Referring patients with severe eating disorders to critical care to facilitate assisted nutrition under restraint:

A framework to support decision making in life-threatening situations

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Editorial project group

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Endorsing Organisations

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Foreword and document guide

This document is intended to assist clinicians in managing this incredibly complex and challenging situation. In order to ensure the provision of adequate information and context, it is comprehensive in length. Users may find it most useful to view the recommendations and appendix, then direct themselves to relevant additional information, provided in the body of the document.

Throughout this document we use the terms families/caregivers when referring to those who may be involved in a patient's care and wellbeing. These terms are inclusive of relatives, friends, carers, named persons, advocates etc.

Disclaimer

This document does not constitute nor replace formal legal advice. Ultimate responsibility for clinical decision making remains with the clinical teams involved in the care of the patient.

REVIEW

Usually within three years or sooner if important information becomes available. This is not a static document. It will be updated to reflect changes in practice and evidence. We welcome any constructive input from the intensive care community on updates. Please get in touch at contact@ficm.ac.uk.

Background

This guidance was written by critical care consultants from the College of Intensive Care Medicine (College of ICM) Legal and Ethical Policy Unit (LEPU) and Intensive Care Society Legal and Ethical Advisory Group (LEAG), consultants in eating disorders psychiatry, consultants in liaison psychiatry, and legal professionals affiliated to LEPU. Input was provided by representatives from the Royal College of Psychiatrists (RCPsych), nutritional experts, lay representatives, patient representatives, and critical care consultants with experience in managing patients with eating disorders in critical care.

Purpose of this guidance

In recent years, the College (former Faculty) of Intensive Care Medicine and the Intensive Care Society, have received a number of enquiries from Intensive Care Medicine (ICM) clinicians, regarding the management of patients experiencing eating disorders referred to critical care to facilitate aspects of assisted feeding with restraint, under mental health legislation. There has been a call for additional ICM guidance in this area, given the complex ethical, medico-legal, clinical, and logistical challenges involved, and the paucity of evidence in the literature.

Several eating disorder cases involving the provision of nutrition under restraint in critical care, have been assessed by the UK courts, where decision making has proven challenging due to the complex nature of the interventions being considered (examples are included in Section 2).

Overarching recommendations for the management of patients with eating disorders are currently provided by the following:

- NICE guideline NG69 Eating disorders: recognition and treatment[1]
- SIGN guideline 164 Eating disorders: A national clinical guideline[2]
- The RCPsych Faculty of Eating Disorders Medical Emergencies in Eating Disorders (MEED) guidance[3].

Whilst widely accepted and well established in practice, these documents do not specifically address the ethical, legal, and practical aspects that may arise when a patient is referred to critical care for assisted feeding under restraint.

The purpose of this framework is to:

- Supplement the current MEED, NICE and SIGN guidelines with a particular focus on patients referred to critical care.
- Support clinical decision making and communication between relevant medical specialties and legal professionals.
- Highlight applicable ethical and legal principles.
- Signpost clinicians to relevant existing guidance and case law.
- Complement, but not replace, the individualised and nuanced decision making required by senior clinicians, involved in these cases; it is not designed to provide prescriptive guidance.

This framework is aimed at the following patient group:

Adult patients (i.e., >18yrs of age in England, Wales and Northern Ireland, >16 years of age in Scotland) with a confirmed diagnosis of an eating disorder who are experiencing life threatening complications consequent to lack of nutritional intake, and in whom all alternative treatment options have been explored or proven unsuccessful.

It is recognised, that although the legal framework differs in children, many of the areas addressed within this document will be applicable to adolescent cases.

TERMINOLOGY

For the purposes of this document, the terms *critical care* and *intensive care* will refer to medical (as opposed to psychiatric) intensive care, unless otherwise stated. HDU refers to high dependency units i.e. those providing Level 2 care (single organ support), ICU refers to intensive care units i.e. Level 3 care (multi-organ support and/or invasive ventilation)[8] and critical care is an umbrella term for both Level 2 and 3 units. The configuration of critical care units differs across the UK; whilst HDUs and ICUs may be separate, in some regions Level 2 and 3 units are combined. It should be noted that admission into a hospital's general ICU should not be confused with intensive treatments for eating disorders which can occur as an outpatient, inpatient medical bed, specialist eating disorders bed (SEDB) or a specialist eating disorders unit (SEDU).

Methodology

This document was developed after the College of ICM was asked by clinicians to produce ethical and legal guidance for ICM clinicians when faced with this situation. Given the complexity of this subject the decision was made to broaden authorship to include relevant clinical experts and a representative from the ICS LEAG to ensure a cohesive approach and consistent messaging. During the document development process, several contributors were invited to provide additional information and expertise.

The legal professional authors of the document are all members of College of ICM LEPU and include representation from the three main UK jurisdictions. The legal section was drafted from the knowledge of the various authors, and by reference to the relevant legislation and key case law in each jurisdiction, including provision of links to public resources.

This document is based on the MEED guidelines, and the editorial group includes authors from MEED and the original Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines[9]. A review of relevant professional guidance was conducted using expertise from within the group to identify key sources. Medline searches included references related to feeding under 'pharmacological restraint', feeding under 'physical restraint, 'enforced feeding' (a term not used within this document, but which exists within the literature), the management of patients with eating disorders or anorexia nervosa admitted to 'intensive care' or 'critical care', and articles describing anaesthesia for patients with anorexia nervosa, or eating disorders. Given the lack of published case reports in this area, input and learning points were obtained from critical care clinicians with experience of these types of cases.

The core group met at intervals to discuss development of the document, before circulating it for wider comment and key stakeholder review.

Due to the lack of previous guidance in this area and paucity of evidence within the literature, it has proven necessary to base some of the recommendations and content of this document on clinical and legal expertise. Whilst it is acknowledged that there is consequently a risk of bias, attempts have been made to mitigate this by including authors and contributors offering a broad range of experience and opinion from differing backgrounds.

Scope

This guidance is intended as a helpful resource for clinicians involved in the care of patients referred to critical care for assisted feeding under restraint. It is not intended for the management of patients with eating disorders, where critical care input is required for other indications e.g., sepsis or trauma.

Recommendations

1. CONTEXT

1.1 The administration of intravenous sedation for the primary purpose of facilitating feeding under restraint in patients experiencing eating disorders should be a rare occurrence. It should only be instituted to save a patient's life as a last resort when **all** other treatment approaches recommended by NICE[1], SIGN[2] or the Royal College of Psychiatrists (RCPsych)[3] have been exhausted. However, admission to critical care should not be delayed when the patient is critically ill and emergency medical treatment is required.

1.2 When ICU admission is being considered as a potential option to facilitate assisted feeding without consent utilising sedation or any form of physical restraint, referral to critical care should occur as early as possible to allow senior clinicians to thoroughly assess the situation with adequate time to do so. This may avoid the need for more invasive interventions. Referral to critical care in this situation should **never** be required as an emergency.

1.3 Close co-working between senior intensivists and senior mental health specialists (both Liaison and Eating Disorders Psychiatry) is required in all these cases and patients admitted to ICU **should** receive regular in-person senior psychiatric review and mental health nursing support.

1.4 Where assisted feeding under physical restraint is being considered, clinical staff should consider both the physiological risks described in the RCPsych Medical Emergencies in Eating Disorders (MEED) Guidance[3] and the additional risk of harm which may arise from the physical restraint itself. The threshold for critical care admission in this situation may therefore be lower, compared to assisted feeding where a patient is not objecting.

1.5 Clinical staff should be aware that a severely underweight patient who appears to be clinically well, may decompensate rapidly and be at risk of death. The RCPsych MEED Guidance's all-age risk assessment framework for assessing impending risk to life[3] should be used to guide decisions about critical care for assisted feeding under restraint.

1.6 The decision to provide IV sedation in ICU should never be based on factors such as local resource limitations, specialist eating disorders unit (SEDU) bed capacity or a lack of referring specialty experience in managing this patient group.

1.7 Treatment decisions concerning the administration of assisted feeding under restraint in critical care, should not be made primarily on the basis of perceived futility. Whilst there is limited published data regarding the outcomes of this patient cohort, most patients suffering an acute deterioration in their eating disorder, will improve after treatment for that episode. This has been supported by clinician feedback; however, it is acknowledged that a more formal reporting system is required to evaluate this further. For patients who develop multi-organ failure and continue to deteriorate however, the same ethical principles should apply as for any patient in critical care and the patient, and their families/carergivers should be fully appraised of this at the outset.

1.8 Where a patient with a severe eating disorder is not objecting, the MEED Guidance on assisted feeding and indications for critical care input should be followed.

2. THE PATIENT AND THEIR FAMILIES/CAREGIVERS

2.1 A patient centred approach **must** be adopted, and the therapeutic relationship maintained; effective communication and family involvement is key (relevant guidance can be found in the MEED guidance).

2.2 Patients should be included, involved in, and informed about decisions regarding their care even if they are detained under mental health law, or are considered to lack decision-making capacity.

2.3 It is important to recognise the potential for distress to the patient and their family/relevant others and consider this in decision making, communication and follow up.

2.4 Patients should be offered appropriate support and opportunity to discuss and debrief before, during, and after any restrictive interventions.

2.5 Carers, named persons or nearest relatives have certain specific rights under mental health and mental capacity legislation. Clinical staff should ensure they are aware of their duties to consult, provide information etc and do so in accordance with relevant legislation and codes of practice.[4,5]

3. PSYCHIATRIC ASSESSMENT

3.1 Capacity assessment in patients experiencing eating disorders can be particularly challenging and should be undertaken by a consultant psychiatrist in-person, prior to the commencement of assisted feeding under restraint without the patient's consent, under the relevant UK Home Nation's capacity legislation. In the acute hospital setting, this is likely to be a consultant in liaison psychiatry. Caveats apply for life-threatening situations, where emergency life-saving treatment should not be delayed.

