Doctors often struggle to assess risk and decision making capacity in patients with severe eating disorders, and to apply mental health legislation to protect individuals' life and health without undue restriction of liberty. The effects of eating disorders on the decision to accept treatment are more subtle than those of most other severe mental illnesses. Risks to personal health and safety are less likely to involve clear cut acute physical violence.

Once the decision is made as to whether to invoke the law, there remains the task of finding means to impose effective treatment for a disorder which requires a range of co-ordinated interventions over many months, sometimes even in the face of persisting refusal.

Principles of UK mental health legislation

- British mental health legislation is embedded in European Human Rights Law. Mental health law may be used to protect survival and quality of life for patients with severe eating disorders.

- UK mental health law makes doctors legally responsible for compulsory treatment if: the individual suffers from a mental condition, there is significant risk of harm attributable to the disorder and legal compulsion is invoked for the least restrictive available treatment to prevent harmful consequences.

- All fully registered doctors may briefly detain patients and provide immediately necessary treatment. Only specially approved psychiatrists (Section 12 approved in England & Wales, and Approved Medical Practitioners in Scotland) can undertake longer detention orders.

- The threat of detention itself constitutes a restriction of liberty, so where consent is inconsistent, legal validation for treatment safeguards staff and patients' rights.

- Individuals with anorexia nervosa are rarely globally incapacitated. They satisfy cognitive tests and retain the capacity to make wills or enter into contracts. However, they cannot rationally balance the consequences of treatment that involves weight gain. Extreme fear of weight gain drives treatment refusal and underestimates the likelihood of death.

- The Code of Practice to the English Mental Capacity Act 2005 specifically mentions anorexia nervosa as a condition where patients may have impaired decisional capacity in spite of having a good understanding of risk. Similarly, Scottish law refers to ‘seriously impaired decision-making ability’.

Mental Health Acts in different legislatures

- In England, Wales, Scotland and Northern Ireland there are differences in timescales allowed for detention, the powers and responsibilities of the next of kin and there are different legal arrangements for children and adolescents.

- England and Wales now have the option of community orders. Scotland’s community orders have been legal since 2005 and do not need to be preceded by hospital orders. Northern Irish Mental Health Law is currently undergoing modification.

- Families and other carers are supported by thoughtful use of legislation.

- ‘Average’ recovery time from anorexia nervosa is 7 years - decades in severe cases.

- Six month orders (extended if necessary) provide a more realistic time-scale for addressing the illness.

- Compulsory treatment provides opportunities for the patient’s rights to be upheld by tribunals.

- Community orders may shorten admissions and allow safer transition from hospital.
• They work best when treatment seeks prevention of deterioration rather than further heroic weight gain.
• They are more successful when consequences are explicit and realistic.

Risk assessment

• Weight (or BMI) alone is not accurate in assessing risk of death and damage. Age, physique, length of illness, speed of deterioration and risks from purging, overactivity and other ‘compensatory’ behaviours complicate matters.

• Nutrition treats physical consequence of mental disorder, where the mental disorder cannot be managed without addressing the physical problem, and where physical consequences must be treated to prevent harm.

• Emergency life-saving nasogastric feeding can be given to a detained patient. There is legal precedent for the use of nutrition as treatment for a mental disorder.

• Colleagues in law and social work bring their own expertise but also expect respectful guidance regarding the nature of eating disorders.

Outcomes

In a study conducted by Ramsay et al (1999) on 80 adult anorexic patients: detained patients had more previous abuse and self-harm as well as more previous admissions, detained patients took longer to gain weight and 12% of detained patients died after 5.7 years compared with 2% of voluntary patients.

In Ayton et al’s study in 2009 on 50 adolescent patients with a mean age of 16, where some were detained under the Mental Health Act 1983 and others treated under parental consent:

• detained patients had worse psychopathology/social functioning, suicidal behaviour and more previous admissions

• MHA-detained patients gained more weight, and had better outcome at 12 months follow up

• there were two deaths in the non-detained group, where the patients had taken early discharge against medical advice. There were no deaths in the detained group.

Further Reading


CPD Online module: GAIN Guidelines: Mental Health (NI) Order 1986 – Modules 1–4

CPD Online module: Mental Health Act 1983: Criteria for detention

Mental Health Act 1983

Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health NI Order (1986)