Faculty of Eating Disorders Newsletter

August 2020

Eating Disorders Faculty Newsletter

Eating Disorder Faculty Newsletter

August 2020

In this issue

Please follow us on Twitter.

Dr Stephen Anderson
@RCPsychEDFac

Introduction to Dr Ashish Kumar

Vice Chair of the Faculty of Eating Disorders

Many of you will know Ashish from his role as Academic Secretary of the Faculty and from the excellent programmes he has organised for recent annual conferences. He is now Vice Chair of the Faculty and I am pleased that has been able to share with us some of his thoughts and experiences of working in the field of eating disorders.

It was a different world when I had pleasure to meet many of you in our Eating Disorder Faculty's annual conference in December 2019, in last many months it has been a very different world- but I hope that most of you are coping well. I am proud of the fact that we psychiatrists and other colleagues working in the field of Eating Disorders have risen to the challenge posed by Covid-19 and have continued to help our very seriously ill patients and their families. I know from confirmed sources and personal knowledge that all our Eating Disorder Services are under-staffed and are helping patients multiple times their established capacity, however we have helped our patients in the best possible manner, even at the risk of our personal safety. Many thanks to you all for your wonderful contribution to our field.

My amazing colleague Stephen (editor of this newsletter) has asked me to write about my role as Vice Chair of the Faculty and my personal opinion about joining Eating Disorders Speciality. I would like to thank my trainer Professor Simon Gowers who was amazing human being, teacher, trainer, researcher and also chair of the committee which developed first NICE guideline on Eating Disorders. It was him who let me learn the art and science of Eating Disorders at my own pace with his inspirational support, including different therapies which helps with recovery of the young people and families from such a difficult condition. We need to have more educators, academics and trainers like him so that we continue to produce very good psychiatrists in this field.

Since my training, it has been a very exciting journey in this field for me, sometimes very challenging but never devoid of thrills, however, I wish I could avail of all the opportunities I had. I was fortunate that government initiative (Under Access and Waiting Time Directive, AWT) to invest £150 million over five years came in 2015 and as clinical lead of Eating Disorder Pathway in Alder Hey Children's Hospital, I led our team to establish one of the first Eating Disorder Services for children and young people under AWT in Liverpool. Around the same time I got elected to Faculty of Eating Disorders (FED) of the RCPsych and from there I got elected as Co-Chair of the Partner, Chapter and Affiliate Committee of the Academy for Eating Disorders (AED).

A combination of intense clinical work with children with Eating Disorders and other co-morbid mental health issues, being National Coordinating Investigator for UK for an antidepressant trial in children, working very closely with the FED in the company of many eminent colleagues such as Sandeep Ranote, Dasha

Nicholls, Agnes Ayton, Jane Morris and Jacinta Tan and working internationally with AED and several amazing colleagues there such as Ursula Bailer, Bryn Austin, Elissa Myers, Stephanie Bauers helped me enhance my knowledge in national and international policies related to ED and mental health and prepared me to take medical leadership role as Deputy Associate Medical Director at Corporate Level within my own NHS Trust (North West Boroughs Health Care NHS Foundation Trust, NWBH). It was a great step forward for our Eating Disorder Community to set-up European Chapter of Academy for Eating Disorders and as the President of the European Chapter of the AED, I have worked with the European Chapter Board to deliver on our agenda of teaching, training, advocacy and research in this field across Europe.

The vital experience of working as academic secretary of the FED for 4 years and learning experience I had from Professor Janet Treasure and Professor Ulrike Schmidt over several interactions helped me to remain interested in research in Eating Disorders and also take up the role of Vice Chair of the FED. In this role, I have worked very closely with my colleague and chair Agnes Ayton to steer some of our faculty work such as completion of MARSIPAN (Pan-age) revision, development of ED (Pan-age) Credentialing Curriculum, learning modules on ED for medical students and doctors in training besides actively contributing to national level policy development in mental health through Policy and Public Affairs Committee (PPAC) of the RCPsych. Agnes and I have also launched a nationwide survey on behalf of our faculty of all the psychiatrists working in Eating Disorders and you can complete the survey here - survey. This survey will help in driving some national policy around resources, workforce, training, teaching and research in the field of Eating Disorders.

