – Protects the right of every person to their life. (There is a positive duty on the police to act). The second paragraph of article 2 provides that death from defending oneself or others, arresting a suspect or fugitive, or suppressing riots or insurrections, will not contravene the article when the use of force involved is no more than absolutely necessary.
- **Article 3** – Prohibits torture and inhuman or degrading treatment or punishment.
- **Article 4** – Prohibits slavery, servitude and forced labour.
- **Article 5** – Provides that everyone has the right to liberty and security of person.
- **Article 6**- Provides a detailed right to fair trial.
- **Article 7**- No person may be punished for an act that was not a criminal offence at the time of its commission.
- **Article 8**- Provides a right to respect for one's "private and family life, his home and his correspondence."
- **Article 9**- Provides a right to freedom of thought, conscience and religion.
- **Article 10**- Provides the right to freedom of expression, subject to certain restrictions that are "in accordance with law and necessary in a democratic society".
- **Article 11**- Protects the right to freedom of assembly and association, including the right to form trade unions.
- **Article 12**- Provides the right for women and men of marriageable age to marry and establish a family.
- **Article 14**- Contains a prohibition of discrimination.

A Police Officers entitlement to use force is contained within the Police and Fire Reform (Scotland) Act 2012.

Under Scots Law, a Police Officer is entitled to use reasonable force under the following circumstances:

Self Defence (under Scots Law this extends to the defence of others).

- To effect a lawful arrest
- To prevent the escape of a subject
- To prevent a crime being committed
- To preserve order

Stage 4: Identify Options and Contingencies

It is not possible to list all the options available to deal with conflict; for example, in certain circumstances to do nothing may be an option. Each of the techniques described in this manual represents a tactical option. It is vital that officers/staff understand the medical implications of each option, as this is likely to be relevant when making the appropriate choice.

An option that carries a high risk of serious injury is less likely to be justified in circumstances where the threat posed carries a limited risk to others. The tactical option chosen must be proportionate to the threat faced in all the circumstances.

Tactical Options

On deciding on the most appropriate tactical option, officers/staff require to fully assess the situation and consider the impact of their actions on the subject. The injury potential of the tactical option deployed must be considered by the officer/staff

The Police Scotland Operational Safety Training Tactical Options Model allows for the fact that each situation an officer/staff faces varies.

Appendix 9: Risk Assessment Matrix

Risk assessment matrix; to assist staff in making their assessment of risk

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can't believe this event would happen – will only happen in exceptional circumstances	Not expected to happen but definite potential exists – unlikely to occur	May occur occasionally, has happened before on occasion. Reasonable chance of occurring	Strong possibility that this could occur. Likely to occur	This is expected to occur frequently / in most circumstances – more likely to occur than not

Likelihood	Impact / Consequences				
		Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Appendix 10: Granting an Emergency Detention Certificate (EDC) or a Short Term Detention Certificate (STDC) in the Community

Deployment of Emergency Detention

Situation A: Patient detainable but no immediate danger identified

If patient is detainable but not willing to receive assessment or treatment but no immediate pressing danger identified, (for example those who are neglecting own welfare due to mental health condition) the GP should contact the MHO to discuss and arrange an MHO assessment and contact sector psychiatrist, to consider feasibility of arranging a short-term treatment order.

During this discussion it should be considered whether a triage meeting is necessary. Police Scotland should only be involved where individuals have a history of aggression or violence, have made threats recently or where current presentation includes threatening / aggressive behaviours.

A triage meeting between Police Scotland / assessing doctor / MHO and any other relevant person such as the CPN should take place the day before any planned detention, where possible. In an emergency it may take place in 'real time'. If there is time to plan such a meeting, contacting the sector psychiatrist would be advisable to again consider whether a STD certificate is appropriate.

MHO/assessing doctor should initially call 101 to arrange police assistance, or 999 in an ongoing emergency. A brief summary of the circumstances will be provided to control room staff, to allow for the initial assessment of threat, risk and harm. ***This should be followed by a request to speak to the relevant duty Inspector/Sergeant for the local area, to discuss police assistance with a psychiatric emergency. The Call Handler should be advised that this is agreed protocol within the Lothian PEP.*** Duty Inspector/Sergeant will aim to call back within 20 minutes.

Initial information regarding potential/identified risks, needs and reasons for police assistance being required will be shared.

