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GOOD PRACTICE GUIDE

Nutrition by artificial means

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Who we are and what we do

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

A psychiatrist calls the Commission's advice service to discuss her concerns about a patient. Claire is a 13 year old girl who has had symptoms of an eating disorder for more than a year. She was referred to an outpatient child mental health service several months ago with a range of difficulties including refusing meals, hiding food, steady weight loss and preoccupation with her physical appearance. Family therapy sessions were commenced but as yet her family have not been able to engage in this and there are indications of bitter disagreement between her parents about the cause and nature of Claire's difficulties. Her condition has rapidly worsened.

Claire was admitted to a Young People's inpatient service one month ago but despite intensive support her condition is deteriorating with desperate attempts to negotiate smaller and smaller quantities of food and supplements. Her physical condition is now giving cause for very serious concern and she is refusing nearly all nutrition. The multi-disciplinary team are considering the use of nutrition by nasogastric tube. Claire is very unhappy about this and her mother refuses to consent to the treatment. She feels Claire would be better off at home. The practitioner is looking for legal and ethical guidance in relation to her grounds for proceeding with nutrition by artificial means.

This scenario is an example of the kinds of call received by the Commission and it demonstrates the complex issues involved in safeguarding the welfare of an individual who puts himself or herself at risk by failing to take adequate nutrition. When the Commission receives a call like this it is our role to explore the circumstances of the individual, reflect on good practice in relation to the law and provide a view on a way forward that best safeguards his or her welfare. The aim of this document is to provide general guidance to practitioners about the relevant legal and ethical issues when they are considering the provision of nutrition by artificial means to a person for a mental disorder in the absence of consent. We also hope that this guidance will be of interest to service users, carers and advocates.

This document does not constitute legal advice. While it provides a legal and ethical framework it would be impossible to provide guidance for every set of circumstances that may occur. People who wish to discuss the implications of the law for specific individuals can contact our telephone service for advice and information. They may also choose to seek their own independent legal advice and we recommend this course of action in some cases.

Practitioners looking for information on medical or other clinical criteria for decision-making in this area of practice should refer to relevant documents produced by the Royal College of Psychiatrists and the Royal College of Physicians ^{1,2}, Healthcare Improvement Scotland ³ and the National Institute for Health and Care Excellence (NICE) ⁴.

In a mental health setting, nutrition by artificial means is most commonly used in the treatment of individuals with eating disorders. However, there are other situations where nutrition by artificial means is an appropriate part of the treatment plan. In cases of severe depression or psychosis individuals may refuse food as a result of delusional beliefs or be unable to eat, resulting in risk to their health. The legal and ethical issues surrounding the use of a nasogastric tube to administer antidepressant or antipsychotic medication are addressed later in this guidance.

What is 'nutrition by artificial means'?

In the context of this guide, nutrition by artificial means refers to nutrition by nasogastric (NG) feeding tube, percutaneous gastrostomy (PEG) tube or intravenous route where this is given as a treatment for eating disorder, or where there is refusal or failure to take adequate nutrition as a consequence of another mental disorder. There is an important difference between these artificial means and forcible feeding. Forcible feeding involves using direct force to make an individual swallow food. The Code of Practice⁵ for the Mental Health (Care and Treatment) (Scotland) Act 2003 (referred to in this guidance as the 2003 Act) clearly states that forcible feeding is not allowed under the 2003 Act and should never be used.

Hydration is not considered part of nutrition for the purposes of this guide. Hydration by artificial means (for example by intravenous drip) is given as a treatment to save life or prevent serious deterioration. Any nutritional component in the fluids used is minimal and nutrition is not the purpose of such treatment. We have therefore chosen not to interpret artificial hydration as 'nutrition' in the context of mental health legislation. We have, however, included guidance around the use of fluids given by artificial means in relation to the 2003 Act.

