

**Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983**

This guidance relates to England only

Previously issued by the Mental Health Act Commission and reviewed October 2008

**INTRODUCTION**

**This note provides guidance on use of the Mental Health Act in the treatment of anorexia nervosa, including whether the Act may provide authority for compulsory feeding in certain circumstances.**

1. The Care Quality Commission (CQC) is sometimes asked about the application of the Mental Health Act 1983 (’MHA 1983’) to patients with anorexia nervosa. For many such patients compulsory measures will be unnecessary. Because patient autonomy is often a long-term objective in the management of the condition, compulsion may be counter-productive. However, it is a condition in which the physical health or survival of a patient may be seriously threatened by food- or fluid-refusal and a decision about whether to use the Mental Health Act 1983 will arise.
2. This guidance note gives advice on the treatment of anorexia nervosa under MHA 1983. There are other possible legislative options for children under the age of 18, especially in the Children Act 1989, but they are not examined here. Reference should be made to chapter 36 of the revised MHA 1983 Code of Practice.

# 3 FAQs

1. May a patient with anorexia nervosa be detained under the MHA 1983?
2. In what circumstances might compulsory treatment be given to a detained patient who has anorexia nervosa?
3. Might treatment for anorexia nervosa include the authority to feed the patient compulsorily?

4 Although these questions will be considered in this Guidance Note, it is necessary first of all to resolve certain issues of definition and diagnosis. These issues apply to all patients who are or may be suffering from anorexia nervosa, including children.

# Anorexia nervosa - definition

1. Anorexia Nervosa is described in the tenth revision of the International Classification of Diseases (ICD-10) under the heading of Eating Disorders (F50.0):

"Anorexia nervosa is a disorder characterised by deliberate weight-loss, induced and/or sustained by the patient. The disorder occurs most commonly in adolescent girls and young women, but adolescent boys and young men may be affected more rarely, as may children approaching puberty and older women up to the menopause. Anorexia nervosa constitutes an independent syndrome in the following sense: a) the clinical features of the syndrome are easily recognised so that diagnosis is reliable with a high level of agreement between clinicians; b) follow-up studies have shown that, among patients who do not recover, a considerable number continue to show the main features of anorexia nervosa in a chronic form".

1. ICD 10 suggests that for a definite diagnosis all the following criteria should be met:
	1. body weight maintained at least 15% below expected body weight;
	2. weight loss self-induced by avoidance of fattening foods or by one or more of the following: i) vomiting; ii) purging; iii) excessive exercise; iv) use of appetite suppressants and/or diuretics.
	3. body image distortion with a dread of fatness;
	4. widespread endocrine disorder involving the hypothalamic/pituitary/gonadal axis;
	5. if the onset is pre-pubertal, pubertal events are delayed or arrested.
2. ICD-10 also refers to the occurrence of depressive or obsessional symptoms; the presence of features of a personality disorder; and the importance of distinguishing somatic causes of weight loss in young patients, including chronic debilitating diseases, brain tumours and intestinal disorders such as Crohn's Disease or a malabsorption syndrome.

# Might a patient with anorexia nervosa be detained under MHA 1983?

1. Mental disorder is broadly defined in MHA 1983. It is a matter for the clinical judgment of the medical practitioners who carry out the medical assessments whether, in the case of a particular patient, the criteria for admission are met.
2. CQC recognises that patients with anorexia nervosa is classifiable as a mental

disorder and can therefore be detained in hospital under the provisions of the MHA 1983[1](#_bookmark0), provided the other criteria for detention are met for either detention under s.2 or s.3 are met and a valid application made. Standard texts of psychiatry[2](#_bookmark1) concur with this view.

1. However CQC believes that it is only in its most severe manifestations that anorexia nervosa may be considered to require compulsory admission under MHA 1983. Detention is justified in rare cases of serious threat to health, where compulsory feeding may be necessary to combat both the physical complications and the underlying mental disorder.
2. If the professionals believe that a particular patient with anorexia nervosa should be detained under MHA 1983, a decision must be made whether to use s.2 or

s.3. The advice contained in paragraphs 4.26 and 4.27 of the revised MHA 1983 Code of Practice should be consulted.

1. Where a patient is detained under MHA 1983 so that s/he might be assessed and/or treated for anorexia nervosa, CQC recommends that his/her detention and treatment be subjected to regular, multi-disciplinary review, and also that artificial feeding be discontinued as soon as is practicable.
2. There are likely to be particularly strong reasons for an application for compulsory admission to be made by an Approved Mental Health Practitioner (‘AMHP’) rather than the patient's Nearest Relative, as advised in the revised MHA 1983 Code of Practice (paragraph 4.28).
3. An AMHP will have the same responsibilities and duties when assessing a patient with anorexia nervosa as s/he would have with a person said to be suffering from any other form of mental disorder. As in other cases, the least restrictive alternative should be used when providing compulsory treatment to a patient with mental disorder. However, in the case of a patient with anorexia nervosa, this principle may be compromised by the need to treat his/her self- imposed starvation.

