




Exploring the Possibilities: Developing Pan-Canadian Best Practice Guidelines for Involuntary Admission and Treatment of Eating Disorders


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No Disclosures



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Learning Objectives

Upon completion of this workshop, participants will be able to:

- Briefly describe and critique current research findings on involuntary treatment in EDs
- Discuss the clinical, ethical, and legal complexities of involuntary treatment in EDs
- Explore the possibility of developing best practice guidelines for involuntary treatment of EDs in Canada


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Workshop Overview

- Review of eating disorders
- Literature review and exploration of clinical complexities (child and adult)
- Newfoundland experience
- Existing guidance for practitioners
 - ❖ Video
- Where to from here?

<http://blogs.fu.ca/services/hedish/?cat=45>



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When treatment is refused...




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Eating Disorders


- Serious, chronic illnesses characterized by a **complex interrelationship between mental and physical** symptomatology
- One of the most intractable and life threatening of all psychiatric disorders
- Controversial ethical and legal issues




Kaye W. Eating disorders: Hope despite mortal risk. Am J Psychiatry 2009;166:1309-1311.
 Bartman ND, Lohr KN, Bulik CM. Outcomes of eating disorder treatment: A systematic review of the literature. Int J Eat Disord 2007;40:293-309.
 Campbell A, Allison M. The Stigma of "Mental" Illness: End Stage Anorexia Nervosa and Treatment Refusal. Int J Eat Disord 2012;45:5 627-634
<http://im.psy.fsu.edu/~lucy/2011/10/03/balance-of-yinyang-in-eat-help>

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Anorexia Nervosa




- **Mean prevalence estimate 0.3% for AN**
 - ❖ Likely underestimated due to:
 - Denial of symptoms
 - Amenorrhea criteria
 - EDNOS
- **Ambivalence or resistance to recovery complicates assessment of illness severity and treatment**




Diagnostic and Statistical Manual of Mental Disorders^{4th} ed APA 1994
<http://www.ncbi.nlm.nih.gov/pubs/books/48799/>
http://calendar.swarthmore.edu/calendar/EventList.aspx?view=EventDetails&eventid=8766&informaon_id=25897&type=&syndicate=syndicate

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Bulimia Nervosa (BN)




- **Mean prevalence estimate 1.0%**
 - ❖ Ambivalence re treatment because of possible weight gain
 - ❖ Denial of symptoms related to shame, not lack of awareness of symptoms




Diagnostic and Statistical Manual of Mental Disorders^{4th} ed APA 1994
<http://www.ncbi.nlm.nih.gov/pubs/books/48799/>
<http://blog.lib.umd.edu/vanm0049/myblog/2011/11/bulimia-nervosa.html>

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Eating Disorders and Mortality



- **Acute malnutrition is a medical emergency- continued restriction, binge eating or purging despite efforts to redirect behavior requires immediate intervention**
- **Patients with Anorexia Nervosa are 6-12 times more likely to die than women of similar age in the general population**
- **AN – highest mortality rate of any psychiatric illness- approximately 10% die within 10 years of onset**



Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders. AED Report 2011
<http://www.ncbi.nlm.nih.gov/pubs/books/48799/>

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Eating Disorders and Mortality




- **Lack of consensus on mortality rates**
- **Scott, 2009: Mortality rates: 4.0% for anorexia nervosa, 3.9% for bulimia nervosa, and 5.2% for eating disorder not otherwise specified**



Scott J et al. Increased Mortality in Bulimia Nervosa and other Eating Disorders. Am J Psychiatry 2009;166:1342-1346
<http://health500.com/eating-disorder-food-matters/>

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Coercion and Involuntary Treatment




- **Most psychiatrists will not hesitate to certify a patient who is acutely suicidal or psychotic with acute potential risk to harm themselves/ others but they may be reluctant to certify someone who is experiencing medical complications of an ED.**
 - ❖ ? Delusional thinking
- **Confusing and intimidating area even for experienced and specialized practitioners (Bryden, 2010)**

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Coercion and Involuntary Treatment



- **Why the reluctance?**
 - ❖ Gray area with no clear guidelines
 - ❖ Trying to respect patient autonomy, preserve the therapeutic relationship and do no harm
 - ❖ Question: Is an ED ever terminal? What about depression?
 - ❖ What does the literature tell us?



