CHIEF PSYCHIATRIST
of Western Australia

OFFICE of the CHIEF PSYCHIATRIST
Community of Practice

Eating Disorders and Decision-making
- Legal, clinical and lived experience perspectives

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Involuntary Treatment of Anorexia Nervosa - The Legal Context

Issue:

Whether patients with anorexia nervosa may be treated without the patient's consent.

Least restrictive option & collaboration

- Least restrictive options for treatment should always be the first options considered.

- Collaborative advanced care planning approach – medical and psychiatric disciplines, and patient and patient's family.

- Respect and dignity with focus on recovery.

Involuntary treatment under the *Mental Health Act 2014* (MH Act)

- Must satisfy the criteria in section 25 of the MH Act.
- May be detained and treated in a general hospital under the MH Act if they require medical intervention to ensure adequate nutritional intake (sections 61 and 131).
- The Chief Psychiatrist must consent to an order authorising a person's detention at a general hospital.

Treatment without the person's consent under the *Guardianship and Administration Act 1990* (GAA Act)

- If the criteria for involuntary treatment under section 25 of the MH Act are not met, treatment under the GAA Act may be possible.

- Person responsible.

- Guardian – plenary or limited.

- Urgent treatment.

Mature Minors

- Minor - a child approaching age of legal competence (18 years in Australia).

- Mature minor - has sufficient intelligence to understand the treatment being proposed – *Gillick* principle.

- Involuntary, life-saving treatment can be provided in circumstances where there is a grave risk of permanent injury - *Fletcher (an infant by her litigation guardian Rylands) v Northern Territory of Australia* [2017] NTSC 62.

Summary

- **Treatment under the MH Act** – a person's circumstances must satisfy the criteria in section 25 of the MH Act for treatment as an involuntary patient.

- **Treatment under the GAA Act** – if a person is unable to make treatment decisions:

  - the consent of a responsible person is necessary if the person does not object to the treatment proposed
  - consent of a guardian (plenary or limited) is required if the person objects to the treatment proposed
  - no consent is necessary if the person requires urgent treatment.

- **Treatment of mature minors** - involuntary, life-saving treatment can be provided in circumstances where there is a grave risk of permanent injury.

