# Guidance for Providers – Administration of Medication without Consent

## Introduction: Reminder of General Principles

* Treatment without consent may be unlawful, and could give rise to liability
* Treatment without consent is an interference with the right to respect for private life under Article 8 of the European Convention on Human Rights; such treatment must be administered in a way that guarantees proper safeguards against arbitrariness
* Medication without consent (including the covert administration of it) is subject to the application of the Mental Capacity Act 2005 (MCA); both could be aspects of continuous supervision and control which indicate the existence of a deprivation of liberty (DOL). In accordance with the MCA, professionals are required to evidence consideration of whether proposed medication (and method of administration):

1. is in the person’s best interests (determined by reference to the MCA’s s4 ‘checklist’)
2. is necessary and proportionate in the circumstances, and
3. that no less restrictive option is available than the one proposed

* Careful consideration must be paid to the justification for medication in all cases, but especially if it may impact on a person's behaviour or mental health, or it is sedative in effect
* Medication should only be administered covertly in exceptional circumstances, and its use evidenced in the care and treatment plan. A review date must be agreed and recorded at the start to ensure covert administration is used no longer than necessary
* Manipulating dosage forms to facilitate covert administration or putting medicines in food and drink often means that medication is being used outside of its product licence. Consideration should be given to licenced alternatives, such as different formulations or a different drug for the same indication, which may be safer for the person
* Pharmacist advice should be sought in assessing the most appropriate and safest means of administration, especially where proposing to use a medication outside of its product licence.

## Definitions and meanings

* Treatment without consent arises where the person receiving care or treatment is unable to consent to it (for consent to be valid it must be a) voluntary, b) informed, and c) capacitous). A *refusal* to consent which does not meet this criteria (i.e. a refusal which is not voluntary, informed, and capacitous) requires further consideration/ investigation
* Covert medication means administration of medication in a disguised format without the knowledge or consent of the person receiving it, e.g. in food or drink
* IMCA means independent mental capacity advocate
* Serious medical treatment means the provision, withholding or withdrawal of treatment in circumstances where:

1. If a single treatment is proposed, there is a fine balance between the likely benefits and the burdens to the person and the risks involved or
2. A decision between a choice of treatments is finely balanced or
3. The proposed treatment is likely to have serious consequences for the person

*Be aware: some decisions regarding serious medical treatment require an application to the court*

* Relevant others means (for e.g.) the person’s family members, RPR (Relevant Person’s Representative), advocate, attorney, deputy, those engaged in caring for them or interested in their welfare. Who the person’s relevant others are will vary from person to person. Where an RPR, attorney or deputy is appointed, they must be included in best interests’ decisions and reviews of care and treatment plans. An attorney or deputy may have authority to decide to accept or refuse medication on the person’s behalf.

**This document is issued as GUIDANCE. Professionals remain responsible for their actions under the law and, where relevant, their Code of Conduct or Standards of Practice.**

## What is Required of Providers?

**In all cases**

1. Take reasonable steps to establish whether the person has/ does not have capacity to consent to medication at the time it needs to be administered, using the MCA’s capacity test (i.e. is the patient unable to make a decision because of an impairment or disturbance in the functioning of their mind or brain?). NB capacity is decision and time specific
2. Make reasonable adjustments/ take reasonable steps to help the person to make their own decision (e.g. use memory aids or non-verbal communication tools) regarding whether to consent to this medication
3. Consider whether this decision can wait. If the person is likely to regain capacity, but the decision to administer this medication cannot wait until they do, continue by following steps 4 to 13 below
4. If a person lacks capacity to consent to administration of medication (including covertly) it must be in their best interests, necessary and proportionate in the circumstances, and the less restrictive option available
5. Confirm if the person has an attorney or deputy with authority to consent to medication on their behalf; an attorney/ deputy has an elevated status in decision making. Check the court order/ attorney document to ensure relevant authority has been granted; lodge a copy with the person’s records
6. If a person refuses to take their medication, consider the possible reasons for this (the person may be unable to communicate their reasons) and whether any difficulties can be addressed e.g. the person has difficulty swallowing or dislikes the taste of the medication, which may be overcome by using a different formulation. The person’s relevant others may offer guidance from their own experience of the person. Difficulties should be referred to the prescriber for further advice
7. If a person is unable to understand the risks to them of not taking their medication, and they are refusing to take it, the medication may be administered covertly in exceptional circumstances in the person’s best interests. The prescriber should indicate the circumstances in which covert administration may be contemplated – if they have not done so, ask them
8. Where covert administration may be required, prescribers will consider the following (by way of example only – they will use professional judgement to consider any other relevant factors):
9. Whether consideration of covert administration should trigger a wider medication review (e.g. to consider if the medication remains necessary, why the benefits of it outweigh any risks, and if the medication is necessary/ justified, what methods of delivering it may be most appropriate)
10. Whether the medication is time specific, e.g. if it is refused in the morning, but may be accepted by the person in the afternoon, is the delay material? How long before the delay is material? How many refusals would it take before a resort to covert administration is justified?
11. How the medication can be safely administered covertly e.g. by placing it in food? This decision will need to be taken in tandem with the person’s relevant others, who may know best what the person is/ is not likely to tolerate
12. If unsure about the best and safest methods for delivering medication in certain circumstances or in respect of combinations of medication, consulting a pharmacist
13. Be aware that where serious medical treatment is contemplated by a prescriber, an IMCA should be appointed if no one is available to consult regarding the person’s best interests, except those providing professional/ paid care
14. The following information must be included in the person’s care plan and readily accessible to relevant healthcare professionals supporting them (including best interests assessors), and to an attorney/ deputy and RPR:
15. consideration of any relevant advance statement or Advance Decision to Refuse Treatment (ADRT), incl previous wishes/ patterns of behaviour e.g. the person always wanted a flu jab when capacitous
16. the medications prescribed, including covertly (what is the medication, what is it prescribed for, and why the benefits of it outweigh the risks)
17. the reason for, and approach to, any covert medication (why is it necessary to administer covertly and how can this be safely achieved, e.g. by placing the medication in food)
18. the details of any regular, on-going review by clinicians, pharmacists and other care professionals (roles and responsibilities for monitoring should be clearly recorded). Reviews should involve the person’s relevant others
19. whether the covert medication plan will continue to be required
20. the meeting/ discussion during which the administration of medication without consent (including covertly) was agreed to be in the person’s best interests, with details of who was involved in the meeting/ discussion. NB A physical best interests meeting (as opposed to a discussion which may take the form of various phone calls or separate meetings) may not be needed unless the nature and effect of the medication in question and/ or its administration is serious. The person should be included in the decision as far as it is reasonably practicable. As a minimum, the person’s attorney/ deputy must be consulted. The extent of the consultation should be proportionate to the circumstances; it may be impossible in an emergency

