



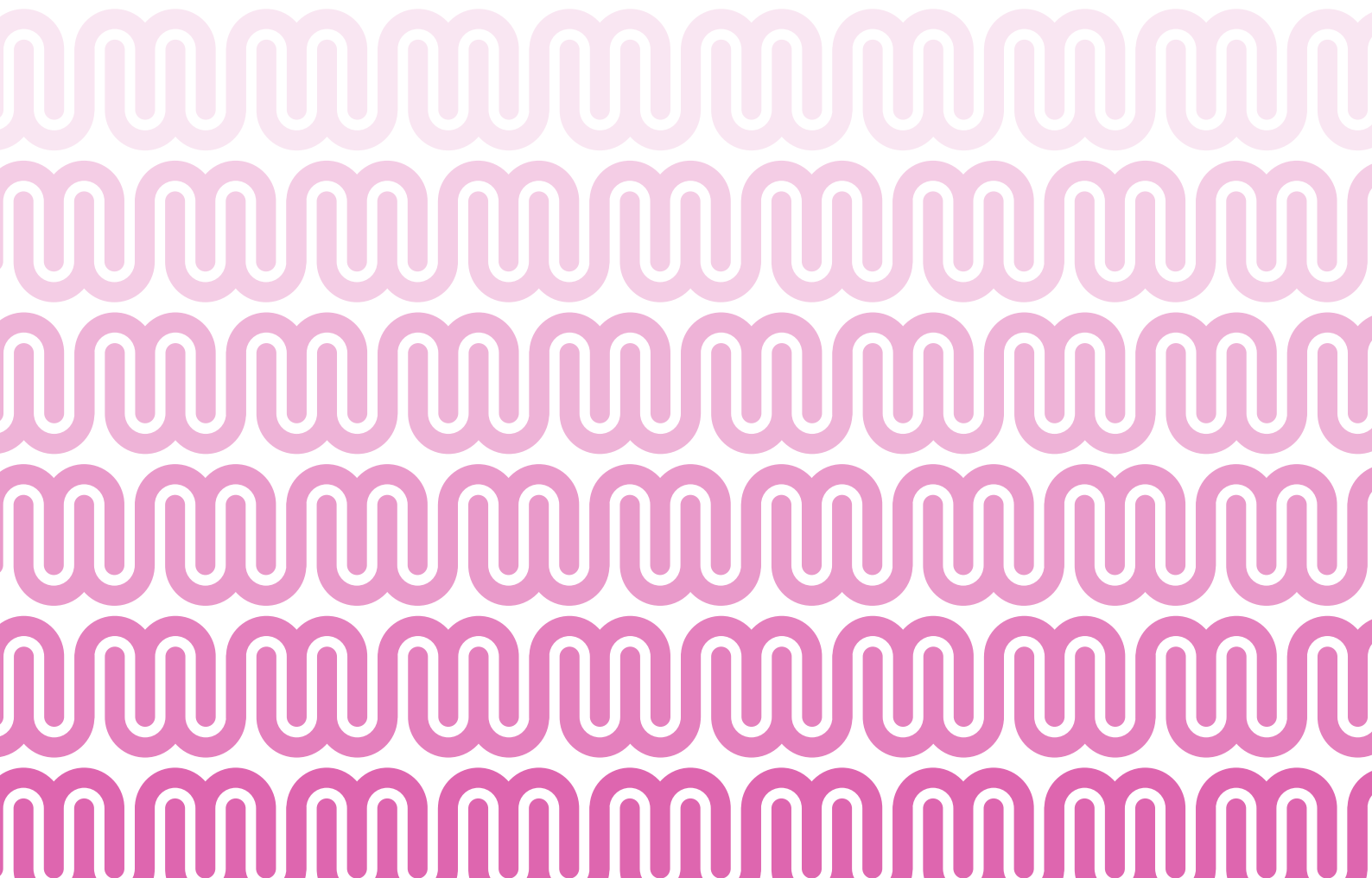
**mental welfare**  
commission for scotland

# **The use of mental health legislation for individuals with 'drug-induced psychosis'**

Good practice guide

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May 2022



# 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

# The use of mental health legislation for individuals with ‘drug-induced psychosis’

This guidance was reviewed with no changes in April 2022.

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## Introduction

When is it appropriate to use mental health legislation for 'drug-induced psychosis'? The following three cases are examples of the range of difficulties we heard about. Some details of these cases have been changed to reduce the risk of identifying individuals.

