CHIEF PSYCHIATRIST
of Western Australia

12 October 2022

Chief Psychiatrist's Community of Practice

Part 1 - Eating Disorders and decision-making – legal, clinical and lived-experience perspectives

Acknowledgement of Country

I acknowledge the Traditional Custodians of the lands on which each of us meet today, throughout Western Australia, and here in Perth, the Whadjuk Nyoongar people, I pay my respects to their Elders past and present.

Recognition of Lived Experience

We acknowledge the contribution or people with lived experience of eating disorders - their advocacy, support, and the valuable resources they provide to people with eating disorders and to clinicians. We are so grateful for their contributions in such a challenging area of practice.

Juliette Stevens, Principal Officer Reviews, Office of the Chief Psychiatrist

Introduction

Welcome to our session taking place in Mental Health Week. This session's focus is eating disorders, which we know from our contact with the sector poses challenges at every level. We've put together two 45 min sessions to try to do justice to this important area. Across these sessions we bring together the legal and clinical aspects, and, set them both firmly within the framework of lived experience. We are always interested to hear your ideas for future sessions.

Key Messages

Decision-making capacity changes over the spectrum of the eating disorder. Practitioners provide the scaffolding at each stage of recovery to support the decision-making capacity of the consumer as they are able.

Give the healthy part of the person a voice. Proactively ask to speak with the healthy part of the person and put limits around the more dominant eating disorder voice. "I want to hear you."

Using the Mental Health Act 2014 (MH Act) compassionately, involves regularly repeating its purpose. In acute malnutrition, the eating disorder is driving reluctance for treatment. Using the Act can be the most trauma-informed way of working at this time to ensure timely treatment.

"'I can trust someone over my eating disorder, please don't trust my eating disorder because I am not safe with it." Lived Experience Shannon Calvert

"I'm going to put some limits around your eating disorder, I'm putting your eating disorder under the Mental Health Act because there needs to be a safe place for the healthy part of you to survive and thrive." Dr Lisa Miller

The paradox of treatment - What is most needed for recovery is what is most feared. Those areas in the brain that are particularly susceptible to atrophy tend to be the parts that are also reinforcing those distortions of shape and body weight and body image, and the preoccupation with weight and shape. Mental health clinicians are well equipped with general skills to support emotional regulation during what is essentially a conditioned fear circuit.

Therapeutic Rapport: Sometimes recovery conversations and choices can be overwhelming, especially understanding the benefits of eating for long term life goals, because they are fixated on the detail. It can feel easier to be sick. A helpful therapeutic approach can be a willingness just to sit alongside, collaboratively get the person through the day with empathy and firm boundaries.

Legal Perspective - When to use which Act?

Prior to considering the use of legal frameworks under which to provide treatment to a patient with anorexia, collaborative advanced care planning across the medical and psychiatric disciplines, with the person and their family, is encouraged. Clearly establish and communicate plans for crises and medical deterioration.

Consider the least restrictive options alongside the prevention of significant harm to physical and mental health or death.

Treatment under the Mental Health Act 2014 (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 Guardianship and Administration Act 1990 (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 to save life or to prevent serious injury to health.

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

If the circumstances of a person requiring treatment for anorexia do not meet the criteria for involuntary treatment under section 25 of the MH Act, treatment under the GAA Act may be possible.

Legal Case Explained

Fletcher (an infant by her litigation guardian Rylands) v Northern Territory of Australia [2017] NTSC 62.

The case was discussed, and a legal summary will be made available on the Chief Psychiatrist's website.

Treatment in this case related to providing nasogastric feeding to a 16-year-old with severe anorexia as an assertive treatment early-on, to prevent adverse deterioration. There were conflicting views on discharge from Flinders Medical Centre (NSW) between their eating disorder specialists at Flinders, and the defendant's receiving hospital Acting Medical Director, in the NT, about when it was necessary to commence nasogastric feeding. Specifically, whether it should be instigated immediately, to prevent a longer term risk of deterioration and death, or should only be used in an emergency of acute risk.

This case makes it clear that involuntary, life-saving treatment can be provided to mature minors in circumstances where there is a grave risk of permanent injury.

Note: The information within this session cannot be counted as legal advice as factors specific to each situation must be considered.

Contact: Community of Practice clinicalreviews@ocp.wa.gov.au

The Clinical Perspective – Eating Disorders and decision-making – Dr Lisa Miller

Several neurobiological factors and psychological factors impact on decision-making in anorexia nervosa.