3.2 The patient's named consultant psychiatrist should physically see the patient and speak to them face-to-face in person, as part of the decision making process.

3.3 A second opinion and advice from a specialist in eating disorders psychiatry is recommended in complex cases prior to ICU admission, and **must** occur if intubation and invasive ventilation is being considered to facilitate feeding under restraint.

3.4 Patients should be under the joint care of a named critical care consultant, a named consultant liaison psychiatrist, and a named consultant in eating disorders psychiatry. Where assisted feeding under restraint is given under mental health legislation, the consultant psychiatrist with overall statutory responsibility for detention and treatment should be clearly identified.

3.5 Where a patient appears to be able to understand and retain information about the risk to their life and the benefits and risks of accepting or refusing treatment, the focus of capacity assessment should be on their ability to consider information relevant to themselves and to use, weigh, or balance it to arrive at a decision.

3.6 A patient transferred from a SEDU to an ICU should remain under the joint care of the named consultant in eating disorder psychiatry. The relevant multidisciplinary staff such as specialist eating disorder dietician should continue to advise the critical care and liaison psychiatry teams, unless a more appropriate eating disorders service accepts a transfer of care.

4. ROUTE OF FEEDING

4.1 Nasogastric tube (NGT) feeding is the preferred route. Post-pyloric feeding by means of a nasojejunal tube **may** be considered in exceptional circumstances, following senior multidisciplinary team (MDT) discussion with the specialist nutrition team.

4.2 Nasogastric bridles should not be considered as standard practice in this patient group, due to the high risk of nasal trauma (consequent to attempted self-removal).

4.3 Where enteral tube feeding is not feasible in adults with severe eating disorders requiring assisted feeding under restraint, parenteral nutrition (PN) either as an exclusive route or supplemental means of nutrition, **may** be considered in exceptional and limited circumstances. Any decision to administer PN must be taken as part of a multidisciplinary approach and under the supervision of a specialist nutrition team.

4.4 Insertion of a percutaneous gastrostomy tube (PEG) in this patient group is extremely hazardous and should only be considered in exceptional situations following MDT consultation e.g., in the presence of a dysfunctional swallow where long-term nutritional adequacy cannot be achieved orally and with a patient's consent (as per the MEED guidance). It is a longer-term consideration not indicated for medical stabilisation and should only be undertaken when a patient is consenting.

5. NUTRITIONAL SUPPORT

5.1 The MDT must set clear predetermined goals at the outset including target weight and/or BMI and the duration of feeding and sedation required to achieve this. It is acknowledged that these goals may need to be amended dependent on clinical progress.

5.2 Collaboration between critical care specialist dietitians and eating disorder dietitians is important to enable the formulation of plans that consider 'non- feed' caloric provision and to advise on an appropriate nutrition prescription. It is important to consider the caloric value of propofol (1.1 kcal/ml), which has a high lipid content to prevent overfeeding/malnutrition. Care should be taken with medications formulated in glucose which may precipitate refeeding syndrome. In patients requiring high doses of propofol, inadequate protein intake may occur (as with any patient in ICU) and both feeding and sedation regimens may need to be adjusted to prevent this.

5.3 Initially when commencing NG tube feeding in critical care, delivering a constant and controlled supply of enteral feed is likely to be the safest way of minimising refeeding risk and episodes of hypoglycaemia in the severely ill patient. Bolus feeding may not be tolerated due to delayed gastric emptying, which can be experienced by any patient receiving intravenous sedation. For awake patients where an intermittent NG insertion regimen is being used, bolus feeding may be the preferred option and administered in line with MEED guidance recommendations.

5.4 Weight gain for patients experiencing eating disorders who receive assisted feeding under restraint in critical care, is complex and not guaranteed. Regular reassessment is essential, and amendment of feeding regimens and routes of administration may be necessary. Care should be taken to ensure factors such as fluid balance do not inadvertently affect measurements of weight and interpretation of BMI changes.

6. PHYSICAL RESTRAINT

6.1 Every acute hospital should have a restraint policy which includes:

- physical and mechanical restraint
- refers to relevant mental health and mental capacity law codes of practice
- describes which clinical staff should be involved in physical restraint for clinical care
- what training should be provided
- the safeguards that should be used to minimise the need for restraint.

6.2 Security guards or other non-clinical staff must not be used to physically restrain patients for clinical care.

7. SEDATION

7.1 Whenever sedation is being administered for this purpose, this should be done in the safest possible environment, and it is recommended that continuous IV sedation is always provided in a critical care area with appropriate monitoring and trained personnel[6].

7.2 The minimum level of IV sedation should be used to facilitate feeding; earlier admission to a critical care area may avoid higher doses of sedation and invasive organ support being required.

7.3 Critical care staff should be aware of the limitations of medical care and monitoring that can be provided in psychiatric hospitals, and the risks associated with delays or late transfers from a psychiatric ward to critical care, once a decision has been made to admit.

8. LEGAL ASPECTS

8.1 Any intervention in support of assisted feeding in this patient group, without patient consent, must be carried out in the least restrictive manner possible and only in accordance with mental health, mental capacity, and human rights legislation.

8.2 It is vital that all those involved in the patient's care in ICU must be clear of and understand the legal frameworks used (these are covered in detail in Section 2). This includes the whole MDT and regular staff briefings e.g. via daily huddles, are recommended to ensure all staff are fully aware of the situation and can ask questions or raise concerns.

8.3 Restrictive interventions should only be applied with appropriate legal authority. When a patient detained in a SEDU under mental health law is transferred to critical care for assisted feeding under sedation, the legal authority to detain and treat should be transferred from the psychiatric hospital to the acute hospital.

8.4 Legal advice should be sought from the trust or health board's legal team where*:

- It is difficult to determine the balance of risk versus benefit for the patient (e.g. when invasive ventilation is being considered purely to facilitate assisted feeding).
- There is uncertainty about legal aspects of the case.
- The clinicians involved cannot reach a consensus regarding appropriate treatment.
- The wishes of the family differ significantly from the clinical team regarding the best interests of the patient.

*The above list is not exhaustive and there may be other situations where legal advice is required. This may involve an application to the appropriate court[7] (see relevant information for each jurisdiction in Section 2).

9. RESOURCES

9.1 In most cases, additional staff resources will be required, and health care organisations will need to make provision for this, at the outset.

10. ONGOING TREATMENT ASSESSMENT

10.1 Regular MDT assessment involving senior medical, nursing and dietetic staff and psychologists, should occur at all stages of the patient's ICU journey. MDT discussions should include the identification and agreement of clear, pre-defined treatment goals, involve regular reassessment and, if the original aims of treatment cannot be met, consideration of alternative management strategies.

11. AFTERCARE

11.1 Recovery after the provision of nutritional support in critical care, requires careful planning and should involve the extended MDT. Specialist advice may be required to support ICU follow up services with input from eating disorders psychologists. Considerations should include the need to:

- Recognise and treat complications which may occur e.g. post extubation stridor or delirium (N.B the causes and treatment of delirium in this patient group does not differ from that of other ICU patients).
- Provide treatment and support for patients who may experience post-event psychological trauma.
- Support the patient as they come to terms with their weight gain.
- Develop individualised physical rehabilitation plans, tailored for patients with very low BMIs and the behavioral aspects of their disease.

11.2 Prospective planning should be considered and include the following:

- Nominated MDT members with an interest in the management of patients experiencing eating disorders.
- Education and training: development of educational resources, training sessions for all MDT members, and cross-speciality educational events.
- The development of local protocols for the management of this patient group together with psychiatry and nutrition teams.

11.3 Patients who have undergone assisted feeding under restraint in an ICU should have access to aftercare and support for post-traumatic symptoms. Where different aftercare services have exclusion criteria, acute hospital and mental health services should have a written agreement about who provides aftercare, to ensure that the patients who are most in need are not excluded from care, support, and treatment.

11.4 Upon completion of acute hospital care, patients who were transferred from a SEDU should be returned to the same unit to maintain continuity of care.

11.5 It is important to recognise and address the potential psychological impact on critical care and psychiatric staff, when faced with a complex clinical situation with which they may not be familiar. Post event debriefing and psychological support may be required. Relevant training and the nomination of clinical staff with a specialist interest/experience in this field should be considered in ICUs most likely to encounter these patients e.g., those in geographical proximity to SEDUs. Additional resources will need to be provided to support this both at the time and after the event.

12. ANTICIPATORY CARE PLANS

12.1 Anticipatory care plans must not be used that:

- Exclude a patient from access to mental health care (e.g. by stating that referrals to liaison psychiatry or other mental health services will not be accepted).
- Pre-emptively state opinions on a patient's decision-making capacity.

SECTION 1: Medical Considerations

EATING DISORDERS

The majority of cases for which this guidance will be applicable to, are patients suffering from anorexia nervosa (AN). This is an eating disorder which has the following features as per the DSM-5 criteria[10]:

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health.
- Intense fear of gaining weight and persistent behaviour interfering with weight gain, even though the individual is at a significantly low weight.
- There can also be a disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or a persistent lack of recognition of the seriousness of the current low body weight.

Typically, those with AN present as one of two sub-types, either:

- The pure restrictive with physical hyperactivity form (70%) or
- The binge eating and purging (bulimic) form

Some patients will suffer from ARFID (Avoidant Restrictive Food Intake Disorder)[11] which can also cause severe malnutrition.

It is essential to appreciate that the refusal to eat or accept nutritional support in patients suffering from eating disorders is not a deliberate or active decision to refuse treatment per se, but a feature of the psychopathology. This condition overwhelmingly affects females (>90%) and is associated with one of the highest standardised mortalities of all psychiatric disorders, secondary to the consequences of chronic malnutrition[12,13] and suicide. Eating disorders are less common in males and as a result, often go unrecognised resulting in late or more severe presentations.

