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GOOD PRACTICE GUIDE

REVIEWED FEBRUARY 2017

This document was reviewed in Spring 2017 in light of changes to the Mental Health Act. We found no changes were required. It was originally published in November 2013.

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Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

Jane is in her 80s and has dementia and lives in a care home. She also has severe arthritis and heart failure. Without medication for these conditions, she is breathless, in pain and more confused and agitated. She does not understand what is wrong and does not appreciate the need to take medication. She refuses all medication offered to her. What should medical and care practitioners do? Not treat her and leave her in distress? Give medication forcibly by injection, causing more pain and suffering? Or consider covert medication?

Mark has a severe learning disability and suffers from epilepsy. He does not understand the need to take medication to prevent seizures. He lives with carers who find that they can get him to take medication if they disguise it in his food. Are they right to do this when he does not know he is taking medication? What would happen if they did not give him medication in this way?

Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is **unknowingly** taking medication. This is likely to be due to a refusal to take medication when it is offered, but where treatment is necessary for the individual's physical or mental health.

Covert medication is not necessarily:

- Giving medication in food or drink to make it more palatable or easier to swallow
- Giving medication via nasogastric or PEG tubes
- Giving medication in the form of patches

But it may be regarded as covert medication if the individual is not told that medication is being given.

Also, this guidance does not apply to individuals who lack capacity but take medication when it is offered. Medical treatment must be given in line with part 5 of the Adults with Incapacity (Scotland) Act 2000 but we do not regard this as 'covert medication'.

We developed this guidance from our reading of existing good practice statements and the requirements of the law in Scotland. We advise anyone considering covert medication to follow this guidance. We have examined:

- The need to consider covert medication
- The legal framework for its use
- Practical guidance in how to administer it
- A suggested care pathway for its use
- Some case examples

Why is guidance needed?

Medication is administered covertly in hospitals, care homes and sometimes by carers for people living at home. The best data on its use comes from care homes in Scotland.

The Care Inspectorate found, when they inspected Scottish care homes during 2012, that 588 (1.6%) out of all 37,411 residents were being given covert medication. Some individuals were receiving as many as ten different medications in covert form.

The use of covert medication appears to be increasing. In 2010, 418 (1.1% of residents) received covert medication. In 2011, the number was 498 (1.3%). It is therefore a good time to revise and re-issue our guidance.

Prior to 2006 there was existing guidance from the Royal College of Psychiatrists¹ and the Nursing and Midwifery Council².

We issued our original guidance in 2006, taking account of the requirements of Scottish legislation.

In 2009, along with the Care Commission (now part of the Care Inspectorate), we found that few care homes had the right information or legal safeguards in place to give covert medication lawfully and safely³. Since then, we have found that most hospitals and care homes are aware of our guidance and refer to it when considering covert administration of medication.

Part 5 of the Adults with Incapacity (Scotland) Act 2000 provides authority to give medical treatment to an individual who lacks capacity. Although there were some submissions about covert medication when the Act was drafted, the Act and associated regulations do not mention covert medication. The Code of Practice for part 5 of the Act now includes a reference to covert medication, and advises anyone considering covert medication to follow the Mental Welfare Commission's guidance.

General considerations

This guidance applies only to situations in which an individual lacks capacity to make a decision regarding medical treatment and refuses treatment. Under human rights law, the right to respect for private life means that individuals capable of making the decision have the right to accept or refuse medical treatment, even where a refusal might lead to a fatal outcome. **Covert medication must never be given to someone who is capable of deciding about medical treatment.**

In the case of adults, there is a presumption in favour of capacity and individuals must be supported to enable decision-making so far as possible. Individuals should be given as much information as possible to enable them to make a decision regarding medical treatment. It is important to assess capacity in relation to individual decisions and not to make blanket 'all or nothing' assumptions. Capacity may change or fluctuate over time.

Where children are concerned, capacity develops according to their age and stage of development. Any child capable of expressing a view should have that view taken into account.

In all situations, where covert medication is contemplated, the individual's rights must be respected. Practitioners must act lawfully and in line with best practice.