Eating Disorders and Decision-making
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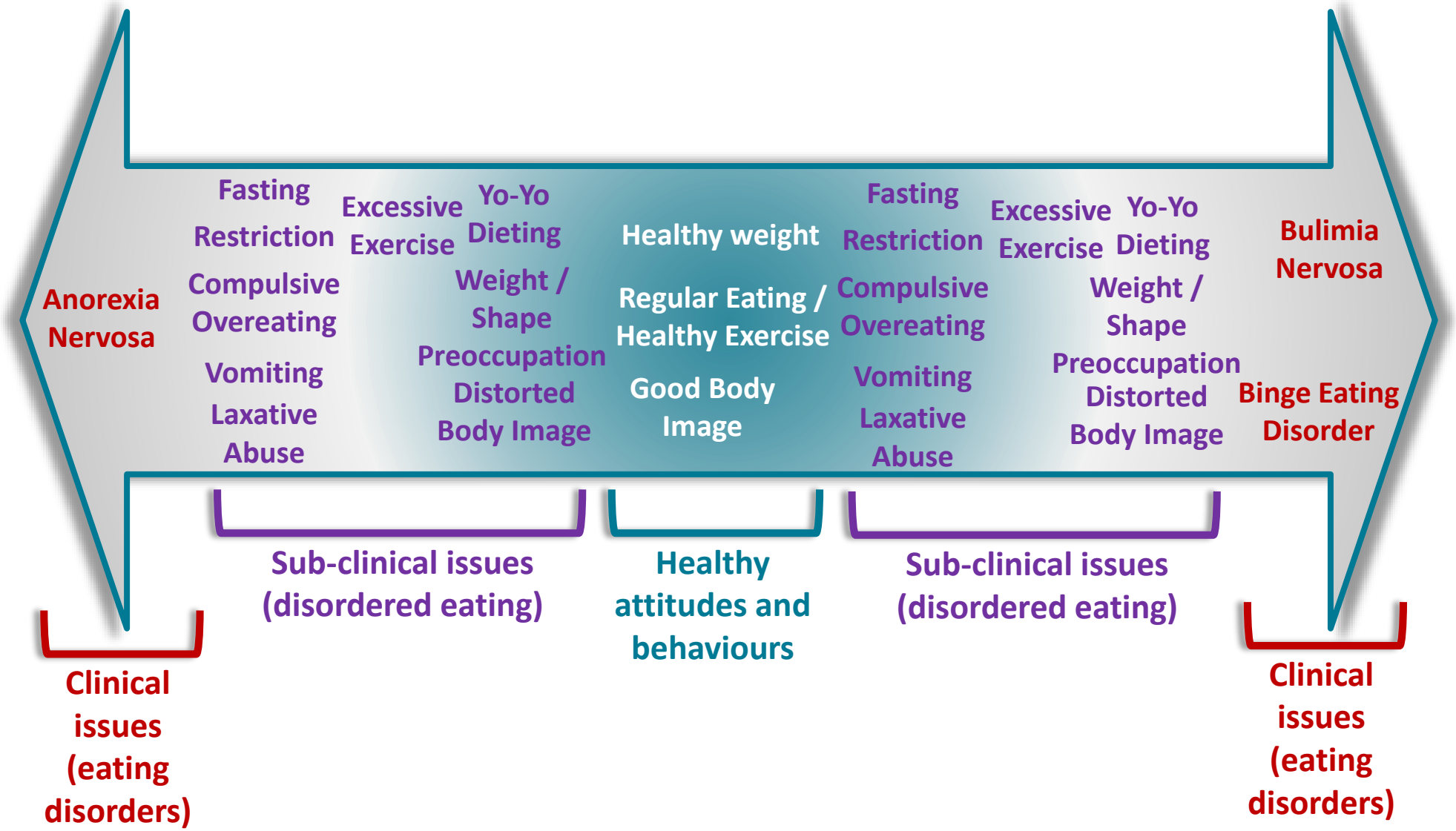
Continuum of Disordered Eating & Eating Disorders



Adapted from: Female coach Nwk on Twitter – Eating Disorder Webinar Disordered Eating vs Eating Disorders. Myers, E.S & Caperton-Kilburn, C. (2017). Winning the war within Nutrition Therapy for clients with eating disorders (3rd ed). Helm Publishing. Lake Dallas, Texas