Medical complications of AN affecting all major organ systems are generally due to malnutrition and weight loss, or to purging behaviours[14]. The clinical course of AN varies greatly and recovery can occur even after many years of illness. Psychological treatments are the treatment of choice. Feeding to normal weight is one of the most important treatments and psychiatric therapies appear to be less effective in severely malnourished individuals, which is why the provision of safe and effective nutritional support is not simply lifesaving, but the foundation on which other treatments rest[2]. Most people with AN can be treated as out-patients. In-patient treatment is usually considered for patients with a life-threateningly low BMI, rapid weight loss, evidence of system failure, significant risk of self-harm or suicide, or no improvement despite appropriate outpatient treatment (as per the MEED Guidance).

Approximately 20% of people with eating disorders do not recover and develop a long-term condition. This condition has been described as severe and enduring eating disorder (SEED) and refers to patients who have refractory eating disorders. Compulsory treatment under the relevant UK home nation's mental health legislation is used in cases of life-threatening AN, when the patient's eating disorder makes it difficult, or impossible to engage with treatment on a voluntary basis in a community setting. This is usually done in a SEDU and, in this situation, nutritional support without the patient's consent would be considered as the **appropriate medical treatment** for the patient's mental disorder. However, it should always be provided via the least restrictive option possible.

Occasionally, intravenous or deep sedation may be required for patients with life-threatening AN to either initiate or continue the provision of assisted feeding under restraint. In these circumstances a transfer to a critical care unit might be required, but it is essential to ensure that **all** other treatment approaches have been explored and exhausted, before this option is considered. The ethical and legal issues in this situation are more complex, therefore close collaboration between liaison and/or eating disorders psychiatry and critical care physicians is required. There may also be a need to consider the application of the England & Wales Mental Capacity Act 2005 (MCA)[15], Adults with Incapacity Act 2000 (Scotland)-AWIA[16] or Mental Capacity Act (Northern Ireland) 2016[17]. Whichever legal framework is in play, as the level of restraint required increases, additional risks are introduced together with ethical and legal challenges, such that formal legal advice will be necessary and court intervention may be required. This is explained in further detail in Section 2, the legal section of this guidance.

MANAGEMENT OF THE EATING DISORDER PATIENT IN CRITICAL CARE

A study of 354 patients with AN admitted with severe malnutrition to a specialist centre in France, reported that up to 10% of that patient cohort, required critical care referral (for all causes i.e., not limited to a need to facilitate assisted feeding)[18]. There are numerous potential considerations for the general intensivist. Challenges in monitoring, particularly around the

compliance of the voluntary psychiatric patient, who may not be used to the enhanced levels of observations, blood tests and invasive procedures that occur on an HDU, or ICU, can place a burden on the patient's relationship with the clinical team[19]. Patients experiencing severe eating disorders may feel insecure and vulnerable in clinical situations[20,21], and this may be compounded in the unfamiliar the ICU environment, where they are surrounded by critically ill patients receiving invasive organ support. Admission to a side room, rather than the open unit, may be preferable but poses additional challenges for patient supervision. Fear of weight gain can cause patients experiencing eating disorders to engage in behaviours that may reduce the effectiveness or prolong their critical care admission including common actions aimed at avoiding food intake such as disconnecting NG tubes and PN lines.

In the recovery phase, patients may exhibit hyperactivity and associated behaviours to increase emergency expenditure, which may place them at risk of deterioration and weight loss. A cohesive approach by the whole MDT is required and include physiotherapists, psychologists and dietetic services. Meticulous planning, handovers and regular multi-specialty meetings are essential to ensure safe and effective care and patients should be involved in these discussions and encouraged to develop daily and longer- term goals.

Whilst there is a paucity of literature around the management of this condition in a hospital's general ICU, it is considered that such patients are at increased risk of morbidity and mortality[22,23]**.** A French study of 68 patients with a confirmed diagnosis of AN admitted to 11 ICUs identified the main reasons for admission as profound metabolic abnormalities and the need for monitoring of vital signs during refeeding. This study also illustrated that during these ICU stays, a variety of complications can occur and included acute kidney injury (in 30% of this patient cohort), hypokalaemia (24%), deranged liver function (21%), hypophosphataemia (16%), cardiovascular complications such as repolarisation problems (16%) and bradycardia (7%), and respiratory tract infection with acute respiratory distress syndrome (8%). 21 patients required invasive ventilation due to neurological complications or hypoxic respiratory failure. Seven patients died (10%); two from refractory hypoxaemia and five from multiple organ failure. Additional rare, but well recognised complications, include spontaneous gastric and oesophageal rupture[24]**.** This data emphasises the potential severity of illness in this patient cohort[25]. **Clinicians need to remain vigilant for signs of these conditions, particularly when full clinical examination and/or investigations may have proven difficult e.g., if the primary focus has been on psychiatric interventions and physical restraint.**

ADDITIONAL FACTORS TO CONSIDER WHEN PROVIDING NUTRITIONAL SUPPORT IN ICU

The MEED safe refeeding guidelines recommend an increase of 5 kcal/ kg/ day every two days, until an intake of 60 kcal/ kg/ day AND weight gain > 0.5 kg/ week is achieved. This needs to be considered in the context of the patient's metabolic and clinical factors. Input from an ICU dietitian to develop an appropriate regimen is imperative for these cases and the ICU dietician should collaborate with a specialist eating disorder dietician. Refeeding syndrome influences the outcomes of AN patients in the ICU, where there is an increased risk of death in those with refeeding syndrome, versus those without. Non-fastidious nutritional support is associated with a higher prevalence of refeeding syndrome[26]. As such, once committed to nutritional support the importance of compliance to ongoing care and observation is of paramount importance.

Over-cautious feeding in patients without an acute inflammatory response, and failure to control eating disorder behaviours, can lead to a situation where the patient never establishes adequate nutritional intake, a condition referred to as 'underfeeding syndrome'. This has been identified in recent coroners' reports as a significant factor in several deaths and appears to be more common in the UK than death from refeeding syndrome[27]. Detailed information is available in the MEED guidance.

The physiological processes around establishing safe nutritional support, avoiding underfeeding syndrome, and ensuring appropriate monitoring can become even more difficult if the psychiatric issues and behaviours caused by the eating disorder are not actively addressed. Failure to engage with eating disorder behaviours can paradoxically lead to an escalation in the intensity of the care required, leading to more invasive and restrictive treatments.

NG feeding under any form of restraint is likely to cause distress and anxiety and may have a significant psychological impact on the patient and those close to them[28]. Admission to an ICU to facilitate NG feeding may heighten these factors and introduce additional fears and concerns. Effective communication is vitally important, to ensure that patients and their families/caregivers are fully informed of the clinical situation and the risks and benefits of the treatments proposed. Additional psychological support may also be required (for both the patient and their families/ caregivers) at the time of treatment implementation and following discharge from critical care. A combined approach from ICU follow-up and eating disorder services may be required.

POST-ICU CARE

Recovery for patients experiencing eating disorders, who have required significant sedation in an ICU to facilitate nutritional support under restraint, is likely to be complex and involve several challenges. This is especially relevant for those who have required intubation and invasive ventilation, who may experience some of the issues known to arise in other groups of patients who require a prolonged period of critical care intervention[29]. Careful planning is required and should involve the extended MDT. Considerations should include the risk of post-event psychological trauma for the patient, and their individual physical rehabilitation needs (e.g., adjustments will be required for patients with very low BMIs).

Clinical Scenarios

The scenarios in this section highlight examples of where patients with severe eating disorders may require referral to critical care to support feeding under restraint.

Section 5 of the MEED guidance includes recommendations for circumstances when NG tube feeding may be required:

- The patient is unable to achieve sufficient oral fluid and nutritional intake from food and/or sip feeds to stabilise and restore physical health.
- The patient is unable to eat at all, but is accepting of NG tube feeding.
- There is life-threatening weight loss (clinicians should use their judgement, but a generally accepted guide is body mass index (BMI) <13 kg/m^2 in adults, or percentage BMI <70% predicted in children) or where there is immediate danger to the patient due to physical deterioration.
- The patient presents with chemical or biochemical instability, including those associated with refeeding syndrome.

Additionally, the MEED guidance makes clear that NG tube feeding may be required in patients with a BMI of >13 kg/m^2 where there has been rapid weight loss significant enough to place the patient at risk, especially where there is concomitant illness or electrolyte disturbance.

NG tube feeding may very occasionally be required under restraint as a life-saving intervention. The MEED guidance states that "*The use of NG tube feeding under restraint should always be a risk-based decision for each occurrence, carried out as infrequently as possible to follow principles of least restrictive practice and prevent traumatisation of patients and those around them*".

Although NG tube feeding will ordinarily be provided in a SEDU, gastroenterology ward or medical HDU, not all patients will tolerate or voluntarily consent to NG tube insertion, and feeding with restraint under relevant UK mental health legislation may be required. Psychological based treatment and evidence-based psychopharmacology should be provided as per the Academy for Eating Disorders Guide to Selecting Pharmacologic Treatment for Patients with Eating Disorders[30]. Antipsychotics such as olanzapine may be beneficial in highly distressed patients with AN, whilst avoiding polypharmacy and benzodiazepines.

If these treatments are unsuccessful, a very small group of patients may require referral to critical care, as illustrated by (but not limited to) the following examples:

- To support intermittent NG tube insertion and feeding under restraint, utilising bolus intravenous sedation (i.e., in an enhanced care area, HDU or Level 2 critical care area).
- To provide intravenous sedation for assisted feeding via NG tube, utilising continuous intravenous sedation (i.e., in a Level 3 critical care area).
- To facilitate intravenous line insertion e.g. central venous catheters (CVC), peripherally inserted central venous catheters (PiCC) or Hickmann lines and support parenteral nutrition (PN) under restraint, in circumstances when an NG tube is not an option.
- To provide monitoring for patients who are medically very compromised (e.g. BMI<12 kg/m^2) and who require medication (e.g. opiates, benzodiazepines) that carry a high risk of respiratory arrest.