1 <http://www.rcpsych.ac.uk/publications/collegereports/cr/cr126.aspx>

2 Ramsay, S (2001) UK nurses receive guidance on covert medication of patients, *Lancet*, 358: 900.

3 http://www.mwscot.org.uk/media/53179/CC_MWC_joint_report%20Remember%20Still%20Me.pdf

The law and covert medication

Under the law in Scotland, there are mechanisms for giving medical treatment to people who lack capacity. The two significant pieces of legislation are:

- The Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act").
- The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act").

Also, staff carrying out public duties must act in line with the Human Rights Act 1998 and comply with the articles set out in the European Convention on Human Rights (ECHR). Family carers are not required by law to act in accordance with these articles, but it is important that they are aware of them. Relevant articles are:

- Article 2: The right to life, where failure to intervene may lead to danger of death;
- Article 3: The right to be free from torture and other inhuman or degrading treatment;
- Article 5: The right to liberty and security of the individual. Any infringement of Article 5 rights should allow the individual right of appeal;
- Article 8: The right to respect for private and family life. Any interference with Article 8 rights must be necessary, proportionate, pursue a legitimate aim and be in accordance with the law.

The 2000 Act covers a variety of interventions for adults who lack capacity. It is based on a firm set of principles that govern all interventions:

- Principle 1: The intervention must be of benefit to the individual.
- Principle 2: The intervention must be the least restrictive in relation to the individual's freedom in order to achieve the desired benefit.
- Principle 3: Interventions should take account of the past and present wishes of the adult.
- Principle 4: Interventions should take account of the views of other relevant parties.
- Principle 5: Interventions should encourage the adult to use existing skills and develop new skills.

Under this Act, incapacity is defined as being incapable of:

- acting; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or
- retaining the memory of decisions.

This incapacity must be because of mental disorder, or inability to communicate due to physical disorder.

Mental disorder is defined broadly but has some exceptions. Inability to communicate only results in incapacity if it cannot be overcome by translation or communication aids.

Part 5 of the 2000 Act covers medical treatment and research. Briefly, the provisions of this part of the 2000 Act are:

- The medical practitioner (or sometimes another health practitioner) assesses the adult's capacity in relation to the treatment decision in question. If the individual lacks capacity, treatment can be given. The practitioner issues a certificate of incapacity under section 47 of the Act.
- The certificate of incapacity can last for up to a year, although it is possible to certify incapacity for three years in some cases.
- The certificate specifies the treatment to be given. Sometimes, it can be accompanied by a treatment plan if the individual has several different healthcare needs.
- Force and detention are only authorised if it is an emergency.
- There are some treatments that carry special safeguards. For the issue of covert medication, it is important to remember that treatment to reduce sex drive can only be given following an independent opinion from an independent medical practitioner appointed by the Mental Welfare Commission under section 48 of the Act.
- The individual may have a welfare guardian or welfare attorney with the power to consent to treatment. If so, the section 47 certificate must still be completed and that person should be consulted (if reasonable and practicable). If this person disagrees, treatment may only go ahead after an independent opinion from a "nominated medical practitioner" under section 50. The Court of Session may decide if there is still disagreement.
- Anyone with an interest in the individual's welfare who disagrees with the treatment can make an appeal to the Sheriff.
- There are rules governing research. We cannot foresee any circumstances where it would be appropriate to use covert medication as part of a research project.

The 2003 Act also has a set of principles. Under this Act, anyone providing treatment must "have regard to":

- The past and present wishes and feelings of the patient;
- The views of relevant others;
- The participation of the patient;
- Provision of information and support for the patient;
- The range of options available;
- Maximum benefit for the patient;
- Non-discrimination;
- Respect for diversity;
- Minimum necessary restriction of freedom;
- Needs of carers;
- Information for carers; and
- Provision of appropriate services.

This Act only covers treatment for mental disorder.

Part 16 of the 2003 Act deals with treatment for people who are subject to compulsion. If capable of consenting, the individual gives consent in writing. The individual can be treated if they are incapable of consenting or refuse to consent. Any drug treatment for mental disorder can be given within the first two months. The responsible medical officer (RMO) must give written reasons for treatment if the individual does not consent. After two months, treatment can only continue with written consent or following an independent opinion from a designated medical practitioner (DMP) appointed by the Commission. Drug treatment to reduce sex drive needs written consent or a DMP opinion from the start.

