Involuntary Treatment of Minors with Severe and Enduring Anorexia Nervosa

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Anorexia nervosa is among the most lethal of all psychiatric illnesses and is increasingly prevalent in children and adolescents. There are limited treatment options specifically for youth with severe and enduring illness who decline treatment. Although treatment guidelines increasingly favor outpatient family-based treatments, there is a continued role for inpatient psychiatric treatment and involuntary commitment for high-risk patients. Providers may be reluctant to pursue involuntary treatment given its controversial nature, and differences in state's commitment laws complicate the development of clear guidelines for this approach. If parents also oppose treatment, providers must consider involving the child welfare system while balancing the impact of terminating parental rights upon long-term treatment outcomes. The case example of an adolescent with severe and enduring anorexia nervosa who opposed involuntary treatment, as did the legal guardian, highlights Washington's unique mental health laws for minors, which allow for temporary suspension of patient and guardian decision-making authority without terminating parental rights. The article discusses the ethics of involuntary treatment, the intersection of anorexia nervosa with the child welfare system, legal cases establishing commitment criteria for anorexia nervosa, and Washington's mental health laws for minors to inform the treatment approach for high-risk adolescents with severe and enduring anorexia nervosa.

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Anorexia nervosa is a severe chronic illness with significant morbidity and mortality.[1,2] It is among the most lethal psychiatric illnesses due to the elevated risk of suicide and medical complications directly related to the illness.[1] The peak incidence of anorexia nervosa is in adolescence, and recent epidemiological evidence indicates that the peak age of onset has decreased over the last few decades to between 12 and 15 years of age, along with a rise in the overall prevalence of the disorder among juveniles.[2] While the diagnostic criteria for anorexia nervosa remain the same regardless of age, children and adolescents are likely at increased risk of consequences compared with adults with an equal percentage of body weight lost.[2] These complications include devastating and often irreversible impacts on physical growth, sexual development, brain maturation, cardiac function, and the gastrointestinal system.[2–7] With the additional multifactorial impact of genetic loading and psychosocial risk factors on medical complications, anorexia nervosa, like other mental illnesses, has worse outcomes with an earlier onset and longer duration of illness.[2,8] Treatment outcomes for children and adolescents are also worse than in adults, with limited research in children under 12.[2] While there is some variation depending on the study, only 50 percent of children and adolescents make a full recovery, while the remaining patients are split between partial recovery and continued severe illness as physical and psychosocial function deteriorate exponentially.[2]

The ego-syntonic nature of anorexia nervosa often limits insight to a level that resembles delusional thinking. Because children may not be developmentally capable of abstract thinking until approximately age 12 and many executive processes continue to develop until early adulthood, anorexia nervosa in children can be even more challenging to treat than in

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adolescents or adults.[2,9–13] There are no approved medications to treat anorexia nervosa and no recommended psychotherapeutic techniques specifically for children under 12.[2,13–15] Several psychotherapeutic treatments have been developed and show benefit, but none have been established as a clear treatment of choice; a 2018 metanalysis of 18 randomized controlled trials of psychotherapeutic treatments for anorexia nervosa in adolescents and adults did not demonstrate that any one treatment approach was superior to another.[8] Determining the optimal treatment setting has proved similarly difficult; a 2019 Cochrane review comparing inpatient, partial hospitalization, and outpatient settings found insufficient evidence that any one setting was superior to another for treating anorexia nervosa.[16]

