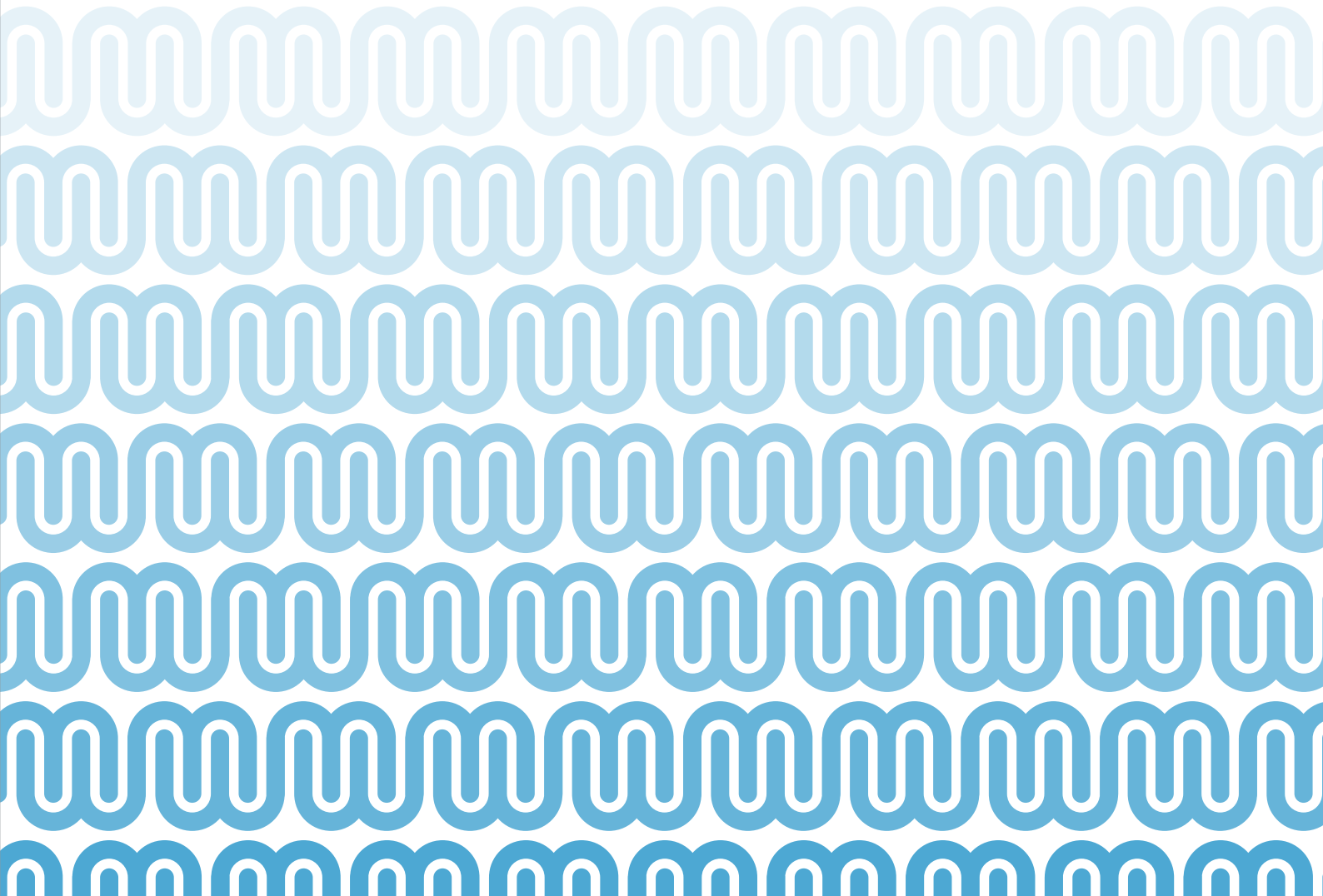
mental welfare
commission for scotland

A review of Psychiatric Emergency Plans in Scotland

25 June 2020



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

A review of Psychiatric Emergency Plans in Scotland in follow up to the Mental Welfare Commission's Place of Safety Reports 2016 and 2018

Contents

Why we produced this report

In 2018 we completed the second of two reports on use and recording of Place of Safety (POS)[1,2]. We consulted with Police Scotland and patient and family carers and collected their experiences of how mental health crises are managed. One of the key recommendations which emerged from our review of Place of Safety Orders was the need to have Psychiatric Emergency Plans (PEPs) which are reviewed regularly by health boards and at least every five years. Comprehensively developed and locally relevant PEPs are recommended by the Mental Health Act Code of Practice[3] (Vol 2 para 58) as a means to help manage the detention of a patient and aspects of multi-agency working. They are also referred to in the Police Scotland Standard Operating Procedure[4] for dealing with patients who present in mental health crisis. Nationally, one of the strategic priorities for the Health and Justice Collaboration Improvement Board, is to focus on mental health and substance use in their drive to improve health and wellbeing in justice settings[5] which in turn builds on the actions contained within the Mental Health Strategy for Scotland in responding to people in mental health crisis[6].

In follow-up to this work in 2019, we contacted every health board in Scotland to request a copy of their PEP and subjected each PEP to detailed review and this report summarises our findings.

[1] https://www.mwcscot.org.uk/sites/default/files/2019-06/Place%20of%20safety%20report%202018_0.pdf
[2] https://www.mwcscot.org.uk/sites/default/files/2019-06/place_of_safety_monitoring_report_2016_0.pdf
[3] https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-2-civil-compulsory-powers-parts-5-6-7-20/pages/8/
[4] https://www.scotland.police.uk/assets/pdf/151934/184779/mental-health-and-place-of-safety-sop
[5] https://www.gov.scot/publications/justice-vision-priorities-delivery-plan-overview-progress-2017-18-new/pages/6/
[6] https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/2/

What we did

We drew up a template[7] outlining content we think would be helpful for inclusion in a psychiatric emergency plan (Appendix A). We included subjects important to patients and carers as reported to us in the consultation phase between the 2016 and 2018 place of safety monitoring reports. The consultation included hearing the views of 172 individuals from across Scotland. We also consulted representatives of Police Scotland, Scottish Ambulance Service, NHS Emergency Departments, and practitioners with experience of NHS and social work services in developing the template.

We identified 14 broad themes which we felt were of priority for a PEP:

1. Initial contact
2. Place of Safety
3. Alcohol and Substance Misuse
4. Transport
5. Resolving Disputes
6. Assessment
7. Sharing Information
8. Missing Patients
9. Young People
10. Carers and Patients with Caring Responsibilities
11. Homelessness
12. Learning Disability and Autism
13. Aftercare
14. Use and Relevance of PEP

For each theme we created a set of questions which reflected the priorities of those we consulted. We then reviewed the most up-to-date PEPs provided to us from all 14 Health Boards to assess whether they addressed each question in our template. We describe our overall findings under the 14 themes and have summarised them in a table in Appendix B and in Graphs in Appendix C. In addition, each Board has been provided with an individualised overview of their PEP, outlining positive aspects of the PEP and where we think improvements could be made when next reviewing their PEP.

[7] https://www.mwcscot.org.uk/node/1475

Themes and questions

1. Initial Contact

"Is it clear who a first responder or a carer should contact if they discover a patient in a mental health crisis?"

Eleven out of the 14 health boards addressed this within their PEP whilst three did not.

In consulting patients and carers in follow up to the 2016 POS report we learned that carers were often unaware of who to call or where to go when seeking emergency help for their loved ones. As a result it is important that any PEP makes it clear who a carer or first responder should contact if they are made aware of a patient in a mental health crisis.

"Are there suitable services that a patient can self-refer to in crisis? Are there services where they can access face-to-face support when appropriate?"

Eight health boards addressed this whilst six did not.

A key component of well-functioning Community Mental Health Services is the ability to effectively respond to individuals in crisis, especially out of hours. This would seem much needed since people with lived experience of mental illness told us that they often have no idea how to get help in crisis. A clear theme which emerged was that pressure on beds and community services can make it difficult to access help in crisis. Individuals with lived experience of mental illness told us that crisis services are highly valued where available, as is access to peer support. In order to ensure a suitable response to individuals in crisis we felt it important to include details of available services within the PEP.

"Is there a description of a clear predictable response to crisis and evidence of crisis care planning?"

Eight health boards addressed this whilst six did not

Access to anticipatory care plans or key information summaries has been highlighted as important by Emergency Department staff. Likewise, patients and carers reported that crisis planning could be helpful, for example, the likelihood of crisis could be predicted and catered for in a more planned way at trigger times such as anniversaries of children having been taken into care. Some people suggested the use of crisis cards that would alert the police and others to know they have mental health problems and indicate who could be contacted. Some suggested that advance statements may be a good tool for the police to be aware of and access in crisis and some wanted to see crisis plans made more widely available.

"Is there appropriate triage and offer of appropriate support to address presenting problems which may not at their outset be diagnosable mental health presentations?"

Three health boards addressed this whilst 11 did not.

One of the key strategic aims of the Scottish Government Mental Health Strategy 2017-2027[8] is to improve access to treatment and joined up accessible services; similarly one of the strategic priorities of the Police and Mental Health Collaboration is to ensure that people are entitled to the right help at the right time. Patients and their carers told us in our consultation that they may be shuttled by the police between A&E and Crisis Services and hospital with no one being willing to take ultimate responsibility for the person's care.

In our 2018 Place of Safety Monitoring Report we were struck by how few people taken to a POS went on to be detained under the MHA, with 79% having had no MHA orders in the period of two months before and two months after the POS[9]. Whilst it may be that they went on to access psychiatric treatment informally or at home it is also worth highlighting that not all presentations have as their cause a diagnosable mental illness, for example individuals might present in crises due to homelessness, substance misuse, domestic violence or a wide range of other difficulties. Patients presenting in crisis need to be able to access appropriate support whether this be mental health or other services. We consulted a representative of Emergency Medicine staff who highlighted A&E's increasing concerns of over-medicalisation of distress and the need for appropriate triage and access to appropriate supports, including 'persons of safety'.

"Have services ways of responding to crisis that minimise the need for police intervention?"

Eleven health boards addressed this whilst three did not.

One of the strategic priorities of the Police and Mental Health Collaboration is to ensure that no individual should be criminalised or stigmatised because of their mental health distress. Individuals with lived experience of mental illness told us that police were increasingly the first port of call for people in crisis with carers and third sector services often being told to call police rather than expecting CMHTs to be able to respond to crisis. Whilst it may sometimes be necessary and appropriate for police to be involved, individuals with lived experience of mental illness did highlight that they can feel criminalised when the police are the principle agency dealing with the crisis. We are aware following our work in preparation of the Place of Safety Monitoring Report 2018 that police in general offer considerable care and professionalism towards often highly distressed individuals, however it is important that there is a clear pathway for patients in crisis which reduces reliance on a police response where other services could respond.

"Is there a clear explanation of powers to gain entry to a patient's home which includes joint police and NHS risk assessment prior to taking action with consideration for minimising risk and distress caused by deteriorating health (with reference to and explanation of: Mental Health Care and Treatment Act 2003 Section 35 Warrant, Section 292 Warrant, Section 293 and 294 Removal Orders, Application of common law in situations of immediate risk)?"

Eleven health boards fully addressed this area whilst three did not.