Despite these two Acts, the legal basis for giving covert medication is unclear. There is a problem in giving medication covertly under the 2000 Act. Part 5 of the Act excludes the use of force, except in an emergency.

We do not interpret covert medication as treatment by 'force'. If a Court decides that it does constitute force, this guidance will be revised. We believe that covert medication will usually be given using the principles and procedures of the 2000 Act. The principles and procedures of this Act provide the basis for most of this guide. For an individual who refuses medication in general, we do not draw a distinction between treatment for physical and mental disorders.

If the individual specifically accepts treatment for physical illness but refuses mental health treatment, we advise consideration of mental health legislation. In this case, administration of treatment is covered by part 16 of the 2003 Act (see above).

In the case of children who have not gained the capacity to make their own treatment decisions, treatment is generally given with the consent of parents and most often administered by parents. Parents should consider the necessity of giving medication covertly and ask for advice from a pharmacist before crushing tablets and/or combining medication with food or drink.

Deciding whether to give covert medication

The practitioner with primary responsibility for the individual's medical treatment has the ultimate responsibility to decide whether or not to authorise covert administration of medication. This decision should be taken following consultation. Before deciding, the practitioner must consider:

1. Necessity

Firstly, it is essential to consider the necessity of treatment. Is it so essential that it needs to be given by deception? For example, some medications, e.g. vitamin supplements, may have only slight benefits. It may be hard to justify giving these medications covertly. Practitioners should base their decision on clinical guidelines if available, for example, the Scottish Intercollegiate Guidance Network (SIGN) guidelines on dementia⁴. Also, a review of medication as recommended by the NHS Scotland Polypharmacy Guidance⁵ may be necessary.

4 <http://www.sign.ac.uk/pdf/sign86.pdf>

5 <http://www.central.knowledge.scot.nhs.uk/upload/Polypharmacy%20full%20guidance%20v2.pdf>

2. Capacity.

Does the individual have the capacity to decide about medical treatment? If so, covert medication must not be considered and would be an assault and a breach of human rights. Practitioners should assess capacity according to the principles explained on page 4 and the definition given on page 5. The Codes of Practice for the 2000 Act give guidance on assessment of capacity. It is very important to give the individual as much assistance as possible. This may include the use of communication aids. Speech and language therapy and/or psychology input may be of value. Our guidance on 'Consent to treatment' covers this in greater detail. If the individual lacks capacity, the practitioner will either certify incapacity on a section 47 certificate (as required by the 2000 Act), or use appropriate documentation where the individual is being treated under the 2003 Act.

Incapacity is decision-specific and can be temporary or permanent. An individual with temporary incapacity could regain capacity to decide about treatment. Covert medication is no substitute for explanation and education. It should only be considered if impaired intellectual function makes this impossible.

As explained above, a child's capacity to make decisions depends on their age and stage and develops over time. In terms of the Age of Legal Capacity (Scotland) Act 1991⁶, children under 16 can consent to medical treatment if they understand what is being proposed. It is up to the doctor to decide whether the child has the maturity and intelligence to fully understand the nature of the treatment, the options, the risks involved and the benefits. Very young children, and those who are not considered to be capable of making their own decisions, cannot either give or withhold consent. Those with parental responsibility need to make the decision on their behalf. When the individual reaches 16, parents may need to consider applying for welfare guardianship in order to continue to do this.

In any situation where a parent or family carer is administering covert medication, we strongly advise following this guidance. Practitioner staff and carers must ensure safe and lawful administration of medication.

We know of family carers who sometimes administer medication covertly. In our view, this must be authorised by the medical practitioner responsible for prescribing the treatment and must be in line with our guidance. Family carers should not take responsibility for this decision.