If a more in depth triage meeting is felt necessary the MHO / assessing doctor making initial contact with police, will co-ordinate the meeting, inviting relevant partners including sector psychiatrist, ideally this would be at least a day prior to an emergency detention.

Focus of the discussion will be on how to effect entry to the individual's home address, relevant prior offending history and potential risks, the role of each organisation and arrangements for transport to hospital as safely as possible. Police will only transport an individual in exceptional circumstances and other means should routinely be organised by the detaining doctor/MHO.

Detention paperwork to be conveyed to the receiving nurse at the admitting Hospital: by the MHO or via SAS or Police who are attending the patient.

Informing Receiving Hospital(s) Coordinating Charge Nurses

GP to inform Coordinating Charge Nurse of receiving hospital of detention and be advised by them of the admitting ward.

Transport

GP should arrange. Mode of transport should be informed by triage discussion and / or risk assessment.

Patient transport can be requested through the Flow Centre: 03000134000. If time frame is greater than one hour, then a one hour ambulance is requested but whether this happens will be dependent on ambulance availability. Where appropriate a Private Ambulance could be deployed via the Flow Centre See *Appendix 12*

Contract taxis could be used to facilitate admission or where appropriate REH minibus vehicle. GP should speak with IHTT (East and Mid Lothian), ACAST (West Lothian) or Coordinating Charge Nurse at hospital base to discuss arrangements for nurse escort where required.

Deployment of Detention

Situation A: Patient detainable but no immediate danger identified.

If patient is detainable but not willing to receive assessment or treatment but no immediate pressing danger identified, (for example those who are neglecting own welfare due to mental health condition) the GP should contact the MHO to discuss and arrange an MHO assessment and contact sector psychiatrist, to consider feasibility of arranging a short-term treatment order.

During this discussion it should be considered whether a triage meeting is necessary. Police Scotland should only be involved where individuals have a history of aggression, have made threats recently or where current presentation includes threatening /aggressive behaviours.

A triage meeting between Police Scotland / assessing doctor / MHO and any other relevant person such as the CPN should take place the day before any planned section, where possible. In an emergency it may take place in 'real time'. If there is time to plan such a meeting, contacting the sector psychiatrist would be advisable to again consider whether a STD certificate can be applied.

MHO/assessing doctor should initially call 101 to arrange police assistance, or 999 in an ongoing emergency. A brief summary of the circumstances will be provided to control room staff, to allow for the initial assessment of threat, risk and harm. This should be followed by a request to speak to the relevant duty Inspector/Sergeant for the local area, to discuss police assistance with a psychiatric emergency. The Call Handler should be advised that this is agreed protocol within the Lothian PEP. Duty Inspector/Sergeant will aim to call back within 20 minutes. Initial information regarding potential/identified risks, needs and reasons for police assistance being required will be shared.

If a more in-depth triage meeting is felt necessary the MHO / assessing doctor making initial contact with police, will co-ordinate the meeting, inviting relevant

partners including sector psychiatrist, ideally this would be at least a day prior to an emergency detention.

Focus of the discussion will be on how to effect entry to the individual's home address, relevant prior offending history and potential risks, the role of each organisation and arrangements for transport to hospital as safely as possible. Police will only transport an individual in exceptional circumstances and other means should routinely be organised by the detaining doctor.

Detention paperwork may be conveyed to the Duty Manager at the receiving Hospital: by the MHO or via SAS or Police who are attending the patient.

Situation B Patient detainable and danger to self and are actively refusing to assessment or transport.

Those who have assessed the patient as needing detention have a duty of care to the patient in this situation and should it be safe to do so, must stay with patient. This could be either the MHO or detaining doctor, in some circumstances both practitioners may be required to stay to ensure safety of all. If there is any risk of violence to the practitioners or relatives, the Doctor/MHO should get to a place of safety and call 999.

If the MHO / Doctor and ambulance are unable to persuade the patient to get into the ambulance, police can be contacted on 101 to discuss involvement and facilitation of transport of the patient to hospital. If police do not believe their involvement is appropriate or advise the necessity of a warrant, the involvement of sector psychiatrist and mental health officer in the procurement of warrants may be the most appropriate route.