Family Role in Adolescent Anorexia Nervosa

There is agreement on the need to involve parents in the treatment of children and adolescents with anorexia nervosa.[2,17,18] The idea of family having a central role in eating disorders dates back to the 1870s, beginning with the belief that parents of adolescents with anorexia nervosa had pathologic tendencies and were a hindrance to treatment.[17–20] In the conceptual shift that began in the 1960s regarding the role of the family in eating disorders, treatment approaches have gone away from "parentectomies" and long-term inpatient hospitalization in favor of outpatient, family-based approaches. The theoretical models suggested by Hilde Bruch, Salvador Minuchin, and others posited specific family mechanisms underpinning the development of anorexia nervosa, which could be targeted by treatment.[17,21,22] The "psychosomatic family" model developed by Minuchin hypothesized that the prerequisite for the development of anorexia nervosa was a family process characterized by rigidity, enmeshment, over-involvement, and conflict avoidance. This occurred alongside a physiological vulnerability in the child and the child's role as a go-between in cross-generational alliances. Minuchin did not blame the parents for causing their child's illness, instead suggesting that the psychosomatic model is a necessary context for the development of anorexia nervosa and thus the aim of treatment is to change the way the family functions.[17]

Although Minuchin's psychosomatic family model has not been replicated in research, suggesting that families of patients with eating disorders are heterogeneous, his belief in the family's already possessing the necessary tools to treat their child's illness endures in family-based interventions.[17,22,23] The role of dysfunctional family dynamics in worsening and perpetuating psychiatric illnesses has also been well established.[22,23] While the psychosomatic family model may not accurately describe the majority of families of youth with anorexia nervosa, such dynamics are still described in case reports, along with the novel and at times paradoxical interventions providers employ to treat refractory cases. As illness severity and chronicity worsen, disordered eating behaviors may also evolve within the context of a dysfunctional family system, making the illness more difficult to treat.

Family-based treatment has the largest evidence base for the treatment of adolescent anorexia nervosa and is recognized as the preferred approach by many national and international bodies.[18] This makes logical sense when considering that, while hospital-based treatment can safely refeed and restore weight, the environment is not reproducible and many patients are unable to apply what they learn in hospitals to their home environments. This helps explain why patients often quickly lose weight immediately after discharge and have high rates of rapid re-hospitalization.[18] Many eating disorder treatment programs emphasize parent education about nutrition and refeeding strategies as their children progress through treatment, regardless of the treatment setting.

Inpatient Treatment of Anorexia Nervosa

Despite the large evidence base for outpatient family-based treatment of anorexia nervosa, there is a continued role for inpatient psychiatric treatment of anorexia nervosa.[18,24] There are accepted criteria in several countries for when to hospitalize adolescents with anorexia nervosa on a medical basis, as well as best practice guidelines for managing medical comorbidities, nutritional deficits, weight restoration, and medication management.[3,4,8,13–15,18,24–28] There are also proposed criteria and treatments for severe and enduring anorexia nervosa: a persistent state of dietary restriction, being underweight, and overvaluation of weight and shape with functional impairment; duration of anorexia nervosa for more than three years; exposure to at least two evidence-based treatments appropriately delivered; and a diagnostic assessment and formulation incorporating an

assessment of the patient's eating disorder, health literacy, and stage of change.[29–31] Given the wide variation in inpatient facilities, there is less clarity on best practices for therapeutic interventions for adolescents with anorexia nervosa in a psychiatric inpatient unit.[18] Studies have not yet established which adolescent patients may benefit from specific treatment modalities and settings, or which treatments may be most helpful for adolescents with severe and enduring anorexia nervosa.[8,18,31]

The hospital remains the only setting in which emergent care can be provided while the patient is monitored for acute medical problems during refeeding, and the inpatient psychiatric unit is often the only setting able to manage complex psychiatric comorbidity and offer involuntary treatment, if needed. While involuntary treatment is reserved for patients that do not respond to less restrictive treatment modalities, it remains an option for patients with a significant safety risk.[1,18,24,32–38] Some providers may be reluctant to utilize civil commitment to treat anorexia nervosa for a variety of reasons; however, the life-threatening nature of the illness increases the risk of adverse outcomes with an unassertive approach.[1,32,33,35] It is difficult to determine mental capacity for consent to treatment in patients with anorexia nervosa compared with other mental illnesses.[39] Many patients are intelligent and self-disciplined, present themselves as credible witnesses during court proceedings, and provide rational explanations for their disordered eating behaviors.[1] At the same time, they are often resistant to treatment, have minimal insight into their illness, and demonstrate irrational behavior in the context of significant morbidity and mortality risk.[40] Patients with anorexia nervosa have been shown to demonstrate difficulties in thought processing and in changing unhealthy values (e.g., associating "fatness" with being undesirable and having low self-worth, placing paramount importance on losing weight and being thin, placing minimal importance on the risk of serious medical problems and death, and holding positive views of anorexia symptoms and their impact on personal identity), which may not be captured with common assessment strategies.[39] The few studies on this topic report conflicting findings on whether this population is more or less likely to lack capacity even when using standardized assessment tools.[39–41] Assessing for capacity among adolescents presents added challenges, given age-dependent variations in cognitive development.[33,35,42,43] Regional differences in civil commitment laws may present an additional barrier to establishing more specific guidelines for involuntary treatment for adolescents with anorexia nervosa.