The legislative context

The Mental Health (Care & Treatment) (Scotland) Act 2003

The 2003 Act makes specific reference to the provision of artificial nutrition in the absence of consent and gives the Mental Welfare Commission a role in safeguarding its use. The Act provides a set of principles that must be taken into account by everyone involved in providing care and treatment to a person who has a mental disorder:

- The person's past and present wishes about his or her care and treatment;
- The care and treatment that will be of most benefit;
- The range of options available for care and treatment;
- The person's individual abilities and background;
- The person's age, gender, sexual orientation, religion, racial origin or membership of any ethnic group.

People giving care should also make sure that:

- Any restrictions on a person's freedom are the least necessary;
- The person being treated under the Act should not be treated any less favourably than anyone else being treated for a mental illness or other mental disorder;
- The needs of carers are taken into account;
- The person being treated is getting services that are right for him or her;
- When a person is no longer receiving compulsory treatment, he or she should continue to get care and treatment if needed.

As the case study in our introduction demonstrates, these principles may come into tension with each other. Where there are competing or conflicting interests or pressures, due consideration should be given to the need to balance the various principles in the Act. We believe it is important for practitioners

to demonstrate how they have balanced the principles when making treatment decisions where the person lacks capacity and/or refuses treatment.

In law adults have the right to make decisions affecting their own life, including decisions about medical treatment. Where an individual has a mental disorder, or is considered to lack capacity to make decisions that are in his/her own interest, the law provides ways in which decisions can be made on that person's behalf. The Mental Welfare Commission's publications *Consent to Treatment*⁶ and *Right to Treat*⁷ discuss best practice in this area. This guidance on nutrition by artificial means should be considered alongside our other guidance on consent.

Nutrition by artificial means may be included as part of an agreed treatment plan in collaboration with the person to be treated. In the treatment of an eating disorder the use of artificial means may be more acceptable for a time to the person than making the constant effort to eat. At the Commission we would expect that this would be the usual context in which feeding by artificial means would occur. On rare occasions, however, it may be necessary to consider providing nutrition by artificial means without the consent of the person. The 2003 Act contains specific safeguards for this situation. We think any decision to treat in this way requires very careful consideration. The provision of safeguards in the 2003 Act and the provision of guidance for practitioners should not be seen as promoting this treatment option. Feeding by artificial means without consent should only be considered where other treatment options have been fully explored and exhausted.

Significantly impaired decision-making ability (SIDMA)

SIDMA is a criterion that needs to be met before anyone can be given compulsory treatment under the 2003 Act. The Act requires the medical practitioner to state the reasons for believing the patient has SIDMA.

SIDMA occurs when a mental disorder affects the person's ability to believe, understand and retain information and to make and communicate decisions. SIDMA is not the same as limited or poor communication or disagreements with professional opinions. SIDMA is a separate but related concept to capacity. It pertains to the specific capacity of an adult to make decisions about medical treatment for mental disorder, whereas the Adults with Incapacity (Scotland) Act 2000, referred to in this guidance as the 2000 Act, covers a range of different capacities. SIDMA, like capacity, can fluctuate.

The 2003 Act does not define SIDMA, although the Code of Practice and other guidance material provide some information. We have heard that it can be difficult to apply this test to individuals with eating disorders.

Some consider that the traditional approach of assessing capacity in terms of reasoning and understanding does not truly capture the difficulties faced by individuals with anorexia nervosa, who can retain understanding and relatively intact reasoning abilities. There is a view that standard tests for capacity fail to capture difficulties relevant to competence to refuse treatment in cases of anorexia nervosa. We discuss these issues further in our Good Practice Guide *Significantly impaired decision-making ability in individuals with eating disorders*⁸.

Authorising nutrition by artificial means

When a person is being treated under the 2003 Act, nutrition by artificial means can only be given if one of the following applies:

- the person has capacity to consent, and gives consent in writing; or
- a designated medical practitioner (DMP) authorises the treatment; or
- the urgent medical treatment provisions apply.