1. Do not confuse BMI with nutritional status. Just because they don't look like they have an eating disorder does not mean they do not have one. Check other nutritional indicators.
1. Altered reward brain circuitry in response to the effects of starvation can reinforce a cycle of not eating in those who have increased genetic vulnerability. A dopamine reward circuit has developed for not eating. Therefore, people don't get that reinforcement - "Aahhh, I've made the right choice by choosing to eat".
2. Brain atrophy due to starvation, especially in adolescents, further impacts decision-making areas.
3. The paradox of treatment - what is needed for recovery is that which is most feared.
4. Cannot see the big picture – overly fixated on detail. Leads to difficulty seeing the value of changing behaviour towards a positive long-term recovery. It all seems pointless, trust is difficult.

Negotiating: Firm boundaries, such as one-to-ones, are so important because the eating disorder will sense if there is a vulnerability which will then drive the person to negotiate in order to engage in compensating behaviours. This in turn can lead to further anxiety, more so than the intervention itself.

Discharge planning: Often we are talking about highly intelligent people whose other cognitive functions might still be intact, and the eating disorder can be very articulate in describing why that person just needs to go home and they'll happily eat at home, even if they have been unable to do so.

> **It's often not until the nutritional state improves that we start to see the healthier part of the person saying "Goodness, yes I really was struggling to weigh up information."**

Questions to Shannon (Lived Experience)

Question: ***What is it like for you in the midst of a situation where you have been placed under the Act, with that Mentalisation approach of having the eating disorder referred to as an external entity, what was it like to have it framed like that?***

The first time being placed under the Act it felt very punitive, shameful like I had broken the law because there was no communication about the purpose of how it could support my care.

When someone places you under the Act you think "oh my God, I've been punished", "this person is evil", "my life is falling apart". That's the nature of the eating disorder, it doesn't allow much time or capacity to reflect or to consider what is going on at the time.

> **A particular psychiatrist said to me "I'm going to give this 48 hours. I'm going to explain to you why we're doing it, and we're going to talk to you about it again tomorrow and the next day". And I did not believe a single word they said, but rest assured … I think that, for me, shifted the shame and trauma response to really understand, I started to look at the Mental Health Act in a different way.**

It's that **continuation and consistency of communication around why the Act was supportive** that was probably the most trauma-informed approach to my care. But at the time, I hated the world, hated everybody, hated myself and the eating disorder as well.

Decisions are overwhelming - When someone is placed under the Act, all of a sudden that choice or that decision-making process is taken away. **Subconsciously there could be an element of relief.**

Question: ***As a mental health nurse we always want to promote recovery, self-determination, choice and empowerment, but in those first 24-48 hours, when you say it seems like everyone is against you, how we promote that therapeutic relationship so as to support you over the whole journey?***

Some of the nurses that supported me through some intensive interventions, in secure units and the medical ward, had very **firm boundaries** and stuck to the plan that was put in place for me.

> **When you're not seeing the wood for the trees, I think conversations around recovery are probably too big, overwhelming. The reality of getting to recovery is too hard - it's more convenient to be sick.**

It was more the **attitude and approach** to how they spoke to me. It was not having the solutions and the answers. **Being ok with not trying to fix it** if I was bursting into tears or feeling like the world was falling apart, but **willing to sit alongside**. If there's negotiating around behaviours and wanting to tweak the rules, firmness helps. Try saying:

"Look, let's just get you through this really hard part, and it's ok to feel really unsettled at the moment."

"Yeah, we're not going to go down that route."

Question: ***As there is a whole spectrum of impaired ability to understand or lack of capacity to make judgements all the way through recovery journey, including outside that point when someone may need involuntary treatment, how do you deal with that?***

Ask to speak to the healthy part of the person. The eating disorder voice will often drown out and prevent the healthy part of the person from speaking. Frequently for voluntary patients I just actually say out loud - "I would like to speak to the healthy part of the you." to give some space to start a conversation. **Dr Lisa Miller**

It's **validation** of that person who probably doesn't validate themselves, at the point where they've got into an abusive relationship with this eating disorder. It's a similar conversation in peer work. **Shannon Calvert**

"I want to take the opportunity to hear and see you", or –

"Our time together is our time for you as a person and right now I feel like the eating disorder is at the table for us and I almost feel like I'm betraying you by giving it time and energy.".

Further information

The presentation for this session is available on our website. For guidance regarding clinical situations contact:

OCP Clinical Helpdesk
reception@ocp.wa.gov.au
Tel: 08 6553 0000

WA Eating Disorders Outreach and Consultation Service (WAEDOCS)
WAEDOCS@health.wa.gov.au
Tel: 1300 620 208

Information about clinical guidance, education and community resources is available at WAEDOCS website page (NMHS), including the Management of Youth and Adults Quick Reference Guide

Legal fact sheets on the involuntary treatment of people with eating disorders and other legal information will be published by the Office of the Chief Psychiatrist. For updates, subscribe to our mailing list at on the OCP website.