Coercive treatment options for **anorexia** under the *Mental Health* and *Guardianship Acts*

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Snapshot

- Eating disorders have significant health and personal impacts on those living with the illness, as well as family and friends who provide care and support.
- Anorexia nervosa is characterised by a distorted view of body weight and shape. When combined with the physical effects of starvation on cognitive function, it can impact on a person's capacity to make decisions about treatment.
- Sometimes coercive treatment is necessary to help a person recover from anorexia.

This article outlines the voluntary and coercive treatment of eating disorders under both the *Mental Health Act 2007* ('***MHA***') and the *Guardianship Act 1987* ('***GA***').

Eating disorders and their treatment

Eating disorders are characterised by disturbances in thinking and behaviour around food, eating, and body weight or shape. Eating disorders are estimated to affect 4 per cent of the population at any one time (i). The three main types of eating disorder are anorexia nervosa, bulimia nervosa and binge eating disorder.

Anorexia is estimated to affect between 0.3 per cent and 0.6 per cent of the population at any one time (ii). The highest incidence is in the 15-19 year age group but can be present at any stage of life. The ratio of female to males with the disorder is estimated to be around 10:1 (3:1 before puberty). Community based studies have found that anorexia is more likely to be under detected in males than females (ii).

All eating disorders have an elevated mortality risk (ii). Medical complications in anorexia can arise from the amount of weight loss, the rapidity of the weight loss and the compensatory behaviours (vomiting, laxative abuse, diuretic abuse, diet tablets and compulsive exercise). Severe starvation can decrease comprehension and concentration. For many people living with an eating disorder, their primary coping strategy is to control their food intake and engage in other disordered behaviours. It is not surprising then that patients frequently refuse to engage in treatment.

People with anorexia can become acutely medically compromised and may require urgent nutritional rehabilitation. The main aim of a hospital admission is to begin weight restoration and interrupt the eating disorder behaviours. While in hospital the patient requires meal supervision, monitoring of the eating disorder behaviours, weighing, and medical monitoring.

Once a person's cognition has been restored through re-feeding, other therapies can begin. Maudsley Family Therapy is the optimal treatment for children and adolescents. For adults, therapeutic inputs may include psychological therapies, medical monitoring, anti-depressant or anti-anxiety medication and dietetic support.

Voluntary treatment

The majority of people living with anorexia receive voluntary treatment. This means that the person can stop treatment at any time. In addition, a person can only agree to voluntary treatment if they have the capacity to do so. A person's capacity may be impacted by the effects of starvation, as well as the distortions of the condition itself. Eating disorders can co-exist with symptoms of anxiety, depression or obsessive compulsive disorder, which also impact on a person's decision making. If a person is no longer capable of giving consent to voluntary treatment, or if voluntary treatment is not successful, involuntary treatment options may need to be considered.

Compulsory inpatient treatment – *Mental Health Act*

A person with anorexia can be involuntarily treated if their circumstances meet the three statutory criteria in *MHA* ss 12–14.

The first criterion is that the person is a 'mentally ill person', which means that the person has a condition which seriously impairs their mental functioning (either temporarily or permanently). The person must also experience particular symptoms, including:

- *delusions*, such as a fixed idea that s/he is grossly overweight;
- *serious disorders of thought form*, including concrete or illogical thoughts;
- *severe disturbance of mood* as a result of malnourishment or depression or anxiety; or
- *if the person is behaving in a sustained or repeatedly irrational way which indicates the presence of these symptoms* including refusing to eat, sabotaging treatment or exercising obsessively.

The second criterion is that the person is at risk of serious harm. The final statutory criterion, which is that there is no other form of safe and effective care, can be satisfied if voluntary care or treatment under a guardianship order is not adequate.

Although a person living with anorexia may be medically stable in hospital, they may relapse quickly after discharge. The *MHA* allows consideration of any likely deterioration in a person's condition and the likely effects of that deterioration, when deciding if the person is a 'mentally ill' person (*MHA* s 14(2)).

In *Ms S* [1999] NSWMHRT 1, the Mental Health Review Tribunal ('**MHRT**') held that anorexia can be involuntarily treated under the *MHA*.

Involuntary treatment under s 84 of the *MHA* can include medication, movement restriction, dietary plans, psychological therapies, re-hydration and naso-gastric feeding (including sedation if necessary for naso-gastric feeding). There are statutory obligations under the *MHA* to maintain contact with family and friends, to keep them advised of medications prescribed, to consult them at the point of discharge and advise of care options after discharge.