Informing Receiving Hospital(s) Coordinating Charge Nurses

Doctor to inform Coordinating Charge Nurse of receiving hospital of detention and be advised by them of the admitting ward. Ambulance staff can convey detention forms and referral letter to hospital with the patient.

Transport

Detaining Doctor should arrange. Mode of transport should be informed by triage discussion and / or risk assessment.

Patient transport can be requested through the Flow Centre: 0300 0134 000. If time frame is greater than one hour, then a one hour ambulance is requested but whether this happens will be dependent on ambulance availability. A Private Ambulance may be the most appropriate option – Flow Centre will coordinate this if a possibility.

Contract taxis could be used to facilitate admission where risk assessed as safe to do so but a Clinician or MHO would need to travel with the patient to the receiving hospital.

Detaining doctor should speak with IHTT (East and Mid Lothian), ACAST (West Lothian) or Coordinating Charge Nurse at REH or other hospital base to discuss arrangements for nurse escort where required. It may be appropriate for the REH minibus vehicle to be used to convey patient to hospital with escort.

Appendix 11: Nurses' Holding Powers (MHCTSA, 2003) – updated 2015

Nurse's power to detain a patient pending a medical examination (section 299)

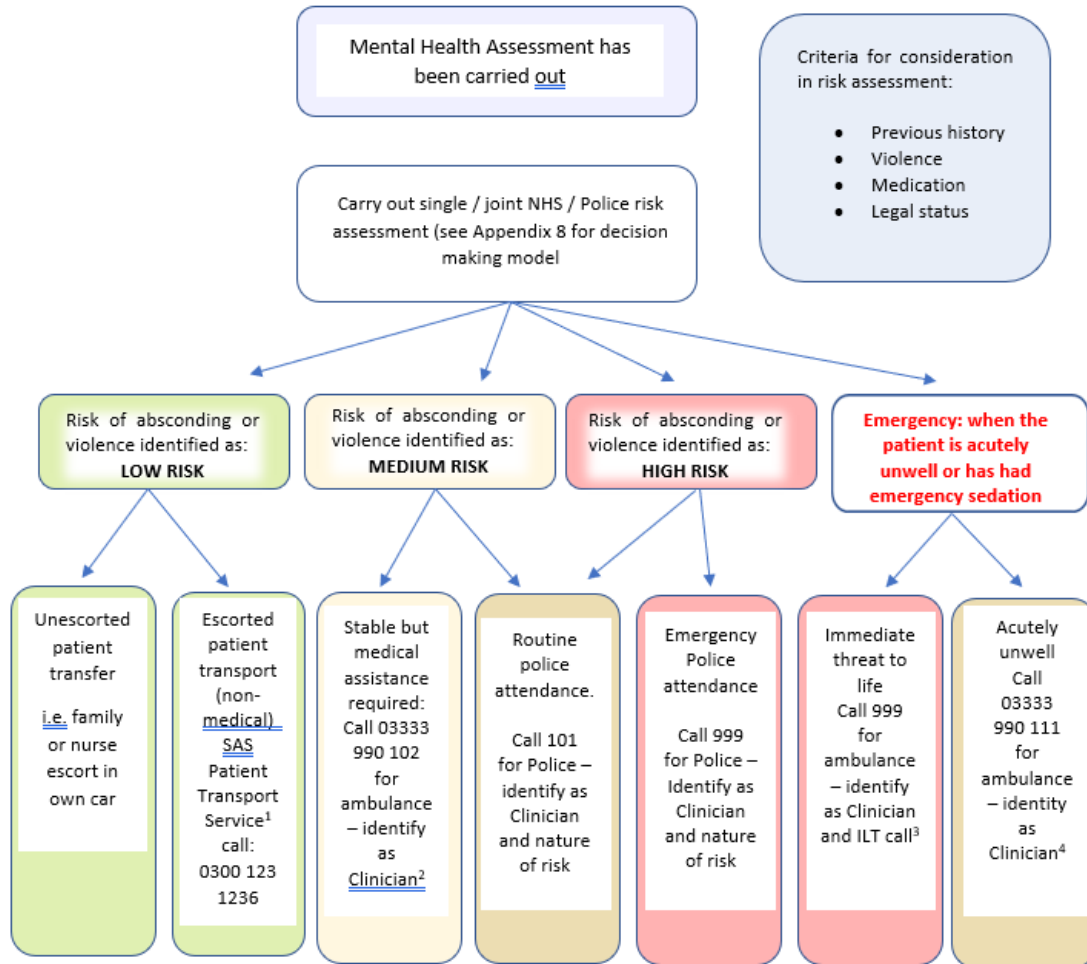
- 1 Section 299 of the Act empowers certain nurses to detain an informal patient who is in hospital receiving treatment for a mental disorder but that treatment is not being given by virtue of the Act or the 1995 Criminal Procedures (Scotland) Act. There is only one exception to this general rule: that is where the patient is subject to a community payback order with a requirement for treatment for a mental condition in terms of section 227A(1) of the 1995 Act. In hospital means within hospital premises, including general hospital wards, accident and emergency departments and clinics held on hospital premises.
- 2 Regulations under The Mental Health (Class of Nurse) (Scotland) Regulations 2005 provide that the nurse must be registered in Sub-Part 1 of the Nursing and Midwifery Order 2001 and their field of practice in Mental Health or Learning Disabilities nursing.
- 3 The patient can be detained by the nurse for a period of up to three hours ('the holding period') for the purpose of enabling arrangements to be made for a medical examination of the patient to be carried out. Best practice is that the medical practitioner should arrive as soon as practicable and that the detention period is as short as possible. As short a detention period as possible will best reflect the principles in Section 1 of the Act, in particular the principle of minimum restriction on the freedom of the patient that is necessary in the circumstances.
- 4 The nurse's holding power should not be used consecutively. If the nurse's holding period of three hours has elapsed without a medical practitioner attending, it would not be best practice to immediately re-detain the patient under Section 299 of the Act.
- 5 A patient may only be detained by a nurse where it is not practicable to secure the immediate medical examination of the patient by a medical practitioner and if the nurse believes that it is likely that the following conditions are met:
 - That the patient has a mental disorder
 - That it is necessary for the protection of the health, safety or welfare of the patient or for the protection of the safety of any other person for the patient to be immediately prevented from leaving the hospital.
 - That it is necessary to carry out a medical examination of the patient to determine whether an emergency or short-term detention certificate should be granted.
- 6 Before deciding whether or not to exercise this power, a nurse should weigh up the likely arrival time of a medical practitioner against the likely intention of the