1 MHAC, *Seventh Biennial Report: 1995-1997*, para 5.2.8; *Eighth Biennial Report:1997-1999*, para 6.14

2 Gelder MG, Gath D, and Mayou R (1996), Oxford Textbook of Psychiatry, OUP, p 376. This states, “rarely the patient's weight loss is so severe as to pose an immediate threat to life. If such a patient cannot be persuaded to enter hospital, compulsory admission has to be used." The issue is debated further by Tiller J, Schmidt U, and Treasure J (1993), British Journal of Psychiatry, 162, 679-680, who argue that compulsory treatment is seen as highly coercive and “conjures up images of suffragettes being force-fed in prison”, but that it “may be an act of compassion ... [recognising] the severity of the illness ... patients and families are immensely relieved to hand over responsibility to the professional team”. The alternative view is to consider anorexia nervosa as akin to a terminal disease and to provide only palliative care.

# In what circumstances can treatment be given compulsorily for a patient detained with this disorder?

1. Where a patient with anorexia nervosa is detained under MHA 1983, then, in accordance with Chapter 23 of the MHA 1983 Code of Practice, valid consent should always be sought for the medical treatment proposed. In particular, the Code of Practice (para 23.33 *et seq*) stresses that it is important to give sufficient information to a patient to ensure that s/he understands in broad terms the nature, likely effects and risks of the treatment, including the likelihood of its success and any alternatives to it.
2. It should be noted that medical treatment under MHA 1983 “includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care”…” the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations” (MHA 1983, section 145). Therefore, it will cover a broad range of activities[3](#_bookmark2), potentially including feeding by nasogastric tube or other means.

# Anorexia nervosa and the capacity to consent

1. Every adult is presumed to have the capacity to decide whether to accept medical treatment, even if s/he refuses treatment for reasons that seem irrational or non-existent. A person is not to be considered incapable of giving consent merely because s/he suffers from mental disorder.
2. The MHA 1983 Code of Practice (paragraphs 23.28 *et seq*) sets out the basic principles that determine whether a patient possesses the capacity to consent. The Law Commission has also drawn attention to the importance of evaluating fully the “capacity to make a choice”.
3. In connection with anorexia nervosa, Lord Donaldson of Lymington, M.R., indicated that although a patient may understand the treatment and the consequences of failure to accept the treatment, certain conditions are capable of destroying his/her ability to make an informed choice, and of creating a compulsion to refuse treatment or only to accept treatment that is likely to be ineffective.[4](#_bookmark3) CQC accepts that some patients with anorexia nervosa – who might have the intellectual capacity to understand the nature, purpose and likely

3 This view, which was expressed in earlier versions of this Guidance, is supported by the decision of the House of Lords in *Reid v Secretary of State for Scotland* [1999] 1 All ER 481.

4 Law Commission (1993) Consultation Paper No. *129 Mentally Incapacitated Adults and Decision-Making. Medical Treatment and Research* - paragraph 2.18 from *Re W* [1992] 3 WLR 758.

effect of treatment – may be unable to give valid consent, perhaps because their capacity to consent is compromised by fears of obesity or by denial of the consequences of their actions. Consideration of the whether the treatment environment constitutes a deprivation of liberty might be an additional reason for considering compulsory treatment under MHA 1983 may be required.

# Section 63

1. MHA 1983, section 63 states that:

“The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being a form of treatment to which section 57, 58 or 58A above applies, if the treatment is given by or under the direction of the approved clinician in charge of the treatment.”

Treatment for many patients with anorexia nervosa might include a behavioural programme designed to help them overcome the compulsion of food refusal. If so, practitioners should be aware of their own ethical and legal obligations, and of the need to avoid treatments that might be degrading or inhumane, such as the restriction of movement or natural functions.[5](#_bookmark4) They should also be aware that their actions must not contravene:

* mental health or other legislation (for example, MHA 1983, section 127, which concerns ill-treatment or willful neglect of a patient), or
* the European Convention on Human Rights (particularly the Article 3 prohibition on torture or inhuman or degrading treatment, and the Article 8 right to respect for one’s private and family life).

# Does such treatment include the authority to feed the patient compulsorily?

1. Part 4 of the Act applies only to medical treatment for mental disorder. Treatment for physical conditions may only be given, therefore, if it is sufficiently connected to the treatment for the patient’s mental disorder. While MHA 1983 clearly allows the administration of medicines in the absence of consent as a treatment for mental disorder, food has not usually been regarded as a ‘medicine’. However, the House of Lords has ruled that feeding a patient by

5 Anonymous (1995), British Medical Journal 311 pp 635-636. This document, written in the form of an open letter, describes one patient's experiences of a strict behavioural regime. The patient deplores the lack of privacy - "giving the effect of a museum exhibit case" - and the fact that even visits to the bathroom were forbidden. The author also emphasises the long-term effects of such humiliating treatment.

artificial means may constitute ‘medical treatment’.[6](#_bookmark5) It follows, and has been accepted by the Courts, that naso-gastric feeding may be a medical process, forming an integral part of the treatment for anorexia nervosa – see *Riverside Health NHS Trust v Fox,*[7](#_bookmark6) where the Judge observed: “until there is steady weight gain no other treatment can be offered for the respondent's mental condition so I hold that forced feeding if needed will be medical treatment for the mental disorder”. A similar conclusion was reached in the case of *B v Croydon Health Authority*,[8](#_bookmark7) which adopted a wide definition of ‘medical treatment’ within MHA 1983.