[8] https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/6/
[9] https://www.mwcscot.org.uk/sites/default/files/2019-06/Place%20of%20safety%20report%202018_0.pdf

We felt that as part of a PEP it would be important to describe applications of the Mental Health Act and common law in respect to gaining entry to a patient's home. Police Scotland cannot force entry to a patient's home without a warrant unless there is immediate risk to the safety of a person within or damage to property. In consultation with the police they stressed to us the importance of a joint risk assessment prior to executing any warrant or order so that an appropriate response can be given which ensures the safety of all involved whilst acting in keeping with the principle of least restriction necessary to minimise stigma and potential criminalisation.

"Is there clear guidance on the role of police which minimises as far as possible the use of force and restraint and ensures they should keep a low profile and avoid criminalising the patient?"

Eleven health boards addressed this area whilst three did not.

People with lived experience told us that they can feel criminalised when the police are the principle agency that deals with them when in crisis. Furthermore involvement of the police can be confusing and bewildering to people who are acutely ill and the police response can feel traumatic. It is therefore vitally important that Psychiatric Emergency Plans emphasise the importance of police keeping as low a profile as possible.

"Does the PEP emphasise sensitive and empathetic responses to patients in crisis? Does the PEP emphasise the need for compassionate non-judgemental care by all professionals involved?"

Twelve health boards directly addressed this area whilst two health boards did not.

During consultation with patients and carers, a key area for them was avoiding over criminalising patients. Some people felt that A&E departments could appear judgemental towards people with a mental illness.

"Is there a plan for prompt provision of AMP/Medical practitioner and MHO out of hours and what their responsibility is?"

All 14 health boards addressed this area.

In order to ensure a safe and adequate response to patients in crisis it is necessary to ensure access to MHOs and medical practitioners for timely detention under the mental health act where appropriate.

2. Place of Safety (POS)

"Is there a clear and appropriate place of safety specified which provides adequate privacy?"

All Health Boards had a clearly defined place of safety but none described the privacy or comfort of places of safety.

Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 confers on the police a power to take a person who appears to be mentally disordered and who appears to be

in immediate need of care or treatment to a place of safety and to detain them there for a period of up to 24 hours. There is an obligation on all relevant local agencies to work closely together to ensure the provision of sufficient places of safety within their localities. Only under exceptional circumstances may a police station be used where a police constable has removed a mentally disordered person from a public place under section 297 of the Act and where no place of safety is immediately available.

Since individuals are presenting in potentially highly distressed states and given that they may have to wait for some time in a place of safety during the assessment process we feel it is vitally important that these places of safety are comfortable and offer appropriate levels of privacy. Police have told us that when they take a patient to a place of safety where they have to wait in public waiting areas with the patient, this leads to perceived criminalization of distress where the public often assume the patient has committed a crime.

"Are there clear guidelines on when each place of safety is appropriate (for example A&E may be a separate place of safety to a Psychiatric Hospital with different criteria for presenting to each)"

All health boards addressed this area.

Some health boards had A&E as one place of safety as well as a separate psychiatric hospital site. We felt that in these cases it would be important to include guidance on which place of safety should be used under which circumstances. The Police SOP highlights that where a person requires immediate medical attention this must take precedence and is a separate issue from the mental health process. An ambulance should be summoned for their conveyance to hospital. We felt it would be important that any psychiatric emergency plan should make it clear when each place of safety should be used.

"Are there clear guidelines for when police should be dismissed and pass responsibility to staff at the place of safety for the welfare of a person taken there for assessment?"

Four health boards had clear appropriate guidance, eight health boards did not address this area at all and two health boards did have guidance but this did not include any joint risk assessment and shared decision making process.

The Police SOP advices "A joint risk assessment process should be carried out by police and NHS staff at the place of safety to ascertain whether or not the relevant person is of risk to themselves or any other person or can be left in the care of NHS staff without police remaining". However we are aware from our 2016 Place of Safety Monitoring Report that often a large amount of police time is involved awaiting the patient's assessment. We recommended that NHS Boards, Integrated Joint Boards (IJBs) and Police Scotland should review processes to reduce delays in assessments, both to reduce time spent waiting by the police and to reduce distress to individuals. Given what we know from patient and carer consultation regarding the potential for feeling criminalised by police presence it is important that there is clear guidance on ensuring police are not involved when they do not need to be.

"Is there a clear procedure for transfer to the most appropriate care facility of a patient from police cells where this has been used as a place of safety but there are no criminal charges?"

Eight health boards addressed this area however six boards did not.

Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 stipulates that "On any rare occasion where a person is held in a police station instead of a place of safety, it would be expected that the person be moved on to a suitable place of safety as swiftly as possible under the circumstances." It would therefore be important to ensure that protocols are in place for the timely transfer of patients out of police cells. We recognized that there may be more detailed guidance within specific protocols for management of people with mental illness in police cells however we felt it would be important to include a clear plan for transfer out of Police cells on the rare occasion they are used as POS and no crime has been committed.

"Is there clarity about the difference in powers and roles of the British Transport Police compared with Police Scotland?"

No health boards addressed this area.

We were aware that British Transport Police have some variations in practice from Police Scotland. We felt it would be important to include consideration of their unique experience within any PEP. This would assist in understanding variations in application of the law given that for example trespassing on a railway line with intent of ending life might be considered a crime by British Transport Police, in similar circumstances where an individual is intent on ending their life on a road, Police Scotland will intervene but may not respond as if this were a crime.

3. Alcohol and Substance Misuse

Is there clear and consistent guidance on when a patient is too intoxicated for assessment which can be agreed by all parties and is not based on arbitrary cut-offs such as blood alcohol concentration?"

Five health boards addressed this area whilst nine did not.

Following our 2016 Place of Safety monitoring report we recommended that NHS services and professionals should not refuse to assess people presenting in crisis for their mental health needs solely on grounds of intoxication. The police standard operating procedure states that "where a person who has consumed alcohol or drugs, appears to answer questions with full understanding of what is being asked of them, it may be assumed that person is able to undertake some form of mental health assessment". We are aware however from consultation with police that at times there can be difficulties when health services have refused to assess people based on the outcome of a breathalyser test, this being in conflict with Police SOP. It is important that a PEP gives clear guidance on determining whether a patient is fit for psychiatric assessment, but this decision should be based on the patient's presentation rather than any arbitrary measurements and where possible local agencies should work to the same criteria.

"Is there guidance which explains the need to consider that an intoxicated patient may have underlying distress or other feature of mental or physical ill health needing urgent treatment?"

Four health boards addressed this concern, a further 10 did not.

Individuals with lived experience of mental illness raised concerns that people had been mistaken as drunk when ill. Whilst often there may be underlying mental illness which is driving a crisis presentation patients may be refused assessment or support because they are intoxicated. We were concerned that certain patient groups such as those who are dependent on alcohol or substances may be denied access to the help they need because they often present intoxicated and underlying acute mental illness is missed.

"Is there clarity of responsibility for intoxicated patients in mental health crisis which includes a plan for what to do when a patient is too intoxicated to be assessed?"

Four health boards addressed this concern, a further 10 did not.

Whilst individuals presenting intoxicated may not be fit for assessment, it would nevertheless be important to ensure that when they are able to be assessed they can be offered appropriate supports. We are aware that when a patient cannot be assessed due to intoxication there may not be a place for them to wait until they are fit for assessment. There is a risk that this could lead to criminalisation of patients who are then taken to police cells in the absence of alternatives. The police SOP highlights that: "it may be difficult for police officers to know whether a person, under the influence of alcohol or other substance, has a mental disorder as intoxication may mask mental health issues. Officers should not see the Police Custody Centre as the obvious solution to the person's care and welfare".

Some health boards did provide a pathway for patients who are intoxicated to ensure they receive appropriate follow-up when able to be assessed. Many however did not address this concern. We noted that some health boards relied on a plan to find an appropriate family member or friend to support the patient but struggled to define a plan where no one was available. We felt that whilst use of informal carers in this situation might be the most appropriate, least restrictive option and preferable to police custody it would also be important to ensure informal carers are not being put in a position where they are dealing with situations they feel unable to manage.

4. Transport

"Is it made clear what mode of transport should be used and under what circumstances? (This could include reference to police van, ambulance, private car or taxi with staff or with family). Does this guidance take into consideration the principles of reducing stigma and taking the least restrictive option?"

All health boards addressed this area.

An important aspect to any PEP is ensuring that patients are appropriately transported to hospital. It is important that the patient is kept safe however the least restrictive option should always be used. Police vehicles should not be used to transport patients to hospital except in circumstances where no other vehicle would be safe.

"Is there provision for transport of an informal patient which is supportive and with financial provision where necessary?"

Two health boards fully addressed this area, three addressed it to some degree but did not suggest financial support for patient or informal carers, nine did not address the area of transport for informal carers at all.

We are aware that informal carers can be heavily involved in supporting their loved ones. Sometimes it may be appropriate for an informal patient to travel independently or with an informal carer into hospital or for assessment. Whilst this may be the least restrictive and best option in some circumstances we felt it important to ensure consideration is given to potential financial difficulties particularly when travelling long distances or potentially using expensive public transport options. In these circumstances we thought it might be reasonable to offer a mechanism for obtaining financial support for travel where necessary and to include guidance on this within the PEP.

"Is there clarity of each professional's role in the transport to hospital of a distressed patient? Is there clear guidance on use of force where appropriate and who is authorised to do this? Does guidance include use of force when a patient passively resists transport to hospital?"

All health boards defined roles of each professional involved in detaining a patient in the community. Thirteen included guidance on the use of force and only one health board did not. However only six health boards included guidance on use of force in cases of passive resistance.

In addition to the use of least restrictive transport available, consideration needs to be given to the role of each professional in the process. Scottish Ambulance Service highlighted the need for clarity of responsibility in this. The police standard operating procedure advises that "a police officer can restrain a person to prevent the commission of a crime or in order to prevent injury to themselves or to another person." In certain circumstances therefore it will be most appropriate that police act to restrain the patient to prevent harm. There may however be other circumstances, such as when a patient passively resists admission to hospital by refusing to move, without threat of violence, when it would not be appropriate for police to intervene. In these circumstances, it is important that police involvement is kept to a minimum and that there are other appropriately trained individuals present to support the patient to hospital using force where necessary.

We noted that a few health boards seemed to rely overly on Police Scotland for any physical restraint. Two health boards included in the PEP reference to a police role in the restraint of a passively resisting patient. It is important that these PEPs are reviewed since this is not offering the least restrictive option to the patient and police restraint is potentially stigmatising and traumatic.

"Is there a safe and appropriate plan for transportation of an intoxicated patient who may require medical intervention?"

Two health boards addressed this area whereas 12 did not.

We felt it would be important to consider the safe transport of an intoxicated individual presenting in crisis. This would include consideration of circumstances when an ambulance would be the only safe option for transport or circumstances where police transport may be more appropriate if the individual was violent but not intoxicated to the extent of requiring ambulance level supervision during transport. We felt this was relevant to a psychiatric

emergency plan since intoxicated patients often present in crisis and require the coordinated approach of police, ambulance service and psychiatric services.

"Are there guidelines for administering medication to a patient in the community (this should detail whose responsibility and under which circumstances and make it clear that police should not be involved in any restraint for the purpose of administering medication)"

Nine health boards addressed this issue but five did not.