One of the above criteria is required from the start of treatment. There is no “two month window”, in contrast to when medication for mental disorder is given under the 2003 Act.

The relevant forms under the 2003 Act are, respectively: T2 (certificate of consent to treatment); T3 (certificate of the designated medical practitioner); and T4 (record of notification following urgent medical treatment).

Where there is consent, a person must be considered capable of giving valid and informed consent. The consent must be given in writing. There is best practice guidance regarding assessing capacity in the Commission’s guide *Consent to Treatment*⁶. Some of the particular issues relating to consent in the treatment of eating disorders are discussed within this guidance.

Where the person is incapable of consenting or refuses consent, a DMP must certify that the treatment is in the person’s best interests. A DMP is a doctor appointed by the Mental Welfare Commission. DMPs receive induction training from the Commission on their role. Annual training meetings provide opportunities for DMPs to update their knowledge. Some of the factors that DMPs should take into account when authorising treatment are contained in this guidance. The DMP is required to “have regard” to the reason for refusal if that reason is known. There are special provisions for children under the age of 18. In this case, where the child’s own RMO is not a child and adolescent specialist, the DMP must be a child and adolescent specialist.

When an opinion is being given for nutrition by artificial means we think it is important that the DMP considers carefully how long to authorise the treatment for. We would recommend that the maximum period that treatment should be authorised for is three months, in the first instance. The DMP may authorise treatment for shorter periods or attach particular conditions, for example that the Responsible Medical Officer (RMO) reviews the need for treatment after a certain period and requests a further opinion. After the first three months it may be appropriate to authorise treatment for a longer period of time. The DMP may also wish to attach particular conditions to this authorisation.

The 2003 Act includes provision for urgent medical treatment, which may be given without consent in order to save life, prevent serious deterioration or alleviate serious suffering. In some circumstances this provision may cover nutrition by artificial means. This could occur where a decision has been taken to provide the treatment and a DMP opinion has been requested, but it becomes essential for the person’s safety to commence the treatment before the DMP has visited. Urgent medical treatment under the 2003 Act must be reported to the Mental Welfare Commission. When a request for a DMP visit has been made the Commission makes every effort to provide this as soon as possible. We expect that the provisions for urgent treatment would, therefore, only be used on rare occasions.

Named persons

In order to help ensure that the views and wishes of a person with a mental disorder are considered in care and treatment decisions, the 2003 Act provides for the appointment of a "named person". The individual's named person has to be informed and consulted about aspects of the individual's care and can also make certain applications on his or her behalf.

In relation to nutrition by artificial means given under the 2003 Act, the following named person provisions are particularly relevant:

- The named person has the right to be consulted when certain things happen, such as when a short term detention or an application for a compulsory treatment order is being considered.
- The named person has the right to receive copies of certain records or information given to the person being treated, including the record that must be made if treatment has been given which conflicts with an advance statement.
- The named person has the right to make applications or appeal to the Mental Health Tribunal for Scotland, for example an application requesting that a compulsory treatment order be revoked or varied.
- A Designated Medical Practitioner must consult with the named person (amongst others), if practicable, before making a decision about authorising the giving of nutrition by artificial means under the 2003 Act.

An individual over the age of 16 and receiving care or treatment under the 2003 Act can choose someone to act as their named person, providing a witness can certify that the individual understands the effect of choosing a named person. Where a named person has not been appointed by the individual, the Act provides for this role to fall by default to the person's primary carer or nearest relative. There are very few situations in which an individual should not have a named person.

The situation is different for people under the age of 16. People under 16 are currently unable to choose their named person. The named person will automatically be the person who has parental rights and responsibilities. In cases where it is thought that this person is inappropriate to act as a named person it is possible to make an application to the Tribunal to have that person removed and replaced. The local authority will be the named person if the child is being looked after under a care order under the Children's Hearings (Scotland) Act 2011.