Laws Governing Treatment of Minors

A 2015 study examining the laws pertaining to inpatient and outpatient mental health and substance treatment in the United States reported that only 18 states were consistent in consent requirements across treatment type and modality.[44] Twenty-one states did not allow a parent or legal guardian to psychiatrically hospitalize a minor without the minor's consent. Eleven states granted minors this right before the age of 16, and four states did not specify an age.[44] Although laws may have changed in the past five years, it remains true that the legal requirements for minor consent to mental health treatment vary considerably between states. There is little research investigating the strategy of involving other systems to compel a minor into treatment.[44]

The state of Washington grants minors 13 years and older voluntary access to psychiatric treatment without guardian consent while allowing guardians to involuntarily hospitalize those minors who refuse treatment.[45] Table 1 contains an overview of these two treatment options. Washington also allows for court-mandated involuntary psychiatric treatment without guardian consent while preserving custodial rights through the Involuntary Treatment Act, which is outlined in Table 2.[45]

The following case illustration describes an adolescent patient with chronic, severe, and treatment-refractory anorexia nervosa. To overcome the patient's own treatment resistance and the family system that helped maintain the illness, the treatment providers utilized involuntary commitment to restore the patient's health on an inpatient psychiatric unit. The case is written to describe a common sequence of medical, legal, and historical events seen in the use of the Involuntary Treatment Act.

Involuntary Treatment Act Case Example

Ms. X received a diagnosis of anorexia nervosa in early adolescence after struggling with disordered eating and body image since childhood. She was hospitalized multiple times during her adolescence for stabilization and refeeding and failed to respond to all levels of step-down treatment due to treatment refusal. Her anorexia nervosa persisted, in part, because

Table 1 Inpatient Treatment Laws for Minors in Washington State

Minor-Initiated Treatment (Voluntary[a])	Family-Initiated Treatment
• Minor can self-admit to inpatient facility without guardian approval if clinician in charge of facility agrees admission is medically necessary and is the least restrictive option. • Upon admitting minor, facility must notify minor's guardians within 24 hours. • Minor may request discharge at any time, in writing, and must be discharged within two judicial days of request (unless admission status changes). • Minor can consent to psychiatric medications without guardian approval, and guardian cannot compel the minor to receive psychiatric medications without guardian approval	• Guardian can bring minor to inpatient facility and request minor be admitted and evaluated to determine whether the minor has a mental disorder and whether inpatient treatment is medically necessary. ◦ Evaluation must be completed within 72 hours; treatment is limited to minimum required for stabilization and evaluation. ◦ Minor's consent is not required for admission or evaluation. ◦ If evaluation indicates inpatient treatment is medically necessary, the minor may be held for treatment. • Independent evaluator must review admission to ensure it is medically necessary between 7 and 14 days of admission. ◦ If not medically necessary, facility must release minor to guardian within 24 hours of notification ◦ If medically necessary, minor may petition court for release 5 days after initial evaluation completed. • Minor must be released within 30 days[b] of either: ◦ Notice of independent evaluation results ◦ Minor's filing of petition for release • Minor can consent to psychiatric medications without guardian approval, and guardian cannot compel the minor to receive psychiatric medications without minor's consent

From Washington State Legislature Chapter 71.34 RCW: Behavioral Health Services for Minors, 2020.
[a] Children under 13 may only be admitted for inpatient mental health treatment with the consent of their guardian and are not subject to the Involuntary Treatment Act.
[b] In the absence of civil commitment.

her legal guardian did not enforce the treatment recommendations when she declined, waiting until emergent medical treatment was required to bring her to the hospital. As Ms. X's illness progressed, she developed chronic medical comorbidities and worsening psychosocial dysfunction.