I have been involved in delivery of high quality of care for our Eating Disorder Patients in last many years as Clinical Lead of my Eating Disorder Service at NWBH and also in different roles. We have to travel a long way and do a lot more to improve standard of care for our patients with Eating Disorders and also their families. We have to improve upon resources, training, teaching, research in our field. We need more psychiatrists and other clinicians who are trained and are passionate about working with children and adults with Eating Disorders. This will develop a momentum at local and national level with our policy makers and commissioners to help invest more resources in the field of Eating Disorders to help with early diagnosis and treatment of patients and also to prevent very avoidable morbidity and mortality and social distress caused by that.

Hope you join forces with our Faculty of Eating Disorders at RCPsych and help our patients and carers!

Nasogastric feeding under restraint in Anorexia Nervosa

The British Dietetics Association guidelines and reflections on use

Dr Jacinta Tan & Sarah J Fuller

Compulsory treatment, that is, treating a person without their consent, is sometimes necessary for patients who have severe psychiatric disorders. This is particularly true for eating disorders, where there are often issues of loss of capacity to make decisions and difficulties in complying with treatment, to eat sufficient amounts or to stop engaging in harmful behaviours due to the need to be in control. In most cases, patients who are admitted to inpatient units manage to eat sufficiently to re-establish a regular eating pattern and if needed restore their physical health. For those who are unable to manage this, patients can agree to consume sufficient nutrition via other non-oral means such as naso-gastric tube (NGT) feeding or in in some cases a more permanent percutaneous entero-gastrostomy (PEG) can be placed for feeding to prevent multiple re-insertions of the NGT. There are however, a very small minority of patients who cannot cooperate with attempts to provide sufficient nutrition, and in lifesaving circumstances may require NGT feeding under restraint. These patients are most likely to be either on a specialist eating disorder unit or on an acute medical ward due to severe and life-threatening malnutrition.

From the ethico-legal point of view, treatment provided without valid patient consent is permissible in the patient's best interests, either if they lack capacity and/or are subject to a treatment or guardianship order. Not all compulsory treatment is against patients' wishes. Eating disorders patients can feel that they appreciate having control taken away from them because the strong drive of the eating disorder makes it too difficult to make and abide by decisions they may wish to make. All compulsory treatment provided against the patient's will however can be problematic and potentially psychologically harmful, particularly if patients do not feel their views are heard or they are treated disrespectfully. Furthermore, treatment against patients' will must be clearly and demonstrably in their best interests and the harms of not providing the treatment must clearly outweigh the harms of imposing treatment. Therefore, coercive, and aversive experiences such as physical restraint and passing of NG tubes should be kept to a minimum both in frequency and duration.

In the United Kingdom, a survey has found a wide range of practices amongst child and adolescent inpatient settings regarding how NGT feeding is provided under restraint, some of which involve inappropriate lengths and frequencies of restraint. Much of this appears to arise from healthcare professionals' difficulty in adapting generic NGT feeding protocols to the context of feeding under restraint. The British Dietetic Association (BDA) has issued guidelines to help clinicians safely deliver NGT feeding under restraint from the Dietetic point of view. For example,

while NGT feeding is typically delivered to physically frail patients in general hospitals using slow infusion pumps which is the delivery mode of choice for acute hospitals, this would lead to hours of restraint for a patient with an eating disorder who was resisting this intervention. The guidelines reflect that patients with eating disorders can safely tolerate larger boluses of fluid through their NGT tube and via the quicker method of a push syringe bolus which will entail far less restraint. Furthermore, a recently published case study paper gives examples of when a patient may require NGT feeding under restraint for lifesaving circumstances.

Neiderman et al. assessed the reactions of both parents and patients to NGT feeding under restraint. They found that the experience still evoked strong reactions. At the same time, 66% of patients and 73% of parents viewed the use of NGT feeding as an unfortunate necessity. Some patients saw the use of this intervention as the first step forward in their treatment, whereas others considered it unhelpful but not detrimental. The research explored potential alternatives to the use of NGT feeding for example, giving more time to complete meals or giving small amounts of food, and 67% and 84% of patients and parents did not consider that any of the suggested alternatives to the use of NGT feeding would be effective or helpful. This underlines the patients' and parents' views of the necessity of NGT feeding under restraint for some.

Although the work we have done is in the under-18 group we would like to suggest that most of it is equally applicable to adults.

