mental welfare commission for scotland

Nutrition by artificial means

Good practice guides

July 2024

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

This guidance was reviewed in April 2024.

Contents

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 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 we explore the circumstances of the individual, reflect on good practice in relation to the law and provide a view 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 aspects 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 Healthcare Improvement Scotland's Scottish Intercollegiate Guidelines Network (2022)[1] the responding

[1] SIGN 164 Eating disorders Revised August 2022 (accessed 15 March 2024)

to medical emergencies in eating disorders (MEED) guidance produced by the Royal College of Psychiatrists (2023)[2] and the NICE guideline on Eating Disorders: Recognition and Management (2020)[3]

In a mental health setting, nutrition by artificial means is most commonly used in the treatment of individuals with eating disorders and usually in an inpatient environment.

In Scotland, the number of patients admitted with an eating disorder has increased from 434 in 2013 to 556 in 2018, an increase of 28% in that five-year period. More recent figures from Public Health Scotland indicate an 86% rise for young people (under 18) between 2019 (125 young people) and 2021(233 young people) admitted with an eating disorder in Scotland.[4]

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.

[2] college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf (rcpsych.ac.uk) (accessed 15 March 2024)
[3] Eating disorders: recognition and treatment (nice.org.uk)(accessed 15 March 2024)
[4] Eating Disorders in Scotland | Scottish Parliament (accessed 5 July 2024)

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 Practice 5 for the Mental Health (Care and Treatment) (Scotland) Act 2003 (‘the Mental Health Act’) clearly states that forced feeding is not allowed under the Mental Health 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 an intervention. 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 Mental Health Act.

The legislative context

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

The Mental Health 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 Commission's publications *Consent to Treatment* (2024)[5] and *Right to Treat* (2022)[6] discuss best practice in this area.

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.

At the Commission we would expect that this (with consent) 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. Feeding by artificial means without consent should only be considered where other treatment options have been fully explored and exhausted.

[5] Consent to treat (mwcscot.org.uk) (accessed 22 May 2024)
[6] Right to treat (mwcscot.org.uk) (accessed 15 March 2024)

The Mental Health 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 Mental Health Act and the provision of guidance for practitioners should not be seen as promoting this treatment option.

The SIGN guidelines mention that there is comparable outcomes with regards weight and body mass index between compulsory and informal patients based on a systematic review, however those detained may have longer lengths of stay. This may reflect the lower weights on admission and increased complexity and co-morbidity and increased number of previous admissions for those treated compulsorily. The SIGN guidance recommends:

> *Clinicians should consider whether the Mental Health (Care and Treatment) (Scotland) Act 2003 needs to be invoked when a patient (of any age) declines treatment. There may be a responsibility to provide compulsory treatment if there is a risk to the person's life or to prevent significant deterioration to health and wellbeing.*

Significant impaired decision-making ability (SIDMA)

SIDMA is a criterion that needs to be met before anyone can be given compulsory treatment under the Mental Health 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 Mental Health 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 as 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. We discuss these issues further in our good practice guide *Significantly impaired decision-making ability in individuals with eating disorders* (2019)[7]. In this document we discuss how rigidity of thinking, inconsistency of decision making, cognitive impairment and low mood might impact on decision making in the context of eating disorders. An analysis published in 2021 considers issues with regards the recording of SIDMA in the context of ensuring that decisions about SIDMA are understood by the people who are impacted by this. [8]

[7] sidma.pdf (mwcscot.org.uk) (accessed 15 March 2024)
[8] SIDMA as a criterion for psychiatric compulsion: An analysis of compulsory treatment orders in Scotland - PubMed (nih.gov) (accessed 15 March 2024)

Authorising nutrition by artificial means

When a person is being treated under the Mental Health 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 Mental Health Act.

The relevant forms under the Mental Health 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.

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 Commission.

The DMP is required to "have regard" to the reason for refusal of treatment if that reason is known. There are special provisions for children under the age of 18. In this case, where the child's own responsible medical officer (RMO) (the psychiatrist leading clinical care) 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 usually recommend that initial treatment should be authorised for 12 weeks. The DMP may authorise treatment for shorter periods or attach particular conditions, for example that the 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 Mental Health 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 Mental Health Act must be reported to the 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. Urgent treatment under the Act cannot be provided in the community – this must be in an inpatient setting. The DMP and the RMO would also take into account any advance statement that has been made with regards relevant treatment and the

views of the named person. The Commission's guidance on advance statements can be found here.

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*, referenced above, includes an examination of how the 2000 Act allows for treatment of mental disorder and how it interacts with the Mental Health Act. We consider that it is unlikely that the 2000 Act should be used in the treatment of eating disorders. If the person is already subject to the Mental Health Act then treatment for mental disorder should take place under the Mental Health 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. The situation where this might be an appropriate framework would be limited e.g., feeding by artificial means might be used when a person who lacks capacity is physically unable to swallow due to a neurological disorder. In the context of mental disorder, and if treatment is given against a person's will or without consent, we advise using the Mental Health Act.