IF YOU LACK ANY OF THE INFORMATION AT A) TO F), ASK FOR IT

1. Consider whether the medication and proposed method of administration – viewed in context of the person’s care and treatment as a whole – now amounts to continuous supervision and control which could constitute a DoL. If your organisation is a managing authority, apply for authorisation if required. If your organisation is not a managing authority, consult with the person’s key worker. If the person has no key worker, contact the DoLS Team for advice on 01472 232244
2. Where there is dispute that medication without consent, or covertly, is in the person’s best interests, and resolution by other means proves impossible, an application to the Court of Protection may be necessary (for guidance on resolving disputes, see Chapter 15 of the MCA Code of Practice). Your organisation’s role in such disputes or resulting application will depend on whether it is a managing authority. Alert the person’s key worker to significant disputes of which you are aware. If the person has no key worker and the dispute relates to a DoL or possible DoL, alert the DoLS Team on 01472 232244; disputes which do not relate to a DoL or possible DoL should be referred via the Single Point of Access (including safeguarding concerns) via 01472 256256
3. Any decision to administer additional medication without consent, or to amend the method of delivery of an existing medication, should follow all of the steps above. Providers must keep such matters under review and ensure that recording is up to date.

## In cases where the person is subject to an authorised DoL

1. Administration of medication without consent, including covertly, should be clearly identified in the authorisation depriving the person of their liberty; such authorisations are likely to include conditions regarding medication review
2. If the authorisation is to be for a period of longer than six months there must be regular, possibly monthly, reviews of the care plan (the regularity of review will depend on the needs of the person and the circumstances e.g. the nature and effect of the medication/ its administration and what is stipulated in any condition)
3. Changes during the currency of an authorisation could arise where:
   1. a new decision to administer medication without consent is made, including covertly
   2. a decision is made to amend the medication being administered, including covertly
   3. a decision is made to amend the method of delivery of an existing medication (e.g. the medication has not changed, but the need to administer it covertly has arisen, or a physical change to the person’s condition necessitates the change)
4. The changes listed at 3 (a) to (c) above should only be made following a best interests’ decision involving relevant care professionals and the person’s relevant others (including the RPR and attorney/ deputy). The person should be involved in the decision as far as reasonably practicable
5. Change to the care plan arising from such a decision should be clearly recorded and notified promptly to a) the Supervisory Body, and b) RPR, attorney or deputy where it has been impossible to involve them in the decision making
6. Alternate medication, similar in prescription, may not represent a change of circumstances triggering a part 8 review; a change in prescription in strength/ dosage, nature and effect will almost certainly do so.

**In an emergency where it is impossible to secure capacitous consent or contact any appointed decision maker (attorney or deputy), provide treatment in the person’s best interests which is immediately necessary to save life or avoid deterioration in their condition (subject to consideration of any valid & applicable ADRT etc). Ensure your actions and reasoning are appropriately documented.**

**Flowchart outlining the process for administration of medication.  Applicable where
a) all reasonable steps have been taken, without success, to help a patient (P) to decide whether to accept/reject this medication and
b) the prescriber reasonably believes that P lacks capacity to decide to accept/reject this medication**