<http://www.mindmydisorder.com/2011/09/14/psychiatric-emergency-neurogenetics-issues-when-on-es-an-d-ded/>

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Involuntary Treatment in Eating Disorders: Literature Review



- Consensus that involuntary treatment is justified when risk of death is imminent
- Less agreement on what constitutes incapacity or incompetence
 - Impact of medical complications
 - Psychological nature of the disease
 - Denial
 - Ego-syntonic
- Few studies on impact of involuntary treatment
- Recognition of children/adolescents as different

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Involuntary Treatment and Imminent Death



- Support for the use of involuntary treatment (IT) including re-feeding almost universal when risk of death is high (e.g. Guarda et al., 2007)
- Studies of practitioner position on this point show strong support for IT in severe cases (e.g. Bryden et al., 2010)
 - ❖ Eating Disorder specialists tend to support intervening with IT earlier to protect health (Tan et al., 2008)

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Competence/Capacity in Eating Disorders



- Defining competence is complex
- Usually involves understanding *and* appreciation
 - ❖ Understanding rarely an issue for EDs
 - ❖ Appreciation often is (Bryden et al., 2010) due to nature of disorder
 - Could be defined as consistency between intention and behaviour which is compromised in AN (Appelbaum & Rumpf, 1998)

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Decision Making: Involuntary Treatment



- Patient's "best interests" is a distinct but related factor
 - ❖ Few outcome studies on impact of involuntary treatment
 - Voluntary and IT patients do equally well during hospitalization in terms of symptom reduction (e.g. Ayton et al., 2009; Guarda et al., 2007; Watson et al., 2000)



www.123rf.comphoto_9209548_four-gears-representing-the-principles-of-medical-ethics-autonomy-justice-beneficence-or-non-maleficence

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Involuntary Treatment



- Follow-up studies of IT show conflicting results
 - ❖ IT patients do worse than voluntary (Ramsay et al. 1999; Watson et al., 2000) with higher morbidity and mortality
 - ❖ At least 1 shows same or slightly better outcomes for IT patients (Ayton et al., 2009)

- <http://www.cmhant.ca/>

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Involuntary Treatment



- Follow-up studies of IT
 - ❖ Evaluation of patients both during and post hospitalization show few ill effects with some reporting patients "converting" to positive or at least accepting views (e.g. Watson et al., 2000; Guarda et al., 2007; Tan et al., 2010)
 - ❖ Experiences of patients are complex and related both to the effectiveness of treatment and the context of the relationships involved (Tan et al., 2010)

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Going into hospital



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Involuntary Treatment



- **Child/Adolescent recognized as different**

- ❖ Use of parental decision making as a form of coercion
- ❖ Greater acceptance of coerced or formal involuntary treatment as preventive - not only as last resort (Bryden, et al., 2010)
 - Likely related to Strober et al.'s (1997) showing improved outcomes in early and aggressive treatment for adolescents

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Summary of Literature



- **The literature does not provide clear guidance about IT of patients with EDs**
- **What currently exists to provide direction?**
 - ❖ APA Guidelines
 - ❖ NICE Guidelines
 - ❖ CPA Ethical Decision Making Guidelines (Bell 2010)



Am J Psychiatry. 2008 Jul;163(7 Suppl):4-64. Review. Treatment of patients v Eating Disorders

National Institute for Clinical Excellence 2004 Clinical Guideline 9 Eating Disor

<http://mediationchannel.com/2009/01/29/mediato-net-hics-how-professional-codes-of-conduct-fall-short/>

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Anderson uses the following analogy when illustrating this complex issue:

"The situation resembles that of a person boarding a canoe headed for Niagara Falls on a journey that begins voluntarily but ineluctably transforms into a non voluntary propulsion towards the falls, with the person at times not recognizing that the upcoming Falls even exist."



