1. INTRODUCTION

1.1 The Mental Health Act Commission ('MHAC') receives many requests from clinicians for advice about the application of the Mental Health Act 1983 ('MHA 1983') to patients with anorexia nervosa. Generally speaking, compulsory measures are unnecessary and, because patient autonomy may be a long-term objective in the management of the condition, they may be counter-productive. However, as anorexia nervosa is accompanied by significant morbidity, there may be occasions when clinicians must decide whether to use the Act. This may be so, for example, when a patient's physical health or survival is seriously threatened by food- or fluid-refusal.

1.2 This guidance note gives advice on the treatment of anorexia nervosa under MHA 1983. There are other 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 31 of the MHA 1983 Code of Practice.

1.3 The enquiries received by the MHAC fall into 3 major categories.

i. May a patient with anorexia nervosa be detained under the MHA 1983?

ii. In what circumstances might compulsory treatment be given to a detained patient who has anorexia nervosa?

iii. Might treatment for anorexia nervosa include the authority to feed the patient compulsorily?

1.4 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.

2. ANOREXIA NERVOSA

2.1 DEFINITION

2.1.1 Anorexia Nervosa is described in the tenth revision of the International Classification of Diseases (ICD-10) under the heading of Eating Disorders
"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”.

2.1.2 ICD 10 suggests that for a definite diagnosis all the following criteria should be met:

i. body weight maintained at least 15% below expected body weight;

ii. 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.

iii. body image distortion with a dread of fatness;

iv. widespread endocrine disorder involving the hypothalamic/pituitary/gonadal axis;

v. if the onset is pre-pubertal, pubertal events are delayed or arrested.

2.1.3 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.

2.2 MIGHT A PATIENT WITH ANOREXIA NERVOSA BE DETAINED UNDER MHA 1983?

2.2.1 Mental disorder is broadly defined in MHA 1983, whilst mental illness is not defined at all. 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.

2.2.2 The MHAC has previously recognised that patients with anorexia nervosa may be detained in hospital under the provisions of the MHA 1983,\(^1\) and this view is expressed in standard texts of psychiatry.\(^2\)

---


\(^2\)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
2.2.3 An application may be made for admission under MHA 1983, section 2 on the
grounds that a patient is suffering from mental disorder of a nature or degree that
warrants his/her detention in a hospital for assessment (or for assessment
followed by medical treatment) for at least a limited period and that the patient
ought to be so detained in the interests of his/her health or safety or with a view
to the protection of other persons. The MHAC believes it is possible that a patient
presenting with symptoms of anorexia nervosa and requiring admission for
diagnostic assessment would fall within this definition.

2.2.4 Provided the other criteria are satisfied and a valid application is made, it is also
the view of the MHAC that it might be possible to detain a patient suffering from
anorexia nervosa under MHA 1983, section 3, on the grounds that such is
necessary for his/her health.

2.2.5 Given that anorexia is capable of being a mental disorder within the terms of
MHA 1983, the relevant professionals must decide whether a particular patient
with anorexia nervosa should be detained under MHA 1983.

2.2.6 The MHAC 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.

2.2.7 If the professionals believe that a particular patient with anorexia nervosa should
be detained under MHA 1983, they must then decide which section s/he should
be detained under. In that regard the MHAC draws the attention of all concerned
to the advice in paragraphs 5.2 and 5.3 of the MHA 1983 Code of Practice.

2.2.8 Where a patient is detained under MHA 1983 so that s/he might be assessed
and/or treated for anorexia nervosa, the MHAC recommends that his/her
detention and treatment be subjected to regular, multi-disciplinary review, and
that any artificial feeding be discontinued as soon as is practicable.

2.2.9 An application for compulsory admission may be made by an Approved Social
Worker (‘ASW’) or the patient’s Nearest Relative. However, MHA 1983 Code of
Practice (paragraph 2.35) advises that

“The ASW is usually the right applicant, bearing in mind professional
training, knowledge of the legislation and of local resources, together with
the potential adverse effect that an application by the nearest relative
might have on the latter's relationship with the patient.”

---

2.2.10 An ASW 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. However, the MHAC believes that it will not usually be necessary to use MHA 1983 in order to care from a patient with anorexia nervosa. Therefore, when a MHA 1983 assessment is requested, it is only in an extreme situation, where the patient’s health is seriously threatened by food-refusal. 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. By bringing his/her own expertise and perspective to bear, the ASW may be able to secure the patient’s voluntary cooperation with treatment, including normal methods of feeding.