### Case 1

*Alex had been known to mental health services for some time. He used amphetamines, cocaine and cannabis intermittently. He had a diagnosis of probable schizophrenia. He became floridly psychotic with hallucinations and persecutory delusions after using drugs. On these occasions, he often came to the attention of the police. He agreed to be admitted to hospital for short periods. Psychotic symptoms subsided within 48 hours. Between episodes, he was withdrawn and slightly paranoid. He had been offered addiction services but declined to attend. He was never treated under mental health legislation.*

*He presented with an acute psychotic episode after taking drugs. He was apprehended by the police because he was acting bizarrely to strangers in the street. He had a concealed weapon but said it was for self defence. He had been hearing voices telling him to kill a family member. Police took him to hospital where, as usual, he agreed to be admitted informally.*

*The next day, his psychotic symptoms subsided and he wished to go home. He was assessed as not detainable as there were no ongoing psychotic symptoms. Unfortunately, he took amphetamines a few days later, acted on the voices he heard and killed a family member.*

### Case 2

*Brian, aged 20 years, had been admitted to the psychiatric unit voluntarily. This was his first presentation and he was not previously known to psychiatric services. He had taken a large quantity of LSD along with Cannabis. He was hallucinating and had no sense of what was real or not. He refused to stay, refused medication, said he wanted to kill himself and was detained under an emergency and then a short-term detention certificate.*

*With medication, he improved quickly and the detention certificate was revoked. He was discharged home with no mental health follow-up.*

### Case 3

*Colin was in his forties. He had been diagnosed as having paranoid schizophrenia since his late twenties. He also used amphetamines regularly and other drugs at times. He had over 30 admissions to hospital because he became unwell as a result of using amphetamines and not taking his medication. He did not understand that this caused him to become unwell.*

*He was homeless for some time and came to the attention of services three years ago. He was detained in hospital and remains on a compulsory treatment order. He has spent time out of hospital and receives medication by depot injection, but he uses drugs at times and can experience psychotic symptoms. Sometimes, this causes him to behave violently, resulting in police involvement and readmission to hospital.*

*The care team wants to support Colin in the community. The care plan would need to involve engaging Colin in help to address his drug taking. There is uncertainty about the use of compulsory powers to enforce this, as well as ensuring continued medication and support.*

These case examples show some of the dilemmas in using mental health legislation for people whose episodes of psychosis appear to be provoked by taking street drugs.

- Should mental health legislation be used at all, especially for individuals who appear to make a very quick recovery?
- How long should compulsory treatment continue?
- Should it be used long-term to try to prevent psychosis arising from drug use?

We could find no existing guidance on the use of mental health legislation in any of the literature we examined. We thought that practitioners would benefit from some guidance in this area.

## **How we approached the problem**

We needed the help of a wide range of organisations and individuals to answer these questions. We contacted mental health, social work, voluntary, criminal justice, service user and carer organisations. We asked them to provide cases where there had been difficult decisions to make. Some of the cases they submitted formed the basis for the above case examples. We invited them to a consultation event in October 2012. Their views and advice formed the basis for this guidance. We are grateful to them and to those who responded when we sent an earlier draft for wider consultation.

# Background

## 1. Mental health legislation

We had to consider the grounds for compulsory treatment as set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the 2003 Act'). Broadly, the grounds are:

- The presence of 'mental disorder': this includes mental illness, learning disability and personality disorder. There are some exclusions. Most importantly, use of, or dependence on, alcohol or drugs does not in itself constitute mental disorder. Mental illness that results from drug or alcohol use, or accompanies it, is a mental disorder under the 2003 Act. The relationship between drugs and mental illness is complex and is dealt with in the next section.
- There is treatment available for the mental disorder: treatment is defined broadly and includes "care, nursing, psychological treatments, habilitation and rehabilitation" in addition to physical treatments.
- Significantly impaired decision-making ability (SIDMA): this applies to civil compulsory orders but not to orders relating to criminal procedures.
- Risk: to the individual's own health, safety or welfare or to the safety of any other person.
- Necessity: there must be reasons why the individual cannot be treated without the use of compulsion.

Detention and compulsory treatment are major interferences with individuals' liberty and personal choice. The grounds for compulsion must always be properly documented and are open to challenge at the Tribunal. All long term civil orders are granted by the Tribunal. It also reviews all long-term civil orders and all mental health orders granted after conviction for a criminal offence.

