FEEDING AGAINST CONSENT
PATIENTS WITH EATING DISORDERS (6)8 to 18 YEARS

- Eating disorders are mental disorders. Individuals with mental disorders may be putting their lives at risk and require in-patient treatment.

- Consideration of legal frameworks for treatment where there is no consent needs to balance patient's right to privacy, confidentiality, to be involved in decision- making and to refuse treatment, against the right of their parents to provide care for them, the duty of others to protect them and their best long-term interests

- Capacity to consent to treatment may differ in AN depending on the stage of illness

- Young people aged less than 16 can be treated against their will if at least one parent consents to treatment on their behalf. However, if the child actively fights the parent's decision regarding the necessity of the treatment, compulsory treatment needs to be considered. This applies to decisions within the zone of parental control (i.e. ones which parents would normally make on behalf of children that are in the best interests of the child).

- However avoid relying "indefinitely" on parental consent in <16 years and try to reengage with patient daily to gain their consent

- 16- to 18-year-olds can be admitted under the Mental Health Act and treated against their will, although this should rarely be required. It is essential, however, that it is done when necessary.

- If both the child and the parent refuse treatment, local safeguarding procedures should be followed and use of the Children Act might be necessary. The Children Act applies up to the age of 18.

Under the Mental Health Act feeding is recognised as treatment for anorexia nervosa and can be done against the will of the patient as a life-saving measure. Although a last resort, the decision to apply the Mental Health Act should be considered from the outset, for example, when a patient refuses treatment in an accident and emergency setting. If paediatric staff suspect that this course of action may be necessary, then psychiatric services should be contacted, as they will be familiar with arranging a Mental Health Act assessment. If the paediatric consultant is not satisfied with the opinion given, there should be direct contact between the consultant and the consultant psychiatrist and the issue escalated until the patient's treatment is safe. A CAMHS consultant with a special interest in eating disorders should be identified to provide second opinions in cases where there is a disagreement or uncertainty.

Moreover, if staff believe that the patient is being denied treatment under the Mental Health Act for any reason, the matter must be similarly escalated between consultants and reasons documented for decisions made. Under the amended Act the responsible clinician must be an approved clinician, in this situation usually a psychiatrist. Trusts need to have managerial structures in place to receive and administer the Mental Health Act detention paperwork. Most paediatric services are in acute trusts, but these organisations should have links with local mental healthcare providers to ensure that procedures and policies are adhered to.

- The Mental Capacity Act 2005 applies only to those 16-18 years and states that a parent cannot override their child's refusal to treatment if >16 years and has capacity.

- If both child and parent refuse treatment, local safeguarding procedures should be followed and use of the Children Act 1989 (2004) might be necessary (up to the age of 18)

- **If a patient is being treated under the Mental Health Act the responsibility for the patient shifts from the Paediatrician to the Psychiatrist**

<u>Other Compulsory Treatments for < 18 years:</u>

- Protecting laws can be used to provide healthcare if there is no consent or lack of capacity

1. *Children Act 1989 (2004)*

- Specific issue Order (section 8) can be used to pass a NG tube
- Care Order (section 37) can be applied if a child is thought to be at risk of significant harm because of care given or not given

- Inherent Jurisidiction of the Court (section 100) can be used to treat against a child's will when there are wider-ranging and longer-term issues

2. *UN Convention on the Rights of Children 1991*

- Children's right to form and express their views (Article 12)
- Responsibilities, rights and duties of parents to provide direction and guidance in the exercise of the child of their own rights (Article 5)
- Best interests of the child (Article 3) takes priority

Coercion and Restraint

- Coercion can include the use of legal interventions, parental consent overruling patient's wishes, using rewards, withholding privileges
- General consensus to support coercion in patients but debatable in those with capacity
- Legal coercion tends to be associated with high health risk, more unwell patients with repeated admissions
- Evidence to suggest that legally coerced patients have a higher mortality rate
- In those > 16 years the Mental Capacity Act allows restraint only if the person using it reasonably believes it is necessary to prevent harm
- Restraint must be proportionate to the likelihood and seriousness of the harm

Always seek legal advice if compulsory treatment is felt to be necessary

References:

1. Junior MARSIPAN: Management of Really Sick patients under 18 with Anorexia Nervosa, January 2012. (www.rcpsych.ac.uk/foles/pdfversion/CR168.pdf)
2. Guideline for the Nutritional management of Anorexia Nervosa, Council Report CR130: Royal College of Psychiatrists London 2004
3. Norrington A, Stanley R, Tremlett M, Birrell G.Medical management of acute severe anorexia nervosa. ADsCh Education and Practice 2012;Volume 97 Issue 2:48-54
4. Mental Health Act 2007 (www.legislation.gov.uk)
5. Mental capacity Act 2005 (www.legislation.gov.uk)
6. Children Act 2004 (www.legislation.gov.uk)
7. UN Convention on Rights of the Child 1991(www.unicef.org/crc)

Dr. G. Baksh 18/11/12