patient to leave. Many patients who express a wish to leave hospital will, after discussion, agree to wait until a medical practitioner arrives to discuss the options further. The nurse should also assess the likely consequences of the patient leaving hospital immediately, taking into account factors such as, for example, the harm that might occur to the patient or others, any recently received messages from relatives or friends, any recent disturbances on the ward, or any relevant involvement of other patients.

The nurse should also take into account the principles of the Act, including considering what action will be of maximum benefit to the patient, what will be the least restrictive action on the patient's freedom as is necessary in the circumstances, and the views of the patient and any carer. While encouragement to remain as an informal patient is often appropriate, the nurse should be careful that the degree of pressure on the patient does not amount to coercion or 'de facto detention'. This would occur if the patient feels that they are being told that they cannot leave, or the threat of detention is being used coercively. In such a situation, the use of the holding power would better protect the patient's rights, providing a legal basis for the detention, a time limit and a proper record.

- 7 Where a nurse does exercise the power, he/she should attempt to communicate to the patient as clearly as the situation will allow what is happening and the implications for them of the power. This may include that the purpose of the use of the power is to allow a doctor to attend and conduct an examination, how long the patient is likely to be detained under the power; the reasons for using it in the patient's individual circumstance, and how the use of the power protects the patient's rights.
- 8 The nurse who has exercised the holding power must take all reasonable steps to inform an MHO of the patient's detention as soon as practicable after the holding period begins. Although there would undoubtedly be value in the patient being assessed by an MHO with previous involvement in the patient's case history, priority should be given to securing an MHO assessment as quickly as possible. Hospital managers and local authorities should work closely together to ensure that nurses have the contact information for the duty MHO service readily to hand both during the day and out of hours. Informing an MHO as soon as practicable after the power beginning is of maximum benefit to the patient because of the importance of the MHO role in a detention certificate.
- 9 Although it would be best practice for the patient's existing RMO or another approved medical practitioner to carry out the medical examination, this may not always be possible. A pragmatic approach should therefore be adopted, particularly where the patient requires immediate medical attention. Should a more junior doctor carry out the medical examination, then the detention options, if detention is required, will necessarily be limited to the issuing of an emergency detention certificate.
- 10 The detention under Section 299 ends when one of the following occurs:

Appendix 12: Transportation Plan



¹Time given for pick up, may be quicker than call an ambulance

²1, 2, 3 or 4 hour response will be agreed

³8 minute response, blue lights / sirens

⁴Response is next available ambulance blue lights / sirens



**Scottish
Ambulance
Service**
Taking Care to the Patient

NOW
One or two hours
Within 4 hours

For patients who do not need immediate intervention but require transport within 1, 2 or 4 hours to provide a level of care not available in the current facility.



Ring **0345 602 3999**

What you must provide:

- Contact Telephone number
- Pickup/Drop Off Location
- Patient Condition/
Working Diagnosis

You will be asked:

- What is the reason for the admission/transfer?
- Does the patient need any equipment? ECG monitoring, carry chair etc?
- Does the patient require any medication? Oxygen, pain relief, fluids etc
- An approximate patient weight

For a scheduled patient transfer request or for a patient requiring repatriation from any geographical region.



Ring **0300 123 1236**

What you must provide:

- Pickup/Drop Off Location
- An approximate patient height/weight
 - Patient mobility?
- Any equipment required for transfer?
 - DNACPR Status?


If you require to cancel this booking please call **0800 389 1333**



Scottish Ambulance Service
Taking Care to the Point of Care

NOW
One or two hours
Within 4 hours

Where transfer is required for immediate (time critical) intervention or for patients who urgently require a level of care not available in the current facility

 Ring **0333 3990111**

Examples of specific pathways which may require immediate transfer:

Obstetrics emergency	Major Trauma
Life-threatening haemorrhage transfer	(Local Emergency Hospital or Trauma Unit → Major Trauma Centre transfer)
Diagnosed AAA	
Diagnosed STEMI for PCI	Hyperacute Stroke



We will then ask some questions around patient location, destination and weight.



Remote and rural immediate transfer requests

Inter-hospital transfer requests from remote and rural locations will be handled by the Specialist Services Desk to ensure that patients receive an appropriate escort and transport platform.

If you are calling from one of the following locations:

- Shetland
- Wick
- Skye
- Millport
- Orkney
- Inverness
- Fort William
- Arran
- Western isles
- Elgin
- Argyll & Bute
- Stranraer

and require an immediate Now transfer, please call:



ScotSTAR Emergency Line 03333 990 222

GUIDANCE

PLEASE EXPLORE PATIENT'S OWN TRANSPORT OPTIONS FIRST

➤ **Volunteer Driver**

Patients who need no assistance. Can mobilise independently with/without walking aids. Must be aged 16 or over.

➤ **Flow Centre vehicle**

- NHS bus and driver with CSW. Both are trained in manual handling, BLS etc
- O2 (4 litres) is available if requested at booking and must be pre-prescribed before the patient is picked up
- Wheelchair transfers are available (Please note that total weight, including chair, cannot exceed 25.5 stones for bariatric transfer and 22 stones for standard transfer)
- Can assist with the patient transfer to and from a chair and up stairs but will not 'lift' patient
- Ramp access for up to 4 steps (must be requested at the time of booking)

➤ **PTS (SAS Patient Transport)**

- Basic Life Support training and O2 availability AED (maximum 8 litres) on board
- Single patient journey available
- Access to radio to request assistance in case of emergency
- Will look to risk assess any scoop or stretchers with stairs that may not be able to fulfil on the day requests

➤ **Medical Ambulance**

- Ambulance Technician Crew
- Full emergency ambulance with the same capability as emergency crew but cannot intubate, cannulate or give IV drugs.