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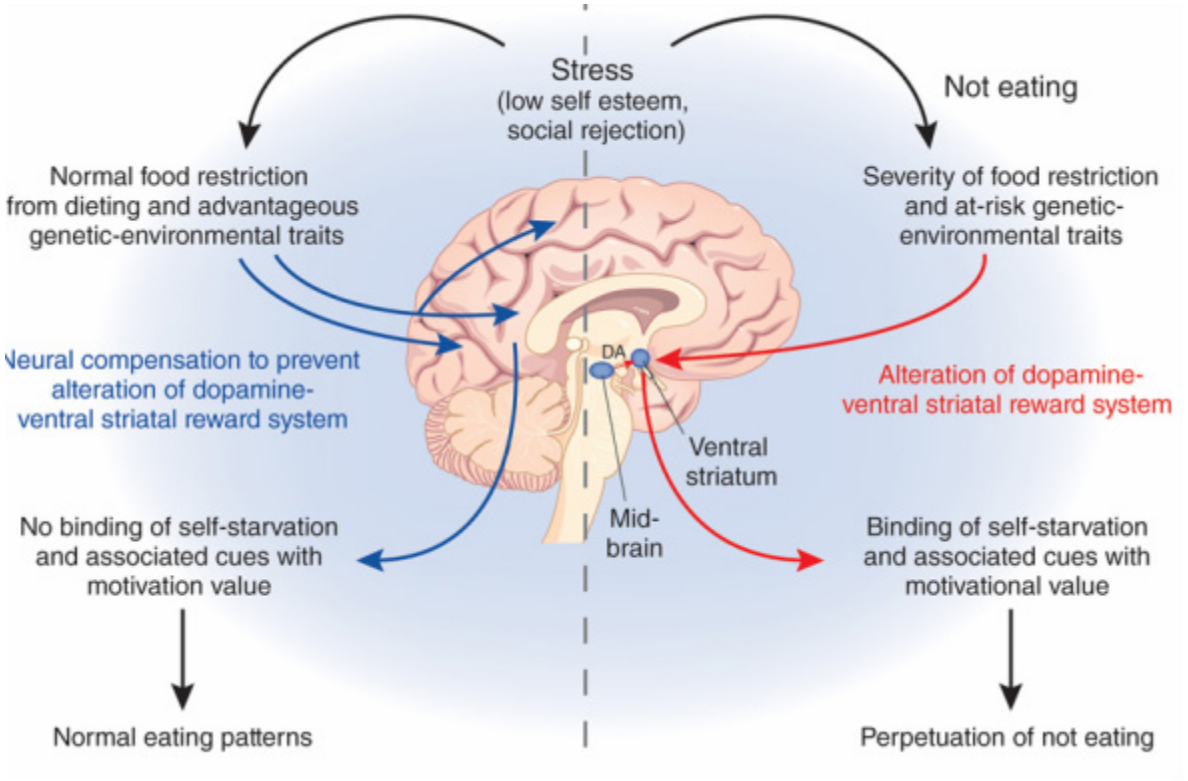
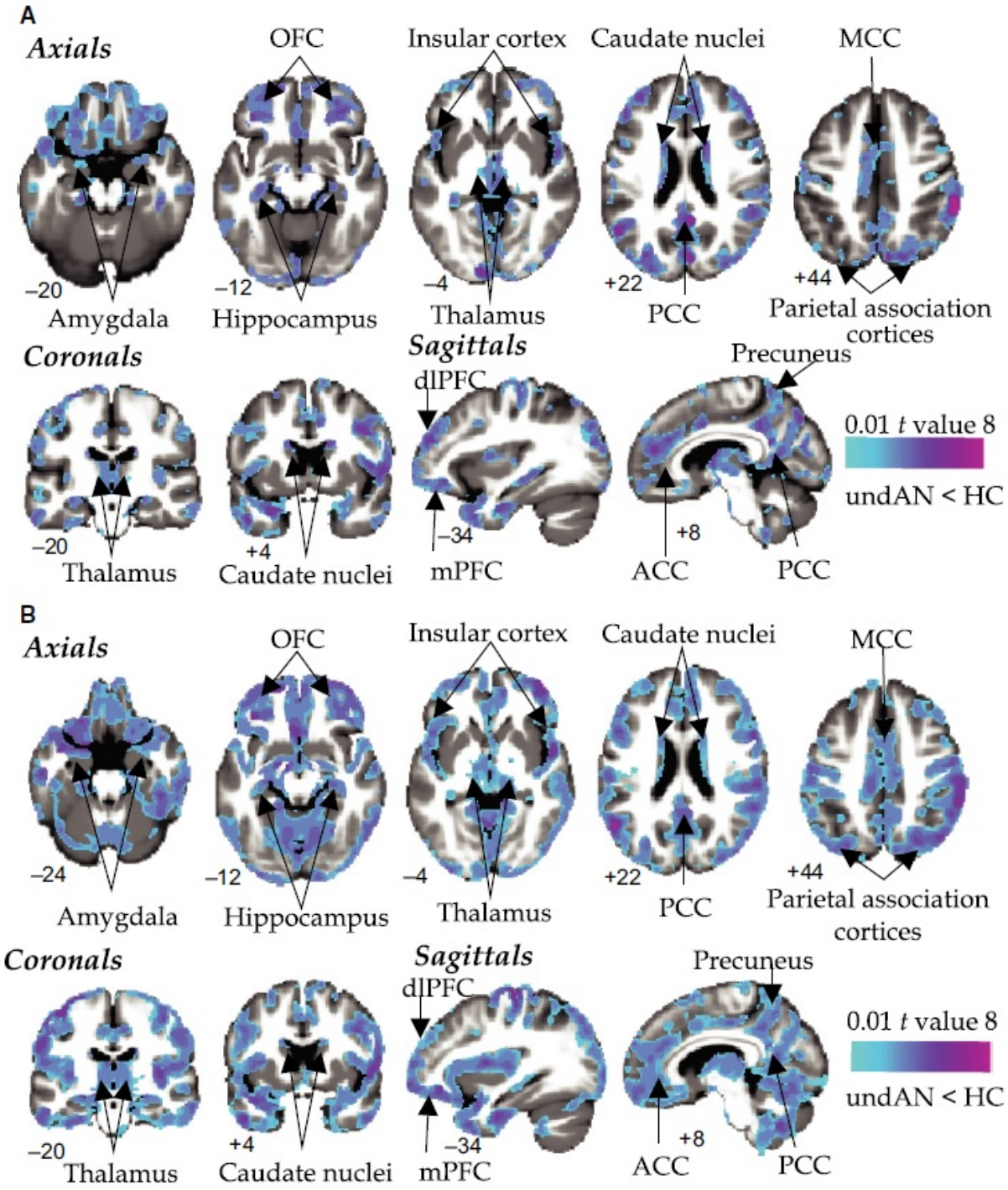


