Eating Disorders Victoria

Response to consultation on the Mental Health and Wellbeing Act 2022

The Act is responsible for a whole range of things relating to mental health care and we welcomed most of the recommendations (see https://engage.vic.gov.au/mhwa). However, part of the Act relates to the use of Compulsory Treatment.

Compulsory Treatment

Current criteria

- the person has mental illness
- because the person has mental illness, they need immediate treatment to prevent:
    - serious deterioration in the person's mental health or physical health, or
    - serious harm to the person or another person
- the immediate treatment will be provided if an order is made
- there is no less restrictive way to enable the person to receive that immediate treatment.

Proposed Changes

- removal of the serious deterioration clause and replacement with "serious distress"
- requiring that the harm being prevented (to the person or another person) must be both serious *and* imminent
- requiring that all other treatment and support options to prevent the distress or harm have been considered and eliminated.

What we submitted

We strongly endorse the objectives and principles underpinning the Act and we welcome the vast majority of the recommendations for changes. In particular, we welcome the strengthening of the rights of the individual living with mental illness and the stronger inclusion of families and carers in all levels of the Act.

We share the desire for minimising the use of the Act for compulsory treatment wherever possible and where needed it should be enacted as humanely as possible and with regard to the rights of the individual.

However, we have some specific concerns regarding the Compulsory Treatment proposed changes and the potential unintended effects on those with eating disorders.

Eating Disorders Context

Persons with Eating Disorders, in particular restrictive eating disorders such as Anorexia Nervosa, are not infrequently coerced into treatment through use of the MHA.

"Anorexia nervosa is an illness with an increased mortality rate from both natural and unnatural causes of death. The characteristics of anorexia nervosa are self-induced low weight, a disturbed body image, and a fear of weight gain (3). Patients with severe and enduring anorexia nervosa are additionally characterized by being ill for a long time and having significant eating disorder symptoms as well as being resistant or ambivalent toward treatment (4). Hence, these patients are specifically at risk of being treated against their will based on both the dangerous and the deterioration criteria "[i]

The unique challenges presented in Anorexia Nervosa include;

- starvation/malnutrition leading to diminished cognitive capacity including lack of insight as to current physical risk
- the experience of severe restriction is calming to the person with the eating disorder, in fact part of its function is to reduce high anxiety
- debilitating anxiety around food intake in the absence of compensatory behaviours - resulting often in a complete inability to choose to eat. Current effective treatment models such as Family Based Treatment rely on caring compassionate ethical coercion, requiring young people to eat in the face of the debilitating anxiety. Young people often refer to the coercion in this case allowing them to "say no to the eating disorder thoughts". There is no reason that turning 18 means that it is any easier for the person with an eating disorder to act against the compelling eating disorder thoughts to not eat, purge, exercise compulsively.

- significant physical health risk resulting in AN having the highest mortality rate of any psychiatric condition
- excessive burden and anxiety in carers (again highest among all psychiatric conditions) who in the absence of the system providing the backstop of compulsory treatment will need to continue to try and encourage/coerce their loved one to eat or stand by and watch them starve to death literally.

We acknowledge that compulsory treatment should be a last resort but there needs to be more research done on how it is used with eating disorders

"Involuntary treatment is usually evaluated negatively by patients, professionals, and relatives (6–10). Inpatient care must thus always aim to find alternative strategies and interventions to involuntary treatment, reducing it whenever possible without neglecting its lifesaving purpose and outcome. To do this, up-to-date knowledge on the involuntary treatment of anorexia nervosa is needed"[ii]

We also know that there are significant improvements needed to ensure any compulsory treatment orders are enacted compassionately, in collaboration with loved ones and within a strong therapeutic relationship. Research in eating disorder has shown that "Compulsion and formal compulsory treatment of anorexia nervosa were considered appropriate where the condition was life-threatening. The perception of coercion was moderated by relationships. What mattered most to participants was not whether they had experienced restriction of freedom or choice, but the nature of their relationships with parents and mental health professionals" [iii]

"People with anorexia nervosa appear to agree with the necessity of compulsory treatment in order to save life. The perception of coercion is complex and not necessarily related to the degree of restriction of freedom" [iv]

Our Concerns

1. Replacing reference to 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress' may be challenging in the eating disorders context. As outlined above, someone with AN at their most unwell may well not experience or be at risk of

distress. In fact, severe distress will be heightened in the face of lifesaving treatment

2. While it could be argued that someone with an eating disorder who is unable to eat will be covered by the serious and imminent harm to themselves, it will leave the decision to compulsorily renourish someone with an eating disorder to a stage where medical risk is very high - when intervening earlier means shorter less traumatic treatment and better outcomes.
3. We believe the adoption of these criteria as they stand will make the clinicians/services roles in supporting our community of affected persons with severe eating disorders very challenging.
4. We understand there is an argument that the Medical Treatment and Planning Decision Act 2016 S53 could be used an alternative to the MHA. This is beyond our capability to fully understand and put forward a position on all the implications, merits or risks in this approach. However, we ask that there is serious consideration and consultation undertaken to ascertain the risks and unintended consequences for those with an eating disorder.
5. Finally, an unclear or unworkable compulsory treatment system for those at serious physical risk from an eating disorder and who are unable to choose to eat will result in an undue and unmanageable burden on families and loved ones.

We ask that further specific consultation with our eating disorder sector (consumers, carers, clinicians and services) be undertaken to ensure there are no unintended negative consequences arising from the proposed changes.