

College Statement on Covert Administration of Medicines

The College recognises the key importance of respecting the autonomy of individuals who refuse treatment. However, there are times when very severely incapacitated patients can neither consent nor refuse treatment. In these circumstances, the College echoes the view of the Law Commission that treatment should be made available to severely incapacitated patients judged according to their best interests and administered in the least restrictive fashion. In exceptional circumstances, this may require the administration of medicines within foodstuffs, when the patient is not aware that that is being done.

The College advocates the following:

- 1 Mental health law legislation such as the Draft Mental Capacity Bill in England and the Adults with Incapacity Act (Scotland) 2000 should be used in all circumstances where they apply.
- 2 All efforts must be made to give medication openly in its normal tablet or syrup form.
- 3 A record of the reasons for presuming mental incapacity (including at the time medication is administered) should be made in the clinical notes. Incapacity should be assessed as per the BMA guidelines (see endnote).
- 4 The patient should be unable to learn, even with support, and there should be a need for them to take medicine as well as a profoundly limited understanding of what is occurring. This will most often be due to severe dementia or profound learning disability.
- 5 Whenever such procedures are considered, there must be clear expectation that the patient will benefit from such measures, and that such measures will avoid significant harm to the patient or others.
- 6 Harm can include both mental and physical harm.
- 7 The proposed treatment plan and reasons for the plan should be discussed by the multidisciplinary team (or between consultant and nurse in charge of the ward in cases of urgency) and a record of the discussion made. In residential or nursing home settings, this might be between the senior nurse or manager on duty, and the consultant or general practitioner. Where patients are living at home with families or carers, we would encourage discussion between carers, the patient's GP and community health teams.
- 8 The proposed treatment plan should be discussed with a relative, carer or nominated representative unless it is clear that the patient would not have wished this.

- 9 The proposed treatment should be discussed with a pharmacist to ensure that medication may be mixed with food and will not be affected by procedures such as crushing. Any medical, cultural or religious dietary requirements should be complied with (e.g. gluten-free for patients with coeliac disease, avoidance of animal gelatin for vegetarian, Jewish or Muslim patients).
- 10 A record should be made of language or communication issues and the methods used to overcome these. For example, if an interpreter is used, note which language or dialect was used. This should also apply to discussions with the relatives.
- 11 The issue of covert medication should be included in the care plan and communicated in writing to the general practitioner. The issues may also require consideration when orodispersible medicines are used.
- 12 The treatment plan should normally be subject to weekly review initially and if the requirement for covert medication does persist, full reviews at less frequent intervals should take place.
- 13 The College believes that this guidance applies to the administration of either physical or mental health medicines.
- 14 The covert administration of medication in patients with schizophrenia and other severe mental illnesses where patients can learn and understand that they will be required to take medication is unacceptable.
- 15 Because this practice should only occur in exceptional circumstances, responses must be subject to review.
- 16 Trusts and organisations should develop a policy on this issue.
- 17 The College does not believe that the practice could ever be justified as part of a research project. Exceptional circumstances do not include research. Covert administration of medication is therefore not justified for research purposes.

Commentaries

Assessment of capacity

There is a presumption that all patients have capacity unless demonstrated otherwise. Patients with capacity must be able to:

- Understand in simple language what the treatment is, its purpose and why it is being proposed.
- Understand its principal benefits, risks and alternatives.
- Understand in broad terms what will be the consequences of not receiving the proposed treatment.
- Retain the information long enough to make an effective decision.

Make a free choice (i.e. free from pressure).

• Endnote on Human Rights Act 1998

We are not aware of any test case under the Human Rights Act 1998 of the practice of administering medication covertly. The following articles of the Human Rights Act seem particularly relevant.

Article 2 'Everyone's right to life shall be protected by law'

Article 3 'No one shall be subject to torture or inhuman or degrading treatment or punishment'

Article 5 'Everyone has the right to liberty and security of person'

Article 6 'Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law'

Article 8 'Everyone has the right to respect for his private and family life, his home, and his correspondence.'

Article 2 Where covert medication enables the provision of effective treatment to someone who would otherwise reject it, this article might be used to justify such a practice. Clearly no treatment may be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatments may, sometimes, shorten life as a secondary result of their administration). Administration of treatments whose purpose is to shorten life is illegal.

Article 3 In an incapacitated individual, repeated restraint and injection of treatment (with attendant risk to life as well) may be more degrading and inhuman than the covert administration of medication.

Article 5 To justify the invasion of privacy which covert medication entails, it must be clear that this invasion is justified by the need for effective treatment.

Article 6 It is essential that, if medication is administered covertly this is done following discussion and with clear clinical records, so that a fair and public hearing may be obtained when required.

Article 8 See comment to Article 5 above.

Related policies

Covert Administration of Medication Nursing and Midwifery Council guidance is accessible on www.nmc-uk.org.uk
Mental Welfare Commission for Scotland, rights, risks and limits to freedom, disguised medication: www.mwscot.org.uk
Ethical Conduct of Research on the Incapacitated, Medical Research Council: www.mrc.ac.uk
British Medical Association and Law Society (1995). *Assessment of Mental Capacity, Guidance for Doctors and Lawyers*. London: BMA.

Related articles

1. Treloar A, Philpot M, Beats B. (2001)
Concealing medication in patients' food.
Lancet, **357**, 62–64.
2. Treloar A, Beck S, Paton C. (2001)
Administering medications to patients
with dementia and other organic
cognitive syndromes. *Advances in
Psychiatric Treatment*, **7**, 444–452.