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.

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 Mental Health Act. The principles of the Mental Health 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 Mental Health Act states that in practice, medical practitioners should look for signs that the child can consent on this basis from when the child is about 12 years old. 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, with more restrictive measures or the presence of resistance indicating that the Mental Health Act should be used.

For older children, however, who have reached sufficient maturity to have gained capacity to consent but are refusing treatment it is appropriate to consider whether the young person meets criteria for detention and treatment, under the Mental Health Act. In this case the Mental Health Act may be considered if the young person's mental disorder significantly impairs his/her ability to make decisions about treatment.

In the Commission's view it is rarely 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 Mental Health Act generally provides a more appropriate mechanism for authorising treatment.

Further, the Mental Health 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 difficulty from the parents of authorising treatment against the wishes of the child.

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 Mental Health 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. We have provided links to relevant guidance notes. 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 dieticians 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.

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 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 Mental Health 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. There is relatively little literature on the use of nasogastric feeding under restraint. Some pointers around questions for consideration when considering whether restraint is required are detailed in a 2022 article.[9]

A distinction should be drawn between the use of force as restraint (to enable the insertion of a nasogastric tube) and the forcible insertion of a nasogastric tube. The Code of Practice for the Mental Health Act 5 states that force should not be used to insert a tube. There is a broad spectrum of 'physical restraint' that can range from holding the patient's hands for reassurance through to several trained staff being involved. Medication as a short active sedative may be preferable in some situations but this depends on very careful assessment of the risks in each individual situation. These are difficult situations for all involved.

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 Mental Health 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

[9] Nasogastric tube feeding under physical restraint on paediatric wards: ethical, legal and practical considerations regarding this lifesaving intervention | BJPsych Bulletin | Cambridge Core (Accessed 15 March 2024)

normal range. This must be considered in line with the principles of the Mental Health 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 Mental Health 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. However, we do not think that an NG or PEG tube should be inserted solely to administer medication for mental disorder.[10]

[10] The Commission's view is that insertion of a NG tube solely for the purpose of giving medication is not appropriate, other than in very exceptional circumstances for clozapine. This exception is that the Commission might condone Clozapine being authorised on a T3B to be given via NG tube as a treatment of last resort. If a request is made to the Commission for a DMP visit to approve NG clozapine, we follow a special protocol, ensure that the treating team have undertaken a full and detailed individual assessment, and a Commission medic liaises closely with the DMP which undertakes the visit.

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 Mental Health Act.

The law, however, does include provision for urgent medical treatment for mental disorder where a person is detained in hospital under the Mental Health 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. In the rare situation, where 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 Mental Health Act if the person's responsible medical officer determines that it is in the person's best interest and subject to the other provisions of section 242 of the Mental Health Act.

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. The Commission has been contacted about difficult situations where treatment has not been successful and there are considerations of withdrawal treatment. For a very small group of people, when all options are exhausted with no recovery, and in the context of a poor quality of life and considerable distress, is to consider with the person, those important to them and relevant stakeholders, whether palliative care options may be preferable. 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.

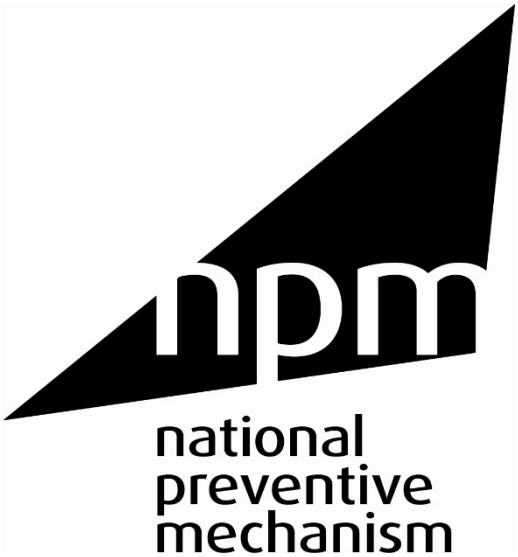
If considering withdrawing or withholding treatment then there needs to be careful assessment of the patient's capacity in respect of their decision to refuse treatment.

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 with the Commission) would be essential before any decision could be taken.

Conclusion

This document provides guidance on the ethico-legal aspects of nutrition by artificial means for individuals with eating disorders and other conditions. It is not possible to address all of the scenarios that may arise in this ethically and legally challenging field.

The Commission can be contacted if there is a need to discuss the relevant aspects of a particular situation.



If you have any comments or feedback on this publication, please contact us:

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk