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'Reforming the Mental Health Act': implications of the Government's white paper for the management of patients with eating disorders

Patients with severe anorexia nervosa have a high mortality and relapse rate, yet specialist services and practitioners are few. A significant minority need detention with involuntary treatment. Furthermore, the mean age at presentation is 16 years, where detention under the

Mental Health Act 1983 or parental consent is unclear and variable. This article addresses the implications of the proposed new Mental Health Act for people with eating disorders. The main issues are those of incapacity, assessment procedures, community detention, detention in 16–18-year-

olds, implications for carers and resource implications. We hope to show that eating disorders, just like other illness categories, have special needs that cannot be blanketed under one process and that the Act has positive features, but also presents significant concerns.

The Mental Health Act 1983 and eating disorders

Anorexia nervosa has the highest mortality of any psychiatric disorder, being in the order of 15% over 20 years (Sullivan, 1995). Despite this, clarification that feeding someone against their will is lawful under the Mental Health Act 1983 only occurred in 1997 (Mental Health Act Commission, 1997). More recently, this policy has been deemed consistent with the Human Rights Act 1998 (Radcliffes solicitors, 2000). Children aged under 16 years have usually been treated under parental consent, but controversy exists over the 16–18-year-old group.

New aspects of the white paper

It is the first part of the white paper 'The New Legal Framework' that is most relevant to eating disorders. The key changes in the Act can be summarised as there being a broadening of definitional criteria for detention, a common assessment pathway for detention for all disorders including a 28-day tribunal, the introduction of powers of community detention, altering detention and representation rights of children and increasing access to independent representation for all patients under detention (Department of Health, 2000a).

The Royal College of Psychiatrists has reacted strongly regarding a number of areas including the broadness of definitional criteria, the reduction of medical supervision and resource implications (Royal College of Psychiatrists, 2001). We will examine how

these issues are relevant to eating disorders in the context of how the new Act is structured.

The common criteria for mental illness and phases of assessment

The white paper proposes a broader definition of mental disorder matched by clearly-set limits on the circumstances appropriate for detention. In contrast to other patient populations (Royal College of Psychiatrists, 2001), diagnostics are reasonably straightforward in eating disorders and the new broadened definition of mental disorder does not cause undue concerns in the field of eating disorders. Re-feeding is always the main treatment with severe cases of anorexia nervosa. Criteria for admission/detention are not formalised, but focus on severe medical or psychiatric risk or failure of community treatment (Szmukler *et al*, 1995). Thus, the first step of the assessment process is relatively uncontroversial, with one exception that centres on the issue of capacity.

Assessment of capacity is recommended but not formalised in the new Act. The Law Commission identified incapacity being present if a person is suffering from disorder of the mind and brain resulting in impaired ability to retain and/or understand a decision and to reason rationally so as to make a balanced decision based on that information (Mental Incapacity Act: Law Commission 1995). Treatment may be provided under common law if it is in the patient's best interest and/or in order to save life or ensure improvement/prevent deterioration in health, while being in line with current opinion. In severe anorexia nervosa, capacity can be compromised in all areas due to



the lack of or fluctuating insight, or occasionally organically-impaired cognitive function. In severe, chronic cases, capacity becomes central as clinicians, patients and carers face difficult questions over treatability and what is in the patient's best interest.

This adds to the risk of the criteria for admission leading to inappropriate detention; notably, the Government claims 'a diagnosis of mental disorder alone would never be sufficient to justify the use of compulsory powers' (Department of Health, 2000b). Thus, a more formalised capacity assessment would be more useful.

The white paper specifies a 28-day maximum assessment period with compulsory treatment and then a tribunal that will authorise a care plan under guidance of expert opinion. However, the rate of improvement in a severely-starved individual with anorexia nervosa will be minimal in 28 days; the patient will still be at high risk and typically very ambivalent and confused about treatment with fluctuating motivation, insight and capacity. Currently, most detained patients are treated under section 3 of the Mental Health Act 1983, with a clear diagnosis, but a slow response rate in severe cases. Mandatory review at 28 days would increase workload and raise inappropriate expectations for patients. Arguably, restricting 'special case' categories to 'dangerous individuals' does not take in the specific needs of other groups of patients.

Compulsory community treatment

Community treatment often fails because of difficulties implementing feeding in community settings. Compulsory community detention could only work if there was support given for meals. Ideally, this treatment should be given in home as well as in clinical settings. With the National Plan's shift to outreach working, support for meals could be given at home or by day-patient services with the aid of compulsory community detention. All this may thus reduce the disruption of in-patient care, enrich treatment and reduce overall care costs (Birchall *et al*, 2002). It may also reduce the high relapse rates post-discharge by reducing dropout from treatment and maintaining consistent levels of high support.