More information on named person provisions can be found in the document *A Guide to Named Persons*⁹.

Advance statements

The 2003 Act gives a person the right to make a written statement setting out how he or she would or would not want to be treated should he or she be unable to make decisions as a result of a mental disorder. An advance statement can include details about which treatments the person feels work well and which ones do not. It is only relevant to treatment for mental disorder, as defined by the 2003 Act, which includes the provision of nutrition by artificial means. The statement may include the person's view on particular medications, therapies or feeding methods. Young people under 16 can make an advance statement, as long as they understand the nature and possible consequences of the procedure or treatment in question.

A valid advance statement must be taken into account when decisions are being taken about care and treatment. For an advance statement to be valid it must be made in writing, signed and witnessed. In brief the following are necessary for a statement to be valid:

- The person making the statement must have the capacity of properly intending the wishes specified.
- It must be witnessed by a clinical psychologist, medical practitioner, occupational therapist, person working in or managing a care service, a registered nurse, a social worker or a solicitor.
- The witness must certify in writing that, in his or her opinion, the person making the statement has the capacity of properly intending the wishes specified in it. The witness does not have to assess the overall capacity of the person, but witnesses that the person was able to make the statement at that time and understood the importance of this. The witness does not have to be involved in writing the statement, nor does he or she have to agree with what the statement says.

Anyone who knows the person well can help him or her write an advance statement and this can include an independent advocacy worker or a key worker/support worker.

An advance statement is best prepared when a person is well enough to discuss the content of the statement and the implications of this with those involved in his or her care. A statement prepared during a time of crisis is less likely to be an accurate reflection of the person's general wishes and feelings. When a person suffers from a chronic mental health condition (such as a long-term eating disorder) that may influence his or her thinking and choices on an ongoing basis and there may be uncertainty as to when the person could be considered well enough to make a valid statement. However, the presence of ongoing symptoms does not in itself mean that the person is not capable of properly intending the wishes expressed in an advance statement. Even where it is thought that the person's capacity to make treatment decisions is impaired, he or she is likely to retain the ability to make valid choices about some aspects of care. For example, decisions about where or how a particular treatment might be given may be less likely to be influenced by disruptions to the person's thinking than the decision to accept or reject the treatment itself.

The advance statement cannot require someone to do anything that is illegal or unethical and it cannot insist on particular treatments or services.

If a decision is made that goes against an advance statement then the person has to be given the reasons for this in writing. A copy of these reasons should also be given to the named person, any welfare guardian or attorney and the Mental Welfare Commission.

An advance statement is distinct from a "living will" or "advance directive", neither of which has any formal legislative basis in Scotland. Living wills and advance directives usually relate to treatment for physical conditions or palliative care.

Further information on advance statements can be found in our good practice guide on the subject ¹⁰.

Adults with Incapacity (Scotland) Act 2000

The 2000 Act provides a legal framework for intervening in the affairs of adults (defined as those aged 16 years and over) with incapacity in order to protect their welfare. Part 5 of the 2000 Act covers medical treatment. The Commission's guidance *Consent to Treatment* ⁶ includes an examination of how the 2000 Act allows for treatment of mental disorder and how it interacts with the 2003 Act.

It is unlikely that the 2000 Act will be used often in the treatment of eating disorders. If the person is already subject to the 2003 Act then treatment for mental disorder must take place under the 2003 Act. However, where a person lacks capacity but does not resist or oppose the treatment, and there is no need for detention, then it may be appropriate to use the 2000 Act to authorise nutrition by artificial means. The relevant section of the 2000 Act is Section 47, and the corresponding certificate of incapacity would be completed by the treating doctor. Feeding by artificial means might be used when a person who lacks capacity is physically unable to swallow. It could also be used to treat people with severe mental illness who are too ill to be able to eat but who do not resist or oppose the treatment.

We would advise using the 2003 Act if it is necessary to give treatment and the person requiring treatment resists or objects to that treatment (or would be likely to object if able to express a view).