Police have stressed to us that they cannot restrain a patient for the purpose of giving medication but occasionally they have been asked to do so when attending a psychiatric emergency. They were keen for clarity on this within PEPs. The police SOP states "A police officer can restrain a person to prevent the commission of a crime or offence or in order to prevent injury to themselves or to another person but not solely for the purpose of allowing medical staff to administer medication". Additionally, patients who have been sedated require medical monitoring and therefore must be transported by ambulance. The police SOP highlights that "Police officers will **not** transport a person suspected of having a mental disorder where the person has been sedated"

"If journey to a place of safety may be complicated (e.g. boat or air travel) is consideration given to the patient's privacy and comfort and is it clear whose responsibility it is to organise and carry out escorted transport?"

Two health boards had clear plans in place which did not involve public transport options, two health boards had clear plans but did not detail how privacy and comfort needs were met, one health board's PEP did not contain detail when we identified that it would be relevant and one did not contain details but referred to separate guidance which we did not have access to but which may have included more detail. The remaining eight health boards did not require such arrangements to be included since boat or air travel was not relevant to their health board area.

We noted that some health boards covering remote areas had to transport individuals in crisis by long and complicated journeys involving travel by air or sea. In these cases there were generally clear and comprehensive travel arrangements described within the PEP. We were not able to establish from the PEP whether using these transport arrangements afforded adequate privacy and comfort. In circumstances when public ferry or chartered flights are used it would be important that the patient has access to a private room or quiet seat to avoid stigma, particularly if they are visibly distressed or traveling with police escort.

"Is there a clear plan for onward travel of a patient following initial assessment at POS and which agency is responsible for this? (Including transfer A&E to psychiatric unit, transfer between psychiatric units, organising transport home where appropriate)"

Nine health boards addressed this area but five did not (one of which referred to escort guidance elsewhere).

Once a patient has been assessed at a Place of Safety the outcome might commonly involve transfer to an alternative care facility. It would therefore be important that there is a clear plan for transport in these circumstances and clarity of responsibility.

5. Resolving Disputes

"Is there a clear plan for what to do when there is a disagreement between professionals? Does this include a plan for timeous resolution and subsequent review for MHOs, AMPs, Medical Practitioners, SAS, Police Scotland, other healthcare staff?"

Two health board addressed this area but 12 did not.

When reacting to an individual in mental health crisis multiple professionals from different agencies may be involved. In such circumstances if there is lack of clarity about respective roles there is a high risk of misunderstandings, and disputes arising between professionals. It is important that disagreement about professional roles is addressed appropriately at reviews and later multi-agency discussions however having clarity about what should happen in an emergency situation will prevent any negative impact on patient care and outcomes.

Many health boards referred to resolving clinical disagreements between GPs and Approved Medical Practitioners or Medical Practitioners and MHOs however only two included an escalation plan which covered all professionals potentially involved in responding to a mental health crisis.

6. Assessment

"Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order requires that the individual subject to the act be taken to POS for the purpose of assessment by a medical practitioner. Does the PEP make it clear who has responsibility for carrying out this assessment at the place of safety?"

Twelve Health Boards Addressed this area but two did not.

When Place of Safety Legislation is being used, section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 clearly states that "the purpose of this detention is to allow a medical practitioner to examine the person and to make arrangements for their care and treatment". During our consultation with patients and carers we learned that sometimes there can be disagreement over who is responsible for assessing patients. This can lead to the experience described by patients of being shuttled by the police between A&E and Crisis Services and hospital with no clinical team being willing to take ultimate responsibility for the person's care. It is therefore vitally important that there is clarity as to who is responsible for assessment at the Place of Safety.

"Is there an outreach service for people when there are concerns about their mental state which prevent them accessing regular services prior to them presenting in acute crisis?"

Four health boards addressed this area but 10 did not.

Whilst the purpose of PEPs are to outline guidelines for responding to psychiatric emergencies an important consideration is also ensuring support is available which could prevent escalation to a psychiatric emergency in the first place. Carers reported difficulties accessing support when their loved one was not yet unwell enough to present in acute crisis but nevertheless there

are significant concerns about their mental state. Some health boards addressed this area, mostly through the 'duty to enquire' which the local authority hold when concerns are raised about a patient. More clarity about access to services and pre-emptive care plans could be helpful here.

"Is there clear guidance on when the police should stay during the waiting time for and duration of assessment with reference to a joint risk assessment of the situation?"

Six health boards addressed the issue of when police should stay with a patient brought for a mental health assessment but eight did not. Four health boards referred to making a joint assessment of the situation to enable such a decision to be made but 10 made no reference to joint risk assessment and decision making.

The Police SOP addresses the role of the police where they are asked to support partners in undertaking their duties relating to 'psychiatric emergencies'. It places particular emphasis on the value of joint assessment stating, "A joint risk assessment process should be carried out by police and NHS staff at the place of safety to ascertain whether or not the relevant person is of risk to themselves or any other person or can be left in the care of NHS staff without police remaining". Provision exists for police to remain throughout the assessment if that is deemed necessary but it must be explicitly justified by NHS staff and recorded by police.

"Are services trauma-informed and sensitive to needs such as to see a specific gender of professional to reduce distress? Are there services appropriate for patients with Emotionally Unstable Personality Disorder?"

None of the 14 Health Boards addressed the need for emergency psychiatric services to be trauma-informed, or to be able to draw on or direct individuals with a known diagnosis of emotionally unstable personality disorder to appropriate local services.

Having system-wide services which are trauma informed[10] is a Scottish Government priority supported by NHS Education Scotland. People presenting in a psychiatric emergency may benefit from having contact with trauma-informed staff in the acute setting.

"If someone is waiting a long time to be assessed are they in a pleasant environment and are they being supported? Is there respect for confidentiality and consideration of minimising any potential stigma?"

Two health boards addressed this area but 12 did not.

Individuals with lived experience of mental illness and carers of individuals with mental illness have very clearly told us of the importance of being assessed in an environment which is pleasant and with a supportive approach. They see this as key to minimising distress to individuals and reducing the trauma experienced by individuals in these circumstances.

[10] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx

7. Sharing Information

"Is there a clear pathway for sharing information which incorporates new GDPR guidance and which includes circumstances when information must be reviewed and shared?"

Ten health boards addressed this area but only four referred to new GDPR guidance. Four did not include any guidance on sharing information between organisations.

The Police and Mental Health Collaboration have included as one of their strategic priorities that "no users should suffer harm due to the organisations' failure to share their information with partners within legally permitted boundaries." This was also raised as a key area in consultation with service users for our Place of Safety and help in Crisis Report who highlighted that some services do not have enough information on people who present in crisis. We therefore felt that any PEP should include a clear pathway for sharing information which would require to be up to date with latest guidance on data protection.

"Is there reference to the duty to share information (as in Caldicott Principle 7: 'the duty to share information can be as important as the duty to protect patient confidentiality') Does guidance include the need for sharing any information which may inform aftercare between professionals including police and health workers and for all parties to collaborate in this with the best interests of the patient as a priority?"

Seven health boards addressed this area but seven did not.

In addition to sharing information to inform risk assessment and management plans for professionals, sharing information between professionals regarding after-care is also of key importance. Police highlighted the importance of information sharing particularly when a patient is being discharged by health services. Police highlighted that there is sometimes the expectation that if the patient is not admitted to hospital then they will automatically be taken to police cells. Police highlighted the importance of all parties being involved in discharge planning which ensures adequate risk assessment and does not assume an individual will automatically remain in police custody if discharged from health services. The police Standard Operating Procedure highlights that there is a responsibility on the police to consider an individual's safety and welfare even after assessment at POS and any role police may have in keeping the individual safe. It is therefore vital for them to have information from mental health professionals following assessment in order to inform their onward plans for the support of the individual.

"**Is there a system in place to ensure advance statements are available at the time of mental health assessment?"**

Eleven health boards addressed this area but three did not.

Section 275 of the Mental Health (Care and Treatment) (Scotland) 2003 Act requires that any person giving medical treatment under the act shall have regard to the wishes specified in an advance statement. Given the relevance this could have during any psychiatric emergency presentation it is important that reference to advance statements and how to access them is included within a PEP.

"Is there a system in place to establish named person and for them to be consulted?"

Eleven health boards addressed this area but three did not.

It is important that there is explanation of the role of named person, the duty to establish if there is one and to contact them given that there is a legal requirement to do so within the Mental Health (Care and Treatment) (Scotland) 2003 Act.

"Is there a system in place to ensure professionals access any anticipatory care plan or key information summary which can inform any assessment and appropriate management?"

Six health boards addressed this area but eight did not.

The use of crisis care planning and access to any anticipatory care plans or key information summaries was highlighted both by patients and their carers and by Emergency Department representative as being particularly important. Some individuals with lived experience of mental illness suggested the use of alert cards to explain their diagnosis to professionals and help them adapt their approach accordingly.

8. Missing Patients

"Is there a clear plan which covers procedures if a patient absconds from hospital prior to assessment or after assessment or during inpatient stay and when to alert/ involve police?"

Eight health boards addressed this area but six did not.

The police Standard Operating Procedure states if a voluntary patient is reported missing, police have no powers to return the person to the hospital, unless they are in mental health crisis. It is important therefore that a psychiatric emergency plan should include consideration of the circumstances and risk assessment and role for police when a patient absconds, particularly since it may not automatically be possible for them to be found and returned by police.

"Is there clear guidance on unwell patients in the community, and reference to appropriate use of Mental Health (Care and Treatment) (Scotland) Act 2003 Section 35 warrant, Section 292 Warrant and Section 293 Removal Order?"

Nine health boards addressed this area but five did not.

In addition to patients absconding during the assessment process or absconding from a period of inpatient treatment, we felt it would also be important to include a plan for managing a patient about whom there are concerns in the community who cannot be found. This would include guidance on the use of warrants and removal orders and role for police and use of missing person protocols.

9. Young People

"Is the definition of young people clear including definitions in differentiating circumstances such as school leaving age, young people in care?"

Eight health boards addressed this area but five did not have any reference to young people within their PEP. One health board made no specific reference to young people in their psychiatric emergency plan but did refer to a separate document which addressed the needs of young people.

According to the Mental Health Act (Care and Treatment) (2003) a child is defined as anyone under 18 years of age (see section 2 of the Act). There are variations in local policies and services available depending on the young person's circumstances, for example a 17 year old no longer in full time education may be expected to access adult services whereas a 19 year old within the care system may remain in some respects the responsibility of child services. It will therefore be important that there is clarity on how a young person is defined within the health board as this will have important implications for accessing services.

"Is there clear guidance on removal of a child or young person to a place of safety and is there an appropriate place of safety for young people?"

Nine health boards addressed this area although often place of safety was A&E and so not specifically a child-focused service. Five health boards did not address this area.

Following consultation with some young people and their families we were aware that there can be limited access to specialist services for young people but that awaiting assessment can feel frightening and intimidating to young people. In addition, police highlighted particular considerations in transporting young people to a place of safety such as the need for appropriate transport and family support.

"Is it clear who is responsible for the assessment and ongoing care of young people presenting in crisis and is the responsible professional adequately trained to deal with young people?"

Nine health boards addressed this area although often the person responsible was a general trained psychiatrist or mental health practitioner. There were generally clear pathways for admission and ongoing care of young people presenting in crisis who required inpatient care. Six health boards did not address any aspects of the care of young people specifically.

Young people and their families felt that young people have access to limited services, and their families can be told by CAMHS to call 101 when their children cannot cope. It is important that there is clarity of responsibility for the assessment and care of young people and that professionals have specific training in the needs of young people to avoid situations where young people and their carers are unsure of how to access help or feel their behaviour is at risk of being criminalised by over-involvement of Police.