Ms. X, now approaching adulthood, again required hospitalization for medical stabilization and refeeding. Since the onset of her illness, Ms. X had not significantly changed in height or weight, while many of her medical comorbidities had progressed to an irreversibly critical stage. Following brief medical stabilization, Ms. X was involuntarily transferred to the inpatient psychiatry unit under family-initiated treatment (Table 1). She did not engage in treatment and declined prescribed medications. She also declined transfer to specialized treatment facilities, and her legal guardian declined to pursue a transfer without her consent. Her hospitalization eventually surpassed the maximum number of days allowed under family-initiated treatment, and she did not consent to continued hospitalization under minor-initiated treatment. As Ms. X remained acutely ill and had declined less restrictive treatment options, the hospital pursued continued court-mandated treatment and compelled medication under the Involuntary Treatment Act due to grave disability. Following initiation of a 72-hour detainment and evaluation by two licensed providers, Ms. X was compelled to receive antipsychotic medication. After an adversarial hearing, the judge ruled in favor of the hospital in detaining the patient on a 14-day hold for grave disability and scheduled a hearing for a 180-day commitment upon completion of the 14-day detainment. Ms. X and her legal guardian subsequently requested transfer to a specialized facility for eating disorder treatment. The hospital allowed for this transfer prior to completion of the 14-day detainment under the Conditional Release clause of the Involuntary Treatment Act.[45] At the time of transfer, Ms. X had reached her highest recorded weight since the onset of her illness and displayed markedly improved treatment engagement, attributed to compelled antipsychotic medication treatment.

Discussion

Ethics of Involuntary Treatment

This case describes the continued role of involuntary inpatient psychiatric hospitalization in the

Table 2 Involuntary Commitment of Minor Children

Community	Inpatient Facility
• Treating mental health professional evaluates minor and determines the minor: ◦ Has a mental disorder ◦ Requires immediate inpatient treatment ◦ Does not consent to treatment • Minor is held up to 12 hours to allow evaluation by a designated crisis responder to commit the minor involuntarily to an inpatient facility. • Minor is evaluated within 24 hours of admission to facility[a] and is advised of rights within 12 hours of commitment.[b]	• Inpatient provider pursues involuntary commitment for a minor initially admitted under voluntary or family-initiated treatment: ◦ Treating provider writes petition for commitment and contacts CCORS.[c] ◦ CCORS representative evaluates patient and writes petition forcommitment. ◦ Treating provider contacts designated crisis responder to evaluatefor involuntary commitment. ◦ Designated crisis responder has until 5 P.M. of 2nd judicial day toevaluate patient for involuntary commitment. ◦ Minor advised of rights within 24 hours of commitment.
14-Day Commitment	
• If further inpatient treatment is believed to be necessary, facility may petition for a 14-day commitment hearing to be held within 72 judicial hours of initial commitment. • At a 14-day commitment hearing, evidence in support of petition is presented by the county prosecutor. • The minor has a right to representation by an attorney, may present evidence, may question or cross-examine witnesses, and may waive presence at hearing. • Guardians may oppose the petition and may be represented by an attorney (court-appointed if indigent). • For a 14-day commitment, burden of proof is on petitioners to demonstrate the minor: ◦ Has a mental disorder and as a result presents a "likelihood of serious harm" or is "gravely disabled" ◦ Requires the treatment provided by the petitioning inpatient facility or a less restrictive alternative treatment found to be in the best interests of the minor ◦ Is unwilling or unable in good faith to consent to voluntary treatment • Judge rules on the outcome of the hearing and advises minor of rights in closing remarks.[d]	
180-Day Commitment	
• If further treatment beyond the 14-day commitment is believed to be necessary, a petition for a 180-day commitment hearing[e] must be filed by the facility at least three days prior to the expiration of the 14-day order. • For a 180-day commitment, the court must find that the minor: ◦ Has a mental disorder and as a result presents a "likelihood of serious harm" or is "gravely disabled" ◦ Needs further treatment that only can be provided in a 180-day commitment[f] ◦ Less-restrictive treatment in the community is not appropriate or available[g,h]	