Altered Reward Circuitry likely develops in response to nutritional restriction in those vulnerable to eating disorders *(Kaye et al)*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Amygdala
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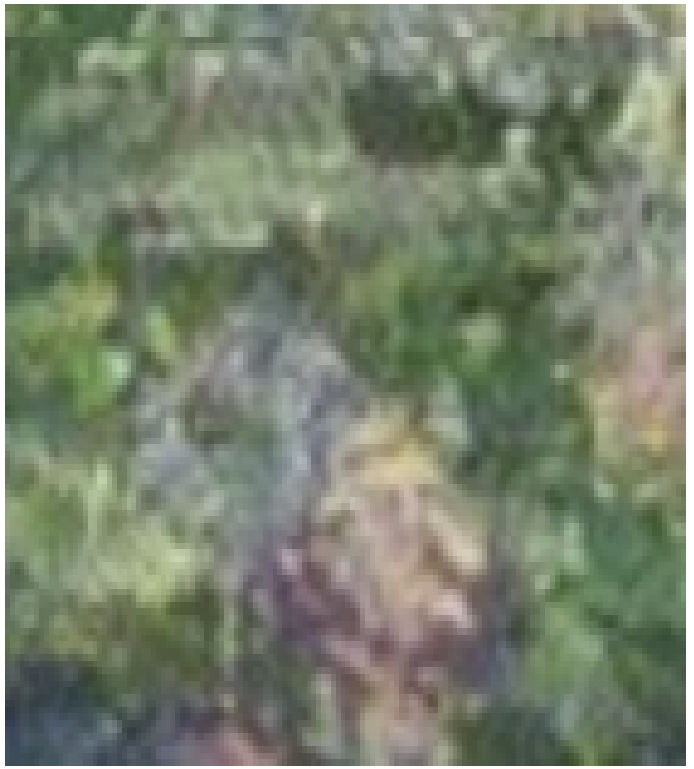
ACC
PCC

How does altered sensitivity to reward processing manifest in AN?– Nothing ”feels” like a good idea