"Are there appropriate local inpatient and community services specifically for young people?"

Seven health boards described outpatient Child and Adolescent Mental Health Services which young people could access in crisis. These health boards all defined clear plans for admission

and specialist care although sometimes this could be out with the health board area or in an adult ward with specialist CAMHS in-reach. Seven health boards did not address this area.

Young people reported that they were often dealt with by adult services when in crisis and that they could feel isolated at home and at school with few services to support them and therefore become more vulnerable. Young people should have access to services appropriate to their needs. When there are no services locally there needs to be specific consideration within the PEP for how to overcome difficulties in supporting young people in crisis appropriately.

"Is specific consideration given to young people in care and their and their support staff's needs?"

Only one health board addressed this area. Two health boards referred to separate guidance specifically on young people which may have included this patient group but we were unable to review. 11 health boards made no reference to this patient group.

The Scottish Government's mental health strategy includes specific consideration of the needs of looked after children. One aim within the strategy is to "ensure that the care pathway includes mental and emotional health and wellbeing, for young people on the edges of, and in, secure care". We found in consultation with staff from specialist services for young people who are in care that it can be difficult to access help for young people in care and staff worry that they may lose out on the care they need. We therefore suggest that a PEP should include specific pathways to ensure that staff working with young people in care can access support for them.

10. Carers and Patients with Caring Responsibilities

"Is there a clear plan for who is responsible and what duties there are in relation to dependents of someone being taken into a place of safety?"

Nine health boards addressed this area but five did not.

Section 278 of the Mental Health (Care and Treatment) (Scotland) 2003 Act stipulates that there is a "duty to mitigate adverse effects of compulsory measures on parental relations" when the mental health act is being applied. Additionally, when a person presents in mental health crisis even when use of the mental health act is not indicated there is clearly a duty to create a safe plan for dependents of the individual who presents in crisis. Parents with lived experience of mental illness told us that they can worry about accessing crisis support if they have child care responsibilities. Some told us that they had been detained by the police and their children had to cope alone at home.

"Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order stipulates that the nearest relative of the individual subject to the order must be informed of the use of the act. Is there guidance as to what information should be shared by each professional involved with relatives and carers and who holds this responsibility?"

Eleven health boards addressed this area but three did not.

Most health boards have given some consideration to information sharing with other professionals. There are additionally some situations when information must be shared with family members or informal carers. For example, there is a legal duty to inform the named person of the patient's admission to hospital when the mental health act has been used and police are required to inform an individual's nearest relative that they have been taken to a Place of Safety. We felt it would be important that a PEP includes clear guidance on what information should be shared with family members or informal carers and who holds this responsibility.

"Is there consideration of carer burden and other dependents when carers are relied upon for informal support?"

Only one health board addressed this area but 13 did not.

Carers have reported that they can feel alone and isolated when constantly supporting acutely unwell relatives. They can at times feel unable to support an individual in crisis and worry about their own health and that of other dependents in the house as well as the individual they are looking after. We therefore felt that a PEP should consider the issue of carer burden and ensure that when planning aftercare for a patient presenting in mental health crisis that there is consideration of the health and wellbeing of individuals caring for the individual and other dependents who may be at home with a patient being cared for in the community.

"Is it made clear that the informal carer does not have to look after the patient and that services are designed in a way that does not pressurise carers into caring for patients?"

No health boards addressed this area.

Carers also reported that they can sometimes be asked by the police to look after people in acute crisis because no other services will do so. They can feel they have no alternative since they do not want the police to take their loved one to police cells. We therefore felt it was of vital importance that the area of carer burden is addressed within a psychiatric emergency plan and that there is consideration of carer needs in planning patient care so that carers need not feel pressurised into caring for patients in an emergency.

"Is it made clear that the informal carer should be sufficiently supported and given the option of statutory services taking over care?"

Only one health board addressed this area, 13 did not.

Given reports from carers of anxieties and fears when they are caring for a loved one who presents in mental health crisis but is not admitted to hospital and given their sense of isolation at times, it is important that they have the support they need to be able to continue to offer support and to remain well themselves. In addition, carers' assessments and support services can ensure carers can continue in their role. Given the integral role informal carers can play in supporting individuals in mental health crisis it would be important to include consideration of support services for them within the PEP.

11. Homelessness

"Is there a direct referral route from homeless services to access mental health or other appropriate support for residents presenting in crisis?"

No health boards addressed this area.

During our themed visit to homeless people with mental ill health in 2017[11] we found that accessing services can be particularly difficult for this patient group. Staff in homeless accommodation can find it difficult to access supports for residents when they have concerns. It is important to have clear pathways to ensure that residents in homeless services can access the support they need when presenting in crisis.

"Following presentation of a patient who is homeless and in crisis, is there appropriate aftercare linking with homeless-specific services?"

Only one health board addressed this area, 13 did not.

An A&E representative highlighted to us the importance of linking-in with homeless-specific services when a patient presents to A&E in mental health crisis and is homeless. Linking with appropriate services to provide safe shelter may prevent further deterioration in mental health and ensure any underlying vulnerability factors which increase the individual's risk of harm and further mental health crisis can be addressed.

"Is there consideration of medical and psychiatric aftercare for homeless patients and a pathway to enable them to access GP and mental health services?"

No health boards addressed this area.

Aftercare is also an area which needs addressed particularly given difficulties in accessing GPs and specialist mental health services when the patient does not have a home address to determine their eligibility for the service.

12. Learning Disability and Autism

"Is there consideration for other conditions which might require specific approaches and management strategies?"

Five health boards addressed this area but nine did not.

Since individuals with a learning disability or autism presenting in mental health crisis may have specific needs which cannot be fully or solely addressed by general psychiatry services it would be important for a psychiatric emergency plan to include guidance specific to this group of individuals.

[11] https://www.mwcscot.org.uk/sites/default/files/2019-06/themed_visit_to_homeless_people_with_mental_ill_health.pdf

13. Aftercare

"If health agencies cannot provide immediate support, is there guidance on follow-up arrangements and alternatives to deal with distress? Does this guidance ensure that when patients present to a service which will not be providing ongoing input that there remains a duty to respond to the distress and re-direct to an appropriate service?"

Only one health board addressed this area, 13 did not.

Some patients told us that they had felt shuttled by police between A&E and Crisis services with no one taking ultimate responsibility for their care. This could be potentially dangerous with patients being declined support and left without the help they need to avoid escalating crisis. It is of vital importance that an individual can easily access appropriate support and, when a service is not appropriate for their needs they can be signposted to the most appropriate place, with assistance if necessary to access the help they need.

"Is there guidance on how to manage patients when they present in crisis despite an assessment stating they do not need immediate treatment? "

Two health boards addressed this area but 12 did not.

Not all patients presenting in mental health crisis will require immediate treatment. Two health boards did describe urgent follow-up arrangements which were available to individuals not requiring inpatient admission but who may require some form of mental health support. We felt this was very relevant to psychiatric emergency planning since it would ensure appropriate care of individuals in crisis who do require an increased level of support but for whom admission to hospital may not be appropriate, and may prevent ongoing distress when needs are not met.

"Is there guidance on the recording of outcomes following a crisis presentation?"

Only one health board addressed this area but 13 did not.

A key aspect of ensuring appropriate care is the recording of decisions and outcomes following crisis and ensuring that key professionals are aware of the individual having presented in crisis. This not only ensures adequate follow-up to reduce the risk of further escalating crisis but also ensures that should the individual re-present in crisis their previous assessment can be viewed and considered during future assessments.

"Is there consideration of carer needs and support?"

Two health boards addressed this area but 12 did not.

In addition to considerations of appropriate aftercare for the individual in crisis, support for any informal carer can also reduce carer strain and can ensure they are able to access correct support for their loved one in future as required.

"Is there help available to people who are at risk of suicide but who do not have impaired judgement?"

Two health boards addressed this area but 12 did not.

One concern raised by informal carers and individuals with lived experience of mental illness was that they can sometimes be reluctant to seek help due to past experiences or a sense that they will not get the treatment they feel they need. This can result in them not accessing help until they present in crisis. We felt it would be important to ensure that support is available for individuals who are not presenting in acute crisis but about whom there may be significant concerns but who may be reluctant to attend appointments or accept offers of support. Health boards often included guidance on the local authority's duty to enquire where concerns are raised and we felt this addressed this area where patients may be at high risk but who have not themselves presented in acute crisis.

14. Use and Relevance of Psychiatric Emergency Plan (PEP)

"Does the PEP have a clear set of values which ensure good quality patient-centred care?"

Thirteen health boards addressed this area but one did not.

We felt that it was important that any psychiatric emergency plan should have a clear set of values focusing on good quality patient-centred care. Most health boards addressed this by listing the Milan Principles or similar value statement at the start of the Psychiatric Emergency Plan. Some highlighted the need for a patient-centred empathetic response to individuals in crisis throughout their PEP. Only one Health board did not address this area as they focused on the practical and legal aspects of managing a person in crisis. We felt it could be helpful particularly given the many professionals referring to a psychiatric emergency plan for there to be some reminder of the need to offer supportive patient-centred care.

"When will the PEP be reviewed? Are there stipulations that under certain circumstances the PEP would be reviewed sooner than the statutory five-yearly review?"

Twelve health boards had reviewed their PEP within the past five years, however two had existing PEPs which were dated prior to 2015.

The Mental Health Act code of practice advises that it would be good practice to ensure the PEP is updated regularly. In our 2018 POS follow-up report we recommended that PEPs should be reviewed at least every five years although there may be circumstances such as changes in local procedures and services which require it to be reviewed sooner.

"Is there a plan for dispersion & easy accessibility of the PEP?"

Five health boards described a plan for how their PEP would be distributed however nine did not refer to this within their PEP.

In order to ensure that all the arrangements agreed within the PEP are followed in practice, it is vital that front line staff dealing with individuals who present in mental health crisis can have ready access to the PEP. We therefore felt it would be helpful within the PEP to include a plan for distribution and accessibility.

“Is there a named manager responsible for PEP publication and review?”

Ten health boards included a named manager or named managerial group responsible for the PEP but four did not.

In order to ensure that any difficulties which arise in the application of the PEP and to ensure that the PEP is reviewed regularly it is important that there is clarity of responsibility for its publication and review. Some health boards had a specific manager and others a managerial group who could be contacted. In the absence of clear lines of responsibility there is a risk of the PEP becoming outdated and of reduced relevance for the care of people presenting in a psychiatric emergency.

“Is there a procedure outlined for recording any emergency clinical actions taken out with the specifics of the PEP?”

Two health boards addressed this area but 12 did not.

We felt it would be important to ensure that the PEP guidance is followed unless in exceptional circumstances and under such circumstances there would need to be a record made of why guidance was not followed. This would ensure that individuals in crisis are receiving the high standard of care laid out within the PEPs and that exception-reporting is reviewed locally.

“Is there a plan for debrief which includes Police, Ambulance and Health and Social Care staff?”

No health boards described a clear debrief facility although one did describe a quarterly review of the PEP and one a biannual review which may have served the same purpose provided representatives from all professional groups were able to attend.