European Convention on Human Rights

The European Convention on Human Rights (ECHR) is a wide-ranging measure that includes a set of rights and freedoms which apply to many areas of life, including medical treatment. By virtue of the Scotland Act 1998 and the Human Rights Act 1998, the Convention has direct legal effect in Scotland, and public bodies have a duty to comply with it. ECHR provisions which are relevant to nutrition by artificial means include Article 2, which protects the right to life; Article 3, which prohibits inhuman or degrading treatment; and Article 5, which restricts the power of the state to deprive a person of their liberty.

When providing nutrition by artificial means it is essential that treatment methods are consistent with the Convention. Treatment must be provided under lawful authority and in a way that is not punitive or degrading. The use of force or restraint is discussed later in this guide.

Children and the law

Legislation contains particular provision for children and young people with regard to treatment for mental disorder and consent. We have already referred to special provisions for young people under the 2003 Act. The principles of the 2003 Act make clear that anyone providing care and treatment under the Act must act in a manner which "best secures the welfare" of a child or young person under the age of 18. This is of particular relevance in considering treatment for a child or young person with an eating disorder, where there may be opposing views about what is best for the individual.

The Children (Scotland) Act 1995 contains general provisions for parental rights and responsibilities, including the rights of parents (or a person granted parental rights) to consent to treatment for a child under the age of 16 years in certain circumstances and providing that the treatment is in the child's best interests. However, children and young people may also be able to consent to their own treatment. The Age of Legal Capacity (Scotland) Act 1991 provides that children under the age of 16 can consent to medical treatment, or withhold consent, if the child has, in the medical practitioner's view, the capability of understanding the nature and possible consequences of the procedure or treatment. The Code of Practice for the 2003 Act states: "In practical terms, medical practitioners should look for signs that the child can consent on this basis from when the child is about 12 years old"⁵.

Where a child under 16 is not capable of consenting due to immaturity, a parent (or person with parental rights) may consent on the child's behalf. However, difficult decisions may arise when a child resists treatment. There should be careful consideration in each instance as to the child's capacity and whether or not it is appropriate to rely on parental consent. For example, in the case of a young child who does not have the capacity to consent to his or her own treatment due to immaturity, parental consent may be appropriate, depending on the nature and severity of the intervention, and the degree of resistance. For older children, however, who have reached sufficient maturity to have gained capacity to consent but are refusing treatment it would be appropriate to consider whether the young person meets criteria for detention and treatment, under the 2003 Act. In this case the 2003 Act may be considered if the young person's mental disorder significantly impairs his/her ability to make decisions about treatment.

Our view is that it would rarely be appropriate to rely on parental consent as the legal grounds for providing nutrition by artificial means to any child with an eating disorder when the child is objecting to or resisting treatment. This includes those children who are not able to consent due to immaturity. In a situation where a young person is resisting or objecting to the treatment of nutrition by artificial means, it is our view that the 2003 Act generally provides a more appropriate mechanism for authorising treatment. The 2003 Act has better safeguards for the child in these circumstances, including provisions for a second medical opinion, than does parental consent. In some cases, it may also remove the emotional burden from parents of authorising treatment against the wishes of the child. In such a situation it is our view that the child should be assessed to determine whether he or she meets the criteria for detention and treatment under the 2003 Act.

A difficult situation can sometimes occur in relation to children who are too immature to consent on their own behalf, where the person with parental rights disagrees with the decision to use nutrition by artificial means and this treatment is thought by the clinical team to be in the best interests of the child. Anyone considering such treatment should take account of the parent's views and the views of the child. There should be a full discussion of the reasons for the decision and the associated risks and benefits. Ultimately, where the child meets criteria for detention the 2003 Act could be used in the face of such a disagreement. We would expect that this would be very rare and that most disagreements could be resolved by discussion.