- Altered dopamine circuit “blinds” to pleasure / reward (experienced as “anxiety” instead of affirmation).
- Altered interoception from under-firing circuits involving NA / ventral striatum, shapes behavior via reduced reward, increased anxiety / harm avoidance

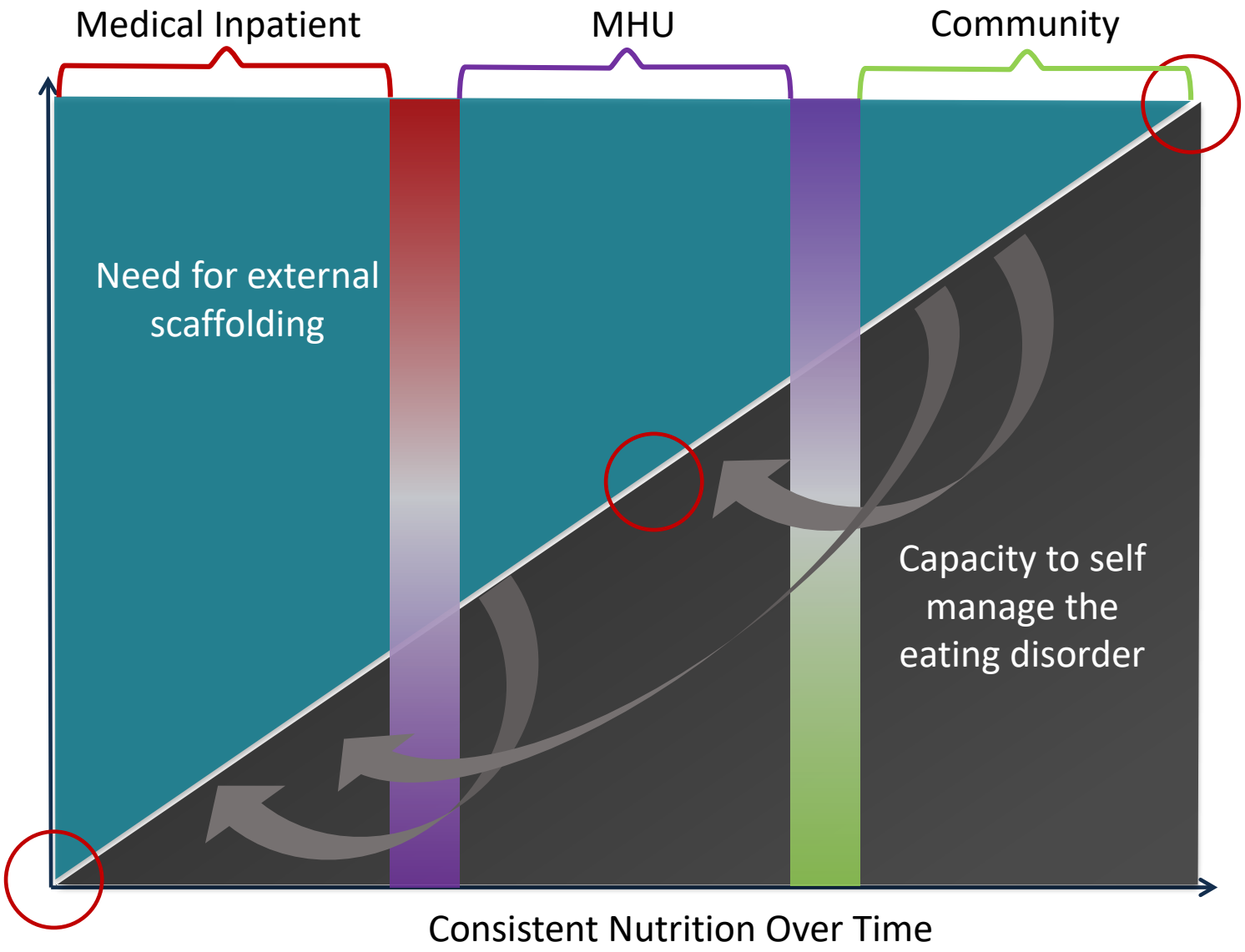
- Only able to experience the “cons” of a decision, not the “pros” at a sensory level
- Being “blind” to reward, makes “trusting” decisions difficult
- Often need a lot of ”scaffolding” to think through details, and weigh up options to build a plan, because they can’t “sense” it through