Prior to the consideration of intermittent IV or continuous sedation in ICU, all other treatment options **must** have been explored, and patient and family/caregiver communication optimised. Whenever sedation is being administered for this purpose, this should be done in the safest possible environment, and it is recommended that continuous IV sedation is always provided in a critical care area with appropriate monitoring and trained personnel[6]. However, the decision to provide IV sedation in ICU should never be based on factors such as local resource limitations, SEDU bed capacity or a lack of referring specialty experience in managing this patient group. A second opinion from a specialist eating disorders psychiatrist in another centre is recommended at an early stage. The experience of the editorial group is that, in many situations where ICU admission for IV sedation is being considered, lower risk options may not always have been fully explored, and it has subsequently proven possible to avoid invasive ventilation.

Cases have also been reported where patients have been referred to critical care to facilitate percutaneous gastrostomy tube insertion. This is not recommended other than in exceptional circumstances e.g. the presence of a dysfunctional swallow where long-term nutritional adequacy cannot be achieved orally (as per MEED guidance), due to the increased risk of complications in this patient group which include peritonitis, pneumoperitoneum, perforation, and abdominal wound sepsis. Establishment of a safe tract is likely to take 4-6 weeks, and invasive ventilation may be required for an extensive period if this approach is adopted, with significant associated risks.

The exact tube feeding regimen should be discussed with an ICU dietitian who can facilitate a full dietetic assessment and prescribe enteral feed. Options in the ICU include feeding continuously or intermittently via a pump or bolus feeding. It is the role of the dietitian to create, monitor and modify the enteral feeding plan (as described in the MEED guidance). Nasal bridles are not recommended in this patient group, as the risk of self-inflicted nasal septal injury is high (based on limited observational data).

Initially when commencing NG tubefeeding in critical care, delivering a constant and controlled supply of enteral feed is likely to be the safest way of minimising refeeding risk and episodes of hypoglycaemia in the severely ill patient. For patients at risk of refeeding syndrome, bolus feeding is not appropriate due to delayed gastric emptying, which can be experienced by patients with AN and those receiving sedation[20] as described in the MEED guidance. For awake patients at lower risk of refeeding syndrome, bolus feeding can be considered.

Common to all these scenarios is the potential need to provide intensive and invasive monitoring and electrolyte replacement, due to the risks of refeeding syndrome. Recommendations for assessing and treating refeeding syndrome are included within the MEED guidance.

SCENARIO 1: INTERMITTENT SEDATION

A 19 -year-old female with AN has been admitted to the regional SEDU. Despite attempts to support and rehabilitate her and treat her psychiatric illness, she requires NG tube feeding, as she is unable to achieve sufficient oral fluid and nutritional intake from food and/or sip feeds to stabilise and restore physical health (as per the recommendations of the MEED Guidance). Oral sedation to facilitate this has proven to be ineffective and whilst she is willing to have the NG tube, she is unable to tolerate NG tube insertion and is refusing intravenous sedation. She is referred to critical care for consideration of periprocedural intravenous sedation under the relevant provisions of the applicable mental health law for intermittent NG tube insertion and push syringe bolus feeding.

SCENARIO 2: CONTINUOUS SEDATION

An 18-year-old female in-patient is referred to the ICU for consideration of feeding under continuous sedation. She has a history of AN and her BMI on admission was 11 kg/m^2 but she has refused oral or NG tube feeding. She was placed under detention using the relevant provisions of the applicable mental health law. Attempts to site a NG tube were physically resisted. Periprocedural intravenous sedation to facilitate NG tube insertion and bolus feeding led to episodes of self-resolving cardiovascular instability. Physical restraint in isolation caused her extreme distress. Her BMI has fallen to 10 kg/m^2 and an MDT meeting has recommended referral to critical care, for the consideration of feeding under continuous sedation. Her parents are fully supportive of this decision.

SCENARIO 3: PARENTERAL NUTRITION (PN) ADMINISTRATION UNDER SEDATION

A 21-year-old male has a severe eating disorder with a BMI of 9 kg/m^2. During a six-month hospital stay under the care of the regional eating disorders team, he has had repeated trials of intermittent NG tube insertion together with a bolus feed and intravenous sedation regimen. Throughout this time, he has been detained under the relevant provisions of the applicable mental health law and all psychiatric treatment options for his eating disorder have been explored. He has been admitted to the ICU for two periods of continuous intravenous sedation, for which he required intubation and ventilation. However, following each admission, attempts to continue enteral feeding without sedation have proven unsuccessful. He has suffered several episodes of sinusitis and has evidence of nasal trauma, to the extent that NG tube insertion is increasingly difficult. His swallow is impaired because of extreme weakness. Following an MDT review, consultation with an independent expert and the support of his parents, the decision is made to proceed with emergency PN administration via a central line, as he is at extreme risk of dying given his BMI. Given the previous issues with NG tube insertion and feeding, the consensus opinion is that central line insertion will require a general anaesthetic for the procedure and a subsequent period of continuous intravenous sedation, endotracheal intubation, and invasive ventilation for several weeks.

CLINICAL, ETHICAL AND LEGAL ISSUES

Clinical issues

- There may be differences in how each specialty considers and evaluates the relevant risks and benefits. Consensus may not be achievable.
- Scenario 1 may be most commonly encountered by critical care staff. Patients should be placed in the safest and most appropriate environment for the level of sedation required, once an MDT decision has been made to proceed with this approach.
- Bolus sedation and intermittent NG tube insertion may be poorly tolerated. The use of continuous conscious sedation in ICU using opiates, benzodiazepines and/or alpha 2 agonists with top-up boluses as required has been described with success but not yet reported in the literature.
- One of the main issues in scenarios 2 and 3 is that deeper sedation or general anaesthetic will be required. In order to enable this, invasive ventilation is required as to the anaesthetic and analgesic drugs used impair airway reflexes and the ability to achieve adequate spontaneous/unassisted ventilation. This introduces significant additional risks, which would not normally be encountered in the provision of nutritional support.

Ethical issues

- All of the scenarios involve restrictive treatments in the absence of patient consent.
- Patients views and values may be overlooked, as clinicians prioritise life-saving interventions and there are risks of medical paternalism and loss of patient autonomy.
- All of the interventions pose significant associated risks of harm, and the balance of beneficence vs non-maleficence is complex[31].
- The balancing of human rights is complex in these situations e.g. Article 2: the right to life vs Article 3: the right to be free from inhuman or degrading treatment (this is highlighted in case 2 of the case law examples)[32].
- Treatment decisions concerning the administration of assisted feeding under restraint in critical care, should not be made primarily on the basis of perceived futility. Whilst there is limited published data regarding the outcomes of this patient cohort, the majority of patients suffering an acute deterioration in their eating disorder, will improve after treatment for that episode. This has been supported by clinician feedback; however it is acknowledged that a more formal reporting system is required to evaluate this further. For patients who develop multi-organ failure and continue to deteriorate however, the same ethical principles should apply as for any patient in critical care, and the patient and their families/caregivers should be fully appraised of this at the outset.
- Hospital ethics committees can be a useful resource and assist in the identification and evaluation of ethical aspects of proposed treatment interventions

Legal issues

- Scenarios 2 and 3 require a more complex evaluation of risk vs benefit and whilst emergency and life-saving interventions should not be delayed, are more likely to require legal advice, especially where differences in opinion exist between the clinicians involved.
- Whilst general anaesthetic and invasive ventilation can be provided under the remits of relevant mental capacity legislation in emergency situations involving critically ill patients where respiratory support is required, the legal position regarding the implementation of these interventions primarily to enable their provision of nutrition in patients experiencing eating disorders without their consent, is more complex. To date, this situation lacks legal clarity, albeit a number of cases have now been considered by the England & Wales Court of Protection (as summarised in section 2) and this is an evolving area of law.

POTENTIAL CHALLENGES FOR INTENSIVE CARE MEDICINE

Practical and environmental challenges

- Critical care nurses, Allied Healthcare Professionals (AHPs) and clinicians have limited experience of patients with complex eating disorders. There is limited baseline familiarity/expertise of caring for patients experiencing complex eating disorders and associated behavioural features.
- When a request is made for consideration of admission to critical care for assisted feeding under restraint in a patient with a complex eating disorder, there may be uncertainty regarding the ethical and legal aspects of the use of physical restraint and intravenous deep sedation (which may be viewed as a form of pharmacological restraint) to facilitate assisted feeding.
- There are practical issues providing both physical restraint and intravenous deep sedation, when inserting NG tubes in non-compliant patients:

- Critical care staff are not routinely trained in physical restraint and will have limited experience in providing this. In patients with a very low BMI significant physical injury can result from physical restraint (e.g. fractures as a result of poor bone health).
- Despite critical care staff having greater experience of intravenous deep sedation, this group of patients have a high risk of recognised complications, following the induction of general anaesthetic[20]. Cardiovascular instability during general anaesthetic may occur and prolonged invasive mechanical ventilation carries the risks of aspiration pneumonia and ventilator induced lung injury. Careful assessment is required to ensure that overall benefit outweighs these significant risks.
- Critical care staff may not be familiar with the safeguards and reporting requirements for the use of mechanical restraint under mental health law.