The principles as set out in part one of the 2003 Act must guide all interventions.

Principles of information, participation, range of options, maximum benefit, carer information and support, minimum restriction of freedom and reciprocity are especially important.

Under the 2003 Act, it is possible to test detained individuals for the presence of alcohol or drugs, but only in accordance with section 286 of the Act and associated regulations. The individual must be designated a 'specified person' and there are specific safeguards that must be observed. This part of the 2003 Act applies to detained patients only. Our Specified Persons guidance<sup>1</sup> gives more information. Note that analysis of urine samples may not detect some 'legal high' drugs.

## 2. Psychosis and drug use

It is important to give a brief overview of the extensive literature on the complex interaction between street drugs and mental illness. Anyone wishing more detailed information should

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<sup>1</sup> <http://www.mwscot.org.uk/media/51854/Specified%20Persons.pdf>

consult *Psychosis with coexisting substance misuse; National Institute for Clinical Excellence guideline on assessment and management in adults and young people. (NICE 2011)*<sup>2</sup>

### **a) Diagnosis**

Diagnosis is made according to criteria laid down in recognised classification systems. In the UK, the tenth Revision of the International Classification of Diseases (ICD-10)<sup>3</sup> is most often used. Sections F10 to 19 of ICD-10 cover “mental and behavioural disorders due to psychoactive substance use”. The categories include acute intoxication, harmful use, dependence and withdrawal. Psychotic disorder due to psychoactive substance use is characterised by:

*“A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state. The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present.”*

This can be hard to distinguish from mental illnesses that occur without being provoked by drug use. Research shows that the interactions between mental illness and substance misuse are complex. Bipolar disorder has the greatest risk for coexistence of an alcohol or drug disorder. There is an earlier onset and worse course of illness in those with bipolar disorder and a drug or alcohol disorder than those with bipolar disorder alone. People with schizophrenia are three times more likely than those without to abuse alcohol and six times more likely to abuse drugs. Some studies have suggested that as many as 47% of people with a diagnosis of schizophrenia have used drugs at some point. Research findings vary depending on where the studies are carried out. A lot depends on local drug availability and culture. Those who use cannabis have a significantly higher rate of readmission to hospital and poorer psychosocial functioning than those who do not. Also, most people with ‘cannabis-induced psychosis’ are later diagnosed as having schizophrenia. See the NICE guidance for more details on research findings.

The NICE guidance also sums up the diagnostic dilemma as

1. Substance misuse either precipitates the onset of, or is a direct cause of, psychosis.
2. Substance misuse is a common consequence of a psychotic disorder.
3. There is a common cause, or vulnerability, to both substance misuse and psychosis.

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<sup>2</sup> <http://www.nice.org.uk/nicemedia/live/13414/53691/53691.pdf>

<sup>3</sup> <http://apps.who.int/classifications/icd10/browse/2010/en#/V>

## **b) Care and treatment**

The NICE guidance has important key recommendations. We have reproduced the most relevant ones below.

### **General points**

- Take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship.
- Stigma and discrimination are associated with both psychosis and substance misuse. Some people will try to conceal either one or both of their conditions.
- Many people with psychosis and coexisting substance misuse fear being detained or imprisoned, being given psychiatric medication forcibly or having their children taken into care.
- All healthcare professionals in primary, secondary or specialist substance misuse services working with adults and young people with psychosis should offer information and advice about the risks associated with substance misuse and the negative impact that it can have on the experience and management of psychosis.
- Encourage families, carers or significant others to be involved in the treatment of adults and young people with psychosis and coexisting substance misuse to help support treatment and care and promote recovery.
- Provide service users with full information appropriate to their needs about psychosis and substance misuse and the management of both conditions, to ensure informed consent.
- Assess capacity to consent in relation to each treatment decision.

### **Identification and access to services**

- Healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs.
- They should also routinely assess adults and young people with known or suspected substance misuse for possible psychosis. Seek corroborative evidence from families, carers or significant others, where this is possible and permission is given.
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental healthcare because of their substance misuse.
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis.
- For most adults with psychosis and coexisting substance misuse, treatment for both conditions should be provided by healthcare professionals in secondary care mental health services such as community-based mental health teams.
- Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services.



- When assessing adults and young people with psychosis and coexisting substance misuse, be aware that low levels of substance use that would not usually be considered harmful or problematic in people without psychosis, can have a significant impact on the mental health of people with psychosis.
- Regularly assess and monitor risk of harm to self and/or others and develop and implement a risk management plan to be reviewed when the service users' circumstances or levels of risk change.
- Biological or physical tests for substance use (such as blood and urine tests or hair analysis) may be useful in the assessment, treatment and management of substance misuse for adults and young people with psychosis. However, this should be agreed with the person first as part of their care plan. Do not use biological or physical tests in routine screening for substance misuse in adults and young people with psychosis.

## Treatment

Before starting treatment for adults and young people with psychosis and coexisting substance misuse, review the diagnosis of psychosis and presence or the diagnosis of the coexisting substance misuse, especially if either diagnosis has been made during a crisis or emergency presentation.

Ensure that adults and young people with psychosis and coexisting substance misuse are offered evidence-based treatments for both conditions. Treatment for psychosis with coexisting substance misuse should follow the same guidelines as psychosis without substance misuse.

When prescribing medication for adults and young people with psychosis and coexisting substance misuse take into account the level and type of substance misuse, especially of alcohol, as this may alter the metabolism of prescribed medication, decrease its effectiveness and/or increase the risk of side effects.

Warn the person about potential interactions between substances of misuse and prescribed medication.

Discuss the problems and potential dangers of using non-prescribed substances and alcohol to counteract the effects or side effects of prescribed medication.

Do not discharge adults and young people with psychosis and coexisting substance misuse from an inpatient mental health service solely because of their substance misuse.

When adults and young people with psychosis and coexisting substance misuse are discharged from an inpatient mental health service, ensure that they have: an identified care coordinator; a care plan that includes a consideration of needs associated with both their psychosis and their substance misuse; and been informed of the risks of overdose if they start reusing substances, especially opioids, that have been reduced or discontinued during the inpatient stay.

The guidance mentions the use of mental health legislation but gives no guidance on the situations where it is appropriate to do so.

## Use of mental health legislation

Using case examples, we consulted with a wide variety of stakeholders over the use of mental health legislation for people with psychosis associated with drug use. Our guidance reflects their views.

### Indications for deciding to intervene using mental health legislation

The use of compulsory powers under the 2003 Act can be essential to deal with an acute crisis. It can also help individuals start to engage with services. It may be a positive step for individuals who lead chaotic lifestyles with multiple substance use, mental health and social difficulties. Some individuals may come to attention via police involvement and adult protection procedures. If so, it is appropriate to seek specialist mental health advice.

Earlier in this document we set out the grounds for compulsory treatment. Where substance use has apparently provoked psychotic symptoms, there are some critical judgements to be made:

- Does the individual have a mental disorder within the meaning of the 2003 Act? Based on all the available evidence, we consider that drug induced psychosis is a mental illness. The suspicion that psychotic symptoms may have resulted from drug use should not, in itself, be a factor in deciding whether or not this criterion is met.
- Treatability, SIDMA and risk all need to be assessed in the same way as for any other individual. Assessing immediate risk may be difficult if, as in case 1 at the beginning of this guidance, the individual agrees to treatment, appears to improve quickly and wants to go home. There are two risks: symptoms may not have completely subsided; and they may recur quickly if the individual returns to using drugs. This needs very careful consideration. In many cases, a longer period of assessment may be needed.
- Necessity needs some thought. Sometimes, the problem will subside when the effects of acute intoxication have worn off. This is especially the case with alcohol. Psychosis associated with other drugs can take longer to resolve. Therefore it may not be necessary to detain individuals whose problems result from intoxication with alcohol as long as there is a safe place to 'sober up'. It is different if drugs are involved or if prolonged alcohol use worsens psychotic symptoms.

## Care and treatment under compulsory powers

This is where the principles of the 2003 Act and the articles of the European Convention on Human Rights (ECHR) are important. The most important points are:

- Information. As the individual starts to recover, it is essential to provide him/her with information about the nature of the psychosis and the harmful effects of drugs. It is also essential to give information about the help available.
- Participation. Engaging the individual in ongoing help and support is the key to recovery and a successful outcome. In our *Hard to Help* report<sup>4</sup>, we commented on the lack of available short-term help for Mr O to engage with services to address his drug use. Drug and alcohol services need to be more assertive in helping people to engage. Mental health services should be able to provide short-term interventions to encourage engagement. Also, the views of young individuals who experience drug-related mental health problems should be sought when planning services.
- Maximum benefit. The NICE guidance is clear that, regardless of the suspicion that drug use has provoked a psychotic episode, the care and treatment should be based on the symptoms and the evidence basis for treating them. As with any episode of psychosis, it is wise to delay regular medication as acute episodes may resolve without treatment. Antipsychotic medication should start with a low dose, increasing to achieve maximum benefit while minimising adverse effects. Some individuals may need rapid tranquilisation.
- Range of options available and duty to provide services. It is not enough merely to treat the psychotic symptoms with medication and then return the individual to the situation where the psychosis developed. It is important to offer help to avoid further drugs use and any stressors that lead to it.
- Minimum restriction of freedom. Even when subject to compulsory treatment, there is a legal duty to minimise restrictions. Under ECHR, the rights to liberty (article 5) and respect for private and family life (article 8) must be observed and any interference must be lawful, necessary and proportionate. Spells of suspension of detention to test out recovery are an important part of the process. Any testing of samples for drug use should have the individual's consent and should be for a clear and specified purpose. Any such testing for an individual subject to detention must be done under specified person procedures, whether or not the individual is consenting.
- Non-discrimination. Help for drug-related mental health problems should be available across the age spectrum. Positive action may be needed to promote services to individuals from some minority groups.
- Involvement of carers. Where the individual agrees, it may be helpful to share information with carers so that they can help the individual engage with services and provide appropriate support themselves. In all cases, taking account of the views of carers is important and does not need the individual's consent. See our Carers and Confidentiality guidance<sup>5</sup> for more detail on this.

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<sup>4</sup> [http://www.mwcscot.org.uk/media/62794/hard\\_to\\_help.pdf](http://www.mwcscot.org.uk/media/62794/hard_to_help.pdf)

<sup>5</sup> <http://www.mwcscot.org.uk/media/51766/carers%20and%20confidentiality.pdf>

The overall aim is to help the individual to recover and to be able to make an informed choice about lifestyle and drug use. Most individuals will reach this stage relatively quickly, but for some it may take longer. They may need a longer period of compulsory treatment.

## **Ongoing care and treatment and decisions to revoke orders**

When the acute episode has subsided, practitioners will need to discuss ongoing care and treatment with the individual and his/her carers. This will involve a decision about when to revoke a compulsory order. The test is whether or not the grounds continue to be met. This may be difficult in some cases.

The offer of ongoing help and support must be based primarily on need and not on whether or not the individual is subject to compulsion. As one of our consultees put it, “no mental health act does not mean no treatment”. Our concern about case 2 in our introduction was that this did not appear to be offered.

It may be necessary to continue compulsory treatment while undertaking a gradual withdrawal of medication, observing for signs of emerging psychosis. In all cases, mental health services should continue to provide follow up care for any individual who leaves hospital while still receiving psychoactive medication.

For individuals with ongoing substance misuse and coexisting mental illness, specific ‘dual diagnosis’ services and/or close collaboration among teams and practitioners will be needed. There are great dangers of differing approaches and failure to share all the necessary information. Some individuals may ‘fall through the gaps’ between services. Our investigation reports *Too Close To See*<sup>6</sup> and *Loss Of Focus*<sup>7</sup> show what can go wrong. There is also the danger that services set tight criteria and exclude individuals who may benefit (see the previous section on the NICE guidance).

Regardless of whether or not there are specific dual diagnosis teams, good coordination and communication among practitioners and with individuals and carers are essential. We repeat our previous view that the care programme approach has much to offer here.

When deciding whether or not to revoke orders, the responsible medical officer (RMO), in consultation with others, must consider the following:

- Does the individual still have a mental disorder? An acute episode of psychosis provoked by drug use may have subsided. Research evidence suggests that further episodes, not related to drug use, are likely. Residual or ongoing symptoms indicate that mental disorder is still present.