From Washington State Legislature Chapter 71.34 RCW: Behavioral Health Services for Minors, 2020.
[a] Minor's guardians are notified of detention and admission.
[b] Minors retain the same rights as adults (i.e., attorney representation, communication/visitation).
[c] Children's Crisis Outreach Response System.
[d] Once placed on a 14-day commitment, the minor preemptively loses the right to possess firearms at age 18.
[e] Minor and guardian rights during the 180-day hearing and the 14-day hearing are the same.
[f] Successive 180-day commitments are allowed (petition must be filed five days prior to expiration of previous 180-day commitment).
[g] Minor may be conditionally released under "least restrictive option" and subject to reasonable conditions, including outpatient treatment upon release; conditional release may be revoked if the minor fails to adhere to the conditions.
[h] A minor on a 180-day commitment automatically becomes eligible for admission to the state-funded Children's Long-Term Inpatient Program.

treatment of severe and enduring anorexia nervosa in adolescents. For patients experiencing severe illness resulting in significant morbidity and mortality risk, having involuntary treatment available as a last resort can be beneficial.

Involuntary treatment of anorexia nervosa is a controversial topic. Some clinicians advocate for expanding the use of involuntary hospitalizations for severely ill patients, given the high risk of adverse consequences including mortality.[1,32–35] Compulsory treatment is typically reserved for severe cases when an individual is at imminent risk of death at the time of admission, and it may be of critical importance in preventing death in patients with severe and enduring anorexia nervosa and psychiatric comorbidity.[1,32–35] Delayed treatment of children and adolescents can result in a variety of irreversible medical problems and psychosocial dysfunction, affecting family and peer

relationships, self-esteem, and education.[2,32] Proponents of involuntary admission assert that patients with anorexia nervosa are unable to appreciate the severity of their illness in part due to cognitive changes resulting from malnutrition and cite a lack of insight as a hallmark of this illness.[32,33,40] While a lack of insight may be more apparent in patients with other forms of severe mental illness, patients with severe anorexia nervosa have a similarly impaired quality of life compared with patients with severe depression or schizophrenia.[34] With children and adolescents, this lack of insight is compounded by developmental limitations; in general, providers utilize broader commitment criteria for minors and may struggle to accept a palliative care model for a treatable illness in a minor when detainment is an option.[1,42,43] Relying solely on parental consent of treatment to override an adolescent's treatment refusal may have a deleterious effect upon the parent-child relationship. Parents of adolescents with chronic, severe, and treatment-refractory anorexia nervosa are often physically and emotionally exhausted and may suffer significant psychosocial dysfunction as a result of their child's illness.[17] Parents are forced either to endure constant pressure from their child to avoid treatment by discharging from the hospital prematurely or to accept continued eating disorder behaviors at home, which helps perpetuate the illness.[35]

Complicating factors to consider in involuntary treatment of anorexia nervosa include the ambiguity surrounding the criteria for legal coercion and the considerable variation between regions, treatment facilities, and individual practitioners.[1,24,32–35,38,42,43] There are also clinical concerns regarding the humanity of coercive refeeding, the efficacy of involuntary psychotherapy, environmental differences between inpatient units and home resulting in limited generalizability between settings, and the role of the structured inpatient setting in allowing pathological behaviors such as rigid attention to detail and inflexibility to thrive.[1,18,32–35,38]