Both trait-based neural circuits and the effects of starvation exacerbate cognitive rigidity and details focused difficulty with “big picture” therapeutic stance



Phases of the Moon –
Distortion of thinking with eating disorders

Improving Nutrition


Medical Inpatient
MHU
Community
Need for external scaffolding
Capacity to self manage the eating disorder
Consistent Nutrition Over Time

The Paradox of Treatment – What is needed for recovery is that which is most feared

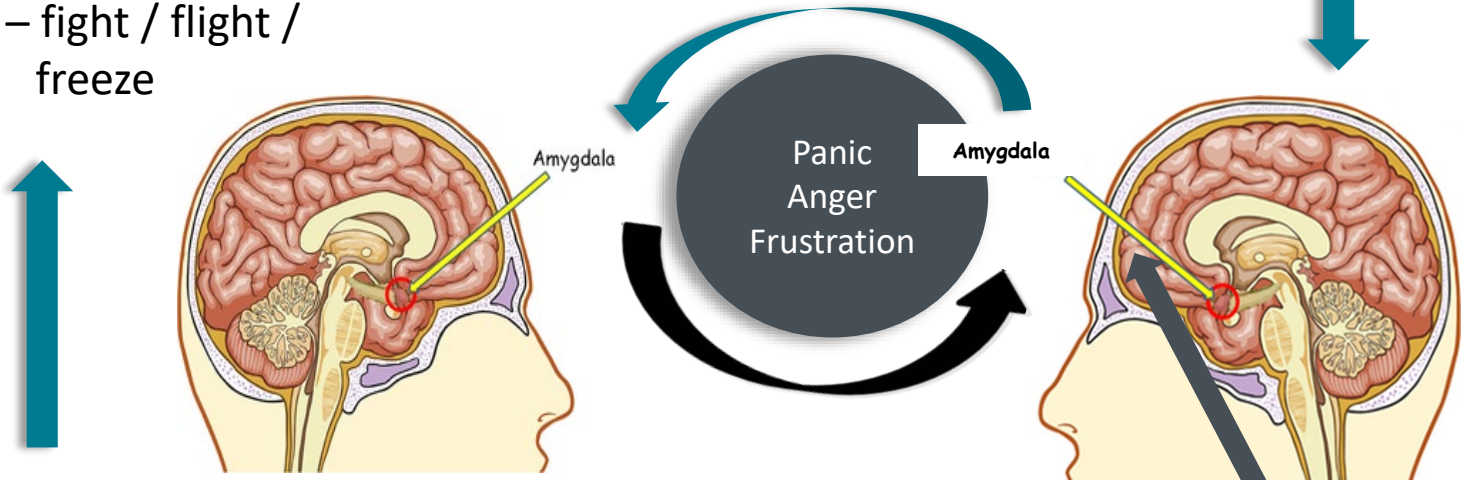
- Starvation (at any weight) can result in medical instability and can be life-threatening - sometimes people with eating disorders need to be treated, even if they refuse (consider nasogastric tube feeding and / or use of MHA)
- Feedback from those with lived experience suggests it is not the intervention itself but the way it was delivered that matters (i.e. "how we were treated as people")
- "We didn't like it but there were times that we needed it"
- A "containing" but compassionate response supports dignity / hope etc. whilst a "shaming" / coercive response can exacerbate pre-existing trauma and drive the eating disorder as a response to low self-worth.