We suggest that to deliver safe and ethical practice, the key issues regarding NGT feeding under restraint are:

1. Clinical necessity – that it should be done only when there is a clinical need, rather than because a patient has failed to follow inpatient rules about eating. Examples of clinical parameters to use are low blood sugars, low heart rates and low blood pressure.
2. Least restrictive option considerations – NGT feeding under restraint is highly coercive and restrictive and there should be a clear lack of other options for the necessary nutrition. For example, if the patient would eat if given more time and support, that should be preferred as a less restrictive option.
3. Staff consensus and solidarity – all staff need to be informed of likely NGT feeding under restraint and achieve consensus so as to contain distress and minimise likelihood of 'splitting' within teams.
4. Always calmly negotiate – clear communication of reasons that nutrition is now imperative and provide options before deciding to NGT feed under restraint.
5. Compassionate discussion of the procedure and the reasons for it with patients and families who need to be clearly informed of why, how and when the procedure will take place.
6. Delivery of NGT feeding under restraint with dignity, ensuring privacy from other patients. Talking to patient throughout process about what is happening and what to expect next.
7. Offering of alternative, less coercive, means of nutrition. Patients should understand that at any time they can choose to receive their nutrition in a less coercive way, for example voluntarily through an NGT, orally via a sip feed or oral diet.

8. Minimise coercion – restraint should be carefully graded (for instance, hand holding if possible, rather than holding down, use of soft surfaces to reduce force of restraint).
9. Restraint always delivered by appropriately trained mental health personnel in adequate numbers, with NGT feeding is also delivered by an experienced health professional who is familiar with the protocol for amounts and rate of delivery in line with the BDA's guidlines.
10. Respect for patients' and families' as well as staff distress by providing opportunity to discuss and ventilate as well as obtain support and reflect afterwards.
11. Regularly review need for NGT feeding under restraint. NGT feeding under restraint should be provided as few times as needed. Clinicians should review the need for this regularly together with patients and families and constantly review what the clinical necessity and exit strategy is.

Conclusion:

NGT feeding under restraint is an unfortunate but occasionally necessary measure that may be needed for severely ill patients on inpatient units. It is important that this is delivered in a consistent, compassionate manner which minimises its use and minimises the coercion and restraint needed. The BDA has published guidelines on the consensus for best practice across the UK and Ireland.

References:

Fuller SJ & Philpot U. (2020) The development of consensus-based guidelines for dietetic practice in nasogastric tube feeding under restraint for patients with anorexia nervosa using a modified Delphi process. J Hum Nutr Diet. https://doi.org/10.1111/jhn.12731

Falcoski P., Philpot U., Tan J., Hudson L.D. & Fuller S.J. (2020) Nasogastric tube feeding in line with new dietetic guidelines for the treatment of anorexia nervosa in a specialist children and adolescent inpatient unit: a case series. J Hum Nutr Diet. https://doi.org/10.1111/jhn.12765

Fuller SJ, Scott O, Nicholls D et al. (2019) Enteral feeding young people with anorexia nervosa under restraint in inpatient settings. Br J Mental Health Nurs 8, 124-128. https://doi.org/10.12968/bjmh.2019.8.3.124

Royal College of Psychiatrists (2012) 'Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa' CR168. Psychol Med 41, 2177-2182.

Neiderman M, Farley A, Richardson J et al. (2001) Nasogastric feeding in children and adolescents with eating disorders: towards good practice. Int J Eat Disord 29, 441. https://doi.org/10.1002/eat.1040

Tan JO, Hope T, Stewart A et al. (2003) Control and compulsory treatment in anorexia nervosa: the views of patients and parents. International journal of law and psychiatry. Int J Law Psychiatry 26, 627-645. https://doi/10.1016/j.ijlp.2003.09.009

Tan JO, Hope T, Stewart A et al. (2016) Competence to make treatment decisions in anorexia nervosa: thinking processes and values. Philos Psychiatry Psychol 13, 267.