There are recognized similarities between substance use disorders and anorexia nervosa; the limited efficacy of involuntary substance use treatment is used as an example when suggesting a motivational interviewing framework for treating eating disorders, as motivation to change is essential for successful treatment.[32,35] While involuntary treatment for patients in the precontemplative stage can be beneficial, it could undermine the patient's engagement in treatment when they have progressed to ambivalence or active change along with the therapeutic alliance.[32] Providers who pursue involuntary treatment are likely to be opposed by the patient and family who are upset that the patient is being subjected to the indignity and lost autonomy of involuntary hospitalization, which can also be stigmatizing.[1,35,46,47] Outcome data comparing voluntary and involuntary treatment suggest minimal clinical differences between these populations, with the involuntary treatment group's longer average length of stay explained by higher acuity.[1,18,33,34]

Despite these complicating factors, multiple studies assert that involuntary treatment of patients with eating disorders is ethically and legally justifiable when the patient is at imminent risk of death from the medical complications of the disorder.[1,24,32–35,38,48] The literature has generally demonstrated that clinicians are more willing to employ involuntary treatment for children and adolescents when compared with adults, especially for younger patients at higher risk.[24,32,33,35,42,43] While the threshold for adults is typically an immediate risk of death from medical complications, the threshold for minors expands to include prevention of irreparable medical or developmental damage.[33,38,42] While many patients with anorexia nervosa express opposition to coercive treatments in the moment, this can be mitigated by positive relationships with caregivers and clinicians, and patients may reverse their opposition during recovery.[35,48] Outcome data also show that a significant portion of patients who do not recover immediately may still recover several years later, which argues against a palliative approach.[29]

Court Cases Involving Anorexia Nervosa

Legal challenges have established that the definition of "gravely disabled" does not require the respondent to be near death, but that the respondent be in danger of serious physical harm because of an inability or failure to provide one's self with the essential human needs of food and medical care.[1] In *In re LaBelle*, 728 P.2d 138 (Wash. 1986), the Supreme Court of Washington rejected the patient-appellants' claim that imminent or present danger must be required for detention, or that a patient be decompensated to the point of "danger of serious harm" at the time of the commitment hearing.[49] The court reasoned that the effect of being placed in the

hospital often eliminates the imminence of one's dangerousness and that maintaining imminent danger as a prerequisite for continued hospitalization may result in the premature release of patients still unable to provide for their health and safety.[49] Furthermore, the court rejected the requirement of a recent overt act to establish danger, reasoning that danger may arise from passive behavior such as an inability to provide for one's essential needs.[49]

While *In re LaBelle* established legal precedent in Washington, how states define "grave disability" as it relates to eating disorders varies. An example in Colorado is *In re P.A.* (unpublished appellate decisions in 2012 and 2013), described by Westmoreland and colleagues.[1] P.A. appealed two trial court decisions determining that she was gravely disabled and required involuntary commitment, which also granted the facility the authority to administer medication involuntarily and place a feeding tube. P.A. alleged that, because her weight had been partially restored in the facility, she was no longer a danger to self or gravely disabled, as she was no longer near death. The Court of Appeals of Colorado upheld both trial court decisions and found that "gravely disabled" does not require a person to be near death, only that the person be in danger of serious physical harm due to their inability or failure to provide themselves with essential human needs of food and medical care.[1]

While *In re P.A.* was similar to *In re LaBelle*, other states have contrasting examples. The Court of Appeals of Iowa in *In re S.A.M.* reversed the Iowa District Court's involuntarily commitment of S.A.M. four months prior.[50] The reviewing court stated that S.A.M.'s weight, risk of metabolic abnormalities, and risk of osteoporosis at the time of commitment could not be considered recent overt acts that demonstrated she was a danger to herself at the time of the appeal.[1,50]