Given the many professionals from different disciplines who may all be involved in offering care to an individual presenting in a psychiatric emergency and given the very varied and complex circumstances under which a patient may present in crisis, it is likely that there will be times where responding to a crisis does not go as planned or where actions must be taken in circumstances on which there is no guidance. We felt it would be important to ensure that there is the opportunity to feedback when things have not gone well and to ensure that arrangements can be agreed to prevent similar difficulties being repeated.

*“***What parties have been involved in writing up the PEP?”**

Six health boards included a list of professionals involved in writing the PEP which included an appropriate wide range of professional groups. Five had consulted with Police, SAS, NHS and Local Authority but it was not clear in what capacity and what particular professional groups had been involved (for example whether NHS included community nurses, inpatient nurses GPs, psychiatrists etc.). Three health boards did not detail any professionals consulted.

A psychiatric emergency plan will only be of use if all professionals potentially involved in responding to a psychiatric emergency can agree to the content and follow it in practice. This involves consulting with a wide range of stakeholders which would include (although not necessarily limited to) the following: police officers, Scottish Ambulance Service staff, mental

health officers and social workers, psychiatrists, GPs, community psychiatric nurses, inpatient nurses, bed managers, A&E staff, crisis teams, CAMHs nurses and psychiatrists, Learning Disability Services nurses and psychiatrists.

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Appendix A: Template PEP Framework Document

Template for what should be included in a Psychiatric Emergency Plan (PEP)

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

Place of Safety (POS)	
Is there a clear and appropriate place of safety specified which provides adequate privacy?	
Are there clear guidelines on when each place of safety is appropriate (for example A&E may be a separate place of safety to a Psychiatric Hospital with different criteria for presenting to each)?	
Are there clear guidelines for when police should be dismissed and pass responsibility to staff at the place of safety for the welfare of a person taken there for assessment?	
Is there a clear procedure for transfer to most appropriate care facility of a patient from police cells where this has been used as a place of safety but there are no criminal charges?	
Is there clarity about the difference in powers and roles of the British Transport Police compared with Police Scotland?	
Alcohol and Substance Misuse	
Is there clarity of responsibility for intoxicated patients in mental health crisis which includes a plan for what to do when a patient is too intoxicated to be assessed?	
Is there guidance which explains the need to consider that an intoxicated patient may have underlying distress or other feature of mental or physical ill health needing urgent treatment?	
Transport	
Is it made clear what mode of transport should be used under what circumstances? (this could include reference to police van, ambulance, private car or taxi with staff or with family). Does this guidance take into consideration the principles of reducing stigma and taking the least restrictive option?	
Is there provision for transport of an informal patient which is supportive and with financial provision where necessary?	
Is there clarity of each professional's role in transport to hospital of a distressed patient? Is there clear guidance on use of force where appropriate and who is authorised to do this?	
Is there a safe and appropriate plan for transportation of an intoxicated patient to POS?	
Are there guidelines for administering medication to a patient prior to arrival at POS (this should detail whose responsibility and under which circumstances)?	
If journey to a place of safety may be complicated (e.g. boat or air travel) is consideration given to patient's privacy and comfort and is it clear whose responsibility it is to organise and carry out escort?	

Is there a clear plan for onward travel of a patient following initial assessment at POS and which agency is responsible for this?(including transfer A&E to psychiatric unit, transfer between psychiatric units, organising transport home where appropriate)?	
Assessment	
Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order requires that the individual subject to the act be taken to POS for the purpose of assessment by a medical practitioner. Does the PEP make it clear who has responsibility for carrying out this assessment at the place of safety?	
Is there an outreach service for people when there are concerns about their mental state which prevent them accessing regular services but they have not yet presented in acute crisis?	
Is there clear guidance on when the police should stay during the waiting time for and duration of assessment and how this should be agreed?	
Are services trauma-informed and sensitive to needs such as to see a specific gender of professional to reduce distress? Are there services appropriate for patients with Emotionally Unstable Personality Disorder?	
If someone is waiting a long time to be assessed are they in a pleasant environment and are they being supported?	
Resolving Disputes	
Is there a clear plan for what to do when there is a disagreement between professionals for example if MHO and AMP have differing opinions about whether detention is appropriate?	
Sharing Information	
Is there a clear pathway for sharing information which incorporates new GDPR guidance and which includes circumstances when information must be reviewed and shared?	
Is there reference to the duty to share information (as per Caldicott Principle 7: 'the duty to share information can be as important as the duty to protect patient confidentiality'. Does guidance include whose responsibility it is to pass information to relevant parties?	
Is there a system in place to ensure advance statements are available at time of mental health assessment?	
Is there a system in place to establish named person and for them to be consulted?	
Is there a system in place to ensure professionals access any anticipatory care plan or key information summary which can inform any assessment and appropriate management?	

Young People	
Is the definition of young people clear including definitions in differentiating circumstances such as school leaving age, young people in care?	
Is there an appropriate place of safety for young people?	
Is it clear who is responsible for assessment and ongoing care of young people presenting in crisis and is the responsible professional adequately trained to deal with young people?	
Are there appropriate local inpatient and community services specifically for young people?	
Is there consideration to young people in care and their and staff's specific needs?	
Carers and Patients with caring responsibilities	
Is there a clear plan for who is responsible and what duties there are in relation to dependents of someone being taken into a place of safety?	
Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order stipulates that the nearest relative of the individual subject to the order must be informed of the use of the act. Is there guidance as to what information should be shared with relatives and carers and who holds this responsibility?	
Is there consideration of carer burden and other dependents when carers are relied upon for informal support?	
Is it made clear that the informal carer does not have to look after the patient and that services are designed in a way that does not pressurise carers into caring for patients?	
Is it made clear that the informal carer should be sufficiently supported and are given the option of statutory services taking over care?	
Missing patients	
Is there a clear plan which covers procedures if a patient absconds from hospital prior to assessment or after assessment?	
Is there clear guidance on unwell patients in the community, and reference to appropriate use of Mental Health (Care and Treatment) (Scotland) Act 2003 Section 35 warrant, Section 292 Warrant and Section 293 Removal Order?	

Homelessness	
Is here a direct referral route from homeless services to access mental health or other appropriate support for residents presenting in crisis?	
Following presentation of a patient who is homeless and in crisis, is there appropriate aftercare linking with homeless-specific services?	
Is there consideration of medical and psychiatric aftercare for homeless patients and a pathway to enable them to access GP and mental health services?	
Learning Disability and Autism	
Is there consideration for other conditions which might require specific approaches and management strategies?	
Aftercare	
If health agencies cannot provide immediate support, is there guidance on follow-up arrangements and alternatives to deal with distress? Does this guidance ensure that when patients present to a service which will not be providing ongoing input that there remains a duty to respond to the distress and re-direct to appropriate service?	
Is there guidance on how to manage patients when they present in crisis despite an assessment stating they do not need immediate treatment?	
Is there guidance on the recording of outcomes following a crisis presentation?	
Is there consideration of carer needs and support?	
Is there help available to people who are at risk of suicide but who do not have impaired judgement?	
Use and Relevance of PEP	
Does the PEP have a clear set of values which ensure good quality patient-centred care?	
When will the PEP be reviewed? Are there stipulations that under certain circumstances the PEP would be reviewed sooner than the statutory 5 yearly review?	
Is there a plan for dispersion & accessibility of the PEP?	

Is there a named manager responsible for PEP publication and review?	
Is there a procedure outlined for recording any emergency clinical actions taken outwith the specifics of the PEP?	
Is there a plan for debrief?	
What parties have been involved in writing up the PEP?	

Appendix B. Analysis of PEP Contents

Analysis of content of Psychiatric Emergency Plans from all 14 Health Boards using an iteratively derived template

Scenarios potentially addressed by PEP	Present in PEP	Not in PEP	N/A or other*
Initial Contact			
Is it clear who a first responder should contact if they discover a patient in a mental health crisis?	3	11	
Are there suitable services that a patient can self-refer to in crisis? Are there services where they can access face-to-face support when appropriate?	8	6	
Is there appropriate triage and offer of appropriate support to address presenting problems which may not at their source be diagnosable mental health presentations?	3	11	
Have statutory services or others ways of responding to crisis that minimise the need for police intervention?	11	3	
Is there a description of a clear predictable response to crisis and evidence of crisis care planning?	8	6	
Is there a clear explanation of powers to gain entry to a patients home which includes joint police and NHS risk assessment prior to taking action with consideration for minimising risk and distress caused by deteriorating health (with reference to and explanation of: Mental Health Care and Treatment Act 2003 Section 35 Warrant, Section 292 Warrant, Section 293 and 294 Removal Orders, Application of common law in situations of immediate risk).	11	3	
Is there clear guidance on the role of police which minimises as far as possible the use of force and restraint and ensures they should keep a low profile and avoid criminalising the patient?	11	3	
Does the PEP emphasise sensitive and empathetic response to patients in crisis? Does the PEP emphasise the need for compassionate non-judgemental care by all professionals involved?	12	2	
Is there a plan for prompt provision of AMP/Medical practitioner and MHO out of hours and what their responsibility is?	14	0	
Place of Safety (POS)			
Is there a clear and appropriate place of safety specified which provides adequate privacy?	14	0	But none described privacy and comfort
Are there clear guidelines on when each place of safety is appropriate (for example A&E may be a separate place of safety to a Psychiatric Hospital with different criteria for presenting to each)	14	0	
Are there clear guidelines for when police should be dismissed and pass responsibility to staff at the place of safety for the welfare of a person taken there for assessment?	4 (two had guidelines	8	

	but not joint or shared decision making)		
Is there a clear procedure for transfer to most appropriate care facility of a patient from police cells where this has been used as a place of safety but there are no criminal charges?	8	6	
Is there clarity about the difference in powers and roles of the British Transport Police compared with Police Scotland?	0	14	
Alcohol and Substance Misuse			
Is there clear and consistent guidance on when a patient is too intoxicated for assessment which can be agreed by all parties and is not based on arbitrary cut-offs such as blood alcohol concentration?	5	9	
Is there guidance which explains the need to consider that an intoxicated patient may have underlying distress or other feature of mental or physical ill health needing urgent treatment?	4	10	
Is there clarity of responsibility for intoxicated patients in mental health crisis which includes a plan for what to do when a patient is too intoxicated to be assessed?	4	10	
Transport			
Is it made clear what mode of transport should be used under what circumstances? (This could include reference to police van, ambulance, private car or taxi with staff or with family). Does this guidance take into consideration the principles of reducing stigma and taking the least restrictive option?	14	0	
Is there provision for transport of an informal patient which is supportive and with financial provision where necessary?	5 (3 yes but no financial reimbursement mentioned)	6	(9 did not address the issue of transport for informal carers)
Is there clarity of each professional's role in transport to hospital of a distressed patient? Is there clear guidance on use of force where appropriate and who is authorised to do this? Does guidance include use of force when a patient passively resists transport to hospital?	14 13 6	0 1 7	(2 Boards referred to police having an active role in the restraint of a passively resisting patient and have been advised to revise this)
Is there a safe and appropriate plan for transportation of an intoxicated patient who may require medical intervention?	2	12	
Are there guidelines for administering medication to a patient in the community (this should detail whose responsibility and under which	9	5	