- Specialised support for families/caregivers will be required, and critical care staff may lack the relevant experience to provide this. Families/caregivers may experience distress, fear, a difference of opinion (to clinicians, or to the patient with the eating disorder) or feel a need to defend the patient's eating disorder.
- Significant moral distress has been reported in critical care staff involved in these types of cases. This may be related to the use of restraint in patients who appear to have capacity to make decisions as to the interventions which are being proposed, which is at odds with the more common critical care situation, where restraint is used in patients who lack such capacity.
- There may be regional variations in critical care provision and configuration that will influence the area to which a patient is admitted.
- Extremely rarely, there may be the need to respond to a referral made under time pressure e.g., an emergency presentation to hospital; however, this should only occur in exceptional circumstance as early senior MDT planning and communication is paramount.

Medical challenges

- The risk of refeeding syndrome, which is defined as a group of clinical and biochemical findings that occur in severely malnourished individuals undergoing nutritional support[33]. Propofol, which has a high lipid content and is a very commonly used drug for the induction of anaesthesia and maintenance of deep sedation in critical care, has been associated with refeeding syndrome[20]. It is important to consider the caloric value of both propofol (1.1 kcal/ml) and medications formulated in glucose to prevent overfeeding and exacerbating refeeding syndrome. In this situation inadequate protein intake may occur. A critical care specialist dietitian will be able to formulate a plan that takes into account 'non-feed' caloric provision and advise on an appropriate nutrition prescription.
- The provision of nutritional support in ICU patients is complex[34]. Weight gain for patients experiencing eating disorders who receive invasive ventilation to facilitate assisted feeding under restraint, is therefore not guaranteed and there is no published data for this specific patient cohort. Unpublished clinical experience suggests that whilst weight gain can occur, it may be challenging to achieve. Factors which may occur in ICU such as intravenous fluid administration or the development of oedema secondary to hypoalbuminaemia, may enhance recorded body weight, but not nutritional status. Suboptimal, or variable, NG tube feed absorption are frequent challenges in patients who are intubated and ventilated. Therefore, it can be difficult to predict the period for which a patient will need to be sedated to ensure that a predefined weight increase occurs, or if this is achievable.
- Invasive procedures may be required to ensure adequate electrolyte replacement for refeeding complications. Line insertion may be more complex, due to potential unorthodoxy of the underweight anatomy and patients may attempt to remove intravenous lines to prevent the successful administration of parenteral nutrition.
- The sedated patient may also be at risk of pressure ulcers, nerve palsies and even fractures, due to anatomy, skin fragility and potential underlying osteopenia associated with malnutrition in eating disorders. Thermoregulation poses a challenge particularly in the sedated patient who will be at risk of rapid hypothermia[35]. Spontaneous organ rupture can occur in severely malnourished patients.
- Other considerations pertinent to ICU care include those related to the pharmacokinetic profile of drugs, particularly those given as infusions, where the volume of distribution of drugs is potentially decreased, consequent to a reduction in body fat (hence increase free plasma fractions). Together with reduced elimination, this predicates an increased effect of commonly used drugs including sedatives and anaesthetics[20]. Dose adjustment may be required.
- Post extubation complications may occur in patients once the endotracheal tube is removed, and these include post-extubation stridor, impaired bulbar function, sputum retention, respiratory failure and delirium. Reintubation may therefore be required. Additionally, patients may become agitated and distressed as they come to terms with the weight gain which occurred during the period of sedation.
- ICU staff may be less familiar with the rehabilitation of underweight patients experiencing eating disorders and careful planning with an MDT approach will be required. Patients may display hyperactivity and a drive to increase calorie expenditure, and the MDT needs to consider how to manage these issues.

POTENTIAL CHALLENGES FOR PSYCHIATRY

- As eating disorder services may not be co-located in acute hospital sites, psychiatrists and other mental health staff may be unfamiliar with the critical care environment (especially Level 3 areas), nursing staff and clinicians, and the types of sedation and organ support that may be required.
- Mental health staff may require support from critical care staff, when emergency situations arise, e.g. if emergency reintubation is required following planned extubation at the end of a predefined period of feeding under deep intravenous sedation.
- Mental health nurses may need to provide support to critical care nurses, regarding psychiatric aspects of care. Mental health nurses may not have specialist expertise in eating disorders psychiatry. Both teams will require education and training, if feasible.
- There will be a need to provide regular specialist psychiatrist input and support to critical care staff and there may be associated logistical challenges with this e.g., when the eating disorder service is located on a different site.
- The consultant psychiatrist in charge of the care of a patient detained under mental health legislation in an acute hospital is usually a liaison psychiatrist, who may not have expertise in the treatment of eating disorders. In this situation, ongoing and close collaboration with a consultant in eating disorders psychiatry will be required.
- There may be regional variations in critical care provision and configuration that will influence the area to which a patient is admitted.
- The time pressured nature of referral/urgency of presentation.
- It can be difficult to manage the psychological issues experienced by the patient including the resistance to weight gain, treatment sabotage, weight falsification and suicidality.
- Some liaison psychiatry services refuse referrals on the grounds that a patient is not 'medically cleared', they are already under the care of an eating disorder team, or that they have an anticipatory care plan which instructs that they should not be seen face-to-face by mental health staff. These practices have no place in contemporary clinical practice.
- Some mental health services use anticipatory care plans which pre-emptively state opinions about a patient's decision-making capacity. This practice is not consistent with mental capacity legislation or the relevant codes of practice. Opinions on decision-making capacity are specific to the decision to be made and the time at which that occurred. Assessment of decision-making requires the responsible clinician to speak to the patient face-to-face-face and in-person.
- Mental health staff may not be able to envisage the severe and long-lasting trauma that can occur in patients who require admission to ICU. Consequently, they may find it difficult to relate to the needs and wishes of patients who have lived experience of this type of treatment.
- There is a high demand for SEDU beds relative to national capacity, such that patients are often admitted far away from home and when a patient is transferred to an acute hospital, their bed may not be kept available. Consequently, when critical care treatment is completed, it may not be possible to immediately return a patient to the SEDU from which they were admitted and transfer to a distant SEDU may be offered, potentially disrupting continuity of care and clinical relationships.
- The legal authority to detain or treat a SEDU patient as an inpatient without consent applies to that hospital only. When a patient is transferred to an acute hospital for critical care, the legal authority to detain must also be transferred from a psychiatric hospital to an acute hospital.
- Patients detained under mental health legislation, or patients subject to decisions made under mental capacity law have statutory rights to advocacy and appeal. Acute hospital staff may be less aware of detained patient's rights and systems may not be in place to facilitate access to advocates or appeals processes.

POTENTIAL CHALLENGES FOR THE PATIENT AND/OR THEIR CAREGIVERS

- Patients and their families/caregivers may feel excluded from the decision-making process; effective communication by clinical and legal teams is essential.
- There is a risk that patients may not understand medical details of the interventions being proposed e.g., what will happen to them, the potential risks involved and the fact they will lose the ability to talk whilst intubated. It is extremely important that adequate explanations using appropriate terminology are provided by clinical teams.
- The loss of control may be very distressing for patients and their families/caregivers.
- Following cessation of sedation, patients may struggle to come to terms with their weight gain.

Support for patients, and their families/carergivers

The families/caregivers of patients experiencing eating disorders who are critically ill, will understandably experience significant concern and it is essential that they are adequately supported. This will require an MDT approach from critical care, psychiatry and psychology given the complexities of the situation. Chapter 7 in the MEED guidance provides significant information for carers of patients experiencing eating disorders.

Additional resources for patients, their carers and professional advisors can be provided by the following organisations:

Eating Disorders:

- Beat eating disorders https://www.beateatingdisorders.org.uk/
- FEAST (Families empowered and Supporting Treatment of Eating Disorders) https://feast-ed.org/
- FREED (First Episode Rapid Early Intervention for Eating Disorders) https://freedfromed.co.uk/

Critical Care

- ICU Steps: https://icusteps.org/information/guide-to-intensive-care/for-relatives
- College of Intensive Care Medicine resources for families/caregivers https://www.ficm.ac.uk/forpatientswhatisintensivecare/children-families-and-critical-care

SECTION 2: Legal Considerations

CHALLENGES IN ASSESSING CAPACITY IN PATIENTS WITH EATING DISORDERS.

Anorexia nervosa (AN) can commonly co-exist with other psychiatric conditions[36] including obsessive compulsive disorder, depression and anxiety. It may also be complicated by a range of other disorders including personality disorder, somatic symptom disorders, post-traumatic stress disorder, functional syndromes and autism spectrum disorders[37]. These can all present additional challenges and require good close working relationships and care planning between liaison psychiatry/psychiatry services and ward teams.

AN can frequently affect patients in their decisional capacity to consent to treatment, out of fear of weight gain or due to a shift in their values and sense of identity in the context of AN; however, other cognitive processes are often left intact, such as the ability to work or study. This means that patients with AN are often found to appear able to reason clearly and can argue articulately with families/caregivers and clinicians about not wishing to have treatment. This can cause concern and confusion regarding the use of restraint, sedation, and indeed any treatment at all, despite the patient having a severe mental health disorder with life-threatening complications. Capacity assessment in these situations must be performed in-person by consultant psychiatrists, and advice sought from specialists in the management of patients with eating disorders.

Assisted feeding under restraint may initially fall within the remit of the relevant home nation's mental health legislation (where feeding would be considered as the **appropriate medical treatment** for the patient's mental disorder, for patients where an eating disorder has been confirmed). However, the potential risks to the patient rise as the level of sedation required to facilitate assisted feeding increases, and interventions not necessarily encompassed by mental health legislation, such as invasive ventilation for the primary purpose of enabling the provision of deep sedation or general anaesthesia, may need to be considered. Under these circumstances, the legal situation becomes much more complex, involving consideration of mental capacity legislation and which interventions will be in the patients best interests or provide overall benefit for the patient will become important.

Even when the mental health legislation offers the power to provide treatment without consent, there may legitmately be questions about whether that power should be used, thinking of the patient's best interests overall. This can be resolved through a court application where there is doubt or a dispute, or to provide reassuarance, for example, where a decision is made not to impose treatment where there might be the power to do so, and this is felt to carry significant risk.