It is important to consider that the significant physical risk to patients with anorexia nervosa may be distinct from the general conditions for involuntary treatment, such as the risk to health and safety of self and others, including the impact upon psychosocial functioning. Compulsory treatment of anorexia nervosa may be counterproductive to patient autonomy in the long term, although there may not be a theoretical reason to assume that patient autonomy is more important in eating disorders than other mental illnesses such as depression and schizophrenia.[35] Given the high risk of mortality in anorexia nervosa compared with other psychiatric illnesses, including a significantly elevated risk of suicide, this difference in approach is not justified by less risk to the anorexia patient.[1,3,4,8,32,35,38,51] Autonomy may not be developmentally appropriate for children and adolescents, especially when considering the compounding impact of malnutrition in anorexia nervosa on development.[2,32–35,42,43] In some cases involuntary treatment may mean that the hospital and treatment providers temporarily assume the parental role when a minor is developmentally and psychiatrically unable to make safe decisions and their guardians are unable to do so alone.

Role of Family in Involuntary Treatment

Even when parents are in favor of treatment, an adolescent's opposition to treatment can be difficult to overcome. Parents deciding not to pursue involuntary commitment can potentially be held responsible for a permissive approach. The case of *United States v. Robertson* involves the tragic death of a 15-year-old adolescent male with anorexia nervosa and bulimia nervosa who resisted his father's continued attempts to get him into treatment, often violently.[52] His father did not pursue involuntary treatment, and the youth died suddenly of cardiac failure due to starvation.[52] The father was initially convicted of negligent homicide, which was then upheld by the Court of Military Review.[52] The U.S. Court of Military Appeals ultimately reversed this conviction, citing insufficient proof that the father's approach of attempting to persuade his son into treatment rather than pursue involuntary commitment was negligent in proximately causing his son to die from anorexia and bulimia.[52]

There are few studies on the involuntary treatment of anorexia nervosa involving children and adolescents, however, and there is limited research on what to do when both the patient and family are opposed to treatment that is emergently necessary.[18,24,33–35,38,44] Literature has demonstrated increased risk of adverse outcomes for adults and adolescents with anorexia nervosa who are discharged prematurely against medical advice.[35,53]

Clinicians may seek to involve the court system when suspecting medical neglect related to an adolescent's anorexia nervosa. In *In the Interest of R.H.*, the Children's Hospital of Philadelphia sought emergency custody of a 15-year-old female with anorexia nervosa because of concerns that she was at serious physical

risk if she left the hospital with her mother.[54] The child had struggled with anorexia nervosa since age nine despite receiving treatment at multiple facilities.[54] The child's mother had requested discharge earlier than advised by treating clinicians on multiple occasions, and each time the child's health had deteriorated rapidly upon discharging to her mother's care, requiring readmission within days due to the child's critical state.[54] The trial court placed the child in custody of the Cumberland County Children and Youth Services, and the mother's later appeal was denied by the Court of Common Pleas of Cumberland County.[54]

Although child welfare laws vary by state, clinicians in the United States are mandated to report medical neglect to a child-protection agency.[55–58] The agency then determines whether to investigate; if an investigation results in a positive finding, it can lead to a temporary or permanent loss of custody and decision-making authority for the legal guardians through court proceedings.[58,59] When a child is in imminent danger, most states require that investigations be initiated within 24 hours.[58] Only 28 states (plus Washington D.C., Guam, and the Northern Mariana Islands) specify a timeframe for completing the investigation or assessment; thus, this can be a time-consuming process that may delay nonemergent treatment and may not be feasible when treating a disorder with high morbidity and mortality risk such as anorexia nervosa if treatment is delayed.[58] Neglect is the most common form of child maltreatment, accounting for 75 percent of calls to child protection agencies and a similar percentage of substantiated claims.[60] Among child abuse fatalities, 75 percent were identified by the U.S. Department of Health and Human Services 2016 survey as the outcome of caretaker neglect.[60] Despite the frequency and grave consequences of neglect, there is no cohesive definition, and it can be difficult to diagnose or prove.[60,61]

Family-based interventions have the most evidence for treating anorexia nervosa in adolescents and target the family dynamics involved in disordered eating through family therapy.[2,8,17,18,62] Inpatient care alone does not treat anorexia nervosa sufficiently in children and adolescents; there is a high risk of rapid weight loss and rehospitalization without an effective outpatient approach to maintain the weight and behavioral changes gained during hospitalization.[18,53] If a minor is removed from parent custody and placed into the child welfare system, the family may be unable to participate in family-based step-down care. As the long-term outcomes of this approach are likely to be poor and add the trauma of removing a minor from the family, involving the child welfare system for medical neglect in anorexia nervosa must be reserved for extreme cases.