Issues in practice

Deciding to provide nutrition by artificial means without consent

As stated in the introduction, it is beyond the scope of this guide to discuss in detail the clinical issues surrounding the decision to provide nutrition by artificial means in the absence of consent. However, there are some key principles which we think should form part of this decision-making process.

The starting point should be that the team providing treatment should seek to engage the person in a sincere and voluntary alliance. Any decision to proceed to treatment without consent should only be taken when the physical risk clearly justifies this and all other possibilities have been considered. Assessment of risk must weigh up the risks versus the benefits of imposing treatment. With regards to physical indicators, there is unlikely to be one single factor that leads to a decision to provide nutrition by artificial means. Practitioners should refer to guidance from the Royal Colleges, HIS and NICE for further information¹⁻⁴.

It is essential that treatment is carried out in a setting where there is an appropriate level of expert knowledge and experience. Services should ensure that there are effective procedures and protocols in place to ensure that this happens. There should be access to specialist dietitians and physicians. Those providing treatment should be familiar with current good clinical practice guidance and treatment should only proceed where the clinical team are confident that the necessary expertise is available.

When the person does not consent to nutrition by artificial means, it is essential that his or her individual needs and circumstances are taken into account before deciding to proceed with treatment. This includes careful consideration of the specific individual reasons that may be leading that person to refuse treatment at that time. The risks of not providing nutrition by artificial means must be considered.

There must have been efforts made to carefully explain the different treatment options that are available, with the opportunity for the person to engage in negotiation around options that may suit her or him.

An approach which promotes autonomy should be adopted. The person's capacity to make choices should be respected as far as possible. For example, even where there may not be overall agreement to the recommended treatment approach there should be negotiation as to the details of how, where and when treatment is provided as far as this is possible.

In keeping with the principles of mental health law, it is important to appropriately involve the person's family (or other key people in his or her life) in the decision-making process.

The intentional use of a strategy which may coerce or unnecessarily frighten the person into agreement must be avoided. Those providing treatment should also be alert to the possibility that coercion can occur covertly.

Overall, consideration of the quality of the relationship between the person and the team providing treatment – the therapeutic alliance – is crucial. It is our view that a decision to treat without consent should not be taken without thorough consideration of the quality of the therapeutic alliance. There must be confidence that the decision is being taken in the best interests of the person.

Force and the use of restraint

The 2003 Act allows the use of force, but only where the person is in hospital. Force should only be used if:

- treatment is necessary and cannot be achieved in other ways;
- the person persistently resists treatment – it is preferable to wait and try again at a later time unless the situation is urgent;
- the principles of the Act are applied.

In particular there must be very careful consideration of alternatives, consultation with appropriate others and minimum restriction of the person's freedom. Any force should be the minimum necessary and only for as long as necessary. There are particular challenges and risks in using physical restraint where the person is frail as a result of an eating disorder. It is therefore important that any care plan which may include the use of force is only carried out where there are sufficient numbers of appropriately trained staff available.

A distinction should be drawn between the use of force as restraint and forcible insertion of a nasogastric tube. The Code of Practice for the 2003 Act⁵ states that force should not be used to insert a tube. There should be very careful consideration of the risks versus benefits of the use of force. Medication may be used as restraint and may be preferable in some situations but this depends on very careful assessment of the risks in each individual situation. A certificate issued by a DMP authorising nutrition by artificial means also authorises the practical steps necessary for the insertion of the feeding tube. This could include medication, such as a short-acting sedative, to reduce stress experienced by the person being treated. In some cases, this medication may already be authorised – the individual may have in place a certificate of the designated medical practitioner (T3) authorising the relevant medication or be within the "two month window" since medication for mental disorder was first given in the episode under the 2003 Act.

Where force or restraint may be required it is of particular importance to ensure that methods used are not punitive or degrading.