INVOLVEMENT OF THE PATIENT AND THEIR FAMILY MEMBERS/CARERS IN THE LEGAL PROCESS

It is essential to ensure that patients are aware of any legal proceedings, and the treatment options being considered, even when they are assessed as lacking capacity. Individual patient values should still be explored, and it is important to provide reassurance and address any concerns the patient may have.

Whilst family members/caregivers cannot make proxy decisions for patients under UK law (unless they have been given the necessary authority, such as a power of attorney with the relevant powers) it is essential to involve them in best interests decision making, so far as is appropriate, to consider their views and ensure they are fully appraised of each stage of the process including details regarding what is being asked of the courts and why. The views of those who know the patient best are especially important to making the right best interests decision for that patient individually, informed by the best possible evidence of the patient's own wishes and feelings, values and beliefs (MCA s4(6) and 4(7)). Care should be taken to maintain patient confidentiality and encourage patients to provide consent for disclosure of information, unless there are safeguarding concerns.

Guidance on the Court of Protection for patients and their carers can be found in the Court of Protection handbook[38]

Applicability of UK Mental Health and Capacity Legislation

ENGLAND & WALES

The Mental Health Act 1983

Treatment under the Mental Health Act (MHA) does not formally require an assessment of the patient's capacity. The different sections of the Act are described in the MHA Code of Practice 2015 (in England)[5] and in Wales the Code of Practice 2016[39].

Admission for treatment under the MHA is usually under Section 3 which requires medical recommendations to be made by two doctors, at least one will be an MHA approved psychiatrist, and for an Approved Mental Health Practitioner (AMHP) (who is usually a social worker but can be from another profession) to be satisfied that it is appropriate to make an application for admission, on the basis that:

1. The patient is suffering from a mental disorder (i.e., anorexia nervosa) that requires inpatient care.
2. It is necessary for the health and safety of the person (or of others) that the mental disorder is treated in hospital.
3. Appropriate hospital treatment is available.

Section 63 of the Mental Health Act enables the administration of assisted feeding under the direction of the patient's approved clinician in the last resort without patient consent:

"The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering if the treatment is given by or under the direction of the approved clinician in charge of the treatment."

Feeding under restraint, in principle, falls within the definition of medical treatment for mental disorders. However, as the interventions required to facilitate restraint increase in intensity, complexity, and likelihood of serious side effects or risks involved, then:

1. As noted above, the interventions may take the form of procedures that do not necessarily fall within the scope of the Mental Health Act 1983, such as invasive ventilation to allow sedation.
2. More broadly, the question of whether the measures are justified may be better analysed by reference to the patient's capacity and best interests.

In either case, the Mental Capacity Act will then play a role. In either situation, there should be a low threshold for seeking legal advice.

The Mental Capacity Act (2005)

In England and Wales, the Mental Capacity Act is a parallel legal framework to the MHA. For a patient who is detained under the MHA, the Mental Capacity Act (MCA) is relevant as the basis upon which medical treatment is provided for physical disorders unrelated to the mental disorder(s) warranting their detention. It is also legitimate for clinicians not to invoke the compulsory treatment provisions of the MHA in respect of feeding under restraint, but rather to use the MCA, even where this feeding constitutes treatment for the patient's mental disorder. However, this cannot be used to circumvent the treatment safeguards in Part 4 MHA 1983, but instead to bolster them. This bolstering of safeguards has happened with increasing frequency in recent years where clinicians have put the question of whether compulsory feeding should take place before the Court of Protection, even in the case of patients detained under the MHA 1983.

Capacity

Patients with disordered eating, especially, but not exclusively, those with AN, frequently struggle with 'using and weighing' information about nutrition and hydration. However, it must not be assumed that a patient with an eating disorder (1) lacks capacity to make decisions about nutrition and hydration simply because of that disorder and (2) lacks capacity to make decisions about other aspects of their treatment. It will therefore always be necessary to consider the patient's capacity to make decisions about sedation separately to their capacity to make decisions about feeding. Capacity should be regularly reassessed and prior to each proposed new intervention.

Best interests

It is a legal requirement to provide the person with all practicable support to enable them to make their own decision (s.1(3) MCA 2005). However, if, even with that support, they cannot make the decision, then it will be necessary to proceed on the basis of what is in their best interests. If the patient in question has made a valid and applicable

Advance Decision to Refuse Treatment (or treatments) that deals with the decision at hand, then they have made their own decision as to what they consider to be in their best interests. If the patient has granted a Lasting Power of Attorney, then, subject to certain formalities, they have granted the power to decide as to what is in their best interests to their attorney. In some cases, a deputy may have been appointed by the Court of Protection to take decisions in the best interests of the patient, although a deputy can never refuse life-sustaining treatment on behalf of a patient.

'Best interests' is **deliberately** not defined in the MCA 2005. However, Section 4 sets out a series of matters that must be considered whenever a person is determining what is in the persons best interests. Ultimately, as the Supreme Court emphasised in *Aintree University NHS Hospitals Trust v James [2014] USKC 67*[40] *"the purpose of the best interests test is to consider matters from the patient's point of view."* The purpose of the process is therefore to arrive at the decision that professionals reasonably believe is the right decision for the patient themselves, as an individual human being – not the decision that best fits with the outcome that the professionals desire.

Involving the Court of Protection

The Supreme Court has made clear that, if at the end of the process of decision-making outlined above, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, an application should be made to the Court of Protection[41]. This is likely to be the case where invasive ventilation is required purely to enable the provision of deep sedation and/or general anaesthesia to facilitate feeding in this patient group, rather than as an emergency treatment for respiratory failure.

An application to court may also be required where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in sections 5 and 6 Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and thus constitute a deprivation of liberty. The authority of the court will be required to make this deprivation of liberty lawful. Note that a Deprivation of Liberty Safeguards authorisation only covers the arrangements for depriving the patient of their liberty at the hospital, not the restraints required to bring about individual acts of care and treatment.

In recent years, several cases have been brought to the Court of Protection concerning compulsory feeding of those with disordered eating, including situations where the authority of the court is sought to sedate in ICU for purposes of such feeding.

SCOTLAND

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

The Act applies to people who have a 'mental disorder' which is defined as any mental illness, personality disorder, or learning disorder, however caused or manifested.

Patients can be detained under the Act via an emergency detention certificate (this is known as an EDC and can be issued by any responsible medical officer for up to 72 hours if prerequisite conditions apply) or short-term detention order.

Compulsory treatment can be given under the Act if the patient has Significantly Impaired Decision-Making Ability (SIDMA). This differs from capacity per se and is not formally defined within the Act. In patients experiencing eating disorders one of the key considerations is whether or not the individual understands the risk of starvation. For this group, the Mental Welfare Commission (MWC) has suggested that following criteria are suggestive of SIDMA[42]:

1. Extreme rigidity of thinking (the individual's thinking and behaviour is so focused on food and weight that she/he lacks the ability to perceive or accept the risk of present or further weight loss).
2. Inconsistency in decision making (the individual may appear at interview to understand the condition and risks but behaves differently).
3. Cognitive Impairment (if tests demonstrate that starvation has caused brain function to become impaired, this is highly likely to constitute SIDMA e.g., inability to retain information, or weigh and balance it).
4. Depressed mood may also lead to the individual failing to understand or process information).
5. It is important to note that the above does not constitute absolute criteria for SIDMA, and the overall clinical context needs to be considered for each patient.

When a patient refuses consent or is incapable of giving it, the Act requires that treatment is authorised by a Designated Medical Practitioner appointed by the MWC, albeit this may take time. For this to occur, a section T3B form must be completed. This includes *"provision, without the consent of the patient and by artificial means, of nutrition to the patient"* under section 240 of the Act[43].

In time critical situations, the Mental Health (Care and Treatment) (Scotland) Act 2003 allows treatment to be administered when it is "*necessary as a matter of urgency for medical treatment to be given to a patient subject to detention authorised by this Act…and the patient did not consent or was incapable of consenting to that treatment*"[43]. In this circumstance, the responsible medical officer can retrospectively notify the MWC via a T4 form (record of notification following urgent medical treatment under section 243) within 7 days of that treatment having been given[44]. The form stipulates that the purpose of the treatment was:

- Saving the patient's life.
- Preventing serious deterioration in the patient's condition.
- Alleviating serious suffering on the part of the patient.
- Prevent the patient from behaving violently; or
- Preventing the patient from being a danger to themselves or to others

The MWC for Scotland has also issued the "*Good Practice Guide: Nutrition by artificial means*"[45] which refers to the administration of nutrition by NG feeding, PEG tube or the 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.

The Adults with Incapacity (Scotland) Act 2000

Treatment for patients experiencing eating disorders may also be given under Part 5 Section 47 of the AWIA if a patient lacks capacity and life-saving intervention is required. The principle of adopting the least restrictive option, should still be applied. It is ordinarily preferable to provide assisted feeding under restraint for patients experiencing eating disorders under the auspices of the Mental Health (Care and Treatment) Act, where greater protections apply. However, where invasive ventilation is required purely to enable the provision of deep sedation and/or general anaesthesia to facilitate feeding in this patient group, the conditions of neither Act may apply, and legal advice should be sought.

Mental Welfare Commission

In Scotland the MWC can also assist in complex cases and those where there is a lack of consensus amongst treating clinicians regarding the best approach for patients who lack capacity[46].

Role of the Court of Session

The Court of Protection does not apply to Scotland, and where complex situations arise, cases may be heard in the Court of Session. There is a lack of legal precedent under Scots Law in this area, and it would be appropriate to consider an application to the Court of Session, in the same situations described above (acknowledging the legal differences between the two regimes) for referral to the Court of Protection in England and Wales. Similarly, clinicians practicing in Scotland, should look to relevant judgments from the Court of Protection, such as those summarised below, as examples. Involvement of the Central Legal Office (CLO) which represents NHS Boards in Scotland should be considered at the earliest opportunity, where court intervention may be required.

