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## Consent in relation to the treatment of eating disorders

In our experience, achieving consent, or managing situations when this is not possible, are fundamental issues in the treatment of patients with eating disorders. This is most clearly illustrated with reference to anorexia nervosa. An obvious reason for this is that in its severe form anorexia nervosa is life threatening – there is much to lose. A second reason is that the ambivalence over treatment that is found in other chronic illness, for example, renal failure (Korsch *et al*, 1978), is complicated in anorexia nervosa by the fact that the treatment and the illness tend to pull the patient in opposite directions, that is, weight restoration versus weight loss.

In this paper we will focus on anorexia nervosa. We will set a general context for consideration of consent. We will describe our approach to maximising the likelihood of consent and to dealing with situations when consent is not achievable.

### Consent

For psychiatrists, achieving clarity regarding the patient's giving or withholding of consent has three functions.

- (a) It protects the rights of the patient.
- (b) It encourages those working with the patient to remain within legal frameworks and to respect the rights of the patient.
- (c) It facilitates the discussion needed to achieve a shared understanding of the problem, the solution and the management plan, that is, it promotes a collaborative approach.

Maximising consent depends on (a) giving information; and (b) working with motivation.

### Giving information

We hope that by giving information we can position ourselves alongside patients and families as part of a team working out how to deal with anorexia and the problems it creates. We describe ourselves as experts on anorexia nervosa. We have a professional responsibility to be up-to-date on the literature. We have an extensive experience of talking with people suffering from this illness. We have observed what tends to happen when patients do X or Y or when we do P or Q. We share this information with patients and their families. We also provide a range of literature for them to read and suggest sources of further information. In this way we hope that we can help patients and families make decisions that move them closer to recovery.

How do we know what information to give at any particular time? Just as giving too little information is unhelpful in that it reduces our patients' ability to make informed choices, giving too much information may also

be unhelpful. In our experience patients may either be overwhelmed by the anxiety of excessive information or may fail to see its relevance to them.

Our solution is to focus mainly on information that will help patients understand their situation and orientate themselves to the future. For most, if not all, patients this will include information regarding the natural history of the illness (Strober *et al*, 1997) and factors that may lead to a better outcome. We also attempt to match information to motivational stages (see below).

### Working with motivation

The giving of consent should not be seen as a single event, established once only and interpreted as an agreement to all the treatments offered. Rather, it should be perceived as an ongoing process in which the patient's level of motivation for change is likely to play a crucial part.

As explained above, anorexia nervosa is a condition characterised by ambivalence to treatment and to change. The balance of motivation, to recover or to remain ill, fluctuates. For instance, patients may become more keen on the idea of recovery if they believe they are about to die of malnutrition or once the benefits of recovery are apparent. On the other hand, motivation for recovery is likely to decrease when patients experience a bloated abdomen or hear comments regarding how much weight they have gained.

Miller & Rollnick's (1991) approach to enhancing motivation in those with addictive behaviour and subsequent adaptations of this work to the field of eating disorders (Schmidt & Treasure, 1997) have been very helpful to us. We now try to work in a way that enhances the motivation for recovery of our patients. We believe that this makes it more likely that the patient will consent to treatment, or to put it more usefully; that we and the patient will work together in dealing with the anorexia nervosa problem.

There are several key aspects to this approach.

### Establishment of a relationship

It is important to establish a relationship in which our role is to promote and support change, but this change is achieved in part through us helping the patient to come to the realisation of the advantages of recovery over remaining ill.

### Working with the motivational state of the patient

Patients may be described in a general sense as in one or other of a number of motivational states. For example,



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'precontemplation' refers to the state of not accepting either that there is an illness or that treatment might be a good idea; 'contemplation' is a state where these things are being thought about; and 'action' as a state of actually doing something about the problem. However, such a categorisation may be rather simplistic. We find it tends to be more useful to think in terms of motivational state for individual difficulties such as vomiting or exercise and to obtain something closer to a motivational profile that then informs treatment as below.

### Matching intervention with motivational stage

Patients who do not accept that they have anorexia nervosa or that they are in need of help, are unlikely to consent to treatment such as weight restoration. If there is an urgent need for weight restoration then this will need to be achieved without patient consent (see below). If there is not such an urgent need then it may be more helpful to focus on helping patients to an understanding that they are unwell. Only then will they be able to move on to considering the costs and benefits of change.