Providing nutrition by artificial means when the individual's weight is within the relevant normal range

We have been asked about situations where it is planned to continue nutrition by artificial means against an individual's wishes, despite the person's weight falling within the relevant normal range. This must be considered in line with the principles of the 2003 Act. While treatment could continue if it would prevent deterioration in the individual's condition, the RMO must consider whether providing nutrition in this way is the least restrictive option. It is likely that in these circumstances it would take some time for the person's weight to fall to the level where health is at serious risk, and it may be hard to argue that the continued provision of nutrition by artificial means is justified. Any decision to continue nutrition by artificial means for a person whose weight is within the normal range would, therefore, have to be considered very carefully.

Medication administered via feeding tube

Medication for mental disorder under the 2003 Act requires authorisation distinct from the authorisation of nutrition by artificial means. The route of administration of medication must be specified – medication by NG or PEG tube is **not** authorised by a certificate authorising oral medication. In addition, specialist pharmacy advice should be obtained before giving medication by this route, as the effectiveness and amount absorbed of the medication may be altered. It may be appropriate to use an NG or PEG tube to administer medication if the person is being fed artificially in this way. We do not think that an NG or PEG tube should be inserted solely to administer medication, although we are reviewing this position at the time of publication of this guidance.

Providing hydration by artificial means

We think that hydration by artificial means does not constitute nutrition for the purposes of medical treatment for mental disorder under the 2003 Act. The law, however, does include provision for urgent medical treatment for mental disorder where a person is detained in hospital under the 2003 Act. In this situation treatment can be given, without consent, to save life or prevent serious harm. It is our view that hydration by artificial means may be given under this provision.

Where it is necessary to continue with this treatment beyond the initial urgency (e.g. for longer than seven days) and where there is total refusal of both food and fluids, it is likely that the person will also require treatment with nutrition by artificial means. If there is no need for the person to receive nutrition, e.g. where fluids alone are resisted as a consequence of the mental disorder, then treatment can continue under the 2003 Act if the person's responsible medical officer determines that it is in the person's best interest.

Withdrawal of treatment in cases of anorexia nervosa

The primary purpose of artificial feeding in cases of severe anorexia nervosa is to save the person's life or to prevent further serious deterioration in physical condition. Feeding in itself will not cure the anorexia nervosa but will hopefully return the individual to a physical and cognitive state where longer term treatments (primarily psychological in nature) can be initiated.

A controversial alternative to continued artificial feeding is to consider not providing life-sustaining treatment but to provide palliative care instead. There will be a small group of people with chronic anorexia nervosa where the clinical opinion is that they have exhausted all treatment options available and have what they and others consider to be a very poor quality of life. For these patients it is vital that there is careful and extensive assessment of their capacity to make the decision about whether treatment by way of artificial feeding should continue without their consent.

Consideration of withdrawal or withholding of life-sustaining treatment in cases of anorexia nervosa is controversial, both legally and ethically. Some expert opinion would hold that this should never happen. If considering withdrawing or withholding treatment then there needs to be careful assessment of the patient's capacity in respect of their decision to refuse treatment. A patient with severe anorexia nervosa who is hospitalised, severely emaciated and suffering from cognitive impairment associated with starvation cannot be considered to have capacity to make a decision about refusing treatment at that time.

It is not for the Commission to give detailed guidance in these cases. This is a complex ethical debate and is outwith the scope of this guidance. However, we expect that withdrawal or withholding of treatment would only ever be considered where the person suffers from an unusually severe and chronic eating disorder, where all available treatment options have been exhausted and where the quality of life of the person was deemed intolerable to him or her. Legal advice and widespread consultation (including the Commission) would be essential before any decision could be taken.

Conclusion

This document provides general guidance on the subject of nutrition by artificial means for individuals with eating disorders and other conditions. It describes both the legislative context and issues in practice. It is not possible to address all of the scenarios that may arise in this ethically and legally challenging field. The Mental Welfare Commission can be contacted if there is a need to discuss the relevant aspects of a particular situation.

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