1. The clinician in charge of the compulsory feeding must be satisfied that the food refusal which is being treated food refusal is part of the mental disorder in order to use the authority of s.63. In these circumstances further diagnostic and monitoring procedures may be necessary, including venepuncture, as part of the medical treatment for the mental disorder of the particular patient. Authority for such additional procedures might also be found under s.63. In addition, it may be possible to justify under the common law action that is taken in an emergency as the minimum necessary to prevent serious injury or loss of life.

# Conclusion

1. In certain circumstances, patients with severe anorexia nervosa whose health is seriously threatened by food refusal may be detained in hospital under MHA 1983. Further, CQC believes that there may be occasions when it is necessary to treat such patients for their self-imposed starvation without their consent, to ensure that they receive proper care. Such treatment might include compulsory feeding to address the physical complications of anorexia nervosa, insofar as this is a necessary precondition to the treatment of the underlying mental

6 *Airedale NHS Trust v Bland* [1993] AC 789. In this case, the patient did not suffer from anorexia nervosa, but was in a persistent vegetative state. The significance of the judgment is that for the first time, it was held that food was ‘medicine’ and could therefore be withheld as part of medical treatment.

7 *Riverside Health NHS Trust v Fox* [1994] 1 FLR 614-622. The patient was a 37-year-old woman with anorexia nervosa, who was detained under MHA 1983, s 3. The Trust sought a declaration that force-feeding would be ‘medical treatment’ under MHA 1983, s 63. Much of the debate was about exactly how the order should have been made, but it was accepted that the matter “reflects the sensitive and difficult nature of the responsibilities of members of the medical profession.” At the full hearing, the Judge had “no difficulty in concluding that feeding is treatment within Section 145 of the [Mental Health] Act.” He found it more difficult to decide whether it would constitute ‘medical treatment for the mental disorder’, but he concluded that no other treatment could be offered until there was steady weight gain. Therefore, he held that “forced feeding will be medical treatment for the mental disorder.” By the time the appeal was heard, the patient's condition had improved. The appeal was allowed on technical grounds, but the President of the Court recognised that if she deteriorated again a fresh application could be made.

8 B did not have anorexia nervosa but a psychopathic disorder. When detained under MHA 1983, s 3 and prevented from harming herself, she refused to eat and her weight fell to 32 kg. Tube feeding was threatened and B sought, and gained, an injunction preventing it. The Court dismissed the argument that MHA 1983, s 58 was relevant, but held that ’medical treatment’ is that which, taken as a whole, is calculated to alleviate the mental disorder; that a range of acts *ancillary to* the core treatment may still falls within MHA 1983, s 63; and that tube feeding will constitute ‘medical treatment’ for the purposes of MHA 1983, s 63 and may be carried out lawfully without the patient’s consent.

disorder. In these circumstances, it might be reasonable to regard artificial means of providing nutrition as medical treatment for mental disorder. However, CQC advises that such treatment must be carefully and regularly reviewed and – to ensure that it represents the least restrictive alternative – that it be discontinued when the patient's compliance can be secured for normal methods of feeding to which compulsion would not apply. Such a review should be multi- disciplinary in nature, and it might need to include the patient's representative.

1. In summary, in every case there will have to be:
* proper consideration of the alternatives;
* a multi-disciplinary decision as to the most appropriate way of managing the patient’s overall care (bearing in mind the importance of securing co-operation in the longer term);
* a mechanism for ensuring that any compulsory treatment is given under the direction of the approved clinician in charge of the treatment;
* a way to end use of the compulsory powers when they are no longer appropriate.
1. When caring for patients with anorexia nervosa, clinicians must give careful consideration to other aspects of their management, recognizing, for example that some patients might be nursed at times on non-psychiatric wards, where knowledge and experience of MHA 1983 is limited. Inpatients with severe eating disorders form a very vulnerable group and independent monitoring of their welfare, particularly in specialised units can be important. [9](#_bookmark8)

Any questions or concerns about this guidance should be sent to:

# CQC Mental Health Act Citygate

**Gallowgate Newcastle upon Tyne NE1 4PA**

9 As indicated in paragraph 2, this guidance note does not address the various options for the care and treatment of children with anorexia nervosa. However, practitioners and parents should be aware of the particular problems that arise with younger patients, particularly as issues of consent to treatment may be dealt with in different ways. For instance, it may be possible for someone with ‘parental responsibility’ for a child to give consent for the medical treatment s/he requires, or for action to be taken under the Children Act 1989.