Initial trials of home treatment could offer patients choice in their management, and possibly allow them to avoid admission. The tribunal could assess the results and admission could be carried out at any necessary stage. A similar process could occur towards the end of in-patient treatment. Key aspects of treatment, such as feeding and psychotherapy, can and need to occur at home. Thus what defines treatment, a clinical setting and a provider of treatment need to be clearly defined. Furthermore, using the new Mental Health Act as the enforcer may empower parents in their role as carers.

This use of the Act could therefore be incorporated as part of a relapse prevention package that some patients might need (Page *et al*, 2002). All this, however, needs to be matched with resources in order to work, including training of outreach teams with the skills and resources to implement feeding at home.

Box 1. Key points

1. The first part of the new Mental Health Act bill is relevant to the field of severe eating disorders.
2. Most of the framing of the Act has been within the context of medication for psychotic symptoms. Thus the idea that there are other forms of treatments (i.e. food for other forms of severe mental illness) does not appear to have been considered. This has implications as to where treatment is delivered and the time course of action.
3. The introduction of community detention offers possible further reduction in in-patient treatment and relapse prevention.
4. Clarification is needed on what constitutes 'treatment' and where it can occur in the community. There needs to be a broader conceptualisation of treatment, i.e. food, not just medication, for anorexia nervosa.
5. We welcome the increased use of advocacy and introduction of the use of the Mental Health Act for 16–17-year-olds rather than parental consent or the Children Act 1989. This will have implications for eating disorder services.
6. The process and time course of change in severe anorexia nervosa is protracted and there will be little change in medical risk and capacity over 4 weeks, thus a compulsory tribunal review will unnecessarily increase work load.
7. There are inadequate resources at present both professionally and financially to finance the proposed changes.

Children, adolescents and their carers

Currently, children under the age of 16 are mostly treated under parental consent where they hold no rights. The management of 16–18-year-olds varies depending on the clinical team and on patient variables. The new Act proposes that all 16–18-year-olds needing detention be treated under the Mental Health Act 1983, affording them full rights of advocacy and independent opinion. This will have implications for both the individual and family dynamics. Without the Act, patients can resent their parents holding this level of control, perceiving admission as punishment and control (key features of eating disorders to begin with). Use of the Mental Health Act 1983 may reduce this, and aid communication and cooperation between the involved parties. However, issues of stigma (a concern often raised by carers and patients) and resources need to be addressed.

Advocacy and carers

The extension of independent advocacy is laudable in a situation where someone is detained. It would be vital, however, that advocates were adequately trained in interpreting medical risk and the ambivalence about the conceptualisation of illness and treatment that is so prevalent in anorexia nervosa.



opinion
& debate

The role of the medical practitioner

A particular concern for the Royal College of Psychiatrists is the indication that patients will not always have medically-trained supervising clinicians. In eating disorders, this raises particular concern, as medical management is integral to the safety and treatment of severely-ill patients. Half of all deaths from anorexia nervosa are from acute and chronic medical complications. We therefore support the medical supervision of detained, and more seriously ill, patients.

Implications for resources

There are significant implications on resources at all levels of the new Mental Health Act. At present, a conflict arises between the knowledge that prognosis for anorexia nervosa is better in areas with specialist services and yet that there is gross depletion of both services and professionals nationally (Crisp et al, 1991).

The reforms would have an impact on services for eating disorders. Community detention could reduce occupancy, although the 28-day assessment would use up considerable amounts of professional time in tribunal work and expert opinions. If budgets remain the same, this would decrease already scarce service access to sufferers further.

Conclusion

Severe anorexia nervosa is distinct in the nature of community and hospital treatment, the high rate of adolescent patients and the rate of medical morbidity and mortality. The new Mental Health Act presents significant concerns and some exciting prospects in all these areas (Box 1). It enhances demands on scant resources and potentially reduces medical input within the field. The opportunity to develop compulsory community treatment is possible if there could be outreach to facilitate home feeding and interventions, such as family work, which enhance carers' skills. However, definitions of what constitutes treatment and place of treatment need to be broadened to achieve this.

We welcome the appropriate use of the Mental Health Act 1983 in adolescents, which acknowledges the difficulties to families of detainment under their consent. The new Act offers more rights to adolescent patients,

aids families and sufferers working together and removes a great burden that can rest on the family.

Overall, we feel that significantly more thought needs to go into the new Mental Health Act for specific terms of severe mental illness, and the implications on resources thoroughly thought through before any revisions proceed.

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