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<http://www.mwcscot.org.uk/media/52063/Too%20Close%20to%20See%20Mr%20F%20Summary.pdf>

<sup>7</sup> <http://www.mwcscot.org.uk/media/51951/Loss%20of%20Focus%20Ms%20Z.pdf>

- Is treatment still available? It is important to remember that treatment has a broad definition and includes care. Some individuals may consistently choose not to engage with services to address drug problems, but may still need care to minimise harmful effects. However, as we discuss below, the use of mental health legislation merely to prevent access to drugs is highly questionable.
- Is SIDMA present? This can be difficult to assess. In case 3, Colin had ongoing symptoms of a mental illness and chose to take street drugs. The RMO had to consider whether or not Colin's decision-making was impaired by mental illness. "Acting as no prudent person would act" is not in itself a mental disorder under the Act. If taking drugs resulted in significant damage to his mental health, did he understand the risk he would be taking? Did he realise that what he had experienced was a psychosis provoked by drug use? If not, the SIDMA test may still be met.
- Is there still a significant risk? The problem (see below) may be that the only risk occurs when the individual takes drugs.
- Is compulsory treatment still necessary? In general, we consider that compulsory treatment may be continued, if other grounds are satisfied, to treat mental illness but not primarily to restrict access to drugs. There are some special scenarios which we consider below.

The tribunal also has an important role here. As well as the duty to test the evidence for the grounds, the tribunal also has to consider the principles of the 2003 Act. It can make certain aspects of care and treatment a 'recorded matter' that must be provided. The tribunal should consider this if it is not satisfied that the individual has been offered enough help to address drug misuse.

## **Compulsory measures to try to prevent drug misuse**

This is the most difficult area on which to give guidance as every individual case is different. In general, using mental health legislation to try to restrict individuals' access to drugs is inappropriate and unlikely to be successful for the following reasons:

- Testing for the presence of drugs and alcohol under specified persons procedures only apply to individuals detained in hospital;
- Testing, or the requirement to attend for testing, is not a measure that can be granted by the tribunal when it approves or reviews a compulsory treatment order or compulsion order;
- Detention in hospital for long periods only because the individual may become unwell through taking drugs is, for most individuals, excessively restrictive and may fail a legal challenge.

There are a few individuals who present a great risk if they use drugs and become mentally ill as a result, although they have no or minimal symptoms of mental illness when drug-free. They may have committed a serious crime or may be judged likely to do so. For those who have committed a serious crime and have restricted status, e.g. under the terms of a compulsion order with restriction order, Scottish Ministers can impose conditions on

suspension of detention or conditional discharge. These conditions can include abstaining from drugs or alcohol and a requirement to submit samples for testing. It may help if the safeguards in the specified persons procedures under section 286 of the 2003 Act were amended to apply to individuals in this situation.

For other individuals, there may be justification for measures to restrict or prevent access to drugs. Even if the 2003 Act is amended, it is hard to see how community measures can be applied successfully. Even continued detention in hospital cannot guarantee that the individual will not be able to get access to drugs, but it may allow testing.

Drug use and drug dealing can be a problem in some hospitals. In addition to tackling a culture of drug use, hospitals should have a range of appropriate activities for young individuals to provide stimulation and reduce the risk of resorting to recreational drug use.

There may be justification for continued use of compulsory powers to try to prevent drug (and, in some cases, alcohol) use. They should not be used as a 'blanket' approach. They should address risks that have been identified for a specific drug or drugs for a specific individual, but only if it can be shown that all the following criteria are satisfied:

- There is a risk of serious harm to others. There should be at least one forensic psychiatric opinion to confirm this.
- There is evidence that the individual will use drugs unless measures are put in place to prevent or detect this.
- The individual has been given adequate help to address drug misuse and that all reasonable attempts at this have been unsuccessful.
- There is a comprehensive care plan in place to address all the individual's needs and promote recovery. Again, we strongly advocate the use of the care programme approach here.

For the very small number of individuals in this category, there may be an argument for extending specified person procedures for testing of samples to some people subject to community treatment. We know that some individuals agree to provide samples in these circumstances. There is a danger of explicit or implicit coercion to do so. The safeguards built into section 286 and associated regulations afford individuals more protection.

## Conclusions

1. If individuals whose psychosis is provoked by drug use meet the grounds for compulsory treatment, we consider that the 2003 Act should be used to protect them and/or others from harm.
2. During and beyond a period of compulsory treatment, individuals should be offered help to address mental health and substance misuse.
3. Compulsory measures must be revoked when the grounds are no longer met, but individuals should still be offered continued help to address their problems.
4. The care programme approach may be beneficial to bring together a range of professionals to ensure there is a unified process for planning, review and risk management.
5. Long-term compulsion may be appropriate for ongoing mental illness but is seldom appropriate if it is primarily to address drug misuse.
6. A small number of individuals may need longer term protection from the harmful effects of drugs. We consider that amendments to the 2003 Act may afford them and others greater protection.





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Mental Welfare Commission 2022