➤ **Emergency Ambulance**

- A crew of 2 Paramedics or 1 Paramedic and 1 Technician.
- Full emergency capability, including intubation, cannulation, IV management and drugs

➤ **Private Ambulance** (*arranged via Flow Centre*)

- Basic Life Support training and O2 availability AED (maximum 8 litres) on board
- Single patient journey available
- Out of area journeys available
- Escort required (Escort may be able to be provided by Private Ambulance)

➤ **Palliative ambulance**

- A crew of 2 with specialist training in palliative care
- Suitable for adults and children
- Stretcher/wheelchair or seated
- Mon–Friday – 9am–5pm

➤ **Out of Area ambulance**

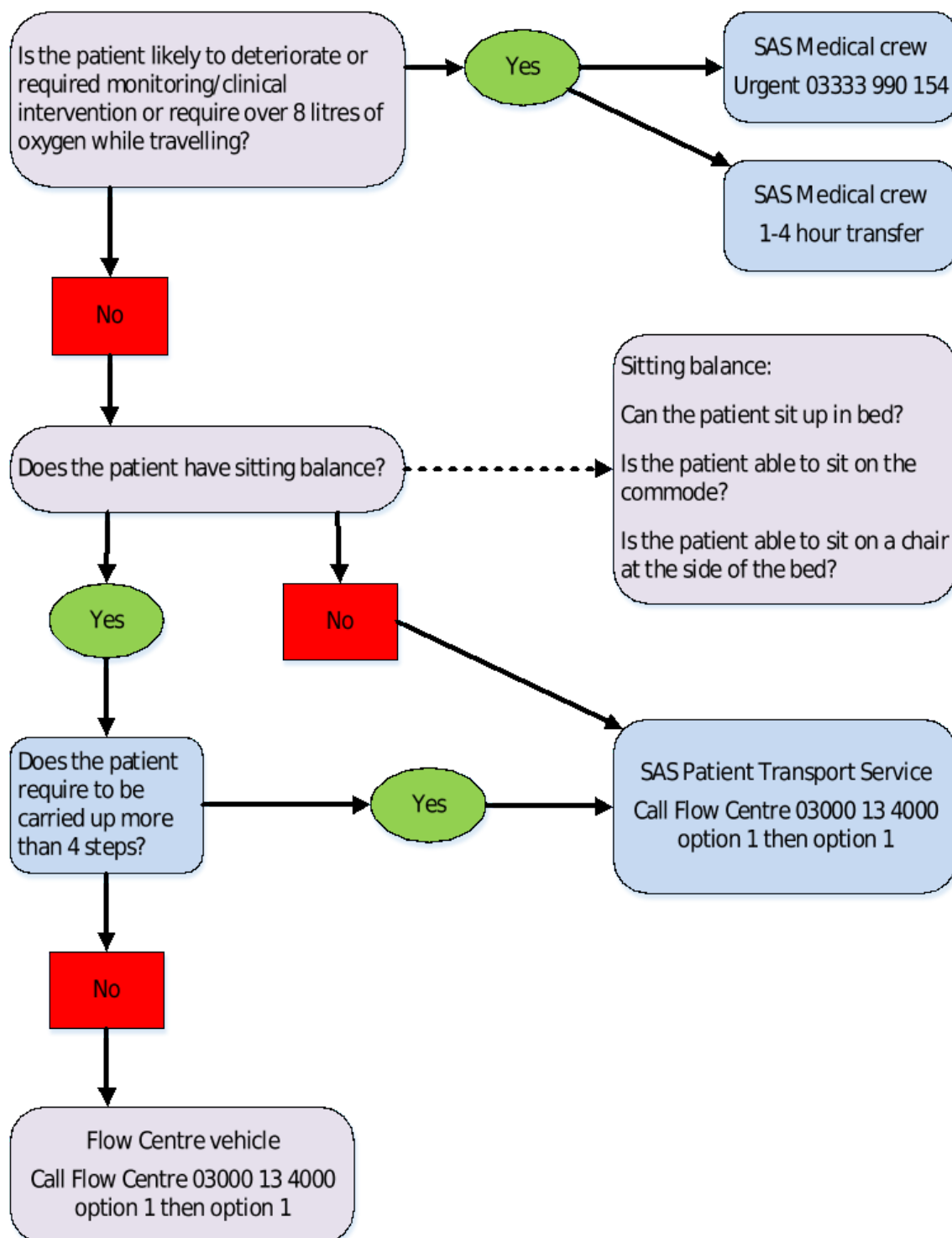
- Basic Life Support training and O2 availability. AED on board
- Crew of 2
- Pre-planned with a minimum of 48-hours notice and requesting the first date required. Out-of-Area requests are sometimes cancelled so, if transport becomes available, the patient may be offered transport at short notice.