Sarah Fuller Pg Dip, BSc (Hons), RD Advanced Specialist Eating Disorders Dietitian
East London Foundation Trust
Bedfordshire & Luton CAMHS Eating Disorders Team

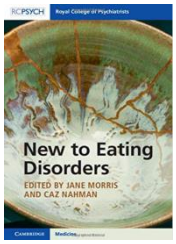
Dr Jacinta Tan
Consultant Child and Adolescent Psychiatrist
Specialist Child and Adolescent Mental Health
Aneurin Bevan University Health Board
Welsh Representative to the Faculty of Eating Disorders

Books

I am delighted to be able to share with you, two new books published by Cambridge University Press, written and edited by colleagues from our own Faculty, and from the College's Sports and Exercise Psychiatry Special Interest Group. Both are available through the CUP website. Editors of both books have kindly provided these summaries of their books.

New to Eating Disorders, Edited by Jane Morris & Caz Nahman

Summary by Dr Caz Nahman



This book was published in June 2020. It is a result of a long-term project from the Royal College of Psychiatrists Eating Disorder executive committee. We wished to develop a resource that would be useful for trainees and professionals new to working within the eating disorders field. We are aware that widely, many health professionals have poor knowledge and training of these illnesses and this contributes to lack of recognition, lack of adequate risk assessment and poorer outcomes for patients.

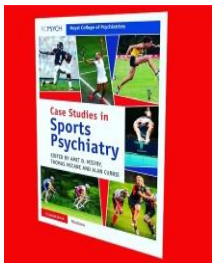
The book is designed to provide a structured framework for clinical supervision sessions with 12 short, easy to read chapters, with links to further reading. The book was trialled with junior doctors, psychology trainees, occupational therapists and other allied health professionals. They felt it helped guide supervision as well as improve knowledge, confidence and approaches to both assessment and patient engagement.
We have tried to make it clinically applicable and practical with many case vignettes – all anonymised, but representing similar stories to many patients we have worked with in the past. We have also emphasized the importance of bringing it all together – formulation, risk assessment and treatment.

Going forward we would like to trial running an online supervision group – we haven't finalised the format or who might wish to join. The group may involve up to 12 professionals interested in learning more about eating disorders and 2 professionals to facilitate. The hope is that to could be offered on an evening, once a week. The only requirements would be to have a copy of the book; to be prepared to lead one of the 12 sessions and to fill out some monitoring about the group. Several members of the executive committee have expressed interest in sharing their time – so watch this space and do let us know if you're keen.

The book is available from Cambridge University Press website and costs £19.99. There is also a blog post on the book's web page

Case Studies in Sports Psychiatry, Edited by Amit D Mistry, Thomas McCabe & Alan Currie

Summary by Amit Mistry



Executive members of the RCPsych Sport & Exercise Psychiatry Special Interest Group (@RCPsych_SEPSIG) led by their new chair Dr Amit D Mistry (@DrAMistryPsych), Dr Thomas McCabe and Professor Alan Currie have recently published the first ever case study book in sports psychiatry called, "Case Studies in Sports Psychiatry". This has been co-authored by leading international Sports Psychiatrists, Sports Medics and Professional Athletes themselves.

Each chapter runs through a typical sport-psychiatric consultation and then gives the reader five MCQ's based on the International Society of Sports Psychiatry (ISSP) curriculum. These include questions related to mental health diagnosis, investigations, biopsychosocial management, ethical themes and potential cultural challenges. In relation to eating disorders within CAMHS and general adult populations, the book covers two typical cases related to disordered eating, exercise addiction and Relative Energy Deficiency in Sport (REDS) often seen in swimmers and endurance athletes.

The book retails at £29.99 although if purchased through www.cambridge.org/9781108720557 with code RCPSYCH at checkout, one can purchase for £23.99. Alternative sources include Amazon online and Waterstones.

Assessing decision making capacity in eating disorders

Dr Jacinta Tan, Aneurin Bevin University Health Board

In five legal cases heard within a short span of time in the Court of Protection of Wales and England, judges reached different conclusions as to whether continuing compulsory treatment and refeeding without consent was in the best interests of patients suffering from severe and life threatening eating disorders.(1) All the judges, however, were unanimous that these five patients all lacked capacity to make decisions about their treatment. In all cases, even in extremis of malnourishment and physical compromise, the patients were found to understand the information and communicate a decision. Nevertheless all five judges found that the anorexia nervosa made them unable to use and weigh the information and they therefore lacked capacity. These rulings make it clear that capacity in eating disorders can be, and perhaps even often is, a problematic issue when people have severe anorexia nervosa. These particularly severe cases of anorexia nervosa in extremis have had a major impact on clinical practice in England and Wales. Since then, anecdote suggests that NHS lawyers advise clinicians in England and Wales not to bring cases to court unless there is conflict, the cases are interpreted as showing that patients can often lack capacity, and best interests can be decided by consensus between healthcare professionals and families in the situation where patients lack capacity and object to their treatment. Capacity, therefore, is now an pivotal issue where we are considered to have sufficient legal predecent to guide clinical practice, and clinicians must therefore become familiar with the legal and ethical issues surrounding capacity.