Anderson A. Eating disorders and coercion. Am J Psychiatry. 2007;164:108-114
<http://www.bing.com/images/search?q=niagara+falls&view=detail&id=647008f7770038a339e43f3a41e840dfaf95840a1e111&FORM=IRP001>

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EDs in Newfoundland and Labrador



- Development of 2 day Interprofessional workshop
- When to hospitalize patients important component
- Pilot workshop results identified need for additional content on involuntary hospitalization



http://www.comeexplorecanada.com/newfoundland_labrador/
<http://www.tuckamorelodge.com/humpback-whale-and-iceberg-85-pictures.htm>

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When to Refer for Hospitalization

- Failure of outpatient management
 - Persistence of binge/purge cycle
 - Failure to gain weight
- Pre-existing medical condition which complicates treatment (e.g. Diabetes)
- Medical Instability
- Refer to Appendix 4-A Guidelines for Medical Instability

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What is Medical Instability in Eating Disorders?

- Definition not universally agreed upon
- Not the usual medical definition of instability
- Eastern Health Consensus **Assessment Guidelines for Hospitalization of Patients with Eating Disorders**

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Criteria	Adult	Child (< 18 years)
Heart Rate	Resting Heart rate < 40 bpm > 110 bpm	Resting Heart rate < 50 bpm daytime < 45 bpm nighttime
Postural tachycardia (lying & standing v/s)	Heart rate change > 35 bpm	Heart rate change > 35 bpm
Hypotension	B/P less than 90/60 mmHg	B/P less than 80/50 mmHg
Postural hypotension (lying & standing)	Systolic B/P drop of 20 mmHg or more	Systolic B/P drop of 20 mmHg or more
ECG	Abnormalities (eg. arrhythmias, prolonged QTc)	Abnormalities (eg. arrhythmias, prolonged QTc)


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Criteria	Adult	Child (< 18 years)
Weight	BMI < 15 or ongoing wt loss despite intervention ED team	< 75% IBW * or ongoing wt loss despite intervention
Serum Potassium (hypokalemia)	**Less than 3.0 mmol/L	< lower limit of normal as per hospital laboratory values
Low Calcium Low magnesium Low Phosphate	< lower limit of normal as per hospital laboratory values	< lower limit of normal as per hospital laboratory values
Dehydration Poorly Controlled Diabetes	As determined by medical personnel	As determined by medical personnel
Hypothermia	< 35.5 degrees C	< 35.5 degrees C
Hepatic or renal or cardiovascular organ systems	organ compromise requiring acute treatment	organ compromise requiring acute treatment

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What to do When an Individual Refuses Hospitalization...

- Legal intervention may be necessary
- Medical Doctors & Nurse Practitioners can certify an individual for an involuntary psychiatric assessment
- Refer to the Mental Health Care and Treatment Act




Statutes of Newfoundland and Labrador 2006 **CHAPTER M-9.1**
AN ACT RESPECTING MENTAL HEALTH CARE AND TREATMENT
(Assented to December 12, 2006)

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Involuntary Hospitalization and Eating Disorders


- Reasons to consider involuntary hospitalization:
 - Medical instability
 - Failure of outpatient treatment resulting in the individual being at risk for death or acute deterioration possibly resulting in death
 - Active suicidal ideation and/or plan
 - Co-morbid psychiatric illness warranting involuntary treatment independent of the eating disorder



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Canadian Psychological Association: Ethical Decision Making Process

1. Identify groups or individuals potentially affected
2. Identify ethically relevant issues (See Code of Ethics)
3. Identify personal biases, stresses or self-interests
4. Identify all possible courses of action
5. Analyze likely short term, ongoing and long term risks and benefits of each action on all parties

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Canadian Psychological Association: Ethical Decision Making Process

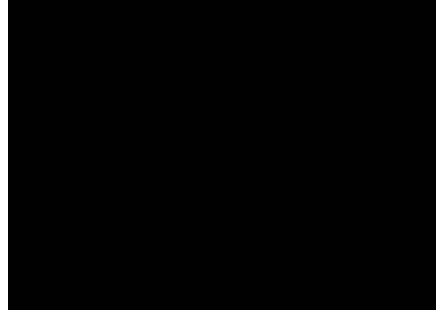


6. Choose one course of action based on consideration of CPA Code of Ethics principles, values and standards
7. Action, accepting responsibility for consequences
8. Evaluation of results
9. Correction of negative consequences and if issues not resolved, go through process again
10. Take action where possible to prevent future occurrences

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What is the Patient Experience?



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Where to from here?



- Is there a need for best practice guidelines regarding involuntary treatment in the management of patients with ED?
- If "Yes", how do we get there?



<http://www.ypp-priorityroad.com/>

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