3. Apply legal principles and procedures.

It is important to consider relevant articles of ECHR and the principles of relevant Scottish legislation. It is particularly important to respect privacy. Under article 8 of ECHR, any interference with privacy, including giving covert medication, must be:

- Lawful: in accordance with a law which allows the right to be restricted i.e. the 2000 Act or the 2003 Act;
- In pursuit of a legitimate aim: this includes the protection of health and the protection of the rights and freedoms of others;
- Necessary: as discussed above under 'Necessity'; and
- Proportionate: this means a balancing act must be carried out. The treatment must be the least restrictive effective means of achieving a legitimate aim. Applying the principles of the 2000 Act set out below is a way to carry out this balancing exercise.

⁶ <http://www.legislation.gov.uk/ukpga/1991/50/contents>

Practitioners considering covert medication must keep these factors in mind at all times.

Treatment will usually be given in line with the 2000 Act. The medical (or other suitably trained) practitioner will issue a section 47 certificate of incapacity. For multiple interventions, this should be accompanied by a treatment plan. It would be good practice for the section 47 certificate or treatment plan to mention covert administration of treatment if necessary.

When considering covert medication, the practitioner must apply the following principles:

- **Benefit.** Is the treatment of benefit to the individual? Treatment that is only being given for the benefit of others cannot be given under this Act. It is not an adequate justification that it would merely be easier to give medication covertly than by any other means. Any benefit needs to be balanced with the risk of giving medication covertly. There may be a degree of risk by changing the way the medication is absorbed. There is also a risk that the individual may taste the disguised medication. This could damage the relationship between the individual and care staff. The individual may refuse food or drink as a result.

Given without regard to safety, covert medication could be dangerous. We strongly advise a risk/benefit analysis before covert medication is given. Where medication is being administered covertly for stressed or distressed behaviour, this must be part of an overall management plan. Other interventions must be considered before considering medication.

- **Minimum restriction of freedom.** Is the covert method the best way to achieve this? Would it cause the individual the least distress? Would other forms of administration result in a need for restraint and/or force? Article 3 of the ECHR prohibits inhuman or degrading treatment. If medication is necessary, it should be given without degrading the individual. Using force, e.g. to administer necessary medication by injection, may be considered degrading if there are alternatives. Likewise, administering unnecessary medication in whatever way, including covert administration, could be regarded as degrading. Also, if administration of medication results in a deprivation of liberty, e.g. by sedating an individual to prevent him/her leaving, this must be in accordance with article 5 of ECHR. We would advise detention under the 2003 Act or welfare guardianship under the 2000 Act in this situation.
- **Take the individual's past and present wishes into account.** It is important to find out why the individual is refusing medication. It is easy just to accept that the individual 'lacks judgement'. However, there can be another meaning behind the refusal. The individual may never have been in favour of taking medication. Also, the refusal could be an indication that the individual no longer wishes treatment. Practitioners need to consider these possibilities. There is a duty, under the right to respect for private life, for an individual's previous clearly stated views on treatment to be taken into account. Advance statements may help, but it is also important to consider anything the individual may have said to relatives or friends in the past. The involvement of independent advocacy will help to determine the individual's present views. The 2003 Act states that an individual with mental disorder has a legal right to independent advocacy.

- **Consult others.** This is especially important if medication is to be given covertly. Those with greatest knowledge of the individual will be able to advise on the best way to encourage him/her to take medication. They will also be able to suggest the most appropriate ways to disguise medication, e.g. by advising on the individual's preferences for food or drink.

There must be a full discussion within the multidisciplinary team. Expert pharmacy guidance is essential (see below). In addition, there must be some consultation outwith the clinical team. If the individual has a welfare proxy (welfare attorney or guardian) with the power to give or refuse consent, that person must be consulted unless impracticable. Treatment cannot proceed if that person objects.

If there is no welfare proxy, relatives and friends most closely involved should be consulted. They may be able to relate information about the individual's past wishes, as well as giving their own views. If there is no relative or friend available to consult, we especially advise the involvement of advocacy. The local authority should be informed as there may be a need for welfare guardianship. In cases of uncertainty, the Mental Welfare Commission may be able to advise. If any person with an interest in the individual's welfare disagrees with a treatment decision, they should be told of the procedure to appeal the decision to the Sheriff.