NORTHERN IRELAND

In terms of relevant regional policy and guidance there is *inter alia*

1. The Northern Ireland Health and Social Care Board publication: *Regional Care Pathway for the Treatment of Eating Disorders*[47]
2. The Northern Ireland Regulation and Quality Improvement Authority Publication: *A Review of Eating Disorder Services in Northern Ireland* (December 2015)[48]

The Mental Health (Northern Ireland) Order 1986 and The Mental Capacity Act (NI) 2016

The two main pieces of legislation specifically relating to mental health are:

- The Mental Health (Northern Ireland) Order 1986 [The Order][49]
- The Mental Capacity Act (NI) 2016 [The Act][17]

The Order provides for involuntary detention and treatment. The system for admission to hospital and detainment involves initial admission to hospital for assessment which can last up to 14 days. Any person who falls within the statutory definition of mental disorder can be admitted for assessment. 'Mental disorder' means mental illness, mental handicap and any other disorder or disability of mind (Article 3). On admission, a patient is promptly assessed and, following the assessment, can become liable to be detained for up to 14 days (Article 9). If diagnosed with a mental

illness or severe mental impairment, a person can subsequently be detained for treatment for a period of six months initially and subsequently up to 12 months. Mental illness means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons (Article 3).

To be admitted for assessment and detained for treatment, patients must fall within the applicable criteria, i.e.

- They must have a relevant mental disorder (as detailed above) of a nature or degree which warrants detention in hospital for assessment/treatment; and,
- Failure to detain them would create a substantial likelihood of serious physical harm to the patient or to other persons (see Articles 4 and 12).

All patients who are liable to be detained can be treated for a mental disorder without their consent under the direction of the responsible medical officer subject to the provisions of Part IV of the Order. For the first three months of a period when a person is liable to be detained, treatment can be administered without the person's consent. After three months, the patient's consent, or a second opinion is required (Article 64). The three month rule does not apply to Article 63 treatments which require consent **and** a second opinion, e.g a surgical operation for destroying brain tissue or to treatments under Article 64(1)(a) such as electro-convulsive therapy. A patient can provide a valid consent where they are capable of understanding the nature, purpose and likely effects of the treatment in question and have consented to it.

In cases of urgency the safeguards contained in articles 63 and 64 are disapplied in relation to any treatment:

- Which is immediately necessary to save the patient's life; or
- Which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- Which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others (Article 68).

Special considerations apply to patients under 16 (Articles 3A-3D). The primary or paramount consideration is ensuring the patient's care and treatment is in the patient's best interests (Article 3A). The Order identifies relevant factors that must be considered and steps taken when determining best interests including enabling the patient to assist in the decision making so far as reasonably practicable, considering the views of the patient insofar as is reasonably ascertainable and consulting with relevant persons (Article 3B). Patients and families/caregivers can be provided with an independent advocate[50].

In *JR18 (Mental Health) Re Judicial Review* [2007] NIQB 104 a woman was detained under the Order. She reacted by going on hunger strike. The Southern Health and Social Services Trust sought a Declaratory Order permitting the provision of nutrition without her consent. The court ruled that the need for the provision of nourishment was a consequence of her mental disorder. It made an order declaring that the trust could provide nutrition without her consent under Article 69 of the Order.

Part of the Mental Capacity Act (NI) 2016 [The Act] was brought into force in 2019. The Act applies to people aged 16 and over. The provisions that would be relevant to treatment for eating disorders have not yet been brought into force.

The inherent jurisdiction

Mental capacity legislation has only been partially implemented in Northern Ireland, primarily in relation to the Deprivation of Liberty or DOLs framework. Most of the other statutory provisions, including those relating to care and treatment that would be relevant in this context, have not been brought into force. Consequently, in addition to the use of statutory powers under the Order, NHS trusts may rely on the common law and utilise the courts' inherent jurisdiction to enable lawful intervention care and treatment. Where an adult lacks capacity, under the common law, intervention is permissible if the proposed care and treatment is necessary and, in the patient's, best interests[51].

The 2020 Serious Medical Treatment Guidance, is broadly applicable in Northern Ireland[52] however there are some significant differences to note:

- Due to the partial implementation of the MCA, the law applied in Northern Ireland is common law based. In *Re PT* [2017] NIFam 1, where the court held that the capacity test in the Mental Capacity Act 2005 could be applied in Northern Ireland, as there was no difference between the statutory test and the common law. Given the partial implementation of the MCA in 2019, it is to be expected that when applying the common law in medical treatment cases courts will take into account enacted provisions of the MCA concerning the determination of capacity and a person's best interests[53]. This will promote harmonisation in the law and consistency in decision-making[54]. Consequently the Supreme Court summation of the capacity test in *A Local Authority v JB* [2021] UKSC 53 (as outlined at page 27 above) appears applicable in Northern Ireland.
- Paragraph 5 does not apply due to the partial implementation of the MCA. In respect of medical treatment, the 'statutory defence' as contained in section 9 of the MCA is amongst the measures that have not yet been brought into force. The applicable law continues to be premised on common law necessity and the patient's best interests. A Declaratory Order can give legal cover to MDT decision making.
- Paragraph 6 of the Guidance is not directly applicable in Northern Ireland. The relevant parts of the MCA are not in force. There is no Code of Practice, and there is no professional guidance specifically addressing the position in Northern Ireland. Consequently, where for example there is disagreement or uncertainty about a proposed intervention, given the lack of statutory and non-statutory provision, it may be advisable to seek a Declaratory Order.

Where an adult has capacity, the principle of autonomy is as a general rule applicable i.e., a person with capacity can either consent to proposed treatment or refuse to undergo recommended treatment. The cases that come before the courts often focus upon the capacity of the patient to provide a valid decision. Often, where the proposed treatment is in the persons best interests, on the basis of the medical evidence, the courts will find that a patient lacks decision-making capacity.

There are no reported decisions involving eating disorder cases in Northern Ireland. There have been a number of cases in England and Wales including *Re E (Medical treatment : Anorexia)* [2012] 2 FCR 523; *Betsi Cadwaladr University Local Health Board v Miss W (by her litigation friend, the Official Solicitor)* [2016] WECOP 13; *North East London NHS Foundation Trust v Beatrice (by her litigation friend the Official Solicitor) and another* [2023] EWCOP 17 and *A Mental Health NHS Trust v BG and Others* [2022] COPLR 466. (See also the case law examples referenced below.) In all those cases (except BG) the court found the patient lacked capacity and the proposed treatment (including in one case [W] outpatient treatment rather than in patient treatment) was in their best interests. In BG, the court found that whilst BG lacked decision making capacity, taking her wishes into account as expressed over a long period of time it was in her best interests to be allowed to receive palliative care and not to be provided with life-saving intervention. All cases turn on their particular facts. In the cited cases there appears no legal reason why a court in Northern Ireland faced with such factual scenarios would not have adopted the same or a similar approach.

Clinical application of the law in practice

Clinical application of the Order and the Act is complex. In this patient group, use of the Order is most fitting, as re-feeding and nutrition are considered treatments, under the Order, for eating disorders. However, use of the Order is only appropriate if the application of those treatments is likely to bring about an alternative outcome in the trajectory of the patient's illness e.g., if someone is in a starvation state, relieving them of that starvation state so that it becomes possible to provide NICE recommended treatment for the eating disorder. Any such decision should involve regional eating disorder clinical experts. Given the complexities of evolving mental capacity legislation in Northern Ireland and lack of legal precedent, early legal advice for more complex cases is strongly recommended.

Case Law Examples

Occasionally, cases involving the provision of nutritional support for patients experiencing severe eating disorders[55] involve the courts. These patients may have refractory eating disorders and fall within the group described as having severe and enduring anorexia nervosa (SEAN)[56] or severe and enduring eating disorder (SEED)[57]. Examples of these cases are set out below, but it is important to emphasise that they are to be regarded as 'worked examples,' rather than directions by the courts as to how such patients are to be treated in general.

When an application to the courts is being considered it is essential that the treating teams identify the following:

- Whether a formal capacity assessment has been made by a senior psychiatrist.
- The patient's previously expressed values and beliefs i.e., before their capacity became impaired.
- Details of each of the treatment options being considered, their potential outcomes and whether all less invasive interventions have been adequately explored.
- The relevant risks and benefit of each intervention.
- Whether those treatments are in the patient's best interests/will be of overall benefit.
- Any areas of disagreement either between the treating teams or the healthcare provider and the family.

1. PENNINE CARE NHS FOUNDATION TRUST V MRS T [2022] EWHC 515 (FAM)[58]

Summary

This case (which owing to the patient's age was heard in the Family Court) considered the situation of a 17-year-old patient with a diagnosis of AN and obsessive-compulsive disorder, who was detained under the MHA and had been refusing to eat for over two years. The application brought by the NHS Trust was to admit the patient to intensive care for a three to seven-day period of continuous sedation to facilitate the provision of nutritional support, an intervention the patient's parents supported. The consensus opinion of her treating clinicians was that her overall prognosis for recovery was good and that all other possible treatment options to provide nutritional support, had been explored. The ICU clinicians, whilst not opposed to intubating and ventilating the patients, expressed concerns that these interventions could result in significant complications including multi-organ failure and death, and could therefore not recommend them. The court found that the patient lacked capacity to refuse treatment and ultimately authorised the intervention proposed by the NHS trust, acknowledging the significant risks involved.

Key points

Evidence was presented by experts in critical care and psychiatry. There was consensus amongst the treating clinicians that all other options had been explored. The courts considered the significant risks involved in continuous sedation and invasive ventilation to facilitate assisted feeding, but ultimately authorised the use of these interventions.