Washington's Involuntary Treatment Act, when employed for adolescents, removes mental health decision-making capacity from both patients and their legal guardians for up to 180 days at a time without terminating the guardians' custody. The adolescent is court-mandated to remain in treatment either in the hospital or in a less restrictive setting, if identified. The family is allowed to continue to participate in treatment without the ability to make treatment and disposition decisions. Including the conditional release clause within the Involuntary Treatment Act streamlines the process of transferring from the inpatient psychiatric unit to a specialized treatment facility for eating disorders, thus granting the patient access to a less restrictive treatment setting while still mandating treatment under the authority of the committing court itself.[45]

A similar process exists in Minnesota following two landmark cases involving patients with anorexia nervosa. In 1987, in *In re Kolodrubetz*, the Court of Appeals of Minnesota held that the committing court may not become involved in treatment decisions when the treatment offered is within accepted professional standards.[63] In *In re Kellor* seven years later, however, the Court of Appeals of Minnesota upheld the district court's decision to grant the patient's request for transfer to an out-of-state facility offering a less restrictive treatment option in the absence of an appropriate in-state option, holding that the trial court has wide discretion in determining the least restrictive setting.[64]

With the responsibility of decision-making capacity removed from both patient and family under the Involuntary Treatment Act (without removing the minor from the custody of the legal guardian), the patient and family can shift their efforts to treatment and adopt a common goal of regaining decision-making capacity by sustaining recovery. While the literature on this subject is limited, there is some evidence of positive treatment outcomes associated with the involuntary treatment of adolescents with anorexia nervosa.[24,33,35] It may reduce a patient's guilt and internal blame about accepting nutrition and treatment. It can indicate to the patient the serious nature of the

condition, and it can mitigate the denial that helps maintain the illness. This approach can reduce the pressure placed on parents because they cannot be blamed for treatment by the patient, and it can enable the patient to view parents as supportive. Involuntary treatment reduces the risk of premature discharge, increases the potential for establishing appropriate aftercare, and may reduce readmission rates.[35] A patient's treatment nonadherence and prioritizing of anorexia over life can change with appropriate treatment, even when this treatment is involuntary.[35,52,65]

The case illustration demonstrates the potential benefits of this approach. The patient and guardian demonstrated an inability to make decisions that would lead to recovery from the illness, significantly increasing the patient's morbidity and mortality risk. Although the patient and guardian opposed involuntary treatment, there were nonetheless several positive outcomes of this process. The patient demonstrated markedly improved treatment adherence and insight into her illness following compelled medication treatment. The patient also admitted that it was easier to focus on recovery when not consumed by escaping treatment. The relationship between the patient and her legal guardian evolved from contentious and enmeshed into a supportive one, allowing them to work together in choosing an appropriate long-term treatment option. By the time of transfer to the outside treatment facility, the patient achieved weight restoration for the first time since the onset of illness. The legal guardian's decision-making authority was restored upon the patient's arrival to the outside facility.[45]

Conclusion

While this case illustration may not be generalizable to the majority of adolescent anorexia nervosa cases, it does present a potential approach for treating any chronic, severe, treatment-refractory mental illness when both patient and family do not adhere to treatment recommendations. Washington's unique mental health laws, notably the Involuntary Treatment Act for minors aged 13 and older, offer this possibility without removing a legal guardian's custody, which allows for a seamless restoration of decision-making capacity upon recovery. The need remains for the development of additional novel approaches to treatment-refractory cases for this vulnerable and high-risk population, along with advocacy efforts aimed at expanding the role of the mental health court system to improve treatment access and outcomes for minors.

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