circumstances and make it clear that police should not be involved in any restraint for purpose of administering medication)			
If journey to a place of safety may be complicated (e.g. boat or air travel) is consideration given to patient's privacy and comfort and is it clear whose responsibility it is to organise and carry out escort?	2 had clear plans (2 had no detail on privacy and comfort)	1 no detail given where this would be relevant	8 N/A as no complicated journeys) 1 referred to separate guidance
Is there a clear plan for onward travel of a patient following initial assessment at POS and which agency is responsible for this?(including transfer A&E to psychiatric unit, transfer between psychiatric units, organising transport home where appropriate)	9	4	1 (referred to escort guidance elsewhere)
Resolving Disputes			
Is there a clear plan for what to do when there is a disagreement between professionals? Does this include a plan for timeous resolution and subsequent review for MHO's, AMP's Medical Practitioners, SAS, Police Scotland, other healthcare staff?	2	12	
Assessment			
Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order requires that the individual subject to the act be taken to POS for the purpose of assessment by a medical practitioner. Does the PEP make it clear who has responsibility for carrying out this assessment at the place of safety?	12	2	
Is there an outreach service for people when there are concerns about their mental state which prevent them accessing regular services but they have not yet presented in acute crisis?	4 (3 of these referred to duty to enquire)	10	
Is there clear guidance on when the police should stay during the waiting time for and duration of assessment with reference to a joint risk assessment of the situation?	6 (Joint RA 4)	8 (Joint RA 10)	
Are services trauma-informed and sensitive to needs such as to see a specific gender of professional to reduce distress? Are there services appropriate for patients with Emotionally Unstable Personality Disorder?	0	14	
If someone is waiting a long time to be assessed are they in a pleasant environment and are they being supported? Is there respect for confidentiality and consideration of minimising any potential stigma?	2	12	
Sharing Information			
Is there a clear pathway for sharing information which incorporates new GDPR guidance and which includes circumstances when information must be reviewed and shared?	10 (but 4 did not refer to GDPR)	4	
Is there reference to the duty to share information (as per Caldicott Principle 7: 'the duty to share information can be as important as the	7	7	

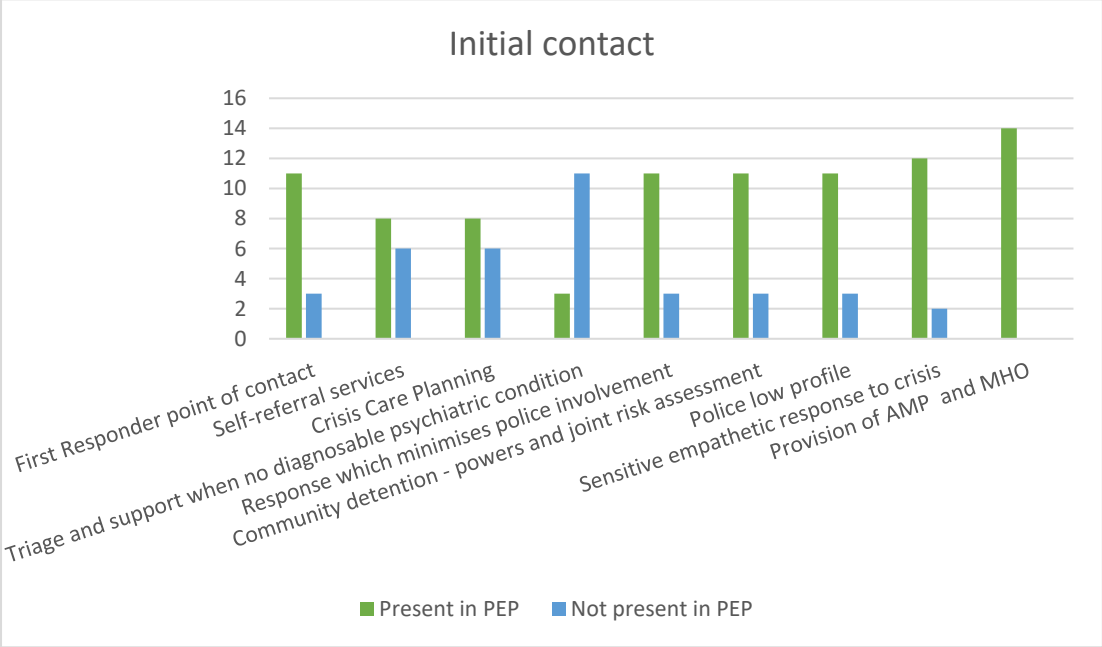
duty to protect patient confidentiality'. Does guidance include the need for sharing any information which may inform aftercare between professionals including police and health workers and for all parties to collaborate in this with the best interests of the patient as a priority?			
Is there a system in place to ensure advance statements are available at time of mental health assessment?	11	3	
Is there a system in place to establish named person and for them to be consulted?	11	3	
Is there a system in place to ensure professionals access any anticipatory care plan or key information summary which can inform any assessment and appropriate management?	6	8	
Missing patients			
Is there a clear plan which covers procedures if a patient absconds from hospital prior to assessment or after assessment or during inpatient stay and when to alert / involve police?	8	6	
Is there clear guidance on unwell patients in the community, and reference to appropriate use of Mental Health (Care and Treatment) (Scotland) Act 2003 Section 35 warrant, Section 292 Warrant and Section 293 Removal Order?	9	5	
Young People			
Is the definition of young people clear including definitions in differentiating circumstances such as school leaving age, young people in care?	8	5	
Is there clear guidance on removal of a child or young person to a place of safety and is there an appropriate place of safety for young people?	9	5	1 referred to a separate document which addressed the needs of young people
Is it clear who is responsible for assessment and ongoing care of young people presenting in crisis and is the responsible professional adequately trained to deal with young people?	9 (but not all had access to specially trained staff)	6	
Are there appropriate local inpatient and community services specifically for young people?	7 (sometimes in out of area or adult services with clear pathways)	7	
Is there consideration to young people in care and their and staff's specific needs?	1	11	2 referred to separate guidance.

Carers and Patients with caring responsibilities			
Is there a clear plan for who is responsible and what duties there are in relation to dependents of someone being taken into a place of safety?	9	5	
Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Place of Safety Order stipulates that the nearest relative of the individual subject to the order must be informed of the use of the act. Is there guidance as to what information should be shared by each professional involved with relatives and carers and who holds this responsibility?	11	3	
Is there consideration of carer burden and other dependents when carers are relied upon for informal support?	1	13	
Is it made clear that the informal carer does not have to look after the patient and that services are designed in a way that does not pressurise carers into caring for patients?	0	14	
Is it made clear that the informal carer should be sufficiently supported and are given the option of statutory services taking over care?	1	13	
Homelessness			
Is there a direct referral route from homeless services to access mental health or other appropriate support for residents presenting in crisis?	0	14	
Following presentation of a patient who is homeless and in crisis, is there appropriate aftercare linking with homeless-specific services?	1	13	
Is there consideration of medical and psychiatric aftercare for homeless patients and a pathway to enable them to access GP and mental health services?	0	14	
Learning Disability and Autism			
Is there consideration for other conditions which might require specific approaches and management strategies?	5	9	
Aftercare			
If health agencies cannot provide immediate support, is there guidance on follow-up arrangements and alternatives to deal with distress? Does this guidance ensure that when patients present to a service which will not be providing ongoing input that there remains a duty to respond to the distress and re-direct to appropriate service?	1	13	
Is there guidance on how to manage patients when they present in crisis despite an assessment stating they do not need immediate treatment?	2	12	
Is there guidance on the recording of outcomes following a crisis presentation?	1	13	
Is there consideration of carer needs and support?	2	12	
Is there help available to people who are at risk of suicide but who do not have impaired judgement?	2	12	
Use and Relevance of PEP			
Does the PEP have a clear set of values which ensure good quality patient-centred care?	13	1	

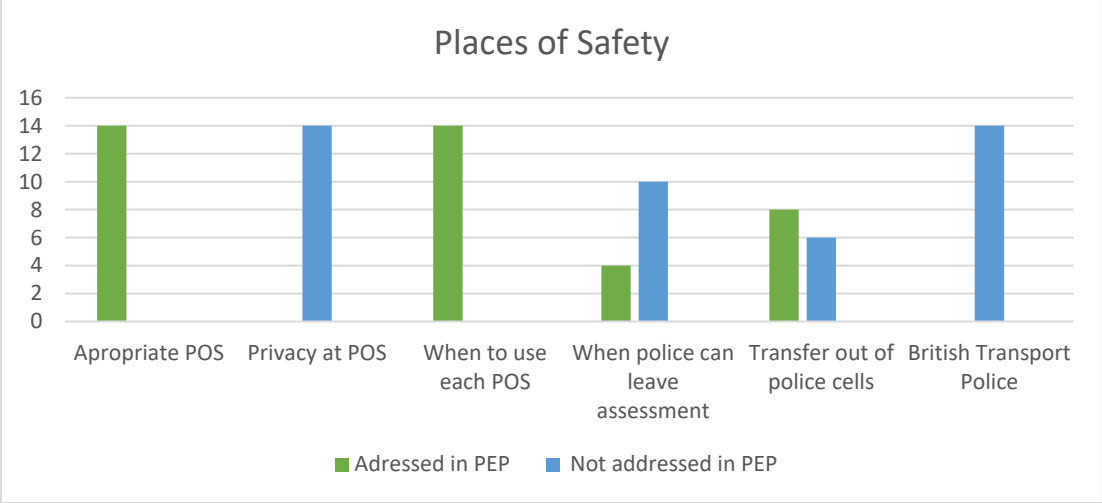
When will the PEP be reviewed? Are there stipulations that under certain circumstances the PEP would be reviewed sooner than the statutory 5 yearly review?	12	2 (PEPs were out of date but under review)	
Is there a plan for dispersion & accessibility of the PEP?	5	9 did not include this within the PEP	
Is there a named manager responsible for PEP publication and review?	10 (of which 2 referred to a group)	4	
Is there a procedure outlined for recording any emergency clinical actions taken out with the specifics of the PEP?	2	12	
Is there a plan for debrief which includes Police, Ambulance and Health staff?	0	14	(1 described a quarterly review of the PEP and one a biannual review)
What parties have been involved in writing up the PEP?	Six wide ranging. Five had unclear consultation with some other agencies	Three gave no detail	