- **Encourage the individual to use existing skills and develop new skills.** This is not a requirement of those administering medical treatment, but it is still good practice. The individual must have every opportunity to understand the need for medical treatment and to make and communicate decisions.

Covert medication in practice

We thought it might be helpful to devise a covert medication care pathway. Appendix 1 gives an example of such a pathway. Some services may wish to develop their own pathways. We would be happy to see this, providing the essential elements described in this guide are included. The medical practitioner primarily responsible for the individual's care should take responsibility for documenting the care pathway, in consultation with relevant others. Once the decision to give medication covertly has been made, the team needs to consider the practicalities of giving it.

Issues to consider are:

- **Can the medication be safely disguised?** Generally, crushing tablets means that the medication is being given outwith its product licence. There may be particular dangers if tablets are crushed. In particular, slow-release or enteric-coated medication must never be crushed. This could be dangerous for the individual. Staff and managers need to be aware of this, as they could be liable for any damage. Before giving medication covertly, there must be documented advice from a pharmacist on how to do this safely. It is not the role of the pharmacist to sanction the use of covert medication. Their specialist knowledge would help to identify the best method of covert administration and identify any risks that might arise. The result should be a 'recipe' for giving each medication safely in covert form. We have provided a template for recording this in our care pathway in Appendix 1.

- **Who is administering the treatment?** Care staff need to understand how to give the medication and there must be appropriate supervision. We would expect to see a care plan to support the covert administration of medication, including the way that each medication is administered. Where family carers are considering giving medication covertly to individuals at home, we still advise discussing this with the prescriber and, in particular, a pharmacist.

It would also be good practice to pass on information about covert administration of medication when care is being transferred, e.g. from hospital to care home. The care plan for this should follow the individual.

- **How is covert medication recorded?** Prescribing and recording documentation in hospitals and care homes should clearly record where that medication is to be administered covertly. This may cross-refer to accompanying documentation, such as the care pathway suggested in Appendix 1.
- **When will the need for covert treatment be reviewed?** It is important to review whether the treatment continues to be necessary. If so, is covert administration still necessary? We advise an early review once the initial decision is made. The Royal College of Psychiatrists suggests weekly review. Our advice is to keep covert administration under regular review and set a formal review meeting for all to share their views. The timescale for this will depend on individual circumstances, e.g. the expected duration of treatment and fluctuating mental state and capacity.
- **What happens if additional treatment is required?** While medication is being administered covertly, the individual may have an apparent need for additional or acute treatment. It is very tempting just to administer this covertly. We strongly advise considering this as a completely new situation and considering all the above issues from the beginning. If possible, there should be one pathway document which can be amended to include new medications added to the regime.

In devising this guidance, the group we consulted considered some case examples. We have given these examples, along with the views of members of the group, in Appendix 2.

Conclusion

There are occasions where covert administration of medication can be considered the best way to provide an individual with necessary medical treatment. It must be given safely and in accordance with the law. By following this guidance, practitioners will be able to demonstrate that they have done their best to comply with best legal and ethical principles when giving treatment in this way.

Appendix 1: Covert medication care pathway

Available to download from www.mwscot.org.uk

Name of patient

DOB

Location

What treatment is being considered for covert administration? Name the actual medication(s).	
Why is this treatment necessary? Where appropriate, refer to clinical guidelines, e.g. SIGN.	
What alternatives did the team consider? (e.g. other ways to manage the individual or other ways to administer treatment) Why were these alternatives rejected?	
Treatment may only be considered for an individual who lacks capacity. Outline the assessment of capacity.	Assessed by:
Treatment may only be administered under a certificate of incapacity (Section 47, AWI) or appropriate Mental Health Act documentation. What legal steps were followed?	Legal documentation completed: AWI S47 MHC&TSA Date:
Treatment may only be given if it is likely to benefit the individual. What benefit will the individual receive from each medication administered covertly?	
Is this the least restrictive way to treat the individual? Give reasons.	
What are the individual's present and past views of the proposed treatment, if known?	
Who was involved in the decision? N.B. A qualified pharmacist must give advice on safe administration if this involves crushing tablets or combining medication with food and drink. N.B. If there is any person with the power to consent (welfare attorney, welfare guardian), then the treatment may only be administered covertly with that person's consent unless this is impracticable.	Practitioner staff involved: Pharmacy advice obtained from: Relatives or other carers involved:

Do any of those involved disagree with the proposed use of covert medication? If so, they must be informed of their right to challenge the treatment.	Yes/No Date informed
When will the need for covert treatment be reviewed?	Date of first planned review:
Covert medication plan: outline method of covert administration for each medication Medication 1 Method of covert administration Medication 2 Method of covert administration Medication 3 Method of covert administration Medication 4 Method of covert administration (add more if necessary)	

Signed:

(Name)

(Designation)

(Date)

Covert medication care pathway review

Name of patient

DOB

Location

Is treatment still necessary? If so, explain why.	
Is covert administration still necessary? If so, explain why.	
Who was consulted as part of the review?	
Is legal documentation still in place and valid?	
Date of next review	

Signed:

(Name)

(Designation)

(Date)

Appendix 2: Case scenarios

We held a consultation event to help us develop this guide. We gave participants some cases to discuss. Some of these cases are included here. While the cases are based on real situations, the details have been changed. None of these cases involve an actual individual known to the Commission. The general issues raised by the cases have been incorporated into the guidance and the care pathway in Appendix 1. We thought it would be helpful to show some of the thought and discussion that the case examples provoked.

Case scenario 1

Mr Smith has dementia and is in a care home. His dementia is severe, he cannot communicate verbally and he resists nursing care. He is a widower and his only close relative is his daughter. She would like to look after him at home, but the difficulty of caring for him would make this impossible. Mr Smith has high blood pressure and heart trouble. He needs medication to keep his blood pressure stable. He is also on diuretics and tablets for angina. Without all of these, he is in danger of stroke, heart failure or a heart attack. He has become increasingly reluctant to take his medication. When he is given tablets, he spits them out. Trying medication in liquid form is no better. Without his medication, his health is in danger. His daughter is very concerned and wants him to get treatment, no matter what.

We decided that covert medication was an option. Before making the decision, we thought that it would be important to consider why he is refusing. Assessment of capacity is essential and there should be a section 47 certificate, ideally with a treatment plan. Also, could he be making a decision not to accept his medication? Has he made any previous statement about not wanting to go on living if he is dependent and in a care home? His daughter and other relatives may have information on this. He may have the right to 'give up', although assessment for depression would be important.

The team needs to consider the risks and benefits of any treatment he may need. For instance, preventing discomfort caused by breathlessness and angina is more important than treatment that, for example, might reduce the risk of stroke by a few percent.

Mr Smith is given his medication covertly. He is taking it and his medical condition is stable. He is still quite resistive and aggressive. His daughter is still keen to try to care for him at home, but only if he is less disturbed. Medication might make this better. You already give him other medication covertly. The daughter asks if he can be given medication to take the edge off his aggression covertly.

We saw no fundamental difference between this decision and the decision to treat his physical condition. It must be considered anew with a full risk/benefit analysis. Is this of benefit to him? Would it improve his quality of life if his daughter cared for him? Might the effect of sedative medication detract from this benefit? Would the team be doing this for his benefit or his daughter's?

His daughter is able to care for him at home. A long lost son appears on the scene. He is horrified that his sister is giving his father medication covertly. He demands that she stops doing this.

We thought that it would be essential to arrange a meeting with the son to explain the decision and talk through his concerns. If he still disagrees with treatment, he should be informed of his option to apply to the Sheriff for an order to stop treatment.

Case scenario 2

Ms Brown has a severe degree of learning disability. Her parents care for her in the family home. They are known to be very caring and have her best interests at heart. She has epilepsy and can have outbursts of aggressive behaviour around the time of her seizures. She can communicate for most of the time but does not understand that she has epilepsy. She does not realise that her behaviour can become a problem at times. Her doctor prescribes anticonvulsant medication for her epilepsy. Usually, she takes this without any problem. Sometimes, when her behaviour becomes disturbed, she refuses her medication. Her parents ask the GP to prescribe it in liquid form so that they can give her the treatment covertly.

