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694 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 6 Covert administration of medicines within food and drink This section deals with covert medication administration within UK law only. Other countries may have different laws pertaining to this area, or indeed no laws or official guidance.1 In mental health settings it is common for patients to refuse medication. People with psychiatric disorders may lack capacity to make an informed choice about whether medication will be beneficial to them or not. In these cases, the clinical team may consider whether it would be in the patient's best interests to administer medication covertly. This practice is known as covert administration of medicines. Guidance from the Royal Pharmaceutical Society and Royal College of Nursing2 and the Royal College of Psychiatrists3 has been published in order to protect patients from the unlawful and inappropriate administration of medication in this way. In the UK, the legal framework for such interventions is either the Mental Capacity Act (MCA)4 or, more rarely, the Mental Health Act (MHA).5 Assessment of mental capacity4,6,7 The assessment of capacity regarding medication is primarily a matter for the prescriber, usually a doctor treating the patient,4,6 or less commonly a pharmacist or nurse. Nurses and allied health professionals who are not prescribers will also have to be mindful of their own codes of professional practice and should be satisfied that the doctor's assessment is reasonable. The assessment must be made in relation to the particular treatment proposed as part of a covert medication care plan. Capacity can vary over time and the assessment should be made at the time of the proposed treatment. The assessment should be documented in the patient's notes and recorded in the care plan. Assessment of capacity should be conducted in line with the MCA code of practice. Guidance on covert administration If a patient has the capacity to give a valid refusal to medication and is not detainable under the MHA, their refusal should be respected. If a patient has the capacity to give a valid refusal and is either being treated under the MHA or is legally detainable under the Act, the provisions of the MHA with regard to treatment will apply (which are outside the scope of this chapter). The administration of medicines to patients who lack the capacity to consent and who are unable to appreciate that they are taking medication (e.g. unconscious patients) should not need to be carried out covertly. However, some patients who lack the capacity to consent would be aware of receiving medication if they were not deceived into thinking otherwise,7 for example a

patient with moderate dementia who has no insight and does not believe they need to take medication but will take liquid medication if this is mixed with their tea without being aware of this. It is this group to whom this guidance applies. Treatment may be given to people who lack capacity if the treatment is in the patient's best interests (Section 5, MCA4) and is proportionate to the harm to be avoided (Chapter 6.41, MCA Code of Practice7). So, there should be a clear expectation that the

Prescribing in older people CHAPTER 6 patient will benefit from covert administration, and that this will avoid significant harm (either mental or physical) to the patient or others. The treatment must be necessary to save the patient's life, to prevent deterioration in health or to ensure an improvement in physical or mental health.4,7 Covert administration must be the least restrictive option after trying all other options. An assessment should be carried out to understand why the person is refusing to take their medicines. Alternative methods of administration (e.g. liquid formulation) and trial of different approaches in nursing care (e.g. explaining to the patient about the medicines at the time they are administered or changing the time of administration to a time of day when the patient is more alert or less distressed) should be considered.8 The decision to administer medication covertly should not be made by a single individual but through discussion with the multidisciplinary team caring for the patient and the patient's relatives or informal carers. A Best Interests meeting should be held, except in urgent situations if the decision cannot wait, in which case a less formal decision can take place with a view to arranging a Best Interests meeting as soon as practicably possible. If it were determined at this meeting that the provision of covert medication would amount to a deprivation of liberty (where previously there was none), then an application for Deprivation of Liberty Safeguards (DoLS) authorisation should be made. Decisions regarding covert administration of medication should be carefully documented in the patient's medical records with a clear management plan, including details of how the covert medication plan will be reviewed. This documentation must be easily accessible on viewing the person's records and the decision should be subject to regular review. It is not necessary to have a new Best Interests meeting each time there is a change in medication. However, when covert medication is first considered, healthcare professionals should consider what types of changes in medication may be anticipated in future and should agree on the thresholds of what changes may require a new Best Interests meeting. This management plan should be recorded in the patient's notes. If significant changes that could cause adverse effects are envisaged, then a new meeting should be held before changes are made. In deciding how often capacity assessments should be repeated, clinicians should follow the guidance within the practical guide to the MCA.6 If there is any evidence that the patient has regained capacity with regard to administration of their medication, an immediate capacity assessment must be done. Decisions in the patient's best interest can no longer be made if they are under a DoLS authorisation for reasons including the administration of medication covertly; this part of the DoLS authorisation will no longer be valid and covert administration of medication must cease immediately. Case law9,10 has dealt with the relationship between the use of covert medication and the need for a DoLS authorisation. A person is deprived of their liberty when they are under continuous supervision and control and are not free to leave. The administration of covert medication will only in itself lead to a deprivation of liberty where that covert medication affects the person's behaviour, mental health or it acts as a sedative to such an extent that it will deprive the person of their liberty. The use of covert medication within a care plan must be clearly identified within the DoLS assessment and authorisation.

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