QUESTIONS THAT WILL BE ASKED WHEN BOOKING PATIENT TRANSPORT:

<ul style="list-style-type: none">• Name• Hospital, Ward• DOB• DNAR status• Medical History• Mobility – independent/requires assistance of 1/assistance of 2/wheelchair dependent/two-person chair (carry)/Stretcher• Walking aids• Weight	<ul style="list-style-type: none">• Covid/respiratory concerns• Address, postcode• NOK contact• Access: how many steps to front door• Stairs in house• Key availability/key safe• Oxygen required• Discharge date• Preferred discharge morning/afternoon
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Appendix 13: Use of Taxis

In accordance with NHS Lothian Taxi Policy (2023), section 5.3.4 only under exceptional circumstances should a taxi be booked to transport a patient into a hospital site from their home address.



Before a taxi is ordered, the person requesting the taxi must have obtained authorisation from the approved authorising manager.

To minimise costs, staff authorising the taxi booking must ensure that the criteria described in section 5. Where the request does not adhere to the stated criteria, the Flow Centre staff will either book an alternative mode of transport or sign post the caller to an alternative. Further guidance is available in the Flow Centre's current Guidance for Transport Requirements [hyperlink to be added]

The Flow Centre may organise taxis to be shared where possible. Someone booking a non-urgent journey may be asked to delay or advance their journey by a reasonable time so that they may be able to share a taxi.

All taxi requests must be made via the Flow Centre on 03000 134 000 24 hours per day.

When a taxi is requested, the following information must be supplied:

- Full name and contact number of the person making the booking
- Name of the department/ward and hospital making the booking
- Cost Centre Number
- Full name of the person for whom the taxi is ordered, and reason for booking e.g. specimen collection
- Date and time for pick up
- Pick up location
- Delivery Destination
- Name of Authorising Manager

In addition, for the transport of patients:

- The patient's full name and CHI number
- Whether the patient is travelling with a DNAR form
- The patient's infection status
- The patient's mobility
- The patient's weight
- Whether the patient is travelling with an escort
- Taxi type required

A request will not be processed unless all the above information is available. In the event that the information is not available and there would be a detriment to patient safety the booking can be taken by the Flow Centre and costed against a generic cost code, where this can then be investigated and passed on the appropriate management team.

Cancellation of a Taxi Booking

Should a taxi no longer be required, staff must ensure that the booking is cancelled through the Flow Centre as soon as possible prior to the journey time. The Board will be charged by the taxi company for wasted journeys.

Appendix 14: Police Scotland - Note on use of PAVA spray



POLICE Scotland

WARNING RE USE OF PAVA SPRAY

This statement is to be read aloud to all officers at all briefings prior to carrying out duties at sporting/similar events.

As you know, when PAVA spray is discharged, people nearby, other than the aggressor, will become aware of its effects. This is what is known as cross-contamination’.

Although cross-contamination in itself is not in any way dangerous to other people, it will be unpleasant and they might try to move away from the affected area. Where use of PAVA spray takes place in the presence of a group of people, which may be a large group, you must be aware of the likelihood of this group or large group, moving away quickly, possibly with thought only for themselves. This may give rise to risk of injury to these people – even although such injury is not directly produced by the spray itself. In extreme circumstances the use of PAVA spray in such instances might produce a feeling of panic.

The benefits in using PAVA spray must be weighed with possible disadvantages of its deployment where cross-contamination may affect a group or large group of persons.

The use of PAVA spray by you, in accordance with your training, will always be with great care whilst on duty (at the stadium or at the event) and is to be used only as a final response option if no reasonable alternative is available. You are reminded that it is for you to justify use in connection with your response to officer and public safety.’

Appendix 15: Mental Health Act forms

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

[Mental Health law: forms - gov.scot \(www.gov.scot\)](http://www.gov.scot)

Emergency Detention Certificate

[DET+1+v7.1.pdf \(www.gov.scot\)](http://www.gov.scot)

Short Term Detention Certificate

[DET+2+v7.1.pdf \(www.gov.scot\)](http://www.gov.scot)

Form – NUR 1 Nurses Holding Power

[Nurse%27s+Power+To+Detain+Pending+Medical+Examination+-+NUR1+-+v7.0+12%C2%A0Jul%C2%A02017.pdf \(www.gov.scot\)](http://www.gov.scot)