

Covert medication

Introduction

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 person 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 person's physical or mental health.

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?

The use of covert medication is widespread. Research suggests that over 70% of

care establishments for people with dementia have used covert medication at some time¹. There is current guidance from the Royal College of Psychiatrists² and the Nursing and Midwifery Council³. The Mental Welfare Commission for Scotland issued guidance in a previous version of *Rights, Risks and Limits to Freedom*. This existing guidance needed to be reviewed in the light of principles and procedures of new legislation in Scotland.

Part 5 of the Adults with Incapacity (Scotland) Act 2000⁴ provides authority to give medical treatment to a person 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 the Act makes no mention of covert medication. While there will be some mention of it in a revised Code of Practice, more detailed guidance is needed.

Agreed starting point

When we consulted with interested parties, there was a consensus that while covert medication

is sometimes necessary and justified, *it must never be given to someone who is capable of deciding about medical treatment*. It was also agreed that:

- It is generally unlawful to administer medication without consent.
- Where the individual is incapable of consenting, it could still be regarded as an assault unless done appropriately.
- The rights of the individual need to be protected.
- Those prescribing or administering covert medication need protection.

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")⁵.

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 person'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 relevant other 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 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 Act covers medical treatment and research. Briefly, the provisions of this part of the 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 person lacks capacity, treatment can be given. The practitioner issues a certificate of incapacity.
- 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 person 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.
- The person may have a welfare guardian or welfare attorney with the power to consent to treatment. If so, that person should be consulted (if reasonable and practical). If this person disagrees, treatment may only go ahead after an independent opinion. The Court of Session may decide if there is still disagreement.
- Anyone with an interest in the person's welfare can make an appeal, on a treatment decision, 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;
- provision of appropriate services.

This Act only covers treatment for mental disorder. Part 16 of the Act deals with treatment for people who are subject to compulsion. If capable of consenting, the person gives consent in writing. The person can be treated if he/she is incapable of consenting or refuses to consent. Any drug treatment

for mental disorder can be given within the first two months. The responsible medical officer must give written reasons for treatment if the person does not consent. After two months, treatment can only continue with written consent or following an independent opinion. Drug treatment to reduce sex drive needs an independent opinion from the start.

Despite these two new 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 a person who refuses medication in general, we do not draw a distinction between treatment for physical and

mental disorders. However, where the person specifically accepts treatment for physical illness but refuses mental health treatment, we advise consideration of mental health legislation.

Deciding whether to give covert medication

1. Necessity. Firstly, it is essential to consider the necessity of treatment. Is it so essential that it needs to be given by deception? Practitioners should base their decision on clinical guidelines if available, e.g. the Scottish Intercollegiate Guidance Network (SIGN) guidelines on dementia⁶.

2. Capacity. Does the person have the capacity to decide about medical treatment? If so, covert medication must not be considered and would be an assault. Practitioners should assess capacity according to the definition given on page 3. The Codes of Practice for the 2000 Act give guidance on assessment of capacity. It is very important to give the person 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.

Covert medication is no substitute for explanation and education.

Our guidance on 'Consent to Treatment' covers this in greater detail. If the person 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 person is being treated under the 2003 Act.

Incapacity can be temporary or permanent. A person 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.

3. Apply the principles of the 2000 Act. Most treatment will be given under this Act. The principles are:

- **Benefit.** Is the treatment of benefit to the person? Treatment that is only being given for the benefit of others cannot be given under this Act. 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 person may

taste the disguised medication and then refuse food or drink. We strongly advise a risk/benefit analysis before covert medication is given.

- **Minimum restriction of freedom.** Is the covert method the best way to achieve this? Would it cause the person least distress? Would other forms of administration result in a need for restraint and/or force?
- **Take the person's past and present wishes into account.** It is important to find out why the person is refusing medication. It is easy just to accept that the person "lacks judgement". However, there can be another meaning behind the refusal. The person may never have been in favour of taking medication. Also, the refusal could be an indication that the person no longer wishes treatment. Practitioners need to consider these possibilities. Advance statements may help, but it is also important to consider anything the person may have said to relatives or friends in the past. The involvement of

independent advocacy will help to determine the person's present views. If the person has a mental disorder, he/she has a legal right to independent advocacy.

- **Consult others.** This is especially important if medication is to be given covertly. 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 person has a welfare proxy (welfare attorney or guardian), 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 person'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 and the Care Commission may be able to advise. If any person disagrees with a treatment decision, he/she should be told of the procedure to appeal the decision to the Sheriff.

- **Encourage the person 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 person 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 person'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?** Sometimes, crushing tablets means that the medication is being given out with its product licence. There are likely to be particular dangers if slow-release or enteric coated tablets are crushed. This could be dangerous for the person. Staff and managers need to be aware of this, as they could be liable for any damage. We cannot place too much emphasis on the involvement of a pharmacist in any decisions.
- **Who is administering the treatment?** Care staff need to understand how to give the medication and there must be appropriate supervision. Informal carers giving treatment at home need education and support. In all cases, they may only give the treatment if authorised by the prescribing practitioner.

- **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 constant review and set a formal review meeting for all to share their views. The timescale for this will depend on individual circumstances.
- **What happens if additional treatment is required?** While medication is being administered covertly, the person may have an apparent need for additional treatment.

It is very tempting just to administer this covertly. We advise considering this as a completely new situation and considering *all* the above issues from the beginning.

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.

Appendix 1: Covert medication care pathway

Available as download from www.mwscot.org.uk

Name of patient

DOB

Location

What treatment is being considered for covert administration?	
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 person or other ways to administer treatment) Why were these alternatives rejected?	
Treatment may only be considered for a person 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 <input type="checkbox"/> MHC&TSA <input type="checkbox"/> Date:
Treatment may only be given if it is likely to benefit the person. What benefit will the person receive?	
Is this the least restrictive way to treat the person? Give reasons.	

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.	

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 is an actual person 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.

Signed:

(Name)

(Designation)

(Date)

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. 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 person'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. We are aware that these certificates are not always used when they should be.

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. 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 carer 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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