Appendix C: Analysis of Existing PEPS

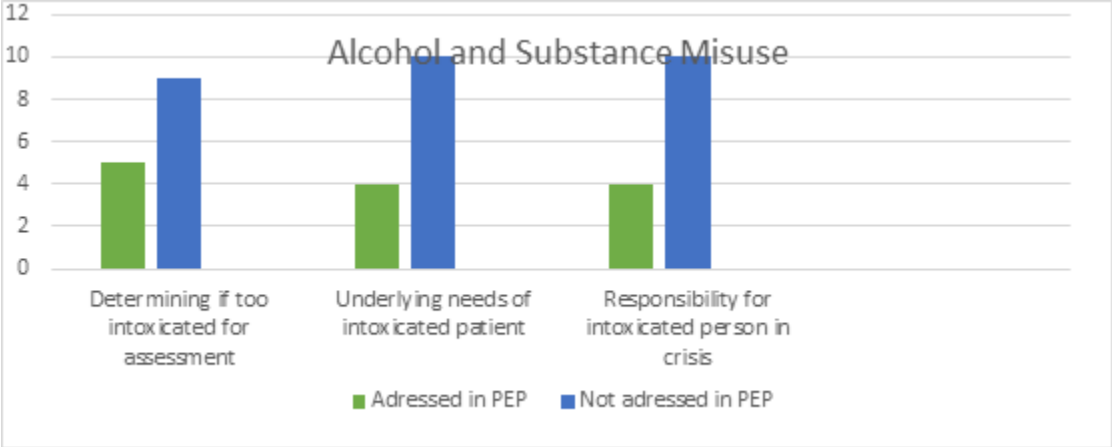
Graph 1: Initial Contact



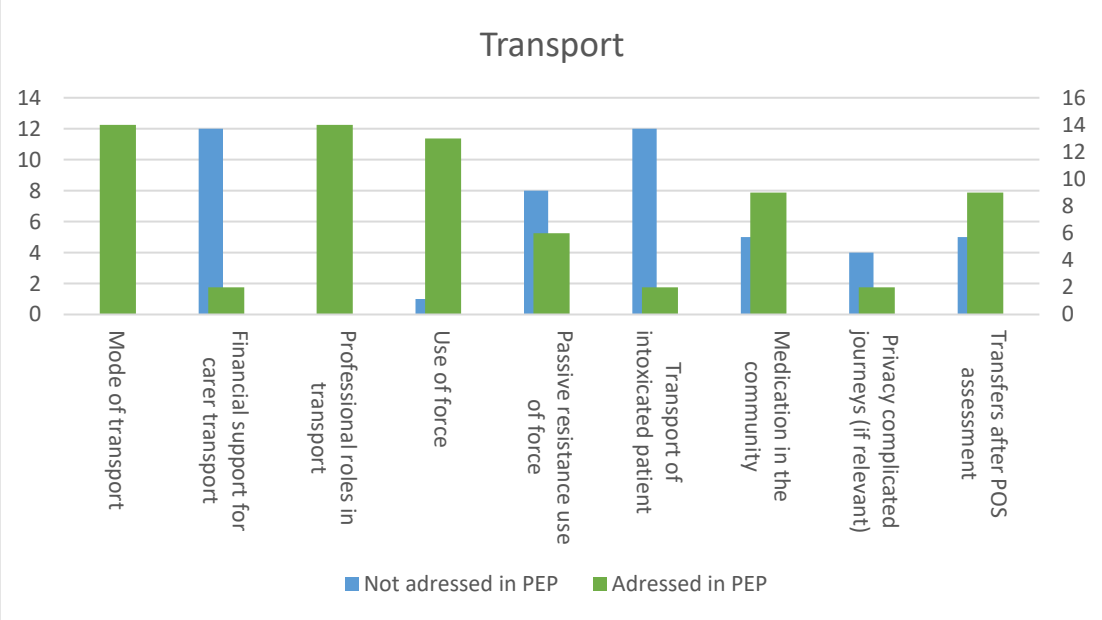
Graph 2: Places of Safety



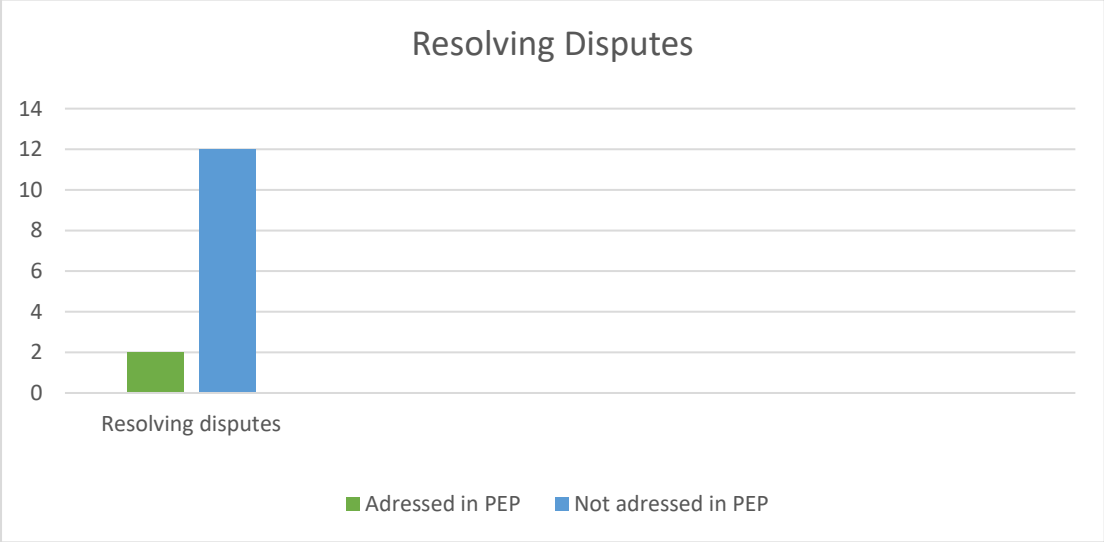
Graph 3: Alcohol & Substance Misuse



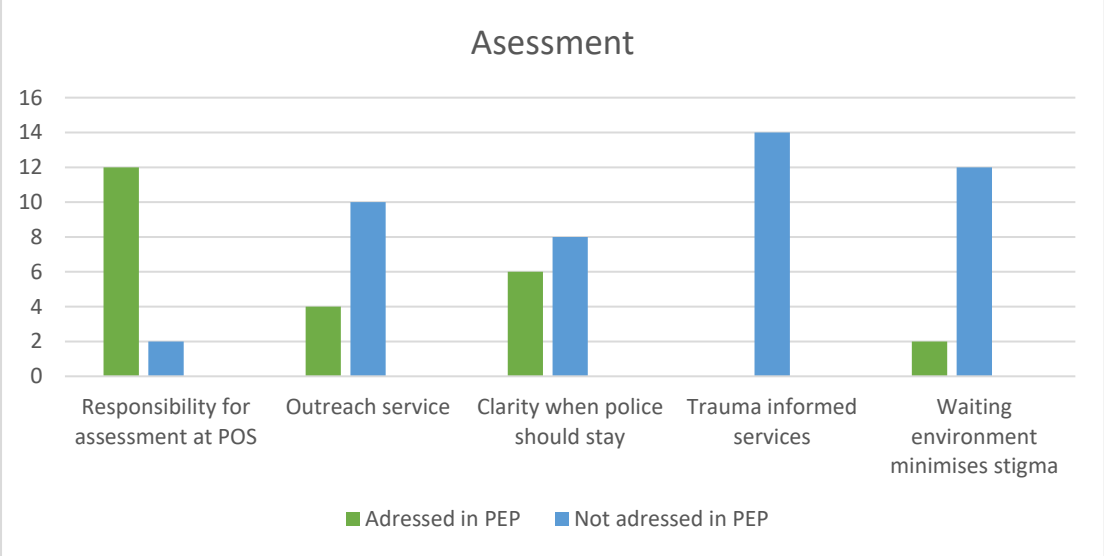
Graph 4: Transport



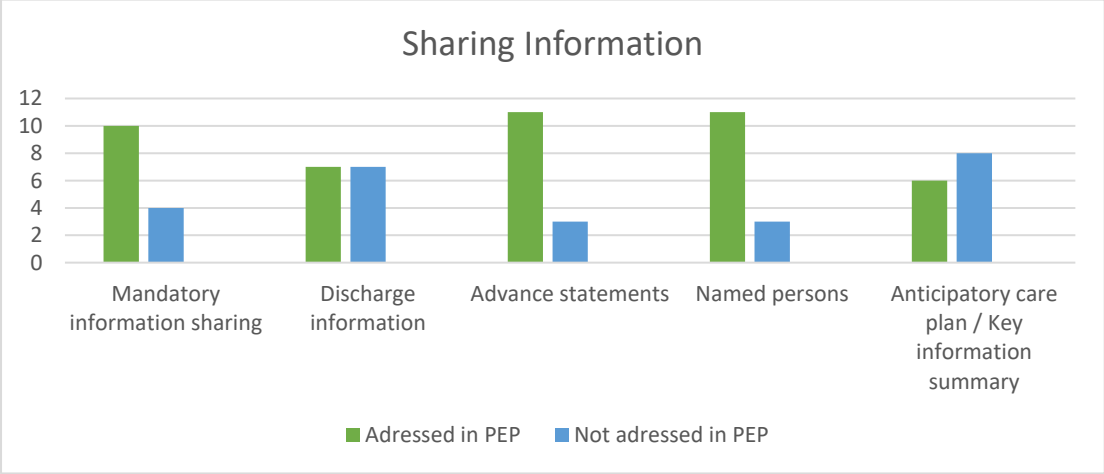
Graph 5: Resolving Disputes



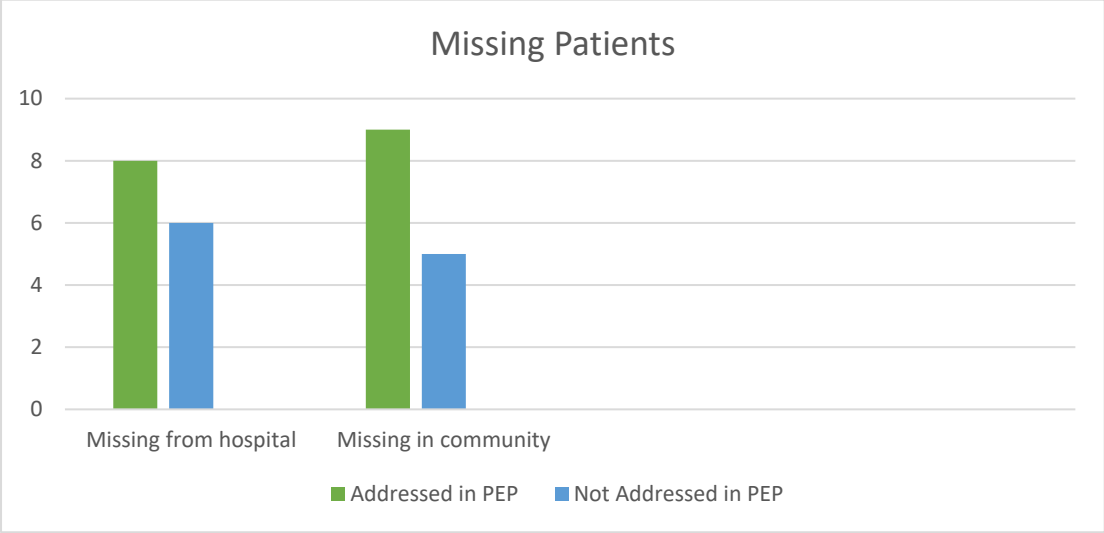
Graph 6: Assessment



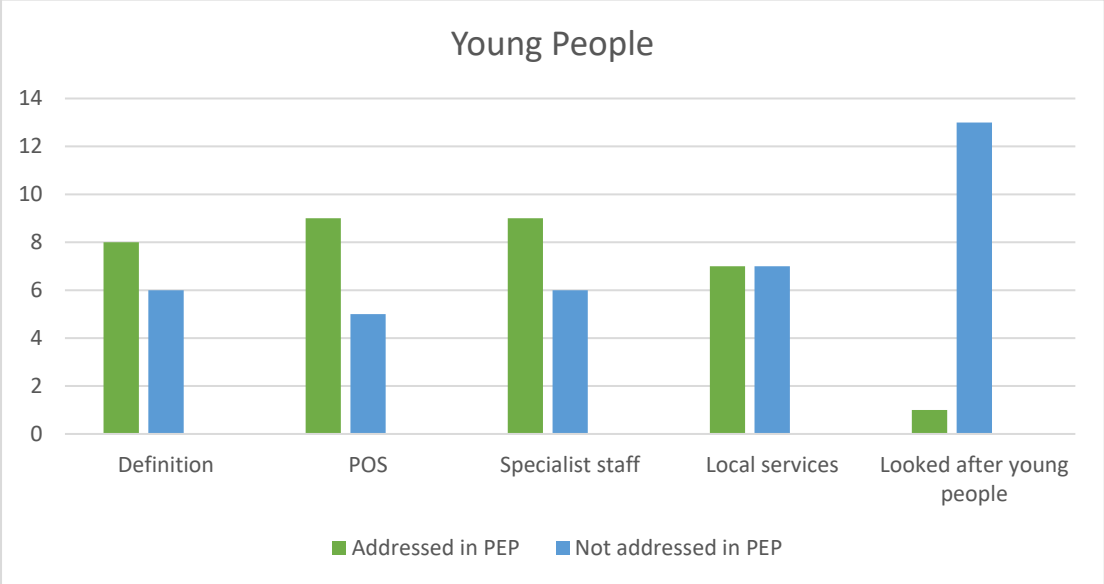
Graph 7: Sharing Information