2.3 IN WHAT CIRCUMSTANCES CAN TREATMENT BE GIVEN COMPULSORILY FOR A PATIENT DETAINED WITH THIS DISORDER?

2.3.1 Where a patient with anorexia nervosa is detained under MHA 1983, then, in accordance with Chapter 15 of the MHA 1983 Code of Practice, valid consent should always be sought for the medical treatment proposed. In particular, the Code of Practice 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.

2.3.2 It should be noted that medical treatment under MHA 1983 “includes nursing, and also includes care, habilitation and rehabilitation under medical supervision” (MHA 1983, section 145). Therefore, it will cover a broad range of activities aimed at alleviating, or preventing a deterioration of, the patient’s mental disorder (MHA 1983 Code of Practice, paragraph 15.4).4

(i) ANOREXIA NERVOSA AND THE CAPACITY TO CONSENT

Every adult is presumed to have the capacity to decide whether to accept medical treatment, even if s/he may refuse it 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.

The MHA 1983 Code of Practice (paragraphs 15.8 to 15.12) 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”.

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

---

4 This view, which the MHAC 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
ineffective.\textsuperscript{5} The MHAC accepts that some patients with anorexia nervosa – who might otherwise retain the capacity to understand the nature, purpose and likely effect of treatment – may not possess the capacity to give valid consent, or their capacity to consent may be compromised by fears of obesity or by denial of the consequences of their actions. In these circumstances, practitioners will need to consider whether compulsory treatment under MHA 1983 may be required.

(II) SECTION 63

MHA 1983, section 63 states:

“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 treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.”

In patients with anorexia nervosa, such treatment might include a behavioural programme designed to help them overcome the compulsion of food refusal. If so, the guidelines on psychological treatments in chapter 19 of the MHA 1983 Code of Practice will apply. In particular, 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.\textsuperscript{6} 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).

2.4 DOES SUCH TREATMENT INCLUDE THE AUTHORITY TO FEED THE PATIENT COMPULSORILY?

2.4.1 At paragraph 16.5, the MHA 1983 Code of Practice indicates that Part IV 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 artificial means may constitute ‘medical treatment’.\textsuperscript{7} It follows, and has been accepted by the Courts, that naso-


\textsuperscript{6}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

\textsuperscript{7}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
gastric feeding may be a medical process, forming an integral part of the
treatment for anorexia nervosa – see *Riverside Health NHS Trust v Fox*\(^8\), 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*,\(^9\) which adopted a wide
definition of 'medical treatment' within MHA 1983.

2.4.2 MHA 1983, section 63 applies only to medical treatment for mental disorder. For
a RMO to prescribe such treatment, s/he must be satisfied that s/he is treating
food refusal as part of the mental disorder. The MHAC recognises that 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. 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.

3. **CONCLUSION**

3.1 The MHAC believes that 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, the MHAC believes that there may be
occasions when it is necessary to treat such patients for their self-imposed
starvation, 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 disorder. In these circumstances, it might be reasonable to regard
artificial means of providing nutrition as medical treatment for mental disorder.
However, the MHAC 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.

\(^8\) *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

\(^9\) 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.
3.2 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 cooperation in the longer term);
- a mechanism for ensuring that any compulsory treatment is given under the direction of the RMO;
- a way to end use of the compulsory powers when they are no longer appropriate.

3.3 When they are caring for patients with anorexia nervosa, clinicians must give careful consideration to other aspects of their management. Patients might need to be nursed on non-psychiatric wards, where knowledge and experience of MHA 1983 is be limited. The presence of several patients with anorexia nervosa - for example, in specialised units – might lead to the development of questionable practices, particularly with regard to force feeding. Hospital managers will also need to be particularly alert to their responsibilities in such cases.\(^1\)

---

As indicated in paragraph 1.2, 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. Alternatively, the High Court may be asked to order the detention of a child for the purpose of medical treatment, as in the case of *Re C (a minor)*, The Times, 5\(^{th}\) March 1997. There, the High Court used its ‘inherent jurisdiction’ over the welfare of children to order that a 16-year-old girl with anorexia nervosa be detained against her will so that she could be given treatment for her eating disorder.