The 4 C's of Meal support

Scaffolding recovery from a conditioned fear through Compassion, Calmness, Confidence, Consistency

Bottom up – Amygdalaic /limbic Threat response "I feel scared – is it Safe to eat?"
If not – fight / flight / freeze

Top-Down – can self-soothe, mentalise (externalise the eating disorder), hold the big picture "Yes we are safe" – co-regulation

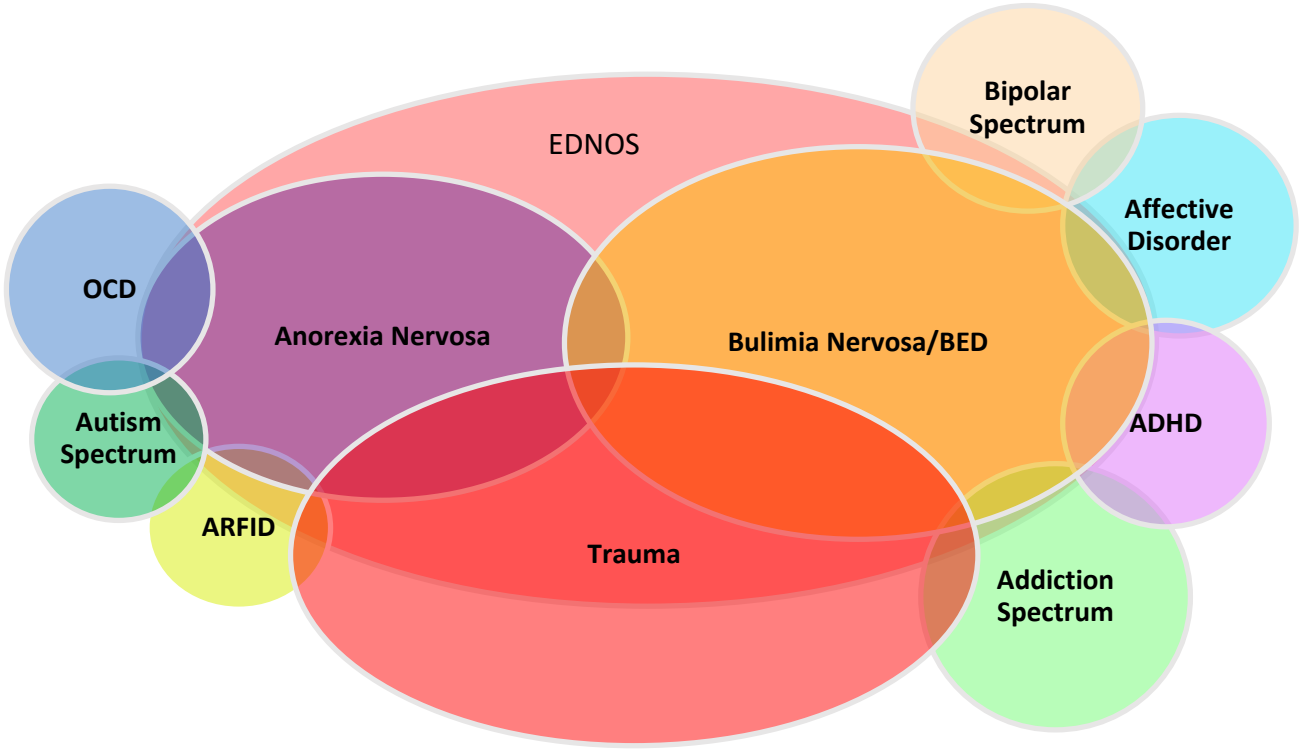


Patient

Clinician / Carer

Training, mentoring, own threat response contained by clear consistent leadership

Intersection of Eating Disorders and other Mental Health co-morbidities:



Adapted from Essential Psychiatry, 4th Ed, Treasure J & Schmit U, 2009.

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Note: *The information in this presentation cannot be considered as legal advice but rather, outlines the broader legal context and parameters. If legal advice is required, processes may be sought via health services.*