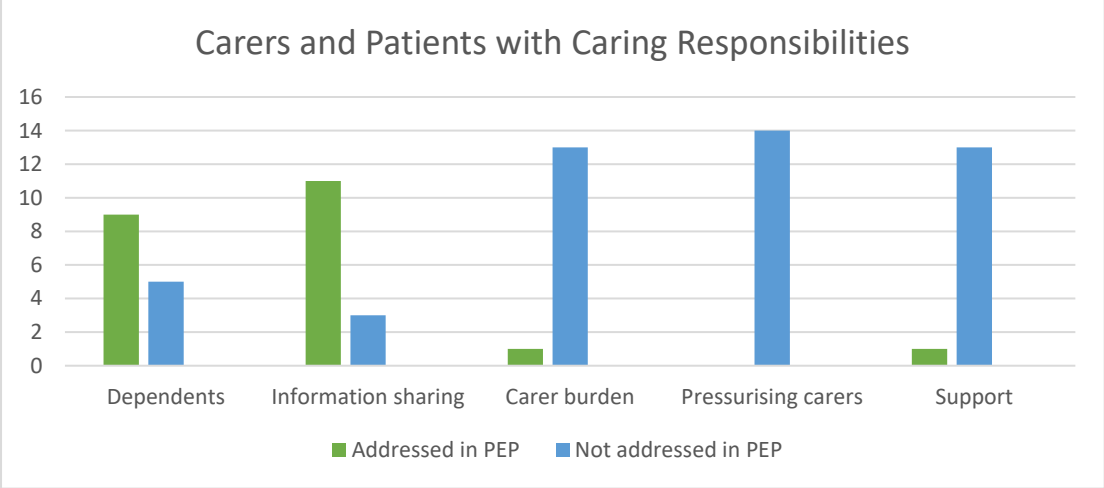
Graph 8: Missing Patients



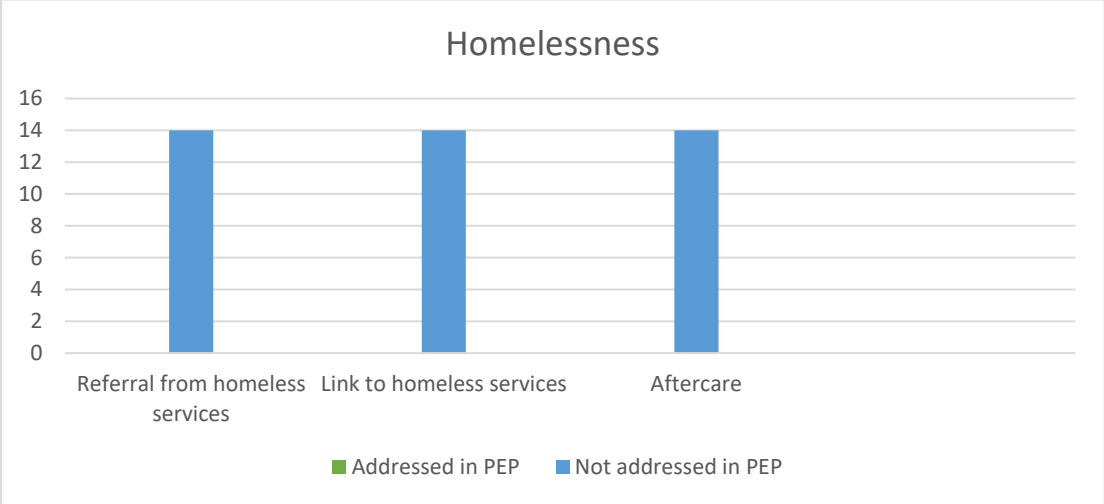
Graph 9: Young People



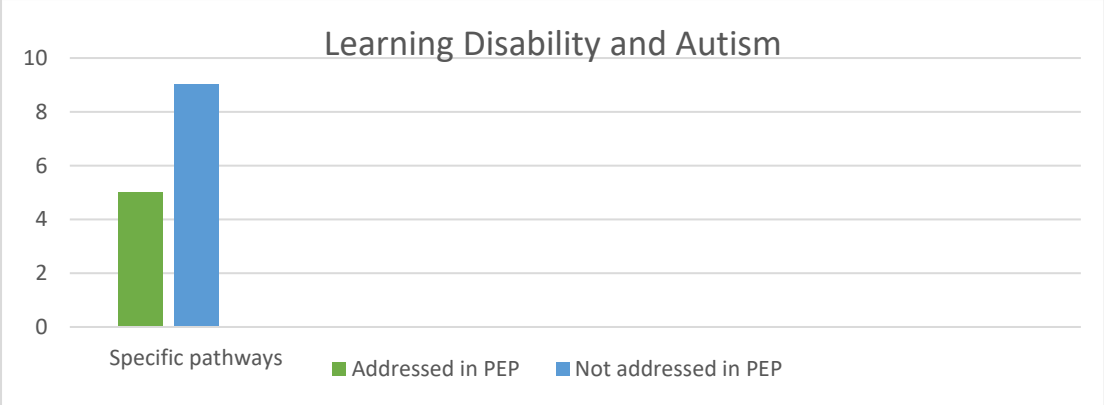
Graph 10: Carers and patients with Caring Responsibilities



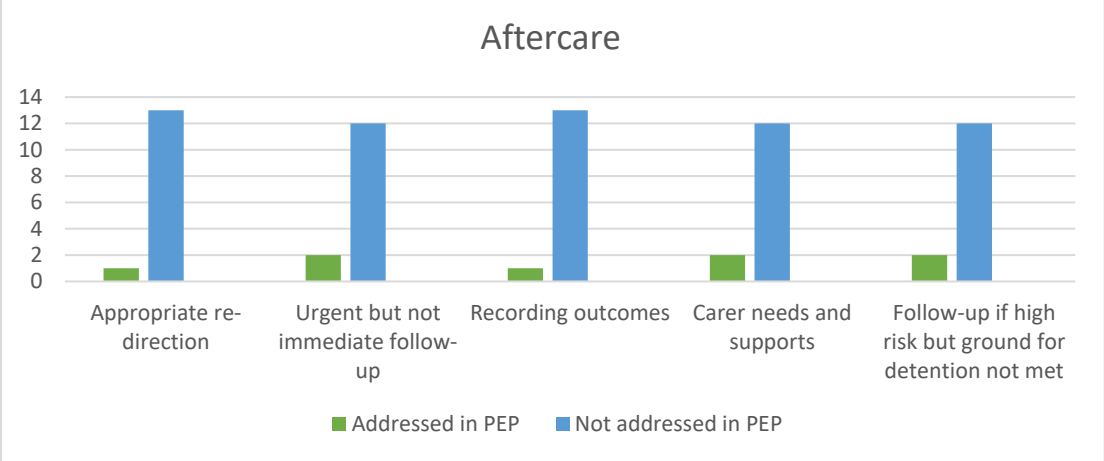
Graph 11: Homelessness



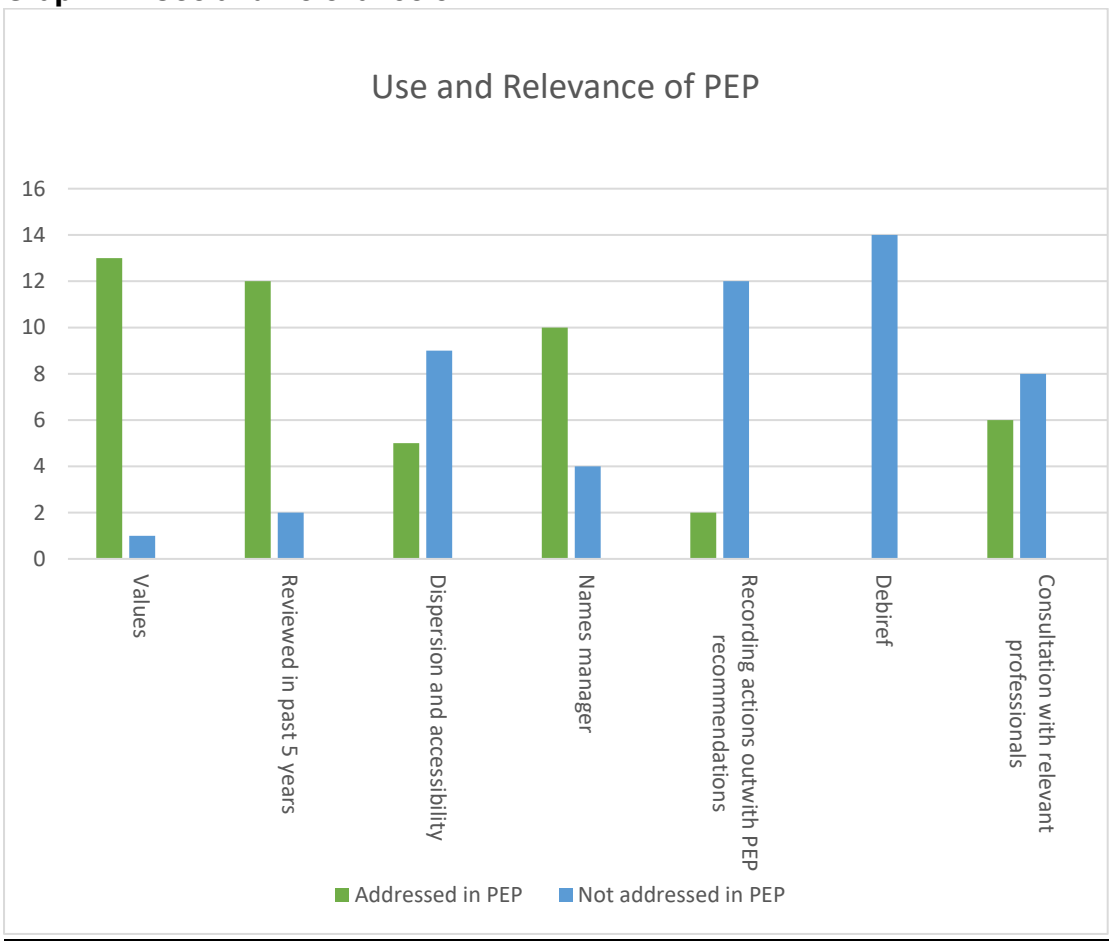
Graph 12: Learning Disability and Autism



Graph 13: Aftercare



Graph 14: Use and Relevance of PEP



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