Information Sheet:

Involuntary treatment options for eating disorders under the *Mental Health* and *Guardianship Acts*

Mental Health Review Tribunal

Snapshot

- This Information Sheet outlines the involuntary treatment of people with eating disorders under both the Mental Health Act 2007 ('MHA') and the Guardianship Act 1987 ('GA').
- 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.
- 'Eating disorders' is a broad term that covers a range of serious disordered behaviours such as bulimia nervosa, binge eating disorder, other specified feeding and eating disorders (OSED) and anorexia nervosa.
- 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. Commonly, persons with anorexia are scheduled under the MHA for care and treatment and under the MHA can also be subject to Community Treatment Orders for ongoing care in the community. Persons with anorexia and other eating disorders may also be subject to involuntary treatment under the GA.
- Sometimes involuntary treatment is necessary to help a person recover from an eating disorder. Both the MHA and the GA can be used to treat a person who requires involuntary treatment. The most appropriate statutory regime will be determined by the person's individual circumstances.
- Even though 'involuntary treatment' can be given under both the MHA and GA, there is an obligation to try to obtain the person's consent to treatment, consider their views and those of their carers (see ss 68 (h-J) MHA, s 14(2) GA).

Eating disorders and their treatment

Eating disorders are characterised by disturbances in thinking and behaviour around food, eating, and body weight and/or shape. Eating disorders are estimated to affect 4 per cent of the population at any one time [i]. As noted above, there are four main types of eating disorders.

Anorexia is estimated to affect between 0.3 per cent and 0.6 per cent of the population at any one time. The highest incidence is in the 15-19 year age group but anorexia 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 compensatory behaviours (for

example, 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.

Commonly, eating disorders occur with other mental health conditions such as major depressive disorder, anxiety disorders, (particularly OCD and social anxiety disorder), post-traumatic stress disorder (PTSD), substance use disorders, sexual dysfunction, self-harm and suicidal ideation [iii].

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. As eating disorders can co-exist with symptoms of anxiety, depression or obsessive-compulsive disorder, a person's decision making capacity may be compromised. 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.

Involuntary Inpatient Treatment – Mental Health Act

A person with anorexia can be involuntarily admitted to a mental health facility if their circumstances meet the statutory criteria of a mentally ill or mentally disordered person in MHA ss 12–14.

In relation to a 'mentally ill person', the first criterion is 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, for example, 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 to themselves.

The final statutory criterion is that there is no other form of safe and effective care; e.g. voluntary care or treatment under a guardianship order is inadequate.

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 (s14 (2) MHA).

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

A person is 'mentally disordered' if their behaviour is so irrational that there are reasonable grounds for temporary care and treatment to protect the person from 'serious physical harm'. A person may be detained as a mentally disordered person for up to 3 days (not including weekends) on no more than 4 occasions in any calendar month.

Under s 84 of the MHA, the authorised medical officer can authorise involuntary treatment including medication. A person with anorexia may require movement restriction, dietary plans, psychological therapies, re-hydration and naso-gastric feeding (including sedation if necessary for naso-gastric feeding).

There are statutory obligations to share information about the person with carers, including keeping them advised of medications prescribed, consulting with them at the point of discharge and providing advice of care options after discharge (ss 73-79 MHA).

Involuntary Outpatient treatment – Mental Health Act

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

A CTO must be offered by a declared mental health facility (s56 MHA), which means that it must involve a public sector mental health team. However, other clinicians (such as those involved in 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 may be breached and ordered to be taken to a mental health facility for assessment and treatment (s58 MHA).

The MHRTs website has a Treatment Plan template that gives guidance as to the conditions that may be included in a CTO.

Involuntary 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 (ss 3(1), 14(1) GA). '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) GA). 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 [iv]. 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 (s 16 GA). The GA gives preference to a private guardian, rather than the Public Guardian (s 15(3) GA). However, it may sometimes be preferable to appoint the Public Guardian to avoid further straining family relationships (see, for example, *CFL* [2007] NSWGT 21).

For a person with anorexia, the functions of a guardian may 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 police/ambulance officers to return the person if they do leave.

Who can ask for involuntary treatment under the MHA & GA?

Under the *MHA,* only the treating clinicians in a public mental health facility can commence involuntary mental health treatment for a person detained in the facility. The person's detention, care and treatment is subject to regular reviews by the MHRT, which family, friends and carers may attend (ss 34-37 MHA). Involuntary outpatient treatment on a CTO may be requested by a medical practitioner, a case manager, the director of community treatment or a designated carer or principal care provider (see s 51(2) MHA).

Under the GA, any person with a genuine concern for the welfare of the person can make an application to appoint a guardian with powers to make treatment decisions (s 9 GA). 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 NSW Supreme Court.

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

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

Which 'involuntary' path is the right one for individual cases?

Involuntary treatment under the MHA is only available in declared mental health facilities, but treatment can start as soon as the person is detained in the facility.

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 18(2) MHA).

Most people with eating disorders are hospitalised in medical wards in public hospitals which are not gazetted, and no private eating disorder clinics are gazetted. 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' (s 33A GA) 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. Even in dark times, it is important to remember that recovery from anorexia is possible.

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

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

iii. National Eating Disorders Collaboration (NDEC).

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

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