Laws vary across the world, as do legal definitions of capacity. In this article, I will focus on principles and restrict the discussion to the United Kingdom and specifically England and Wales, for simplicity; my hope is that the reader might be able to apply the principles to their own local context with adjustments for their own legislation. Please note that 'decision-making capacity' may also be called 'competence' in other countries, such as the USA. Although the research and legal cases cited involve anorexia nervosa in particular, it is possible and even likely that people who have other eating disorders may also suffer from similar difficulties in capacity.

As mental disorders, eating disorders falls under both the scope of both mental health and mental capacity legislation in England and Wales. On the one hand the Mental Health Act 2007 could be used to deliver treatment of a mental disorder (but not of other unrelated medical conditions) without a patient's consent if there is a significant risk posed to the individual (or others), without reference to capacity. The Mental Health Act Commission and subsequently the Care Quality Commission have clarified that re-feeding constitutes treatment of an eating disorder under the meaning of the Mental Health Act in England.(2) On the other hand, the Mental Capacity Act 2005 in England and Wales and the Adults with Incapacity (Scotland) Act 2000 allow decision-making by others regarding treatment and other aspects of life in the best interests of a person, if that person lacks capacity. A new Mental Capacity Act (NI) 2016 was slated to

come into operation on 2 December 2019 in Northern Ireland, so the situation is complex and in transition at present.(3)

With the availability of mental health legislation, why would we need to assess capacity and look to use mental capacity legislation? There are (at least) three scenarios where this might be useful:

1. Where the disorder is considered by clinicians to be untreatable and they need to decide whether to accede to patient refusal of treatment, nutrition or life-sustaining measures;
2. Where the disorder may be treatable but there is doubt in the clinical team about whether formal compulsory treatment is appropriate, so knowing capacity status can guide the team as to how much weight they should give to patient decisions which may not be in their own best interests;
3. Contentious cases, for instance prolonged use of mental health legislation, where the assessment of capacity may help inform clinical and tribunal decisions.

The definition of incapacity varies between different legal jurisdictions (see text box at the end of this article for current definitions applying to the United Kingdom). Grisso and Appelbaum in the USA developed the MacCAT-T instrument of competence which conceptualises capacity as: Understanding, Retention, Appreciation, and Reasoning (comparative and consequential).(4) Importantly, the mental capacity laws applying in England, Wales and Scotland require that incapacity arises from disturbances of mind, which includes mental disorder. Studies have shown that there are high rates of incapacity amongst inpatients in acute general medical and psychiatric wards. (4–6) Worse still, however, psychiatrists and in particular physicians often fail to detect patients' incapacity.(4,7,8)

In some cases of mental disorder, it is evident that a person lacks capacity, for example if a patient is floridly thought disordered from schizophrenia or severely cognitively impaired from dementia. In eating disorders, however, sufferers typically have the ability to understand and retain information, and indeed many possess an impressive knowledge of their illness and its risks. Furthermore, many of them can continue to function at fairly high levels in other domains such as academic studies or financial management, yet their decision making regarding treatment of eating disorders may raise doubt.

There are many ways in which eating disorders may affect the ways in which, or the reasons *for* which, people with eating disorders might make decisions about whether or not to accept treatment. Any assessment of capacity therefore needs to be both thorough and nuanced to pick up more subtle but significant difficulties in decision-making. The application of the Mental Capacity Act in the five law cases suggests that the main difficulties are generally categorised under the broad criterion 'ability to use and weigh information'.(1) This criterion, however, is poorly defined within legislation and gives little guidance to the clinician in terms of how to assess this. A suggested format for assessment of capacity in eating disorders which should help clinicians to perform a full assessment of factors which may affect capacity is given below.