### Involving families

We do this in a similar way to how we work with patients; sharing knowledge about the disorder, and about what does and does not help, clarifying where responsibility for change lies and linking this explicitly to a motivational framework. This also requires an understanding of the family's motivational state, and how this can be discrepant from the patient's. Addressing this discrepancy can help to lower high expressed emotion, which we know is associated with an increased risk of drop out from treatment (Le Grange *et al*, 1992). We also encourage families to recognise and share their expert knowledge of this illness so that they can gradually move from a position of victim to one where they have a sense of their own influence on the course of events. Mechanisms for this include a Parent's Support Group, and the involvement of patients and their parents in teaching events.

### Supporting ideas generated by patients or their families when possible

An example of this is where we recommend admission of a patient suffering from anorexia nervosa. It is not uncommon for patients to say that they are prepared to gain weight but that they will do this at home. Often on the basis of the past history, we do not share their confidence. However, we have learnt that unless patients are in a dangerous physical state we tend to do better to support their plan. This has two advantages. The first is that sometimes patients are right and we are wrong and they do succeed. The second is that once they have had a chance to try their plan, if it does not succeed, they are

often more open to considering alternatives. This may lead to their consenting to our original suggestion.

### When consent is not achievable

Such situations fall broadly into two main categories.

#### When a patient of whatever age, who has the ability to understand their choices regarding the illness and treatment offered, refuses consent

In these circumstances our approach tends to be as follows:

- (a) Check that the patient has been given and understood all the relevant information regarding the risks and consequences of their not consenting to the treatment offered.
- (b) Involve significant others, for example the family, in the discussion.
- (c) Check that we understand what it is that the patient is not consenting to, for example, the whole treatment package or a particular aspect.
- (d) Check that we understand what the patient is proposing and consider how feasible this is.
- (e) Take a view as to how crucial the treatment being refused is, and how urgent.
- (f) If it is not crucial or urgent, for example, a slight further weight gain that we would prefer but which may or may not make any difference to the patient's health or prognosis, then we would tend to accept the refusal to consent and attempt to continue with a motivationally-based collaborative approach.
- (g) If the treatment concerned is crucial and urgent, for example, weight restoration in a patient with bradycardia and arrhythmia secondary to low weight, then we are prepared to provide treatment without consent but under the terms of the appropriate legislation. This may be under the Mental Health Act 1983. The Mental Health Act Commission (Guidance Note 3; 1997) has clarified that anorexia nervosa is a mental disorder under the terms of the Act and that compulsory feeding may be a medical treatment in this context. The Government's Green Paper on *Reform of the Mental Health Act* also proposes that "feeding contrary to the will of the patient" should be considered a "specified treatment" (Department of Health, 1999). Patients aged below 18 who withhold consent, even if they fully understand the issues, may also be treated with their parents' consent under the terms of the Children Act 1989 (see below).

#### When a child under 18 is unable to understand the nature of the treatment and the consequences of refusing it

In these circumstances treatment can proceed on the basis of parental consent (eg. permission to admit to an



in-patient unit). This is a right held by parents under common law. However, we would again recommend that an on-going attempt to enhance the patient's level of competence and motivation for treatment should be adopted. Where a particularly high level of treatment intervention is required (eg. naso-gastric feeding plus sedation or physical restraint), legal advice should be sought as to whether proceedings under the Children Act would be appropriate. This has the dual effect of ensuring that the patient's views are formally considered, and that the clinician is protected from accusations of assault or trespass.

## Mental Health Act or Children Act?

The decision as to whether to use the Mental Health Act or the Children Act with patients under 18 who understand the issues but refuse consent, is a complex one. Practice varies between clinicians and familiarity with both legal frameworks is necessary. Advantages of using the Mental Health Act include that the patient is then provided with the safeguards afforded by the Act. Advantages of using Children Act proceedings include that this avoids the stigma of the Mental Health Act. Patients who have been detained and treated under the terms of the Mental Health Act will be unable to travel visa free to some countries, such as the USA, and will be required to provide supporting medical evidence regarding current mental health status before a visa is provided. There may also be implications for emigration applications. It may make more sense to use proceedings under the Children Act in younger children and to use the Mental Health Act with older teenagers. For a more detailed discussion of the ethical and legal dilemmas

connected to this issue see Honig & Bentovim (1996) and Freeman (1992).

## Discussion

We recommend an approach that focuses on collaboration with patient and family, on giving information, on motivational enhancement and on clarity regarding issues of consent. In our view such an approach maximises opportunities for successful treatment and provides safeguards for patients and staff alike.

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