2. A MENTAL HEALTH NHS TRUST V BG [2022] EWCOP 26[59]

Summary

This case involved a 19-year-old patient (BG) with a four-year history of AN, who had been suffering from complex mental illnesses for 10 years, in addition to AN. By the time the case was heard, BG had received over 1000 episodes of NG feeding under restraint, during repeated hospital admissions. Her wish was for such interventions to cease, and she was actively involved in court proceedings. In this situation, the application to the Court of Protection was that whilst BG lacked capacity to refuse treatment, it was in her best interests that no further treatment be provided against her wishes. The application was supported by her parents, an independent expert and the Official Solicitor. The court concluded that it was in BG's best interest for compulsory treatment to end.

Key points

This case considered the extremely rare situation of a patient with a confirmed diagnosis of an eating disorder, who had repeatedly been fed under restraint and for whom all possible treatment options had been unsuccessful. The judge also considered BG's human rights and examined the balance of Article 2 (right to life) against Article 3 (the right to be free from inhuman or degrading treatment). The Court ultimately supported the decision for compulsory treatment to cease, and BG subsequently died several months later.

3. EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST V DL & ANOR [2023] EWCOP 47[60]

Summary

This case involved the decision to provide NG feeding under pharmacological restraint, for a patient (DL) who did not have a formal diagnosis of an eating disorder. DL, who was in her thirties, was detained as an inpatient under section 3 of the MHA and had a history of mild learning disability, complex PTSD, a dissociative disorder and a borderline Emotional Unstable Personality Disorder. She had been restricting her intake of nutrition and hydration for a two month period prior to the Court of Protection hearing and it was accepted by all parties, that without intervention she would die. Despite her refusal of nutritional intake, DL still wanted to live. Nutritional support under physical restraint was assessed as being likely to exacerbate her PTSD, and an escalation plan involving feeding via an NGT tube under full sedation (i.e., pharmacological restraint) on the ICU was proposed by her treating psychiatrists, who also believed that this this would be most in line with DL's wishes.

Significant concerns regarding the legality and risks involved in doing so, were raised by the critical care clinicians who would have to enact this intervention and favoured an initial step-wise approach of escalating restraint and the option of a PiCC line.

The Court considered the risks and benefits of providing nutrition under continuous pharmacological restraint together with the requirement for invasive ventilation. The judge ultimately concluded that DL lacked capacity to make decisions about her nutrition and hydration and that the provision of nutrition and hydration in accordance with the proposed escalation plan (i.e. feeding via an NGT under pharmacological restraint in the ICU) was lawful and in her best interests.

Key points

This case explored the use of continuous sedation and invasive ventilation to facilitate enteral nutrition in a patient who was suffering from a mental health illness but did not have a diagnosis of an eating disorder. The Court considered the risks and benefits as presented, despite disagreement amongst the treating teams and ultimately supported the decision to intubate and ventilate the patient. The overriding reason in this case, was the likelihood of failure and subsequent delay in re-establishing nutrition, had the other proposed options been attempted.

4. ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST & ANOR V LV [2025] EWCOP 9 (T3)[61]

Summary

This case involved a patient (LV) who had a history of AN, autism spectrum disorder, severe depression and anxiety. She had been in hospital for more than three years, initially in paediatric care (which included a stay in paediatric ICU) then in adult care, where she had been detained under section 3 of the MHA. She was fed via an NG tube under physical restraint, but was able to regurgitate at will, and vomit spontaneously to the extent that she continued to lose weight, despite the administration of feed. At the time the case was heard, her BMI was 11 Kg/m^2. Her condition was assessed as life-threatening and after exploring all options, the consensus opinion of the clinicians involved and an external expert, was that sedation, intubation and invasive ventilation in ICU was the only way to facilitate the provision of nutritional support. The trusts applied to the Court to seek:

- A declaration that LV lacked capacity to conduct proceedings and make decisions about her care and treatment.
- A declaration that it was lawful and in LV's best interests to be admitted an in ICU for a period of feeding under sedation.

The Court determined that LV lacked capacity to refuse nutritional support and that sedation, intubation and ventilation to facilitate NG feeding were in LV's best interests and authorised the treating clinicians to proceed.

Key points

This case considered the considerable risks, including death, of sedating, intubating and ventilating LV, but Morgan P ultimately concluded that this should be undertaken as "*an option of last resort*" given the likelihood of death without this intervention. Relevant to the decision was that there were "*aspects of* [LV's] *behaviour are not consistent with someone who holds no hope for a future life and thus no interest in the future*" such that although LV had expressed a wish to die, the clinicians and the court concluded that this was not her true belief. This was a particularly complex case where the treating clinicians were in unanimous agreement that *all* other treatment options had been exhausted given the nature of her psychiatric diagnoses and ability to regurgitate feed, such that despite the administration of NG feed, LV had continued to lose weight. Morgan P noted that "*Here when I look at the other side, at what lies in the balance against all that is risky; all that which in other circumstances would be an intolerable affront to her autonomy, what I contemplate is her imminent death.*"

LV's case was an exceptional situation, and future cases may not meet the above threshold for best interests/overall benefit set out in this case by the Court of Protection. Clinicians should assess any patient referred to critical care for assisted nutrition under restraint, in an individualised and nuanced basis and apply the clinical, ethical and legal recommendations highlighted within this framework document.

End of life care in eating disorders

Defining when end of life care should be considered in patients experiencing severe eating disorders, is beyond the scope of this document. This is a complex and extremely rare situation[62], and decision making will require referral to the relevant courts.

Conclusion

The decision to administer intravenous sedation for the primary purpose of facilitating feeding under restraint in patients experiencing eating disorders, is highly complex. It should only be instituted when ***all*** other appropriate treatment options have been explored. However, admission to critical care should not be delayed when the patient is at significant risk and emergency treatment is required.

Decision making should involve all treating teams, the patient and their families/caregivers. As the risks of the intervention increase, e.g. where invasive ventilation is required, legal advice should be sought at the earliest possible stage.

Recommendations for Audit and Research

The longer-term outcomes of patients experiencing eating disorders admitted to critical care to facilitate assisted under restraint feeding remain unknown. Only a small number of cases have involved the courts and no central database for cases referred to critical care currently exists. Future work should focus on collating this data to enable a more evidence-based appraisal of relative risks vs benefits. Research involving the use of critical care databases such as ICNARC and SICSAG may be beneficial, and the publication of clinical case reports may aid clinicians encountering the complex situations.

As more of these cases involve the courts, the legal situation may become clearer, especially with regards the overlap between mental health and capacity legislation and the remit of each in these types of cases.

The Royal College of Psychiatrists has set up an expert reference group to develop a position statement on Severe and Long-Standing Eating Disorders which includes representatives from the College of Intensive Care Medicine. The output from that group may highlight future areas for research and development that is applicable to this critical care document.

Whilst this document is addressed at adult patients, it is recognised that these types of clinical scenarios may involve children and adolescents. Supplementary guidance is planned in due course which will focus on specific legal and ethical aspects involving similar treatment decisions in paediatric patients.

Appendix 1: Steps to explore when considering referral and admission to critical care to facilitate assisted feeding under restraint

Step 1: Prior to ICU referral

- Ensure that all alternative treatment options have been explored and that a second opinion from a specialist eating disorders psychiatrist has been sought.
- Establish whether the patient has capacity (this must be done in-person, by a consultant psychiatrist).
- If the patient lacks capacity, undertake a best interests assessment (England, Wales and N Ireland) or evaluation of overall benefit (Scotland).
- Ensure the patient and their family/carers have been adequately informed of the proposed treatment plans, including details of what will happen and why.

Step 2: At the time of ICU referral

- Involve the patient and, where appropriate, their representatives in discussions and decision making.
- Arrange an MDT with senior staff members (including representatives from psychiatry, psychology, critical care and the nutrition team) to discuss all potential treatment options, explore the least restrictive options for nutritional support and determine treatment outcome goals.
- Plan the duration of sedation or anaesthesia-this will require assessment of the balance of risks vs time, to achieve target weight/BMI.
- Consider the logistics of nutritional support: determine the choice of feeding route (NG absorption may be impaired, TPN may be required), request specialist dietician input and assess the risks of refeeding syndrome vs inadequate feeding.
- Seek advice from hospital medical ethics committee, if applicable.
- Ensure plans are made to provide additional staff resources during the patient's ICU admission (include mental health nursing support and regular senior psychiatry review).
- Ensure provision is made to provide psychological support for the patient, their families and staff involved.
- Ensure all team members understand the legal processes being applied and the treatment options being considered, together with their potential risks and benefits. Identify areas of consensus, disagreement and concern.
- If intubation and invasive ventilation is being considered, seek early legal advice and follow the recommendations in section 2 for the relevant jurisdiction.

Step 3: Initiation of sedation

- Ensure clinical examination and necessary investigations have been undertaken before sedation is administered (this may have been challenging to achieve previously especially when the focus has been on psychiatric management and/or the patient has been restrained).
- Explore the least restrictive options for sedation. Intubation and ventilation should only be considered as a last resort option.
- Where intubation and invasive ventilation is being considered, consider specific risks of induction e.g. aspiration, electrolyte abnormalities, and post induction hypotension.

Step 4: Maintenance of sedation

- Regular reassessment is required exploring whether treatment goals have been achieved and if any complications have arisen.
- Ensure regular MDTs and daily staff safety huddles are undertaken and ongoing communication with family/carers (and patient where applicable i.e. dependent on level of consciousness).

Step 5: Emergence from sedation and extubation

- Consider the risks of post extubation stridor and bulbar dysfunction. Emergency reintubation may be required.
- The patient will need to come to terms with the weight gain which occurred whilst they were sedated; management plans for this should be developed.
- Risk of delirium exists especially after prolonged sedation-ensure family are aware of this. Additional time in ICU may be required.

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