Format for the assessment of capacity in eating disorders

1. Assess ability to understand and retain information

Checking understanding and retention is fairly straightforward – disclosure can be followed by a request for the patient to repeat the information back in his or her own words. The MacCAT-T competence instrument provides a structured and systematic framework for doing this.(9) Where the assessment of capacity is legally important to document clearly systematically, it is advisable to use this or a similar standardised and well structured approach.

2. Assess ability to use information

This can be assessed in the course of the discussion and by asking the patient for his/her reasons for the decision as well as to generate possible consequences for each option, as provided in the MacCAT-T instrument - it should become evident whether the patient is able to use the information provided.(9)

3. Assess appreciation of information and facts of the decision

Appreciation, not seen in UK legislation but found in Grisso and Appelbaum's definition of competence, is the ability to apply the information to oneself. This can be a problem in eating disorders, for example, a patient may say, "I understand that's the definition of an eating disorder, I understand I have those features, and I understand eating disorders need treatment; but I do *NOT* have an eating disorder and therefore I do not need treatment". This clearly would affect capacity to make decisions about treatment for an eating disorder.

4. Assess presence of compulsion

Look for compulsions (or obsessions) that may prevent the patient from acting on the basis of his/her understanding or even desires. The Code of Practice of the Mental Capacity Act 2005 for England and Wales gives an example that patients with anorexia nervosa may be unable to 'use and weigh' treatment information as part of the decision-making process: "For example, a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore." (MCA Code of Practice, 4.22)(10)

5. Assess for changes in values due to the eating disorder

It is part of the core criteria of anorexia nervosa that a person should either have a fear of fatness, or an overvaluing or pursuit of thinness. This dread of fatness and overvaluing of thinness, found in many eating disorders, means that being thin or losing weight becomes disproportionately highly valued by sufferers, in some cases this is even valued above life itself. This disproportionate value can drive some patients to decide, even after they have weighed up the options, not to have treatment because they would rather die than gain weight.(11)

6. Assess for changes in identity due to the disorder

One of the characteristics of eating disorders is that they can be egosyntonic disorders, that is, experienced as part of the self and also consistent with one's own values. Further, many people with eating disorders become ill as adolescents, and may as adults have little or no sense of who they would be without the disorder. This intertwining of the disorder with the sense of self can make it difficult to decide to have treatment in order to recover from it; for example, patients may be either unable to envisage a self without eating disorders.(12–14)

7. Assess for depressive features, loss of hope and affective elements

Eating disorders have clear effects on emotion and mood; there is a high rate of comorbidity of depression. It is important to assess for depressive features and particularly for suicidality, more covert wishes for death (for example, wanting to die thin) and inability to envisage or hope for recovery, all of which would affect how options are weighed. Charland and colleagues further argue that beyond comorbid depressive disorder, anorexia nervosa itself may have clear affective components, fitting Ribot's historical conception of a 'passion' in its very nature. These components include having a fixed focus and intrinsic motivational force and attachment; these may drive patients towards certain options and have an impact on decision-making.(15)

Conclusion

There are several ways in which eating disorders can affect decision-making. This does not mean, however, that all patients who have eating disorders lack capacity. It also does not mean that all patients who have eating disorders should be compelled to have treatment, though it should be borne in mind that patients themselves favour compulsory treatment in order to save life.(16) Capacity must always be assessed at the time for the decision at hand. The assessment of capacity requires a careful and systematic approach, but as the MacCAT-T instrument acknowledges, even with formal instruments, in the end the judgement of the presence or absence of capacity is a clinical, global judgement.

Legal definitions of incapacity or capacity within the United Kingdom

Definition of incapacity in England and Wales (Mental Capacity Act 2005):
The inability –
(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means)"

Definition of incapacity in Scotland (Adults with Incapacity (Scotland) Act 2000)**:**
A person who is not capable of –
(a) acting; or
(b) making decisions; or
(c) communicating decisions; or
(d) understanding decisions; or
(e) retaining the memory of decisions.

Definition of incapacity in Northern Ireland (Mental Capacity Act (Northern Ireland) 2016):
Meaning of "unable to make a decision"
4.—(1) A person is "unable to make a decision" for himself or herself about a matter if the person—
(a) is not able to understand the information relevant to the decision;

(b) is not able to retain that information for the time required to make the decision;
(c) is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or
(d) is not able to communicate his or her decision (whether by talking, using sign language or any other means.