It is likely that treatment will be necessary. The GP would need to consider the individual's capacity. Communication aids and education would be very helpful and involvement of the multidisciplinary team is essential. If this fails, then covert administration could be considered. This must be covered by a certificate of incapacity.

In this case, the GP decided to prescribe the medication and let the parents administer it covertly without any legal steps being taken. He also gave them some sedative medication in liquid form in case Ms Brown becomes very disturbed. They use this very rarely.

Mrs Brown, the mother, takes seriously ill and is admitted to hospital. Caught between the needs of his wife and his daughter, Mr Brown asks for respite care for his daughter. She is admitted to a domestic style short stay/respite facility with 24 hour professional staffing. The staff are told about the arrangements for giving medication covertly. They are unhappy about doing this under the informal arrangement between the GP and the parents.

Our advice would be to get appropriate legal documentation completed as soon as possible. In the meantime, she may suffer if she does not get the treatment she needs. Continuing her anticonvulsant treatment could be justified in this way as an emergency. Giving sedative treatment is less likely to be justified. Care facilities need to have policies about covert medication. We worried that some people might not get necessary treatment if the care facility has a blanket policy against such treatment.

Case scenario 3

Mr Jones suffers from schizophrenia. Without medication, he becomes very paranoid. He sometimes agrees to take medication but often refuses because he does not like the side effects. He lives at home with his mother who is very caring but also afraid of him when he is paranoid. She is very keen that he gets his medication. A year ago, he was being given medication by depot injection. He agreed with his doctor and his mother that he would come off the depot and take oral medication instead. He is not being treated under any legislation.

A new community psychiatric nurse takes Mr Jones on to her caseload. When she visits, Mr Jones says that he has stopped his medication because he feels he can manage without it and he has put on a lot of weight, a known side effect of the treatment. However, his mother takes her aside and quietly tells her that she has been giving Mr Jones his medication crushed up in his food.

This is a very difficult situation. The mother should not have been doing this and must be advised to stop. If she refuses, stop the prescription. We had mixed feelings about telling Mr Jones about his covert treatment, as it would risk the relationship with his mother and possibly the mother's safety. Ideally, she needs the support to tell him herself.

While the nurse is trying to sort this out, Mr Jones is admitted as an emergency to a general hospital. There is no connection between this and his mental illness. He needs to stay in for at least a fortnight. His mother tells the staff to give him his antipsychotic covertly.

The staff should not agree to this. Assessment by the liaison psychiatric team is appropriate. He should be offered treatment. He would be likely to refuse as from his point of view he has been free from treatment for months and is mentally well.

We thought that the most appropriate action was for him to remain free from drug treatment. The mental health service would need to monitor his mental health carefully when he goes home and be ready to intervene if he shows signs of becoming ill.

Case scenario 4

Mr Black is in a care home. He has a mild degree of dementia and loses things regularly. He believes that someone is coming into his room and stealing his possessions and frequently calls the police. The lost items always turn up and it is clear that he has mislaid them. He does not accept this and all efforts to help him have failed. He is on several medications for physical conditions. He has taken these for many years and is fully aware of what he is on and why. He is seen by an old age psychiatrist. She thinks that antipsychotic medication might help but he adamantly refuses this. She considers using mental health legislation to give compulsory treatment in the form of a depot injection. The care home staff are unhappy about the trauma that removal to hospital and forcible treatment will cause. They ask if they can give him covert medication.

We were unhappy about the suggestion to use covert medication. Remove the word 'dementia' and the question of covert medication is unlikely to arise. We also questioned the need for medication and advised a careful risk/benefit analysis. In this situation, any treatment would need to be under the terms of mental health legislation. We had sympathy with the desire that he should not be removed to hospital. However, we still felt that covert treatment was not appropriate. He could not be treated by force in the care home, but he could be treated under a compulsory treatment order if force was not used. If force was necessary, the team would need to consider whether admission to hospital for treatment would be of enough benefit to outweigh the distress and disorientation that it may cause.

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