Compulsory outpatient treatment – *Mental Health Act*

The MHRT may also make orders for compulsory outpatient mental health treatment under a community treatment order ('**CTO**') (*MHA* ss 50-56). A CTO could require a person to attend regular appointments, take medications or attend weigh-ins.

A CTO must be offered by a declared mental health facility, which means that it must involve a public sector mental health team. However, other clinicians (such as an eating disorders outpatient program) can offer services as delegates of the public sector case manager.

If a person does not comply with the requirements of a CTO, they can be forcibly taken to a mental health facility for assessment and treatment.

Compulsory treatment under the *Guardianship Act 1987*

A guardianship order can be made for a person with an eating disorder if they are totally or partially incapable of managing their person because of a disability (*GA* ss 3(1), 14(1)). 'Disability' is defined to mean a person who is restricted in one or more major life activities to such an extent that he or she requires supervision (s 3(2)). This restriction may be because of an intellectual, physical or psychological disability, or because the person is a mentally ill person.

Anorexia can have psychological and physiological impacts on a person's ability to make decisions (iii). Supervision is often needed to ensure that a person does not sabotage treatment (see for example *CFL* [2007] NSWGT 21; *WYP* [2014] NSWCATGD 45).

A guardianship order must specify the guardian who is to be appointed, and the functions that the guardian can exercise. The *GA* gives preference to a private guardian, rather than the Public Guardian (s 15(3)). However, it may sometimes be preferable to appoint the Public Guardian to avoid further straining family relationships (see for example *CFL* [2007] NSWGT 21).

The functions of guardianship that might be needed for a person with anorexia include:

- the ability to provide substitute consent to medical treatment;
- the authority to override the person's objection to treatment;
- accommodation decisions (e.g. to require the person to attend a residential program);
- a coercive accommodation function to prevent a person from leaving a clinic and to authorise the police/ambulance officers to return the person if they do leave.

Who can ask for compulsory treatment?

Only the treating clinicians in a public mental health facility can decide to commence involuntary mental health treatment. Compulsory inpatient treatment under the *MHA* is subject to regular reviews by the MHRT, which family and friends are welcome to attend.

Guardianship applications can only be made for people aged 16 years or over. Applications are primarily made to the Guardianship Division of the NSW Civil and Administrative Tribunal ('**NCAT**'), but can also be made to the Supreme Court. Any person with a genuine concern for the welfare of the person can make an application (*GA* s 9).

Proceedings in NCAT for a person with anorexia must sometimes be conducted on an urgent basis, including outside of normal business hours in extreme cases. The Tribunal will be keen to involve and receive evidence from the person, their family, concerned friends and treating health professionals.

An initial guardianship order can generally only be made for a maximum of one year (*GA* s 18(1)). In most cases, the Tribunal must conduct a review hearing upon the expiry of the order to determine whether the order should be renewed, varied or permitted to lapse (*GA* s 25 and s 25C).

Which path is the right one?

Compulsory treatment under the *MHA* is only available in declared mental health facilities, but treatment can start as soon as the involuntary patient process begins. A person who is admitted for involuntary treatment under the *MHA* can be treated in a medical ward if they need medical stabilisation or nutritional restoration (s 33).

Most people with eating disorders are hospitalised in medical wards in public hospital which are not gazetted, and no private eating disorder clinics are gazetted. Compulsory treatment in these settings needs to be sought under a guardianship order.

If the person has not been admitted under the *MHA*, and (a) lacks the capacity to consent to medical treatment and (b) has not objected to the treatment proposed, then a 'person responsible' (see *GA* s 33A) can provide substitute consent in most cases. If the person objects to the proposed treatment then an order of the Supreme Court or NCAT is required for the treatment to proceed.

Conclusion

Anorexia is an illness that places immense pressure on those living with the condition and those who provide care and support. Although it can be difficult for family, friends or health professionals to decide to apply for orders to permit compulsory treatment, in some circumstances such action can be lifesaving. In dark times, it is important to remember that recovery from anorexia is possible.

i. The Butterfly Foundation. *Paying the Price – The economic and social impact of eating disorders in Australia*. 2012.

ii. Smink FRE, Hoeken D & Hoek HW. 'Epidemiology of Eating Disorders: Incidence, Prevalence and Mortality Rates' *Current Psychiatry Reports* (2012) 14:406–414

iii. Keys, A, Brozek, J, Henschel, A, Mickelsen, O, & Taylor, H. L. (1950) *The Biology of Human Starvation* Univ of Minnesota Press, Minneapolis, MN **LSJ**