Jacinta Tan
Consultant Child and Adolescent Psychiatrist, Aneurin Bevan University Health Board, Wales
Welsh representative to the Royal College of Psychiatrists' Faculty of Eating Disorders
Committee Member, the Royal College of Psychiatrists' Professional Practice and Ethics Committee.

References

1. Cave E, Tan J. Severe and enduring anorexia nervosa in the court of protection in England and Wales. Cave, Emma Tan, Jacinta (2017) Sev Endur Anorex Nerv Engl Wales Court Prot Int J Ment Heal Capacit Law [Internet]. 2017;23(17):4–24. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3075225
2. The Care Quality Commission. Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983 [Internet]. London; 2011. Available from: https://www.bl.uk/collection-items/guidance-on-the-treatment-of-anorexia-nervosa-under-the-mental-health-act-1983
3. Department of Health for Northern Ireland. Mental Capacity Act Legislation [Internet]. 2019 [cited 2020 May 16]. Available from: https://www.health-ni.gov.uk/mental-capacity-act-legislation
4. Appelbaum PS, Grisso T. The MacArthur treatment competence study. I: Mental illness and competence to consent to treatment. Law Hum Behav. 1995;19(2):105–26.
5. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med. 2007;357(18):1834–40.
6. Lapid MI, Rummans T a, Poole KL, Pankratz VS, Maurer MS, Rasmussen KG, et al. Decisional capacity of severely depressed patients requiring electroconvulsive therapy. J ECT. 2003;19(2):67–72.
7. Raymont V, Bingley W, Buchanan a., David a., Hayward P, Wessely S, et al. Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. Lancet [Internet]. 2004;364(9443):1421–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15488217
8. Owen GS, Richardson G, David AS, Szmukler G, Hayward P, Hotopf M. Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. BMJ. 2008;337(August):a448.
9. Grisso T, Appelbaum PS. Assessing Competence to Consent to Treatment. Oxford: Oxford University Press; 1998. 224 p.
10. Office of the Public Guardian. Mental Capacity Act Code of Practice [Internet]. London; 2016. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

11. Tan JOA, Stewart A, Fitzpatrick R, Hope RA. Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values. Vol. 13, Philosophy, Psychiatry, & Psychology. 2007. 267–282 p.
12. Tan JO a, Hope T, Stewart A. Anorexia nervosa and personal identity: The accounts of patients and their parents. Int J Law Psychiatry. 2003;26(5):533–48.
13. Hope T, Tan J, Stewart A, Fitzpatrick R. Anorexia nervosa and the language of authenticity. Hastings Cent Rep [Internet]. 2005;41(6):19–29. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22253066
14. Craigie J, Hope T, Tan J, Stewart A, McMillan J. Agency, ambivalence and authenticity: the many ways in which anorexia nervosa can affect autonomy. Int J Law Context [Internet]. 2013;9(1):20–36. Available from: 10.1017/S1744552312000456%5Cnhttp://ezproxy.net.ucf.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=85634068&site=ehost-live
15. Charland LC, Hope T, Stewart A, Tan J. Anorexia Nervosa As A Passion. Philos Psychiatry, Psychol. 2012;Forthcomin(4):353–65.
16. Tan JO a, Stewart A, Fitzpatrick R, Hope T. Attitudes of patients with anorexia nervosa to compulsory treatment and coercion. Int J Law Psychiatry [Internet]. 2010;33(1):13–9. Available from: http://dx.doi.org/10.1016/j.ijlp.2009.10.003

Future Events & Notices

Faculty Annual Conference

Note from Dr Matthew Cahill, Academic Secretary

This is quite a challenging time at the moment for me as Academic Secretary given the lockdown situation. The conferences have moved to online webinars which is a new concept for the College, as well as the Faculty. There is a lot of work going on to try to maintain the delivery of high quality presentations and education, with the technology to cope with the demand.

But on a positive note, it may allow us to reach people and places which we couldn't before. By offering a remote conference, we are able to reduce the cost, which may allow more trainees, service users and carers to join, as well as an increased international audience.

The Faculty subgroup is working hard to advertise the event, as well as trying to secure speakers and presenters. The title of the conference is 'Enhancing Treatments and Improving Outcomes' and will run from Thursday 5 November to Friday 6 November. We are attempting to deliver a two day conference, with live events, pre-recorded presentations, and posters. The first day will focus on Trauma and Eating Disorders, and the second day on Barriers to Recovery and Novel Treatments. We are gathering momentum as we speak.

We have a dedicated and motivated team working hard to create this, in order to make it more successful than our conferences have ever been, but we are in unchartered waters. Any support from the faculty would be hugely appreciated, particularly if you have something to present, either live, or as a pre-recorded video. Please get in touch with me.

Call for BJPsych Advances Editorial Board members

Would you like to take an active role in deciding the future direction of BJPsych Advances, the Royal College of Psychiatrists' CPD journal for Consultant Psychiatrists? We are looking for new board members to join the BJPsych Advances Editorial Board and would be pleased to hear from you. We specifically welcome applications from people with expertise in one or more of the following areas: Perinatal Psychiatry; Eating Disorders; Old Age Psychiatry. We also particularly welcome applications from consultant psychiatrists based in Canada and New Zealand as we wish to encourage new authors and readership in these areas.

About BJPsych Advances

BJPsych Advances distils current clinical knowledge into a single resource, written and peer-reviewed by expert clinicians to meet the CPD needs of consultant

psychiatrists. Each issue includes commissioned articles dealing with physical and biological aspects of treatment, psychological and social interventions, management issues and treatments specific to the different psychiatric subspecialties. Articles typically discuss comprehensive, practical approaches to clinical problems and explain the full range of therapeutic options, with useful features like MCQs, summary boxes, and associated commentaries. BJPsych Advances is essential reading for practising mental health professionals who need to be kept informed of current ideas, techniques and developments in psychiatry.

https://www.rcpsych.ac.uk/members/posts-for-members/detail/bjpsych-advances-call-for-new-editorial-board-members

Schema Therapy for Eating Disorders & Complex Comorbidity

Online interactive (zoom) workshop

Presenter: Dr Susan Simpson 3 & 4 September 2020

This workshop will provide therapists with an opportunity to learn powerful techniques for working with these populations, including those with high complexity and comorbidity (e.g. OCD, rigid personality traits, PTSD). Anyone interested in knowing how to implement schema therapy using mode work with severe and complex eating disorders, would benefit from this workshop. This workshop will train participants in implementing techniques for working with entrenched core beliefs with eating disorders and complex comorbidity. You will also have an opportunity to learn some ways of adapting schema therapy for eating disorders in a group context.

The workshop will offer you methods to cope with these challenging situations and will include:

- Methods to formulate complex eating disorder thoughts, behaviours, urges, & comorbid disorders using schema 'modes'
- Imagery & chair-work to set limits on self-defeating 'inner critic' mode
- Recognise & learn to work with common coping modes in Eating Disorders including: Flagellating &, Invincible Overcontroller modes, and Helpless Surrenderer modes
- Imagery rescripting. empathic confrontation & chair-work to bypass strong coping modes, especially the 'Overcontroller' and 'Detached Self-Soother' modes
- Working with clients who are reluctant to participate in experiential work & to connect with emotions.
- Methods to access vulnerability & distress in eating disorders.
- Enhancing client's Healthy Adult mode

- The latest evidence-base for Schema Therapy with Eating Disorders & common comorbidities

http://www.schematherapyscotland.com/courses/schema-therapy-working-with-eating-disorders-complex-comorbidity/

The Linda Tremble Foundation

Community support for people and families affected by eating disorders

The Linda Tremble Foundation is a charity which provides support in the community to people with eating disorders and their families. We run support meetings in Fife, Glasgow, Perth and Stirling as well as Zoom calls during Coronavirus and are aiming to expand into Edinburgh and other areas of Scotland.

We are seeking volunteer Board members to join a forward looking and inclusive organisation in supporting the strategic direction and development of the charity's service delivery. We help to provide early intervention as well as supporting those who need support over the longer term.

This rewarding role is an opportunity to increase your transferable skills and join a strong and friendly team of trustees and Development Manager with diverse and complementary skills.

We are particularly seeking professionals with experience of treating people and families affected by eating disorders. If you are interested in learning more, please contact Andrew Macmillan on 01337 828727.